

London School of Economics and Political Science

Sexual Health Policies and Youth

A case study of the Maldives

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Declaration of Authorship

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Abstract

This research examines sexual health (SH) policies and experiences of youth, using the Maldives as a case study. Youth SH is a controversial and under-researched issue in The Maldives, an Islamic state where premarital sexual activity is a punishable offence. This thesis addresses the question: *To what extent, and why is there a mismatch between official Maldivian SH policies, services and data and the lived experiences of youth in Maldives?* It is a mixed methods study involving four research methods and sets of data: i) qualitative in-depth interviews (n=61) with youth aged 18-24 years from three sites within the Maldives; ii) key informant interviews (n=17) with policy actors and service providers; iii) a web-based quantitative survey of Maldivian youth (n=480); and iv) secondary analysis of the Maldives DHS 2009.

There are four main findings from this research, three of which are substantive, and one of which is methodological. Sociocultural and religious factors heavily influenced policymaking, service provision and youth experiences. Contrary to most theocratic states, the SH policymaking process in the Maldives is shaped by policy actors and institutions whose strengths have more sociocultural basis than religious expertise.

Whilst published official data and original secondary analyses of the MDHS suggest that premarital sexual activity among youth is very limited; this thesis finds extensive reporting of sexual activity. This contrast was also reflected in youth's knowledge of STIs- where official data displayed a higher level of awareness than found through in-depth interviews and the web-based survey- and their experience of unwanted pregnancies and abortions, which appear to be under-reported in official data.

Analyses of the web-based survey using the same questions as the DHS show significantly higher levels of reporting of sexual activity, showing a strong modality effect on survey response. Results from the web-based survey demonstrated that if sociocultural factors were removed from questionnaire design (e.g. censorship of certain issues) and administration (e.g., privacy and anonymity- difficult to achieve

in small island communities typical of the Maldives); it is possible to improve response rates and quality of the data.

Finally, this thesis highlights two key characteristics of the relationship between SH policy, services, data and youth experiences in the Maldives. Firstly, youth SH experiences appear to be disconnected from SH policies, services and data. Secondly, there is a mutually reinforcing relationship between official SH data and policies, where restrictive policies dictate the type and extent of data that may be collected, which then reinforce justifications for the current restrictive policies and limited services. Policy implications of this research include identifying and addressing the links between SH policymaking and religious and sociocultural factors, and addressing the subsequent effect on SH policy and services for youth.

بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

In the name of Allah, the Most Gracious, the Most Merciful

وَلَا تَجْعَلُوا اللَّهَ عُرْضَةً لِأَيْمَانِكُمْ أَنْ تَبَرُّوا وَتَتَّقُوا
وَتُصَلِّحُوا بَيْنَ النَّاسِ وَاللَّهُ سَمِيعٌ عَلِيمٌ ﴿٢٢٤﴾

And make not Allah's [Name] an excuse in your oaths against doing good, or acting rightly, or making peace between persons; for Allah is One Who heareth and knoweth all things

Surat Al-Baqarah [2: 224]

Dedication:

To three generations of women I try to emulate:

My mother, Ayesha Moosa

My sisters, Faathin and Sham'aa

My niece, Fareen

And to my father, Abdullah Hameed. There is none such.

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Acronyms

ADB	Asian Development Bank
AIDS	Acquired immune deficiency syndrome
CDE	Commerce, Development and Environment (Pvt Ltd)
DESA	Department of Economic and Social Affairs (UN)
DNP	Department of National Planning
HIV	Human immunodeficiency virus
IPPF	International Planned Parenthood Federation
MHRYS	Ministry of Human Resources, Youth and Sports
MOE	Ministry of Education
MOH	Ministry of Health
MOHF	Ministry of Health and Family
MOJ	Ministry of Justice
MPND	Ministry of Planning and National Development
MYDS	Ministry of Youth Development and Sports
MYS	Ministry of Youth and Sports
NAC	National HIV/AIDS Council
NCB	Narcotics Control Bureau
PAHO	Pan American Health Organisation
PAI	Population Action International
PRB	Population Reference Bureau
RH	Reproductive Health
SHE	Society for Health Education
STD	Sexually transmitted disease
STI	Sexually transmitted infection
SH	Sexual health
SRH	Sexual and reproductive health
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WAS	World Association for Sexual Health (previously World Association of Sexology)
WHO	World Health Organisation

Chapter 1 Introduction

An island that might be paradise to, say, a person on vacation, may at the same time be a prison to an islander seeking opportunities or services not available there (Royle, 2001, p. 22)

The Maldives is one country among many where the need for sexual health services for unmarried men and women is contested.

Globally, there is a reluctance to address the overtly political and culturally-sensitive aspects of sexual health (WHO, 2006) despite gaining global significance as a public health concern in the 1994 International Conference on Population and Development (ICPD) (PAHO & WHO, 2000; WHO, 2006). It is particularly difficult to establish in some Islamic countries under *Shari'a* (Islamic Law) that makes premarital sexual activity illegal and socially unacceptable. At the 2002 Technical Consultation on Sexual Health, it was noted that:

Politicians and health practitioners alike were quick to collude with the pretense that, all over the world, populations divided neatly into the majority – those who were chaste before marriage and faithful within it – and the minority, who were deviant or promiscuous. This essentially political response led to slow reactions and questioning of contemporary assumptions about sexuality and sexual behavior. (Aggleton, 2006, p. 10)¹

The sentiment that the root cause of slow progress in youth sexual health includes a lack of political will and enabling policy environments is echoed often (UN Millennium Project, 2006; WHO, 2006), and the need for national-level prioritisation and commitment has been reiterated at *ICPD+5* (UN, 1999a), *ICPD at 10* (UNFPA, 2004), and (UNFPA, 2009b) *ICPD/15* (UNFPA, 2009a, 2009b). Programmatic recommendations commonly involve taking a holistic approach in addressing sexual health (PAHO & WHO, 2000; UN Millennium Project, 2006), incorporating sexual and reproductive health (SRH) services into mainstream health services (UN Millennium Project, 2006; UNFPA, 2009b), the importance of addressing gender disparities (Pamar, 2006; UN Millennium Project, 2006) and encouraging

¹ “In the absence of Peter Aggleton, this presentation was read by Gary Dowsett” (WHO, 2006, p. 10)

participation of NGOs, faith-based organisations (FBOs) and youth in programme development (UN, 1999b; UN Millennium Project, 2006; UNFPA, 2004; WHO, 2006). However, these too, depend upon political commitment.

Although international agencies, conventions, and donors are established influences on levels of national commitment prioritising sexual health (SH), less is known about country-level influences on national policies. Sociocultural and religious influences are often characterised as inhibiting factors to implementing SH policies and services (Aggleton, 2006; Pamar, 2006; UN, 1999b; UN Millennium Project, 2006; UNFPA, 2004), but there is little understanding of the pathways of influence exerted by sociocultural and religious factors. Improved understanding might increase the range of acceptable approaches to promote SH in some contexts. This research seeks to contribute to such understanding by mapping the ways in which sociocultural and religious factors influence SH policies and programmes for young people, based on a case study of the Maldives.

The Maldives is particularly suited for this research because it is characterised by three factors common to countries that find SH issues challenging to address. Firstly, it is among the Small Island Developing States (SIDS), only graduating from the list of Least Developed Countries (LDCs) in 2011, with high dependence on international donors (UN website, 2011). Secondly, 25% of the total Maldivian population is aged between 15-24 years (MYS et al. 2005)- an age group that presents high risk of sexual ill-health as it usually marks onset of sexual activity, and sometimes unsafe sexual practices (WHO 2006). Thirdly, the Maldives is a wholly Muslim country where premarital sexual activity is illegal and socially unacceptable, making adolescent and youth SH- priority areas in global SH- particularly challenging to address within national policies and programmes.

1.1. Research Question

This research is guided by the following research question:

To what extent, and why, is there a mismatch between official Maldivian sexual health policies, services and data and the lived experiences of youth in the Maldives?

The research question is purposively kept concrete and narrow to avoid broad generalisations. Youth SH in the Maldives is a sensitive issue for a variety of religious and sociocultural reasons, often cited as a reason for the lack of official data and limited services (CDE, 2003; MOH, 1995, 2004a). In order to further our understanding of youth SH in Maldives and to have explanatory power in other similar contexts, it is necessary to identify when, how, and why sociocultural and religious factors influence SH policies and services.

In order to answer this research question, four objectives need to be met:

- Objective 1: Describe the context of sexual health data, policies and services for Maldivian youth
- Objective 2: Describe youth sexual health experiences
- Objective 3: Identify whether there is mismatch between official sexual health data, policies and services and youth experiences of sexual health
- Objective 4: Analyse the reasons for these differences between official sexual health data, policies and services, and youth experiences of sexual health

The first two objectives are necessary context-setting objectives, given how Maldivian SH remains largely under-researched (Chapter 2). Although the development of SH programmes in the Maldives is documented, there is no detailed analysis of the actors and agencies involved in Maldivian youth sexual health policies and services. By meeting Objective 1, it will be possible to not only identify sexual health actors but also map the ways in which they interact during the policy process. Objective 2 is necessary in order to establish the lived experience of Maldivian youth with respect to sexual health, drawing on perspectives from both married and unmarried youth. Objectives 3 and 4 allow comparison of official and youth narratives so that divergences may be identified and examined, and their possible causes established.

1.2. Overview of thesis

In the following chapter, I review the relevant literature, situating Maldives in the global context, both in terms of SH and other Islamic policy contexts. In chapter 3, I describe the research design and the different methods used for this research.

Chapter 4 establishes the Maldivian SH policy and service context within which Maldivian youth experience SH issues. The analysis is presented in 3 parts. First, I provide an overview of how the SH policies and services in Maldives have evolved in the past 30 years. Secondly, I establish a topology of the different stakeholders involved in Maldivian youth SH policy and services, identifying their roles in shaping Maldivian SH, their relationship to each other, and their strengths and limits. Finally, I describe the outcome of these relationships and their evolution that have led to current SH services and policies for youth in Maldives.

In chapter 5, I explore Maldivian youth's SH issues, comparing the official data that is made available to policymakers and service providers with youth narratives collected using in-depth interviews and a web-based survey. These two sets of data - official data and youth narratives - are compared in parallel, under six broad themes of SH: sexual behaviour, contraception, STIs and HIV/AIDS, unwanted pregnancy, abortion, and sex education. For each theme, I explore young people's reports of their SH experiences, attitudes and perceptions, both their own and that of their peers, drawing from both quantitative and qualitative evidence.

In Chapter 6, I build on youth and policy analyses, and drawing together the evidence from the 2009 Maldives Demographic and Health Survey (MDHS), my web survey, in-depth youth and key informant interviews and policy review, this chapter will achieve three things. Firstly, I describe whether the different components of youth sexual health in the Maldives, policy, services, and official data converge or diverge from young people's sexual health experiences. Secondly, I explore influences that have shaped and continue to shape these convergence and divergence and examine the pathways of their influence. Finally, I revisit the research question- *To what extent, and why, is there a mismatch between official Maldivian sexual health policies, services, and data and the lived experiences of youth in the Maldives?*

In chapter 7, I discuss the implications and limitations of the research, examining whether or not the findings may be applicable to similar contexts and thus offer insight on how and why sociocultural and religious factors might influence youth sexual health policies.

Chapter 2 Context

In this chapter, I contextualise this research in five parts. First, I describe the epistemological perspective from which I approach this study and review the literature. Secondly, I examine what is meant by *sexual health*, exploring the ways in which, and why, the concept has evolved, and the factors that influence the different interpretations of sexual health. Thirdly, I narrow the focus to sexual health of young people, describing why youth sexual health is important and challenging. Then, I describe sexual health research in Islamic settings, examining whether and why Islam poses additional challenges to youth sexual health policies, programmes and research. I contextualise the Maldives in relation to other Islamic countries regarding the ways in which religion influences policies, particularly sexual health policies. Lastly, I provide an overview of the geographical, demographical, sociocultural and political context of the Maldives, the setting of this case study.

2.1 Epistemological perspective

This study is conceptually based on interpretivist epistemology, which acknowledges the value of subjective knowledge and meaning, and takes the ontological position of social constructionism (Cameron, 2007). Although this stance is often criticised by positivists for not providing a way of assessing the knowledge value of interpretations, in the same way falsification does for positivists, it recognises local knowledge (Cameron, 2007). There are three main reasons why this framework was chosen for this study.

Firstly, the social constructionist approach is characterised by the recognition that what we deal with in the world is not an unmediated reality or truth but rather a reality that has been constructed and determined by social processes (Gill, 2000). Thus, social constructionism lends itself particularly well to this research as it allows the examination of two conflicting narratives (official narratives versus youth narratives) that reflects the constructed reality of two groups (policy participants versus youth), but have been determined by social processes common to both, the setting of the Maldives.

Secondly, policies and processes are subject to deconstruction and interpretation (Lejano, 2006), which may be used to break down the policymaking process, allowing for the identification of factors that influence and determine this process. Moreover, interpretation is based on the researcher's background, their cultural perspectives, shaped by their own personal experiences and understanding (Creswell 2009), and this allows me to take my positionality into consideration throughout the research process.

Thirdly, social constructionism affords the use of social constructs. In addition to examining the sociocultural and political influences, this study also explores whether religious influence on policy and practice is best understood as a social construct. It is more than inherent features of Islam and values that lead to its influence on SRH issues. It is also in the way religious values are constructed (and perhaps manipulated) in the social arena by groups of people with varying knowledge and interests.

2.1.1. Analytical framework

In evaluating possible choices for an analytical framework for Maldivian youth sexual health, I considered the malleability of elements associated with each theory or framework. The policy analysis done for my Master's dissertation involved the use of Hogwood and Gunn's policy process framework (Hogwood & Gunn, 1984). Although the results of this analysis explained how youth SRH policies in the Maldivian context most likely digressed from the issue definition stage because of the highly value-laden and politicised nature of SH, I was not able to glean further explanations on how or why it was so politicised, or discern any varying stances among the policy actors. Thus, the framework for the current research needed to not only account for the policy process of negotiation but also the language used and the actors involved.

A focus on the individual actor suggests that public policies are shaped by individual actors who are guided by their self-interest to achieve a result to their best advantage (Public Choice Theory) or to maximise social welfare (Welfare Economics) (Howlett & Ramesh, 1955; A. Schneider & Sidney, 2009). At the other end of the spectrum, institutions shape policies by virtue of their capabilities and objectives (Neo-

Institutionalism and Statism) (Howlett & Ramesh, 1955). While there are nuanced versions of either side, they do not cover the balance of individual and institutional power my previous research suggests is characteristic of the Maldivian SRH policy subsystem.

The analysis of Maldivian SRH policy and its contributors (Chapter 4) uses the social constructionist approach to Social Problems Theory. In this section I argue that this conceptual framework is appropriate for this study of Maldivian SRH for its attention to both the definition of a social problem and the identification of those who define it as a social problem.

Developed by Blumer (1971) and Spector and Kitsuse (1973), this approach differed from other understandings of social problems in that the definition is subjective (Best, 1993). This radical redefinition shifted the emphasis from studying the social situation (that was considered problematic) to the process of defining and identifying a social problem and the groups that do so (Best, 1993). Applied to the current research, this would mean exploring who was involved in identifying sexual health of Maldivian youth as a social problem, and examining the process that led to it.

First- is it a social problem? Blumer, defines a social problem as “products of a process of collective definition” (1971:298 in Schneider 1985) whereas Spector and Kitsuse include people’s definitional activities as part of the social problem (J. W. Schneider, 1985), while Fuller and Myers aptly states “social problems are what people think they are” (Fuller & Myers, 1941, p. 25). As I discuss in Chapter 4, document review shows that youth sexual health is considered a problem- for example, what is to be done about nonmarital pregnancies among young people? Although this concern appears to be very functionalist- that is, what is to be *done* about it- such an approach does not suit this research. According to the functionalist approach, “a social problem exists when there is a sizable discrepancy between what is and what people think ought to be” (Merton 1976:7 in Miller and Holstein, 1993). But what is *what is*- how do we know what is and what ought to be? A social constructionist approach takes into consideration the cultural ideals and shared constructions of knowledge (Miller & Holstein, 1993), which is imperative in

researching sexual health in a context where sex has religious and cultural connotations.

One major criticism that unsettled and somewhat split the social constructionist approach to social problems is the challenge to the accuracy of claims-makers (those who initially claim a situation as problematic) (Miller & Holstein, 1993; J. W. Schneider, 1985). Strict constructionists (such as Spector and Kitsuse) reject this critique and consider it unnecessary to evaluate the accuracy of claims-makers' definition of a social problem (Best, 1993; Miller & Holstein, 1993)- for example, it is unnecessary to evaluate whether there are cases of nonmarital pregnancies among youth. Adopting this stance seldom has use within policy contexts - policy change (i.e., an attempt to solve a social problem) often requires some form of attempt to verify claims.

In contrast, contextual constructionists (such as Best) maintain that there is an objective, empirical reality to a social problem- although social constructionist research must accept that what it will capture is a social construction of this 'reality', it is possible to evaluate claims-makers' definitions using statistical and other information on the conditions of this problematic situation (Best, 1993; Miller & Holstein, 1993). Thus in order to have policy relevance, this stance is better suited for the current research.

A similar criticism was made in regards to the role of the social analyst examining the definitional activities of social problem participants, that there was a tendency to consider participants' definitions as misinterpretations of the 'facts', having a 'superior' access and entitlement to identify participants' 'errors' (Best, 1993). However, this is countered by the use of reflexive writing forms where "such texts are organised to remind readers that authors are aware of the rhetorical devices that they use to construct textual realities, and that they offer understandings that are partisan and potentially contestable by others" (Miller & Holstein, 1993, p. 13).

The social constructionism approach allows me to recognise my role in the definitional activities in this research, indeed even the point at which I decide to apply the Social *Problems* Theory. The word 'problem' has the power to orient the

analyst to a certain route where the social condition is viewed only as problematic, which would affect my enquiry, and therefore impact the results. Recognising this, I base my decision to use the theory on how document review on Maldivian SRH consistently identify youth SH issues such as nonmarital sexual activity and pregnancies as a social condition that needs something to be done about it. And according to Kitsuse and Spector, “[t]he existence of social problems depends on the continued existence of groups or agencies that define some conditions as a problem and attempt to do something about it” (1973, p. 415).

Joseph Schneider’s review of the social constructionist approach to Social Problems Theory sparked a number of studies applying said approach (Best, 1993). In it, he describes a four-stage natural history model suggested by the works of Spector and Kitsuse, Blumer, Fuller and Myers, that allows the examination of the causes of social problems and how they are defined, redefined and sustained (J. W. Schneider, 1985). In stage one, collective claims are made about a social situation that some groups find undesirable or in need of remedy. Stage two is initiated when a government or official agency recognises this situation as a social problem and charges it as the mandate of some institution. Stage three follows, where the legitimisation of the social problem sets off a new wave of definitional activities (redefinition). It culminates in stage four where the original claims-makers find it difficult to work within the ‘system’ constructed in previous stages, and they attempt to develop alternative remedies to the social problem (J. W. Schneider, 1985).

In Chapter 4, I apply this model on the Maldivian SH context, demonstrating that *sexual health* underwent many changes to evolve into youth SRH. Thus, several ‘social problems’ were identified by groups of people and it is by using Social Problems Theory that I am able to examine this process of definition, its participants and the most recent ‘product’.

2.2. Sexual Health

In this section, I establish the scope of this research by examining two aspects of the concept of sexual health- how sexual health has evolved in the way it is defined, and how it is operationalised with respect to reproductive health.

The first internationally-accepted definition was presented by the WHO in 1975:

Sexual health is the integration of the somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love. (WHO, 1975)

Based on reviews of sexual health by Giami (2002) and Edwards and Coleman (2004), I identify five instances where *sexual health* was redefined. Firstly, the above definition was formulated among health professionals convened by the WHO in 1974 and revisited in 1983 to explore how sexology could be incorporated into WHO's programmes on family planning and sexuality (Edwards & Coleman, 2004). Giami remarks upon how the 1975 report devoted much to sexology (the scientific study of human sexuality, sexual interests and functions) its methods and therapeutic goals and points out that the leading experts at this consultation were sexologists who soon thereafter formed the World Association of Sexology (WAS) that continues to work closely with the WHO (Giami, 2002). The 1983 consultations reaffirmed the 1975 definition of sexual health but emphasised that *sexual health* cannot be understood without an understanding of *sexuality*¹, which also served as a way of separating the biological aspects of sex from *sexual health* (Edwards & Coleman, 2004).

The second redefinition came in 1987 with a WHO report that effectively retracted statements from previous consultations; *sexual health* was not considered as a public health issue but "as an issue relating to the contradiction between individual choice and cultural values" (Giami, 2002, p. 14). Where the 1975 report highlighted the need to overcome religious and cultural constraints to sexual health, the 1987 report urged that sexual health programmes need to be taken within these constraints and not against them (Giami, 2002). Moreover, the report argued against defining *sexual health* as such a normative definition would exclude some people on the basis of being sexually unhealthy (Edwards & Coleman, 2004).

¹ The corresponding definition of *sexuality* was: "an integral part of the personality of everyone: man, woman, and child. It is a basic need and an aspect of being human that cannot be separated from other aspects of life" (Langfeldt and Porter, 1986, cited in Edwards, 2004).

The third main shift in the conceptualisation of *sexual health* came over a decade later in 2000 from technical consultations between the WHO, Pan American Health Organisation (PAHO) and the World Association for Sexology (WAS) where experiences from the HIV/AIDS epidemic spurred on the need for measurable indicators of sexual health (Edwards & Coleman, 2004; Giami, 2002). The resulting PAHO/WHO/WAS definition of *sexual health* explicitly stated that achieving *sexual rights* is conditional to achieving *sexual health* (PAHO & WHO, 2000). Further links were made to *responsible sexual behaviour* and *sexually healthy society* so that *sexual health* espoused both individual and collective responsibility (Giami, 2002).

The fourth and fifth instances where *sexual health* was reconceptualised involve a difference in emphasis given to the concepts now linked to *sexual health*- *access to information and services* and *responsible sexual behaviour*. In 2001, the then US Surgeon General released a *Call to Action to Promote Sexual Health and Responsible Sexual Behaviour* that emphasised the concept of *responsible sexual behaviour* (Edwards & Coleman, 2004) but defined it differently to the 2000 PAHO/WHO/WAS definition. Where PAHO/WHO/WAS emphasised free and responsible sexual expression, the US Call to Action was based on an individual's ability to make appropriate choices in accordance to community values and norms, for example- abstinence (Giami, 2002). In contrast, the 2001 UK National Strategy for Sexual Health and HIV disassociates *sexual health* from *responsible sexual behaviour*, making no mention of appropriate choices or abstinence. Instead it emphasised informed choice and the duty of the health system to prevent negative outcomes of sexual health by providing access to information and services (Giami, 2002).

Having recapped the major changes to the understanding of *sexual health*, consider the most recent definition provided by the WHO in 2002:

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free from coercion, discrimination and violence. For sexual health to

be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (WHO, 2006, p. 5)

This definition that contains “a bit of everything” (Aggleton, accessed 10 June 2012) has not changed in over a decade although it continues to be officially labelled a ‘working definition’ (WHO, 2006). This broad and all-encompassing definition has been criticised as being “somewhat utopian” based on which hardly anyone could be classified as ‘sexually healthy’ (Sandfort & Ehrhardt, 2004, p. 183). This is similar to the criticism aimed at the WHO classic definition of *health* (which closely reflects the wording of the *sexual health* definition): “a state of complete physical, mental and social well-being and not merely the absence of disease” (WHO, 1948, p. 1). Saracci (1997, cited in Edwards & Coleman, 2004) is among the critics who challenged the utility of such a definition, remarking that it presents an ideal state that may never be achieved. Conversely, other experts such as Sandfort and Ehrhardt argue that these definitions present a goal to aim for, rather than a description of a current state (Sandfort & Ehrhardt, 2004).

Despite the drawback of researching a broadly encompassing, potentially utopian concept, I use the above WHO (2002) definition of sexual health in this research. This is largely because it shifts the emphasis from individuals to macro-level social systems and it implies that the environment needs to be free from coercion, discrimination, and violence. Seidman calls it a ‘communicative sexual ethic’ as opposed to a normalising ethic that focuses on the sex act (Edwards & Coleman, 2004). Although countries such as the UK, in its National Strategy for Sexual Health and HIV, have been described as being devoid of moral values attached to sex and sexual health (Giami, 2002), countries governed by Islam cannot divorce sexual health from morality which makes their definition unsuitable for a case study of a theocratic country such as the Maldives.

Definition changes and challenges notwithstanding, *sexual health* became “fashionable” (Sandfort & Ehrhardt, 2004, p. 182) during the 1990s- Sandfort and Ehrhardt (2004) show that references to *sexual health* in academia rose substantially in the 1990s. However, much like the review by Giami (2002) and Edwards and Coleman (2004), Sandfort and Ehrhardt (2004) do not reflect the close linkages

between *sexual health* and *reproductive health*, linkages that I would argue are central to how *sexual health* is understood and operationalised today.

This aspect was explored by Lottes who notes the common use of the term *sexual and reproductive health* since the 1994 International Conference on Population and Development (ICPD) (Lottes, 2000). The 1994 ICPD was instrumental and revolutionary (Margolis, 1997) in establishing the importance of sexual and reproductive health, providing the impetus to consolidate SRH programmes (WHO, 2010). With 179 countries ratifying a 20-year plan to improve SRH programmes (Glasier, Gülmezoglu, Schmid, Moreno, & Van Look, 2006), the 1994 ICPD promoted the understanding of *sexual health* as a component of *reproductive health*.

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so... Reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and wellbeing by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases (UN, 1994a, p. 40).

This inextricable link forged between *sexual health* and *reproductive health* by the ICPD is often commented upon (e.g., Lottes, 2000; Girard, 2003; WAS, 2008; WHO, 2010). Here I explore this link, identifying two core tensions that emerged. First, whether or not *sexual health* is a part of *reproductive health* instead of vice versa. Second, whether or not *sexual and reproductive health* should be separated into *sexual health* and *reproductive health*.

Regarding the first tensions, various challenges have been made to the ICPD understanding of *sexual health* as part of *reproductive health*. For example, Lottes (2000) points out that sex can have many purposes and reproduction and procreation is just one of them. This is echoed by the WHO that states “since most sexual activity is not directly associated with reproduction and is of relevance throughout

the lifespan, sexual health may be considered as a broader concept” (WHO, 2010, p. 5) as well as the WAS that claim that sexual health is not only independent of an individual’s reproductive years but also sexual orientation and whether or not individuals reproduce (WAS, 2008). In the journal *Choices* published by the International Planned Parenthood Federation (IPPF) European Network, Girard (2003) writes:

...this definition makes sexual health a part of reproductive health than the reverse. The ICPD was about population, so it is therefore not surprising that reproduction is a cornerstone of its Programme of Action. Nevertheless, in a perfectly coherent environment, sexual health should be the overarching category and reproductive health a subset” (Girard, 2003, p. 4)

It would appear then that most of the key players involved in conceptualising and promoting sexual health – the WHO, WAS, IPPF – express dissatisfaction with the ICPD definition of sexual health that categorises it as a component of reproductive health. The UNFPA and other ICPD-based documentation (e.g. UNFPA 2004, 2006, 2009; UN Millennium Project, 2006) use the term *sexual and reproductive health (SRH)*, which raises the second debate- should *SRH* be separated into *SH* and *RH*? This disagreement has received less attention, but I argue that this lies at the core of operationalizing sexual health in policies.

Lottes argues that a distinction between *RH* and *SH* needs to be made. That *RH* covers more medical problems related to pregnancy, childbirth, and reproductive rights, and *SH* covers broader issues on sexual behaviour, identity and knowledge, however this dissociation might be problematic because of the number of overlapping issues (e.g. STIs that cause fertility problems) (Edwards & Coleman, 2004; Lottes, 2000). This begs the question- is it necessary to separate *SH* and *RH*?

Ketting claims that being linked to *reproductive health* gives *sexual health* legitimisation and makes it less controversial (Ketting, 1996) - this sentiment is echoed by the WAS (WAS, 2008) as well as the WHO:

Since the ICPD meeting, the term “sexual and reproductive health” has become standard in most parts of the world, although in some

regions there are cultural and political sensitivities that limit use of the term *sexual health*, and where the term *reproductive health* is interpreted and made operational as one that implicitly includes sexual health-related issues” (WHO, 2010, p. 5)

It is worth considering if shrouding *sexual health* within *reproductive health* or *SRH* is necessarily negative. Arguments to separate the two concepts include the fact that it negates the purpose of defining *sexual health* in the first place. A number of discussions and negotiations were made to formulate a definition of sexual health that not only espoused freedom from negative outcomes such as diseases and infirmity but also freedom for sexual expression and fulfilment (Edwards & Coleman, 2004; PAHO & WHO, 2000; Sandfort & Ehrhardt, 2004; WAS, 2008; WHO, 1948, 2006). If *SH* is absorbed into *RH* to avoid controversy surrounding sexuality, what remains is a negative definition of *sexual health* in the avoidance of disease, which is arguably easier to track and measure than sexual fulfilment, for example (WAS, 2008), but this does not capture holistic idea of *health* being not the mere absence of disease but a state of complete physical, mental, and social wellbeing.

As Helfferich explains, the aim of having definitions is “not to describe a real state of health, but to formulate an ambitious ideal that will encourage governments to create conditions conducive to health” (Lottes, 2000, p. 13). With the lack of a clearly defined *sexual health* do governments know what conditions they should create? According to the WHO, it detracts from the importance of sexual health issues (WHO, 2010), so does it reduce the importance of sexual health programmes from reproductive health programmes? Failing to define the issue at the initial stages of the policymaking process could derail the impact and outcome of the policy and any subsequent programmes (e.g. Hogwood & Gunn, 1984; Spicker, 2006). Ketting (1996) claims that this does indeed happen in service provision- the combined term *SRH* detracts from effective and appropriate service provision because the nature of *SH* problems and *RH* problems are very different. There is also the possibility that hiding *SH* in *SRH* could be affecting more than service provision because as Giami (2002) points out:

...a clearly stated concept of sexual health may be useful, because such a concept offers a framework for thinking about goals to be accomplished, and issues to be explored. It can help organise research and action. It can also offer a framework for evaluating ongoing investigations and policies. (Giambi, 2002, p. 184)

PAHO's claim that an ill-defined *sexual health* is used as a "euphemism for information on sexually transmitted infections" and sometimes used "to promote a narrow approach to education on reproduction" (PAHO & WHO, 2000, p. 9) indicates a more disingenuous use of the combined term *SRH*.

On the other hand, if combining the two terms gives sexual health programmes broader impact (Lottes, 2000) - a pragmatic advantage to operationalising *sexual health*- is it necessary to identify and force this separation? On its own, *sexual health* draws attention to the non-procreative aspects of sexuality, which, Giambi argues, was largely legitimised when *sexuality* was entered into public health discourse as a result of availability of oral contraceptives, the HIV epidemic, and the sexual revolution (Giambi, 2002). However, Aggleton points out that since the HIV epidemic, there has been a drive to identify and enumerate 'risky behaviour' which allows some sexual behaviour to be labelled as risky and some not (Aggleton, 2006), adding more layers to the social control of sexual behaviour by categorising some as sexually legitimate. Thus, despite the advancements of sexual rights made by the sexual revolution, it is still debateable as to "who is, or has a right to be, sexual, under what conditions, circumstances and context, and for what purpose or motivation?" (Pamar, 2006, p. 6). Do young people have this right?

Young people's sexuality conflicts with many religious and societal values (Giambi, 2002). While sexuality is a moral issue in most contexts (Giambi, 2002) that makes *sexual health* uncomfortable for many people (Glasier et al., 2006) and taboo especially at public policy levels (WAS, 2008), adding 'young people' magnifies it (Ingham & Mayhew, 2006). I address this in the following section.

2.3. Sexual health of young people

In this section, I discuss why it is challenging and important to study youth sexual health, with reference to the epidemiology of sexual ill-health among young people.¹

Approximately 18% of the world's population is between ages 15 and 24 years (UN & DESA, 2011). According to the WHO, adolescents (10 to 19 years) and youth (15 to 24 years) are particularly susceptible to sexual ill-health in all countries (WHO, 2010). This is mainly because adolescence is often marked by initiation of and experimentation in sexual activity (Pamar, 2006), and often unsafe, which exposes them to the risk of sexual ill-health (Coleman, 2006). It is particularly important to reduce this risk because sexual health during adolescence and youth can impact sexual health later in life (Coleman, 2006; Pamar, 2006). As a result, young people's sexual health is often identified as a separate target necessary to address to reach SRH programmatic goals nationally and internationally (Coleman, 2006; PAI, 2002; SHE website, 2011; UN, 1994a, 1999b; UN Millennium Project, 2006; UNFPA Maldives website, 2010; UNFPA website, accessed 29 May 2012; WHO, 2006; WHO, UNFPA, & UNICEF, 2006). It is unclear whether separating *youth sexual health* serves to raise its profile and draw more attention or whether it implies that key components of *sexual health* are not applicable to *youth sexual health*.

According to the WHO Framework for Action (WHO, 2010, p. 6) (which also highlights youth sexual health in a separate point), the key elements of sexual health include the following:

- STIs and Reproductive Tract Infections (including HIV)
- unintended pregnancy and safe abortion
- young people's sexual health and sexual education
- sexual dysfunction and infertility
- violence related to gender and sexuality (including Female Genital Mutilation)
- sexual orientation and gender identity
- mental health issues related to sexual health
- the impact of physical disabilities and chronic illness on sexual well-being
- the promotion of safe and satisfying sexual experiences

¹ I use the terms 'youth' and 'young people' interchangeably

One drawback of a holistic definition of sexual health is that it is too broad and cross-disciplinary, making it difficult to incorporate all the elements into one piece of research. Therefore for this research, I exclude some of the elements listed above, based largely on a lack of expertise. I am not equipped to study effect of mental health issues, physical disabilities and chronic illness on sexual well-being and therefore will exclude those elements from this research. Similarly, I do not have a background in sexology to explore satisfaction of sexual experiences or sexual identity. Infertility is in decline for most countries (WHO, 2010) and while sexual dysfunction has been shown to affect between 8% and 33% of the adult population (WHO, 2010), there are no worldwide data to indicate it is an important condition among young people. On the other hand, sexual violence is common and multi-country studies show that 15-71% of women have experienced sexual violence by an intimate partner, with young women particularly vulnerable to sexual coercion (WHO website, 2011a). However, the lack of data on sexual violence in the Maldives limits quantitative exploration and I do not have the sufficient training or expertise to probe experience of sexual violence in qualitative interviews. I now provide an overview of the remaining elements of sexual health, explaining why they are particularly relevant to young people. Table 1 summarises worldwide statistics of selected sexual ill-health and shows the proportion of those occurring among young people (UNICEF, 2011).

Indicators	All ages worldwide	Youth (aged 15-24) worldwide
Adolescent birth rate ¹ (per 1000 women aged 15-19 years)	N/A	50.5
Adults and children living with HIV	34 million ²	5 million ³
HIV prevalence (%) ⁴	0.8	Male 0.3 Female 0.6
Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS (%) ⁵	N/A	21
New cases of the 4 curable STIs (gonorrhea, syphilis, chlamydia, trichomonas) per year ⁶	448 million	Largest proportion of STIs believed to occur to youth aged under 25 ⁷
Unintended pregnancies per year ⁸	80 million	-
→Proportion terminated by induced abortion ⁴	40 million	7.6 million ⁹
Unsafe abortion rate (per 1000 women aged 15–44 years) ⁴	14	N/A
HIV/AIDS burden (DALYs) (% of total Global Disease Burden)	3.8	-
STDs excluding HIV (DALYs) (% of total Global Disease Burden)	0.7	-
Abortion (DALYs) (% of total Global Disease Burden)	0.5	-

Table 1: Worldwide statistics of adverse effects of sexual ill-health and the proportion of those occurring among young people

Unintended pregnancies (including unwanted and mistimed pregnancies) account for 40% of pregnancies annually and are disproportionately common among young women (WHO Europe, 2011). This vulnerability of young women to sexual ill-health is most strongly linked to two factors- vulnerability to sexual violence and contraceptive use and access (Coleman, 2006; WHO Europe, 2011). Societal factors such as poverty, lower levels of education and male-dominant norms- which are common in many developing countries- expose young women to sexual coercion which could lead to unwanted pregnancies (WHO, 2006). Although some

¹ MDG Indicator 5.4: Per 1000 women aged 15-19 years (WHO Data Repository)

² 2009 statistics (UNAIDS, 2010)

³ (UNICEF, 2011)

⁴ (UNAIDS, 2011)

⁵ MDG Indicator 6.3 (Statistical Annex: Millennium Development Goals, Targets and Indicators, 2011)

⁶ (WHO website, 2011b)

⁷ (Bearinger, Sieving, Ferguson, & Sharma, 2007)

⁸ Per 1000 women aged 15–44 years, (PRB, 2011)

⁹ (Glasier et al., 2006)

pregnancies occur within the context of marriage and 30% of girls in developing countries are married by 18, early pregnancies are the leading cause of death among girls 15-19 (WHO, 2011). However, preventing early marriage does not guarantee unintended pregnancies as late marriage coupled with fall in average age of menarche lengthens the period of exposure to premarital pregnancies which are socially unacceptable in many developing contexts (WHO et al., 2006).

Along with negative effects on their life-courses (e.g. withdrawal from education), young women are often faced with stigma associated with premarital pregnancy, resulting in isolation from family, exclusion from community, and lack of marital prospects which in turn impacts on their social and economic status (Coleman, 2006; Pamar, 2006). In order to avoid guilt and shame of premarital pregnancies, many young women seek abortion (Coleman, 2006). On a global scale, it is estimated that 20 million unsafe abortions¹ are performed each year, and almost 19 million take place in developing countries (WHO Europe, 2011). According to Glasier and colleagues, over 40% of unsafe abortions worldwide are performed on young women under the age of 25 (Glasier & Gülmezoglu, 2006). Young women are also more likely to seek abortion at a later stage of pregnancy due to denial, fear of exposure, or lack of access to help, amplifying the risk of negative outcomes that include death (WHO et al., 2006). Unsafe abortion rates are strongly linked to legality of abortion in that country (WHO, 2009) - using South Africa as an example, Grimes and colleagues remark upon a 91% drop in abortion-related from 1994 to 1998-2001 once the country's abortion policies were revised to legalise abortion (Grimes et al., 2006). However, they caution that the impact of revising abortion laws does not address the demand for abortion but rather reduces clandestine abortions shifting the burden of abortion-related morbidity (Grimes et al., 2006). Such direct effects of SRH policy is uncommon, especially on youth populations and case studies from developing countries show that even if abortion is permitted, lack of knowledge and shame often prevent young women from seeking safe and timely abortions (Brown, Jejeebhoy, Shah, & Yount, 2001). Young people's access to legal abortion services can be constrained by economic factors such as financial dependence on family, and

¹ *Unsafe abortions* is defined by the WHO as “a procedure for terminating pregnancy carried out by attendants without appropriate skills, or in an environment that does not meet minimum standards for the procedure, or both” (WHO Europe, 2011, p. 6)

sociocultural factors such as fear of being labelled as ‘failing as a real woman’ (for choosing abortion) by community (Brown et al., 2001). Many of these barriers are applicable to young people’s access to contraceptive services.

According to DHS comparative reports, with the exception of youth in Sub-Saharan Africa, knowledge of at least one modern contraceptive method is nearly universal among young people (Khan & Mishra, 2008). Despite this widespread knowledge, lack of modern contraceptives is attributed to 0.3% of deaths worldwide (WHO, 2009). Analysis of over 30 WHO case studies in Africa, Asia and Latin America show that condom use is erratic among young people in developing countries and abortion-seekers report incorrect condom use (Brown et al., 2001). Young people aged 15-19 consistently report more contraceptive failure than women aged 20-49 (Advocates for Youth, 2011), suggesting a gap between youth knowledge of contraceptive methods and correct use.

Young people’s access to contraceptive services has received much attention since the ICPD identified the need to improve young people’s access to high quality, youth-friendly health services (UN, 1999b; UNFPA, 2009b; WHO, 2010; WHO et al., 2006). The 1994 ICPD call for universal access to SRH services emphasised a more holistic, rights-based approach rather than a needs-based approach. This involves a shift in requiring programme rationales to be based on individual’s rights to services rather than prevalence (or other population-level data) to providing these services (WHO, 2010). Integrating sexual health services with other health services such as maternal and child health services have been promoted by the UNFPA as a way of meeting the need for accessible and acceptable contraceptive services (UN, 1999b), and has achieved success in some countries (e.g., Malaysia, Cambodia and regions in India) in lowering rates of unintended pregnancies (WHO, 2010). However, most healthcare systems still tend to reflect vertical programmes (where services are provided alongside each other), and insufficient multisectoral collaboration has hindered integration of services (WHO, 2004). Moreover, many WHO member countries argue against the necessity of youth-specific services and information campaigns, and frequently cite lack of funds and resources- this is met with criticism from sexual health experts who say what is lacking is the necessary political will to address youth sexual health (PAI, 2002; WHO, 2006).

According to the UNFPA, about 500,000 young people- mostly women- get infected with STIs (excluding HIV) every day (UNFPA website, accessed 26 June 2012). Moreover, nearly half of new HIV infections occur among young people, with young women more at risk than young men in addition to biological vulnerability, this is also due to societal norms that expose young women to sexual coercion and early sexual initiation, lower their ability to negotiate condom use, and economic barriers to seeking services (WHO et al., 2006). Addressing STIs and HIV/AIDS even in the context of youth sexual health, has been relatively less problematic than unintended pregnancies in the policy arena. The disease-oriented approach and focus on evaluation and allocation methods (e.g. DALYs - disability-adjusted life years) favour prioritization of programmes targeting HIV/AIDS and STIs as opposed to unwanted pregnancies, as the latter is not a ‘disease’ (UN Millennium Project, 2006). However, there have also been differences in priority given to STIs programmes compared to HIV/AIDS programmes. Despite having several commonalities, including mode of transmission, HIV/AIDS and STI programmes have not always been integrated (UN Millennium Project, 2006). The devastating rate and magnitude as well as the successful advocacy efforts linking AIDS to poverty, led to HIV/AIDS being identified as a separate Millennium Development Goal while universal access to SRH services failed to feature as an original MDG (Glasier & Gülmezoglu, 2006). This led to a decrease in funding for non-AIDS sexual health issues in 2006 because at the time of the ICPD, 70% of funding for SRH was linked to HIV/AIDS (Glasier & Gülmezoglu, 2006). The divergence in funding was, however, minimised when ICPD financial targets were harmonized with MDG (UNFPA, 2009a). Although the UN has attempted to rectify the divergence between STIs and HIV by explicitly drawing links between the MDGs and ICPD targets (UN Millennium Project, 2006), Glasier argues that while “some governments have overcome their distaste and confronted the HIV/AIDS crisis”, other STIs considered “less glamorous” -remain neglected (Glasier & Gülmezoglu, 2006, p. 1551).

Providing young people with sexual health information is one of the key components in global SH guidelines for achieving good sexual health for youth (PAI, 2002; UN, 1994a, 1999a, 1999b; UNFPA, 2009b; UNFPA website, accessed 29 May 2012; WHO, 2010; WHO et al., 2006). Sexual education in and out of schools on issues

that include sexuality, contraception, STIs and HIV/AIDS are generally successful in improving awareness of risk and risk reduction strategies as well as intention to practice safer sex (Wellings et al., 2006). Despite this, it is often debated whether or not sex education in school equips young people with the knowledge to avoid the consequences that have been thus far powerful deterring factors (pregnancy, STIs), thereby hastening sexual debut (Remez, 2000; Wellings et al., 2006). Few countries have national education policies that mandate comprehensive sex education in schools (UNFPA, 2006; Wellings et al., 2006). The abstinence-only programmes that persist in many US states are one example despite being shown as a violation of the Convention on the Rights of Children (CRC) in obstructing the child's right to, and not be denied, information to protect their health (Ingham & Mayhew, 2006).

Abstinence is often not an option for poor women and girls who have no choice but to marry at an early age. Being faithful will not protect a woman whose partner is not faithful. And using condoms is not a decision that a woman can make by herself... (Gates, in Glasier & Gulmezoglu 2006, p.1551)

This quote from Bill Gates' speech at the XVI International AIDS Conference in Toronto, 2006 (quoted in Glasier & Gulmezoglu 2006) criticises a common approach to youth sexual health. The ABC strategy- *Abstain, Be faithful, use a Condom*-promoting behaviour change of young people was welcomed as a shift away from exclusive focus on treating SH issues (WHO, 2010) but it fails to acknowledge the broader factors that contribute to youth vulnerability to sexual ill-health. This is reminiscent of the disproportionate focus on risk compared to vulnerability that was characteristic of some of the early responses to HIV/AIDS and STIs (WHO, 2006). Risk and vulnerability in the sexual health context is defined as follows (WHO, 2010, p. 13):

Risk is the probability that a person will acquire an infection and/or disease. Certain individual behaviours (such as unsafe sex) increase this risk. Risk is also influenced by multiple factors among which are aspects of the person's physical and psychological development, and their sexual history, exposure to abuse, ability to negotiate in relationships, awareness of sexuality-related issues, access to support, and membership of social networks.

Vulnerability forms a backdrop to risk-taking, and arises from the broader social, political and environmental factors that provide the context in which people act, so influencing the kinds of risks they take. These contextual factors include the political economy of the setting (and its inequalities and exclusions relating to gender, ethnicity and sexuality) and its legislative context, as well as the existence or absence of health and education programmes, and their accessibility, quality, content and delivery.

Aggleton (2006) argues that undue concern with individual risk has led to high reliance on programmes focusing on IEC (information, education, and communication) campaigns and life skills education. These strategies are based on the premise that youth are rational decisions makers who would, with the right skills and information, make the least risky decision when it comes to sexual behaviour (WHO, 2006). However, as Pamar raises “What does it mean to make a decision related to one’s sexuality when public knowledge of sexual activity is a serious social liability with potential long-term social sanctions and stigma?” (2006, p. 7).

Sexuality has always been difficult for politicians and policymakers to talk about or address, and youth sexuality and sexual activity outside of ‘regular unions’ (i.e., formal, socially-sanctioned unions), even more so (Aggleton, 2006; Glasier et al., 2006; PAI, 2002). Although the 1994 ICPD was instrumental in establishing sexual rights, there was a reluctance to accept all aspects- a number of Islamic countries agreed to the Programme of Action with reservations with regard to specific targets on addressing sexual health of youth and unmarried individuals (Glasier et al., 2006). Proceedings of the 1994 ICPD show that the following countries expressed reservations on Chapter VII of the Programme of Action ‘Reproductive Rights and Reproductive Health’ that addressed provision of information and services to young people:

(e) on chapter VII, the representatives of the Libyan Arab Jamahiriya, Yemen, Egypt, Indonesia, Algeria, Afghanistan, the Syrian Arab Republic, El Salvador, Kuwait, Jordan, Malta, the Islamic Republic of Iran, Malaysia, Djibouti, and Maldives (UN, 1994b, p. 132)

Coupled with the decreasing age of sexual initiation (now estimated to occur between 15 and 19 years of age), prevalence of premarital sexual activity has risen,

although the increases tend not to be as high as people perceive them to be (Wellings et al., 2006).

However, 18 years have passed since the ICPD declaration and little progress has been made to demystify youth sexuality so that there may be more institutional commitment to youth sexual health. If the taboos related to sexuality mean that information and services for young people are restricted (PAI, 2002), this sets up a vicious cycle between stigma, services and sexual ill-health. In the next section, I examine these issues in Islamic countries.

2.4 Sexual health in Islamic countries

One of the earliest debates that arose during the first technical consultations on defining sexual health was regarding the role of religion. The 1975 WHO sexual health technical consultations' report included religion and cultural constraints as a barrier to overcome in order to achieve good sexual health, whereas the 1987 WHO consultations' report used religious adherence to argue against defining sexual health and developing a framework for sexual health (Giami, 2002) (also see section 2.1). Since then, perceptions regarding the role of religion in sexual health have become less polarised. The 2006 report on the most recent technical consultation on defining sexual health includes the following quote:

Religion can be either a protective or a risk factor, depending on the social and cultural context (Mahmoud, 2006, p. 11)

This encapsulates an understanding of the varying nature of religion, which I would argue is essential to studying youth sexual health in Islamic contexts. In this section, I first provide an overview of Islam, followed by a discussion on the ways in which Islam influences policymaking in different countries. Lastly, I review the ways in which Islam is depicted in sexual health literature. The aim of the review is to contextualise Maldives among other Islamic countries to situate the extent of religious influence on youth sexual health policy and policymaking.

2.4.1 Islam

Houben states that “[i]n contrast to Christianity, Islam is much more than a religion; it is a ‘way of life’ that encompasses all areas of human activity, private and public,

ranging from the theological to the political” (Houben, 2003, p. 149). Despite this, there is wide variability in Islamic doctrine when it comes to SRH related issues such as fertility, contraception for family planning, and abortion (McQuillan, 2004). This may be attributed to the combination of two factors. Firstly, present-day Islamic societies are heterogeneous (Obermeyer, 1992) and degrees of religious conservatism (Roudi-Fahimi, 2004). Secondly, there is no hierarchical clerical structure in Islam (McQuillan, 2004; Obermeyer, 1992). The absence of such a hierarchy means that there is no final authority on what is the ultimate ‘party-line’. The use of political terminology here is not entirely inappropriate because the way in which Muslims get direction on a particular issue is complex and dependent on factors that are simultaneously political, social and religious.

Sharia (Islamic law) is Divine Law for Muslims (Roudi-Fahimi, 2004). It is primarily based on the holy Quran (the Book); *hadith* (the deeds and collected sayings of the Prophet Muhammad); and secondarily (because these themselves depend on the Quran and *hadith*) on *qiyas* (analogy); and *ijma* (consensus) (Mehryar, Ahmad-Nia, & Kazemipour, 2007; Obermeyer, 1994; Roudi-Fahimi, 2004) (See Appendix B for glossary of terms). Variations in interpretation of *hadith*, as well as the different levels of emphasis given to *qiyas* and *ijma* separate the Schools of Islamic Jurisprudence¹ (Obermeyer, 1992).

The two main Schools of Islamic Jurisprudence are the *Sunni* and the *Shi’a* schools. One (if not the definitive) distinguishing feature of Shi’ites is that they believe Imamism is the exclusive right of the descendants of Imam Ali, Prophet Muhammad’s son-in-law, whereas the *Sunnis* do not revere Imams to the same extent (Roudi-Fahimi, 2004). Accordingly, the Schools also differ in the extent to which they accept the practice of, and who has the authority for, formulating legal rulings based on religious interpretation (Obermeyer, 1994).

The divergence revolves around the acceptability of the ‘man-made’ sources of jurisprudence (*qiyas*- analogy, *ijma*- consensus), and their methods of formulating

¹ Not equivalent to ‘denominations’ in Christianity, but represent different ways of interpreting Islam (Roudi-Fahimi, 2004)

rulings. Religious interpretations, varying from liberal-reformist to puritan-fundamentalist, are made by religious leaders and political leaders of Islamic societies (Obermeyer, 1992). If some religious rulings are formulated (and contested) by people part of real-world institutions and are based in real-world contexts, then religious influence (exerted by these rulings) is socially constructed.

Iyer's (2002) study about contraceptive use in India found differences between Muslim and Hindu users. Hindu women, unlike their Muslim counterparts, tended not to consult religious leader over personal matters, including contraceptive use. Thus, Muslim *mullahs* exerted more influence over their community than Hindu religious leaders (Iyer, 2002). A large proportion of Muslim women in this study do not seem to have perceived the theological ambiguity regarding contraception, but rather perceived that Islam prohibited it (only 1% thought it was permitted). Upon interviewing the local *mullah*, Iyer found that he did not agree with proponents of contraception and therefore did not encourage the women to use birth control. It would be too simplistic to infer a causal relationship here, but it seems that instead of religious doctrine, the way religion is being interpreted and presented may be the stronger factor here (Iyer, 2002).

This notion of religious values being susceptible to social interactions prompts a connection to Goldscheider's emphasis (in his work on the influence of religion on fertility) on the importance of examining the social organization of religion (1971, cited in McQuillan 2004). In order to examine the social organisation of religion of Muslim countries, differences in wholly Muslim countries compared to less Muslim-populated countries as well as the distinction between countries ruled by Islamic law and those influenced by Islamic law (Roudi-Fahimi, 2004), need to be recognised. A further distinction can be made between societies governed by different Schools of Islamic Jurisprudence.

Tober and colleagues (2006) maintain that the *Sunni-Shi'a* is a tempting yet unfruitful analytical distinction because the differences do not account for an individual's acceptance or rejection of family planning. However, I will argue that the *Sunni-Shi'a* difference can affect the social organisation of religion and account for the institutional influence it exerts, which in turn affects policymaking and

individual behaviour. In the following section, I examine this using the concept of theocracy.

2.4.2 *Theocracy*

Theocracy is defined as “a priestly order or religious body exercising political or civil power” or a state so governed (Oxford English Dictionary, 2008). Although an understanding of this concept is necessary for this case study, a review of theocracy in totality is beyond the scope of this review and its historical links with secularism and governance cannot be explored. This review draws on theocracy in order to examine how Islam influences SRH policymaking, particularly in the Maldives, by contextualizing the country among other Islamic countries. I do this in two stages- firstly I formulate a continuum of theocratic countries in order to contextualise the policymaking environment in the Maldives. Secondly, different countries’ approaches to sexual health and possible links with theocracy will be explored.

To make this review manageable I applied selection criteria to identify Muslim-populated countries with meaningful parallels and divergences from Maldives. For this, I compiled a matrix containing data on a range of indicators on religion, SRH policies, and youth-specific indicators for over 50 countries. A selection of the data is provided in Appendix C (including a screenshot of the full matrix to indicate the size). In order to contextualize this research on the Maldives, 3 other countries were selected to represent countries with varying proportions of Muslim populations as a proportion of the total population (Iran more than 90%, Indonesia from 70-89%, and Malaysia from 50-69%). In order to organise this comparison I first evaluate approaches to assist with the theocratic assessment.

The first set of guidelines considered were Grim and Finke’s (2006) indexes on religious freedom, because the sub-indexes (government regulation, government favoritism, and social regulation of religion) could be used to infer the extent of influence exerted governance by religion¹. The indexes, devised to address the

¹ Based on these indexes, the Association of Religious Data Archives (the ARDA), housed at the Department of Sociology at the Pennsylvania State University, and provides scores for the indexes for 196 countries, with the exception of the United States.

limited data for cross-national comparisons on religious issues, were developed by coding the International Religious Freedom Report (of 2003) (Grim & Finke, 2006).

The International Religious Freedom Reports are prepared annually by the U.S. Department of State, and the individual country reports they contain are used for various legislations on foreign relations (U.S. State Department, 2010). Gathered and compiled through U.S. Embassies using a variety of sources (including governmental and non-government organisations, news, human rights monitors), the information is detailed, containing specific events of relevance.

The specific purpose of the data collection is evident from the regular references to impact on the U.S. only (e.g.: “There were no reports of forced religious conversion, including of minor U.S. citizens who had been abducted or illegally removed from the United States...”; U.S. State Department 2007, p. 522). The U.S.-specific lens used in data collection must be taken into account in any use and interpretation of the coding of this information, and the indexes developed from it.

In addition to biases from coding, there are potential flaws in explaining Islamic governance based on, and using Western constructs of secularism (Hurd, 2007). Hurd argues that the pervasiveness of religion in Islamic societies is outside the socially and historically constructed frameworks on secularism. Moreover, the integration of religious and political authority in Islamic societies automatically places them on one side of the Western notion of the religious/secular divide - on the side with negative connotations of dogmatism and hegemonic policies (Hurd, 2007).

For example, the Judeo-Christian secularism considers Islamic tradition to be an irrational mingling of religion and state- fundamentally different to their own separationist views (Hurd, 2007). Since this is a politically authoritative thought prominent in the U.S., particularly influential in international relations, political Islam, when evaluated within these confining assumptions, does not get a favorable review in U.S. foreign policy (Hurd, 2007). One limitation of Hurd’s (2007) descriptions of the nature of religious influence on politics in Islamic countries is the reference to the undesirability of theocracies:

Political Islam is defined *a priori* as a threat to democracy, the privileged status of the private sphere and a step toward theocracy. This presumptive transgression is often linked rhetorically to the alleged Muslim proclivity for terrorism and totalitarianism... (Hurd, 2007, p. 357).

Presenting theocracy as the anti-thesis to democracy creates another divide between a Western category and an intrinsic feature of Islamic societies, much like the religious/secular divide she criticised. Moreover, it does not take into account the different interpretations of Islam and how these variations could lead to varying relationships between religion and state.

Given how Hurd's (2007) argument is made in the context of foreign policy, the concept Political Islam may not be suitable for discourse exploring comparisons between Islamic societies. However, it is important to acknowledge epistemological underpinnings that might be present in the International Religious Freedom Reports and in indexes derived from it. For this reason, this review will not be relying on the indexed rankings nor considering the reports as authoritative or unbiased.

Recognising that the guidelines needed for this literature review should not have epistemological underpinning that are biased against structures intrinsic to Islam, nor should it be so rigid that it is impossible to capture the *Sunni-Shi'a* differences, I derived a set of guidelines from McQuillan's (2004) study of religious influence on fertility.

According to McQuillan, "religious values are most likely to matter when religious institutions have the means to communicate values to their members and to institute mechanisms to promote compliance and punish nonconformity" (2004, p. 32). In addition to these three elements, this review draws on another aspect highlighted by his example from 19th century Quebec, where the Catholic Church was able to exert unrestrained influence on people's social lives, particularly fertility behaviour, because of its hold over health, welfare, and education systems in the country (McQuillan, 2004). So a fourth element that would guide this review is examining how much other sectors (such as health and education) depend on religious institutions.

This review chooses a societal perspective on religion rather than indicators of religiosity or affiliation. Indicators of religiosity or affiliation fail to capture the influence from the web of religious institutions, and it is by virtue of this influence that people have the opportunity and inclination for affiliation (Lesthaeghe and Wilson 1986 cited in McQuillan 2004). A fifth element in the framework involves how individuals feel a stronger sense of attachment to religion when it is tied to their national identity (McQuillan, 2004).

In sum, the elements (adapted from McQuillan 2004) that provide guidance on assessing how theocratic a country is in its governance and policymaking are:

- What is the extent of the institutional influence exerted by Islam in the country?
- Do the religious institutions have the means to communicate their values to their members?
- Are there mechanisms in place to promote compliance?
- Are there mechanisms to punish non-compliance?
- Is a person's religious identity tied to their national identity?

In order to contextualize the extent of religious influence on policymaking in the Maldives, I selected four countries (from the Muslim-populated countries given in Appendix C) for this review: one was selected purposively (the Maldives); and, three selected on the basis of the proportion of their population that is Muslim (Iran > 90%, Indonesia 70-89%, and Malaysia 50-69%). I then reviewed each of the four countries according to the guidelines above, exploring the extent of religious influence, which then informed the continuum in Figure 1. Reviews for Iran, Malaysia and Indonesia are provided in Appendix D, a summary of Maldives is given below.

Religious influence: Maldives

The Maldivian population is 100% Muslim, Islam is the state religion, and Maldivians are prohibited from practicing other religions (U.S. State Department, 2010). The Supreme Council for Religious Affairs became the Ministry of Islamic Affairs in 2008- it

regulates religious affairs by being the authority in accrediting Imams and approving the content of religious teachings, which are regularly communicated to the public at Friday prayers and through the media (U.S. State Department, 2010). Institutional influence is evident in the education sector as there are religious schools (with Arabic as the language of instruction), in addition to all other schools where Islamic instruction is mandatory for Maldivian pupils (U.S. State Department, 2010). Although there are no tensions specifically attributed to a Sunni-Shi'a divide, the School favored by the Maldivian government is implicit in its Constitution that stipulates that the President and the Cabinet of Ministers must be Sunni Muslims, (Government of Maldives, 1997). The 2008 constitution further stipulated that members of parliament and the judiciary must also be Sunni Muslims, and that Atoll chiefs must be Muslims (Government of Maldives, 2008).

Box 1: Summary of religious influence in Maldives

Based on reviews of the Maldives, Malaysia, Indonesia and Iran according to McQuillan's guidelines on studying the influence of religion, I suggest the following continuum to contextualize Maldives among other Islamic countries.

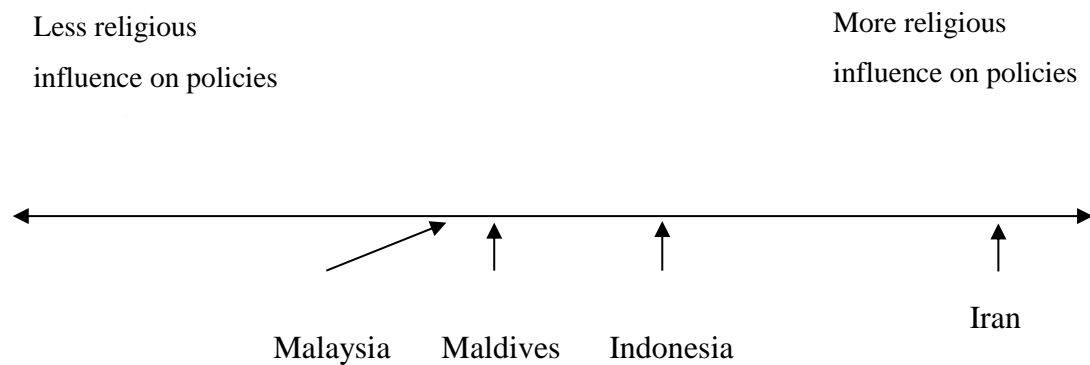


Figure 1: Continuum of selected Islamic countries based on influence of religion on policy

While the guideline was intended to tap into conditions that did not rely on which School was most prominent in that society, it has brought the differences between *Sunni* and *Shi'a* Schools to the center of the theocracy assessment. For example, Maldives belongs to the *Sunni* school, whereas Iran belongs to the *Shi'a* School. A distinguishing feature of *Shi'*ites, is the belief that Imamism is the exclusive right of

people of a certain descent (Roudi-Fahimi, 2004). Shi'ites attach more reverence to Imams and the knowledge and power that come with that political and religious authority. This makes the hierarchy much more rigid than is present in countries of the *Sunni* school, and is more likely to be a more prominent part of society. So some countries chosen here have fundamental beliefs that place them on the heavily theocratic side of the continuum.

This automatic placement of Shi'ite societies was at first thought to be fixed and unchanging while countries of the *Sunni* school, like Maldives, do not carry a belief that automatically dictates a certain level of religious influence on governance. So their position on the continuum is much more open to change, depending on the will of the ruling party. On the contrary, it seems from the cases of Malaysia and Indonesia, that *Shi'a* positions on the continuum can also vary depending on the political will of the party in power, because allowances and restrictions placed on *Sunni/Shi'a* practices are political decisions (Marcinkowski, 2008; U.S. State Department, 2007), thus leveling the field for unrestrained comparisons.

The heavy emphasis given to the practice of *ijtihad* (formulation of legal judgment) in policymaking in *Shi'a*-majority societies makes crucial decisions susceptible to manipulation. Obermeyer (1994) also raises the issue of distinguishing between instances of authentic religious influence and situations where elements of Islamic tradition are selectively evoked to facilitate goals of political actors. Abortion, for example, is an issue that involved debate among Shi'ite imams both in Iran and Indonesia, and in both cases, the result was in favor of prohibiting it. But how much of the debate and decision was religious?

Admittedly, the declaration of fatwas does seem to lead to wide-spread acceptance because of the validation it provides. For example, Iran's fatwas permitting family planning was widely disseminated, and the acceptance is evident from the disappearing urban/rural differences in contraceptive use prevalence, a feat not achieved by any other Muslim country (Roudi-Fahimi, 2004).

While fatwas can contribute to effective implementation of SRH programmes, there is a danger of using them as legitimatising tools. Tremayne (2006) highlights

instances where fatwas have been issued in Iran allowing gender reassignment surgery, stem cell research, and organ donations- all of which raised considerable debate and were not always based on consensus, but rather on an intent to keep up with the latest technologies (Tremayne, 2006). She emphasises an instance where a fatwa regarding assisted reproductive technologies (ARTs) lead clients to ignore moral and ethical concerns in the choice of donors (Tremayne, 2006).

In brief, the rigidity of Shi'ite hierarchies, the direct influence they have on policymaking, and the exercise of religious and political authority on people's lives necessarily places them towards the more theocratic end of the continuum. Iran is placed on the extreme right because of its strict adherence to Shi'ite belief; Indonesia is placed next because Shi'ite religious organizations have direct influence on policymaking and have mechanisms to communicate their values widely, Maldives follows next because the legal system and national identity are more closely linked to Islam and Sharia, than Malaysia.

It is interesting to view the continuum alongside the SRH indicators presented in Table 2 below.

Indicator:	1	2	3	4	5	6
	Adolescent fertility rate (births per 1000 women aged 15-19) (2005-2010) ¹	Level of concern about adolescent fertility ¹	% Women married before 18 years ²	% Births to women age <20 years (2005-2010) ¹	% Births to women age <20 years attended by skilled health personnel (2006) ³	Grounds on which abortion is permitted ^{1, 4}
Maldives	No data	Major concern	No data	6	No data	1, 2
Iran	24	Major concern	30	6	No data	1
Malaysia	15	Major concern	8	10	No data	1, 2, 3
Indonesia	24	Major concern	24	3	No data	1

Table 2: Youth-specific SRH indicators for selected Islamic countries

Youth-specific indicators were chosen because SRH issues among youth, especially among unmarried youth, are often contentious issues in Islamic countries as

¹ Population Division of the UN Secretariat 2007

² Population Action International 2007

³ Population Reference Bureau 2006

⁴ Grounds on which abortion is permitted: (1) to save the woman's life; (2) to preserve physical health; (3) to preserve mental health; (4) rape or incest; (5) foetal impairment; (6) economic or social reasons; (7) on request

premarital sexual activity is legally punishable under *Shari'a*. There is a tendency to avoid addressing these (as evidenced by the absence of data) despite acknowledging that it is a major concern (see Indicator 2). The indicators regarding marriage (Indicator 3) and fertility (Indicators 1 and 4) of adolescents and youth were included to demonstrate SRH rights, such as the voluntary entry into sexual relationships. On these counts, Iran and Indonesia report relatively high percentages, prompting questions on social or religious pressure to enter wedlock at a young age. Furthermore, the disparity between the percentage of youth married (Indicator 3) with the percentage of youth giving birth (Indicator 4) might be indicative of unwanted pregnancies and illegal abortions. Despite this, none of the countries are able to report on percentage of births to young women attended by skilled health personnel (Indicator 5). A final point of interest is how the grounds for legal abortion (Indicator 6), arguably the most self-evident indicator here, is a direct reflection of the arrangement on the theocracy continuum.

An obvious limitation of this review is the small number of cases that have been studied thus far. It was originally thought that Hessini's (2007) study of abortion policies and practice in the Middle East and North Africa might be used to add more Islamic states to the continuum. Although her categorisation of liberal laws (including Tunisia, Turkey), somewhat restrictive laws (including Algeria, Jordan, Morocco), and very restrictive laws (including Yemen, Egypt, Iran) across a range of Islamic countries were based on thorough review of abortion policies (Hessini, 2007), sufficient information about the social organisation of Islam in those societies –according to the framework I proposed– could not be gleaned. For this reason, these countries were reserved for further study. Another limitation would have to be how I was unable to systematise the placement of the countries on the continuum. Quantifying it might not capture the depth of the framework questions but it might be useful to explore processes employed by Grim and Finke (2003) in devising their indexes on religious freedom.

Islam is an all-encompassing and diverse religion, and though religion and politics are inextricably linked Islamic states, there is great variability in pathways and extent of religious influence on policy. Thus far, the argument that religious influence can be understood as a social construct seems to be sound. Religious influence does seem

to be shaped and maintained by people belonging to real-world institutions in real-world situations- cumulatively, this is the social organisation of religion and this, in turn, seems to play a role in policymaking in Islamic societies. By conceptualising the influence of Islam on policy as a continuum of Islamic countries, I have hopefully given some insight into the policy context of the Maldives.

2.4.3 Islam in SRH literature

In this section, I examine the ways in which Islam features in sexual and reproductive health literature (not limited to youth). In order to cover more breadth and to compare differences, I first discuss Islam in reproductive health literature before examining Islam in sexual health literature.

Islam in RH literature

One of the main RH elements linked to Islam is high fertility, largely a result of the close connection between Islam and Arab countries where high fertility rates were a subject of concern in demography and SRH literature on that region in the 1980s (for example, total fertility rate for 1985-90 in Jordan was 6.2, Iran 5.2, Oman 7.2) (Omran 1980, Nagi 1984, Caldwell 1986, cited in Obermeyer 1992; Faour 1989). Linking Islam with Arab countries might be easy because the religion is one of the main determinants of the socio-cultural profile of Arab countries (Hasna, 2003). However, after the September 11th attacks, Islam and its influence was afforded increasing scrutiny and it was common in U.S. political rhetoric to use Middle East and Islam synonymously (Johnson-Hanks, 2006). Although causal links between Islam and demographic trends in the Middle East had been implied before (Faour, 1989; Obermeyer, 1992), the popular debates on ‘reproductive politics’ were now about ‘Muslim fertility’ (Johnson-Hanks, 2006, p. 21).

However, upon examining these dramatic concerns about rising Muslim fertility leading to “violence, revolt, and Jihad” (The Sword of Militant Islam, cited in Johnson-Hanks 2006: 13), there was no evidence of Muslim fertility as a global phenomenon (Johnson-Hanks, 2006). By analysing demographic data from West African countries where there were nontrivial proportions of non-Muslims among Muslims, Johnson-Hanks found that reproductive rates of Muslims were similar to their non-Muslim co-nationals. She states that although Islam’s influence in creating

social traditions was undoubtedly significant, this influence was not uniform enough to produce similar effects on demography (Johnson-Hanks, 2006). This echoes findings by Obermeyer (1992) over ten years earlier, in response to claims that Islam promoted high fertility in the Middle East.

In addition to encouraging high fertility, Islam has also been described as producing a culture which “supports conditions that are conducive to high fertility” such as polygamy and low status of women (Fagely 1965 cited in Obermeyer 1992; Schenker 2000). Islam permits polygamy which allows men to have up to four wives at the same time, upon the condition that the wives are all treated equally (Begum, 1997; Obermeyer, 1992; Sargent, 2006). This allowance is actually practiced to a lesser extent today (Schenker, 2000) and is discouraged in some Muslim-majority countries, like Bangladesh (Begum, 1997). Moreover, it is usually practiced only by those who have the financial capability to equally provide for more than one spouse (Obermeyer, 1992).

The argument that women are attributed low status in Islam is a central feature of the confrontation between Islam and Western countries and is not likely to be resolved easily (Obermeyer, 1992). The link between low status of women and high fertility takes two mutually reinforcing pathways in the literature. One is that being prescribed a lower status than men reduces chances of attaining an education and employment, both of which are linked to improved health and low fertility (Obermeyer, 1992; Roudi-Fahimi, 2004). Secondly, legal and economic dependence on the husband makes the option of divorce unfeasible, increases likelihood of polygamy, and limits alternatives to childbearing (Begum, 1997; Hessini, 2007).

The position of Islam regarding the permissibility of family planning is a debate that has continued between religious scholars for over 1000 years (Musallam 1983 and Omran 1992 cited in Sargent 2006), and it is now generally accepted that Islam permits contraception and family planning (Roudi-Fahimi, 2004; Sargent, 2006). However, this ambiguity has led to international perceptions of Islam promoting large populations of Muslims to increase power (Johnson-Hanks, 2006), and some Muslims believe that contraception is part of a Western conspiracy to control their population and diminish their power (Roudi-Fahimi, 2004; Sargent, 2006).

Islam in SH literature

With regard to how Islam features in sexual health literature, what is immediately striking is the limited number of large-scale studies linking Islam to sexual health elements (in the same way RH indicators such as high fertility was linked to Islam). This may be attributed to the fact that many Islamic countries do not acknowledge behaviours considered to be illicit and sinful, such as premarital sex- this drastically reduces nation-wide data and literature on sexual health issues such as unintended pregnancies, STIs, HIV/AIDS, and abortion (DeJong, Jawad, Mortagy, & Shepard, 2005; Hasnain, Sinacore, Mensah, & Levy, 2005). Moreover, Elam and Fenton remark upon the difficulties in conducting qualitative research on sexual health issues among Muslims- they report how in the presence of another Muslim (even if it is the researcher), Muslim respondents gave very limited responses on sexual health matters, often qualifying their responses with “as you know” with frequent comments like “as we know from the Qur’an” (Elam & Fenton, 2003).

When the 1994 ICPD declaration called for universal access for SRH services, most of the Muslim-majority countries in attendance endorsed it but reserved the right to implement it within their legal framework (Roudi-Fahimi, 2004) (see quote from 1994 ICPD report in section 2.3). As an example, the written reservation statement submitted by the Islamic Republic of Iran reads:

The Programme of Action, although it has some positive elements, does not take into account the role of religion and religious systems in the mobilization of development capabilities. It suffices for us to know that Islam, for example, makes it the duty of every Muslim to satisfy the essential needs of the community and also imposes the duty of showing gratitude for benefits by utilizing them in the best possible way, as well as the duties of justice and balance.

We therefore believe that the United Nations should convene symposiums to study this matter.

There are some expressions that could be interpreted as applying to sexual relationships outside the framework of marriage, and this is totally unacceptable. The use of the expression “individuals and couples” and the contents of principle 8 demonstrate this point. We have reservations regarding all such references in the document.

We believe that sexual education for adolescents can only be productive if the material is appropriate and if such education is

provided by the parents and aimed at preventing moral deviation and physiological diseases (UN, 1994b, p. 146)

What this entails is that these services are legally inaccessible to unmarried people as that would be outside the legal framework of *Shari'a*. In addition to restricted services, there is policy silence among most Islamic countries on sexual health, especially on unmarried youth (DeJong et al., 2005).

The issue of abortion, however, is one where there is a lack of consensus among Islamic scholars about its permissibility (Bowen, 1997) and as a result receives relatively more attention in Islamic contexts than other sexual health issues. At the 1994 ICPD, Muslim delegations were said to have 'broken rank' from their agreement with the Vatican- while both groups united on their objections to youth sexual health services, Muslim countries agreed to the use of abortion in well-defined circumstances (Bowen, 1997). As a result, abortion services are available in many Islamic countries but at varying levels- Jordan permits abortion on grounds of risk to physical health (of the mother) while in Sudan abortion is permitted in cases of rape, and Turkey permits abortion in all grounds as long as it is within the first trimester (Hessini, 2007). Dudgeon and Inhorn (2004) report a further link between Islam and abortion- studying men's influence on women's SRH decision-making, they report that even in Islamic countries where abortion is permitted (such as Turkey), the policy requires the husband's permission for a woman to seek abortion services. That it requires the husband's permission reflects comments by Bowen (1997) and Hessini (2007) about how authorities in many Islamic countries turn a blind eye to the fact that some abortions are bound to be a result of nonmarital sex.

According to Hasnain (2005), reluctance to acknowledge incidence of illicit sexual activity (such as nonmarital, homosexual, and MSM practices) have led to inadequate responses to HIV/AIDS in many Islamic countries in Asia and the Middle East. Furthermore, she claims that environments created by conservative Islamic policies discourage people from reporting or getting tested, which in turn lead governments to underestimate prevalence and be complacent in their programmes (Hasnain et al., 2005). According to Obermeyer (2006), the stigma associated with HIV/AIDS stems from moralizing discourse in many Middle Eastern countries where

HIV is seen as divine punishment for deviating from Islam. Similarly, in Pakistan, stigma attached to STIs is reported to prevent people from getting tested (Shafiq & Ali, 2006). As a result, there are no available estimates on the countrywide burden of STIs and most citizens have little knowledge of STIs or modes of transmission (Shafiq & Ali, 2006).

The limited practice of sex education in schools in many Islamic countries has also been criticized. As evident from Iran's ICPD reservation quoted earlier (UN, 1994b), there is disagreement about the acceptability of providing sex education to young people because sexuality is considered too taboo to discuss in most Muslim countries (Ahsan, 2007). A study by Kaaya and colleagues in Sub-Saharan Africa demonstrates that even if sex education programmes are accepted in a school, the teachers then faced difficulties at the implementation stage- for example, delivering safer sex messages in Muslim communities where premarital sex is condemned (Kaaya, Mukoma, Flisher, & Klepp, 2002). Mishal (Mishal, 2009) outlines an 'Islamic approach' to combating HIV/AIDS that includes raising awareness about sexual health issues by involving religious leaders- the involvement of religious leaders was found to be effective in promoting safe sexual behaviour in Kenya (Maulana, Krumeich, & Van Den Borne, 2009). In-depth study done by Holzner and Oetomo (Holzner & Oetomo, 2004) in Indonesia raises an important point that even in the absence of sexuality education and information, young people in Muslim societies are being bombarded with sexual imagery from globalised media, making sex education as important, if not more, than in non-Muslim societies.

Islam is also criticised as limiting assisted reproduction to be performed only between married couples (Schenker, 2000) although some Islamic societies Iran have been criticised by ART experts as being too liberal in their approach to assisted reproduction and disregarding moral and ethical guidelines (Tremayne, 2006). There are also several instances where Muslim women are linked with female circumcision and mutilation (e.g. Saadawi 1980 cited in Obermeyer 1992) even though female genital cutting does not only take place in Muslim societies (Snow, 2001).

Having covered a range of ways in which Islam features in SRH literature, one feature seems to emerge distinguishing between RH and SH literature. Many RH

studies are dependent on surveys (such as the DHS), limiting their claims to be based on data where respondents have self-identified themselves as Muslim and display high fertility compared to respondents who identify themselves as, for example, Christian (e.g., (Omran 1980, Nagi 1984, Caldwell 1986, cited in Obermeyer 1992; Faour 1989). Although some sexual health studies do identify Islam as a background characteristic with no claims about correlation (e.g., (Glover et al., 2003; Karim, Magnani, Morgan, & Bond, 2003; Koenig et al., 2004), most sexual health studies use Islam as having a more direct influence on sexual health outcomes (e.g. (Dudgeon & Inhorn, 2004; Shafiq & Ali, 2006)). Thus, Islam seems to be linked to reproductive health issues as a factor that creates contexts that are conducive to undesirable reproductive health outcomes (such as high fertility) whereas Islam features as a much more central factor in sexual health issues (such as abortion, sex education, and unintended pregnancies). This is because, as discussed earlier in this chapter, sexual health is much more dependent on religious beliefs than reproductive health, making religion a crucial element in sexual health policies and programmes.

2.5 Maldives

As this research is a case study set in the Maldives, in-depth information about Maldivian SRH context is presented throughout the thesis. This context-setting section deals with information about the geography, demography, sociocultural and political context of the Maldives.

The Maldives is an island nation located in the Indian Ocean and comprising approximately 1192 coral islands divided into 20 administrative atolls. A Republic since 1968, Maldives is wholly a Muslim country and follows the *Shari'a* or Islamic law- although Islam had been practiced in moderation in the past; there is a growing influence of Islamic fundamentalism (Munch-Petersen, 2010).



Figure 2: Map of the Maldives¹

¹ Source: Map data from www.gadm.org using ArcGIS Desktop 9.3.1 software in ESRI ArcMap 9.3.1

Populated by homogeneous race of mainly South Asian heritage speaking a common language (*Dhivehi*), the country has a total population of 330,652 people (DNP, 2012). With 194 islands inhabited among which 131 islands have a population of less than 1000 (and only one with more than 10,000 people), geographical dispersion makes equitable service provision difficult. For example, health services are organized into a four-tiered system providing island (Health Centre or Health Posts, depending on population size), atoll (Health Centers or Atoll Hospitals), regional (Regional Hospitals) and central-level services (MOHF & ICF Macro, 2010; Regional Office for South East Asia WHO South East Asia, accessed 26 June 2012). Given the high concentration of health services, schools, and employment opportunities in the capital Male', it is inhabited by 35% of the total population, making it one of the most densely populated cities in the world (DNP, 2012).

High annual population growth rates (averaging 3% per annum) in the 1970s through to the 1990s (3.4% per annum) (MOH, 2001) combined with limited family planning available in the outer atolls (UNFPA Maldives, 1994) resulted in a young population structure. Currently, 25% of the total Maldivian population is aged between 15-24 years, and from this age group, 31,191 youth (41%) live in Male' (MPND, 2006).

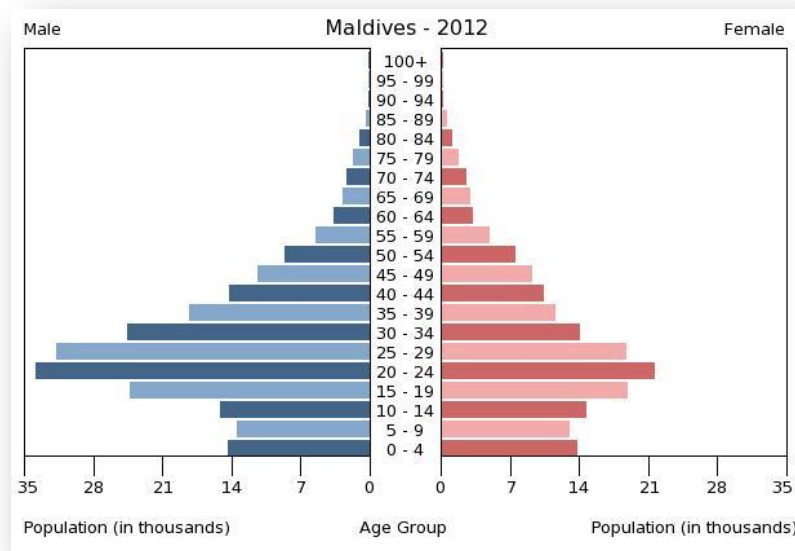


Figure 3: Population pyramid of the Maldives¹

¹ Source: US Census International Database
(<http://www.census.gov/population/international/data/idb/informationGateway.php>)

Culturally, Maldivian society used to be stratified by class and socioeconomic status (Colton, 1995) and the influence of Islamic and South Asian traditions had shaped a society with a bias in favour of men, usually seen in legal situations involving property rights and inheritance (Razee, 2000). This changed with economic development post 1970, increased employment opportunity and higher education, resulting in changes to gender roles- most women are no longer confined to domestic roles but now engage in employment and education, achieving better positions economically and socially (Razee, 2000). As noted in the Asian Development Bank paper on the status of Maldivian women-

“[w]hile overt and deliberate sex-based discrimination is totally absent in the Maldivian psyche, it is being recognized that gender- and poverty-related disparities and concerns are surfacing as a consequence of rapid economic development and breakdown of the traditional systems of familial and social relations” (ADB, 2011, p. 10).

The political climate in the Maldives has been volatile in the last decade, with a lot a lot of civil unrest in opposition to the then government that had not changed in 30 years. Presidential elections in 2008 led to a change in government but unrest continued, raising the incidence of crime and gang violence. Data collection was first attempted soon after the elections but was discontinued due to safety concerns (See Appendix A for timetable). Although the political climate had somewhat stabilised by 2011, escalating unrest and protests in early 2012 led to the President’s resignation, which in turn has spurred on more unrest from opposing sides. My positionality in this context is described further in the next chapter.

2.6 Conclusion

Sexual health has evolved in the past four decades in response to social, political, biological and ideological influences that include the sexual revolution, the HIV/AIDS epidemic, and the growing youth population. In contrast to reproductive health, sexual health is often considered sensitive because of its links to sexuality, particularly youth sexuality. As a result, sexual health of young people is difficult to address in policies and programmes, despite persisting evidence of sexual ill-health among youth. These challenges are magnified in Islamic contexts where religious

influence is prevalent in policies and societies, leaving youth sexual health largely neglected in many Islamic countries. In the following chapters, I examine religious and sociocultural factors that influence youth sexual health in the Maldives, firstly describing my methodology for this research.

Chapter 3 Methodology

According to early Social Problem theorists Fuller and Myers (1941):

Every social problem has both an objective and a subjective aspect. The objective phase consists of a verifiable condition, situation, or event. The subjective phase is the awareness or definition of certain people that the condition, situation, or event is inimical to their best interests, and a consciousness that something must be done about it. (Fuller & Myers, 1941, p. 25)

Although I would not categorise components of Maldivian youth sexual health so dichotomously, some components are verifiable by quantitative data (incidence of premarital sexual intercourse, for example) while other components (such as differing opinions on what can be done about youth sexual health) require more in-depth qualitative exploration. In this chapter I describe the methodology of this study in three main parts: first I describe the research design based on the overarching research question, then I explain and provide rationale for the methods used for data collection and analysis, and lastly I discuss challenges and limitations of this study.

3.1. Research Design

The research design was derived from the overarching research question and guided by the four objectives:

To what extent, and why, is there a mismatch between official Maldivian sexual health policies, services and data and the lived experiences of youth in the Maldives?

- Objective 1: Describe the context of sexual health data, policies and services for Maldivian youth
- Objective 2: Describe youth sexual health experiences
- Objective 3: Identify whether there is mismatch between official sexual health data, policies and services and youth experiences of sexual health
- Objective 4: Analyse the reasons for these differences between official sexual health data, policies and services, and youth experiences of sexual health

Consistent with the research question and objectives, the SH policies and services in the Maldives need to be investigated from two perspectives: Maldivian youths' perspective, and the 'official' perspective. The latter perspective is drawn from policymakers, service providers, INGOs, NGOs, youth workers, and researchers- essentially, non-youth who engage with policies, services and data regarding Maldivian youth SH. Their level and type of involvement with SH policy, services, and data are further discussed in *3.2.1 Key Informant Interviews*.

The youth perspective is drawn from Maldivian individuals aged between 18-24 years. Since approximately a quarter of the Maldivian population is aged between 15-24 years (MPND, 2006), the upper limit for inclusion in this research is set at 24 years, though the lower limit is restricted to 18 years. This is because although the minimal age for legal marriage is 18 years, ambiguity in the current legislation permits marriage before 18 if the child has reached puberty, with the permission of child protection agencies (Government of Maldives, 2006). In addition to this complication, parental consent will be required to survey those under 18 years- given the sensitive nature of the topic, this might pose difficulties in getting access to youth without parental involvement, which in turn might make youth hesitate to participate or respond candidly. I discuss the limitations of restricting the lower age to 18 in section 7.1.

3.1.1. Researcher reflexivity and positionality

With regard to my positioning in this research, especially in how it creates and reduces 'social distance' (Collumbien, Busza, Cleland, & Campbell, 2012) between the researcher and the research population, four points warrant recognition. First, I approach this topic from a position of prior knowledge and experience working on policy implementation and strategy development in the Maldives. In addition to having worked with policymakers, I am also informally acquainted with many of them. The latter is atypical for a person of my age (28 years) and I recognise that that opportunity is a result of belonging to a political family and being introduced through familial links. This was advantageous in gaining access to some key informants as well as providing some respondents a sense of shared knowledge, allowing for more discursive interviews than might otherwise have not been the case.

However, power imbalances are not fixed or unidirectional (Bennett, 2002) - there were instances where upon recognising my surname, the key informants were guarded about disagreeing during discussions and reluctant to openly discuss a sensitive topic such as sexual health.

Secondly, I need to recognise my position as an advocate of youth sexual health- the commitment I feel towards sexual health issues for Maldivian youth has been a driving force through the PhD process. It was a concern during fieldwork that my stance on this issue might be apparent during interviews with youth respondents. Through the iterative process of improving the interview protocol during the pilot phase and main data collection, I was able to refine question phrasings and remove telling signs of my stance, as well as reflect upon and moderate the nonverbal cues I tended to display while disagreeing. Despite this reflexivity, there was a learning curve and subsequent review of transcripts shows that at times I used leading questions e.g.: “Do you think being married or unmarried makes a difference when it comes to SH and RH?” Where this was the case, I have avoided using quotes generated from responses to these questions.

Thirdly, the impact of my being a young Maldivian female must also be acknowledged. As Maldivians are of a homogenous race, the outward dissimilarities were limited to dress code. While I made an effort to dress appropriately during fieldwork, it would have been apparent that my background was relatively more privileged than some respondents. However, the same would have been indicated from the information sheet stating I am being educated in London. I was surprised that many youth respondents, most often female, made congratulatory comments for doing a PhD. During fieldwork, it became apparent that where one got higher education did not matter as much as where one got primary and secondary education. There was shared knowledge of connotations that came with having studied at certain schools, certain regions, and certain subject streams in the Maldives. As such, youth from Male’, where I too grew up, identified with me more than youth from atolls and I, too, tended to be more relaxed with them. Youth from the atolls possibly felt more of a power imbalance, as the only people who tend to visit islands to conduct studies had institutional, often governmental affiliations. In contrast, Male’ youth would feel less intimidated as I am one of them, coming from the same

city. Another similarity that seemed to work in my favour was my age. While having a late-twenties woman question policymakers may have been uncommon, it worked most favourably with my interviews with youth aged 18 to 24 years. I was young enough for them to feel comfortable in their language styles, their attire, their attitudes, I was old enough for them to realise it was a serious piece of work I was undertaking and to respond accordingly.

The last key note regarding positionality stems from religion, and it is one I was unable to address or minimise. I am female, unmarried and not wearing the *hijab* (Muslim veil or headscarf). Although this would not normally affect any day-to-day interaction, discussion on religious issues brings it to the fore. With religious experts, it is a power imbalance- feminist research methodologies acknowledge power imbalances where dominant and subordinate roles are created based on structural inequalities, personal differences, and the acceptability of knowledge and ways of knowing (Bennett, 2002). With youth respondents, it is a matter of being 'religious enough'. I detect an unspoken question as to why, if I feel I am religious enough to talk about their personal religiosity and beliefs, do I not wear the veil myself? During my pilot study, it was a tense moment for me, and once or twice found myself explaining that I am not condoning 'un-Islamic' behaviour (such as premarital sexual activity) and that I felt that religion was a big part of my life. However, after reflection, I came to terms with the fact that I had decided to tackle this issue, regardless of the connotations that comes with researching this. Religion, religiosity and religious influences are further discussed in later chapters.

3.1.2. Evolution of the research design

Finalising the research design of this study was a lengthy and dynamic process, often as a result of contextual shifts. The original research design included a social attitudes survey and focus group discussions (FGDs) with Maldivian youth (aged between 18-24 years) as well as key informant interviews with relevant policymakers and service providers. However, I learned after starting this research that a Demographic and Health Survey (DHS) was underway in the Maldives, calling into question the need to do primary survey data collection.

In light of this, I revised my research design by substituting the survey with secondary data analysis of DHS data. Despite the differences in data yielded, I substituted FGDs with in-depth interviews with youth because the removal of the survey would allow me one form of interaction with youth- I decided to use this opportunity for an in-depth one-on-one interaction rather than risk low participation that may have occurred with FGDs. I retained the key informant interviews (with policymakers and service providers) component of the original research design. There were three main advantages of changing the research design. Firstly, I would be able to draw on nationally representative data from the DHS, and would be among the first to do so, as this is the first time youth-relevant SH data has been collected in a harmonised and standardized format in the Maldives. Secondly, it gave me the opportunity to explore the attitudes and perspectives from a qualitative angle and in-depth, a feature I was unable to incorporate into the original design because of the need to generate broad, representative data. Thirdly, I was able to use a method (i.e. in-depth interviews) that might be more effective in Male' (the capital of the Maldives). Past surveys have typically reported low response rates from youth in Male' (MOH, 2004c), where 41% of the youth population reside (MPND, 2006).

A further development during the research was the introduction of a web-based survey, as a methodological experiment. Following the release of the Maldives DHS 2009 preliminary results and my preliminary analyses of the data, I made the decision to add primary quantitative data to further explore the youth perspective (See 3.2.4 *Web-based survey* for further discussion).

The order of the data collection- qualitative interviews, then secondary analysis, followed by the Web Survey- is not what I would have done ideally. Given the lack of data on youth sexual health experiences and behaviour, it would have been ideal to use representative quantitative data to identify themes and patterns of behaviour, and then conduct qualitative interviews to test if the themes raised captured their experiences, and add a nuanced narrative to the distribution of behaviour demonstrated by the quantitative data. However, the fact that access to the MDHS data was not only uncertain but also highly delayed by over a year made it impossible for me to conduct the research in that order. Nonetheless, once the MDHS dataset was released, it became apparent that my order of data collection may

have actually been better suited for the situation. Without the in-depth interview data from two field sites, it would have been difficult to identify that the MDHS may have not captured youth sexual behaviour and SH issues.

The final research design, that included two qualitative methods and two quantitative methods, is summarised in Figure 4, and the following section describes and justifies each of the research methods in detail.

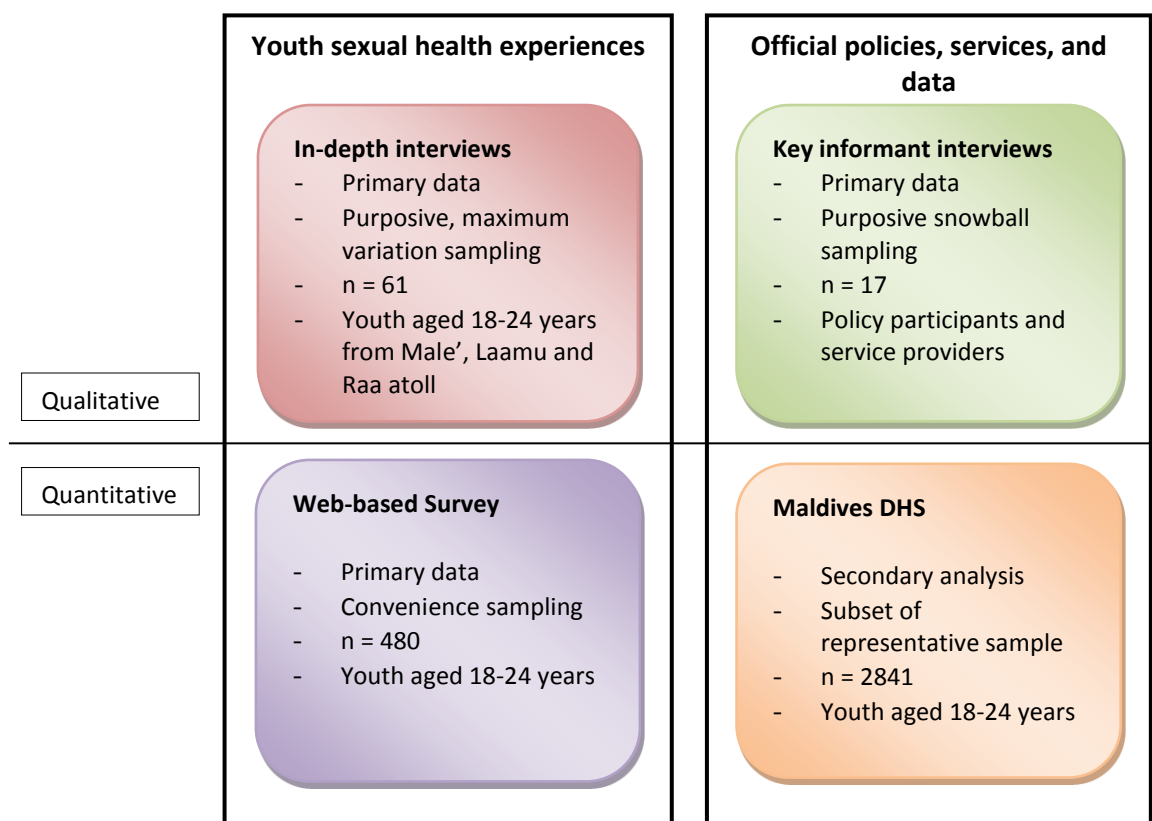


Figure 4: Research design with methods, sampling and sample size

This study employs the use of a combination of qualitative and quantitative methods of data collection. It follows a Sequential Exploratory Strategy in which qualitative methods are employed first and bear the most weight (Creswell, 2009). Quantitative data collection and analysis is then incorporated to further examine an aspect- such as the distribution of a particular phenomenon within a chosen population, or testing an emerging theory (Hanson, Creswell, Clark, Petska, & Creswell, 2005). In the case of this research, the qualitative methods (in-depth interviews with youth and key informants) were conducted first, followed by secondary analysis of the Maldives DHS 2009 to illuminate the breadth of some issues highlighted from the in-depth interviews with youth. The secondary DHS analysis led to an emerging theory

regarding the influence of sociocultural factors on data, which then led me to develop a web-based survey to test some of these emergent ideas.

Described below are the four research methods used in this research, along with their purpose, sampling, and research instruments used for each.

3.2.1. Key informant interviews

The purpose of conducting key informant interviews was to generate data for:

- Objective 1: Describe the context of sexual health data, policies and services for Maldivian youth
- Objective 3: Identify whether there is mismatch between official sexual health data, policies and services and youth experiences of sexual health
- Objective 4: Analyse the reasons for these differences between official sexual health data, policies and services, and youth experiences of sexual health

Document analysis

Document analysis and review was an essential precursor to the key informant interviews, informing a large part of the policy context discussed in Chapter 4. In addition to providing a narrative of how sexual and reproductive health progressed in the Maldives, it also allowed me to identify institutions and individuals who would form the key informant sample. The documents I covered were not limited to those labelled ‘policy’ documents (e.g. *National Youth Policy 2002*, *Population Policy of the Maldives 2004*) - I included strategies (e.g. *National Reproductive Health Strategy 2005-2010*), plans (e.g. *Health Masterplan 1996-2010*), census and survey reports (e.g. *Population and Housing Census of the Maldives 2006*, *Reproductive Health Survey 2004*), health reports (e.g. *The Maldives Health Report 2004*) and reports from INGOs (e.g. UNFPA’s *ICPD+10 and Beyond: Progress, Achievements and Challenges in the Maldives 10994-2004*) and NGOs (e.g. CDE’s *Reproductive and Sexual Health of Adolescents in the Maldives*).

In order to capture the sociocultural, religious and political influences that surround policymaking and policy actors and institutions, document reviews are a necessary

departure point, but do not suffice as policy documents usually reflect only the outcome and rarely the process of negotiation between policy actors that led to their final form. Nor do surveys, such as the DHS, allow us to understand the sociocultural, political and religious influences on policymaking, as it is not just a description of the policy environment that is required but also an exploration of how these influences are expressed and constructed during interactions. As Creswell notes:

[Subjective meanings] are not simply imprinted on individuals but are formed through interaction with others (hence social constructivism) and through historical and cultural norms that operate in individual's lives (Creswell, 2009, p. 8)

Therefore, this study used key informant interviews with a range of informants in order to gain insight of the policymaking process from multiple points of view.

Respondent Selection

The sampling technique for key informant interviews was snowball sampling. As a point of departure I reviewed all of the available documentation on SH-related strategies and projects to identify potential key stakeholders and contributors. Key informants were drawn from organisations directly involved in SH policymaking and those involved in SH service provision. These include, at the policymaking level, former and current officials from the Ministry of Health (six respondents, including two clinicians), Ministry of Youth (two respondents), UNFPA Maldives (two respondents), and the former Religious Council (now the Islamic Ministry) (one respondent). From the service provision and projects level, key informant interviewees include former and current projects workers and staff at the Youth Health Café (one respondent), Adolescent Unit (Reproductive Health Centre, Indira Gandhi Memorial Hospital) (two respondents), Life Skills Education project (two respondents, including one former official at the Ministry of Education), and the Society for Health Education (NGO) (one respondent).

Negotiating access

Key informant interviews were conducted throughout the fieldwork period, as some respondents had busy schedules and travelled often. This lengthy duration was not problematic as I was concurrently conducting in-depth interviews with youth.

Having the key informant interviews across the length of the research period meant that I could explore emergent and changing themes e.g.: pre- and post-DHS preliminary results.

The first step involved identifying key informants, identifying the reasons why I considered their contribution valuable, and making contact with them. First contact was attempted by email during fieldwork preparation in London, but I received few replies. I then attempted to contact them by phone after arriving in Maldives, with better results. This approach worked well, as I managed to establish rapport with the key informants as dates, times and venues were arranged as they wished.

All key informants (n=17) that I approached agreed to be interviewed, though some service providers required more clarification as to how they were expected to respond- i.e., as staff at their organisation or as individuals working in this field. I explained this was their decision- the information sheet and consent form I provided to each key informant (see Appendix F) required them to state how they wished to be cited. Most opted to speak as individuals, and consented to be cited with broad reference to the organisation they belonged to (e.g., respondents from MOH would be identified as 'MOH official' and not by their department or job title). I was pleased to note their responses reflected this- once a good rapport was established, their own views, whether or not they contradicted the organisation they worked for, tended to be expressed frankly. All of the components of key informant interviews - their identification, the process leading up to the interview, and their views are included in the analyses.

As I discuss later in section 7.1 Limitations, I was unable to gain access to more than one Religious Council member. Apart from one religious scholar, I was unable to identify religious experts involved in SH policies and programmes until much later in the fieldwork phase- given their current high ranking (for example, one member is currently the Deputy Minister of the Islamic Ministry), it was not possible to secure any meetings during the fieldwork period. The one religious expert I was able to interview was quite senior in age and misunderstood the format of the interview to be more of a lecture (of Islamic teachings on SRH, which enhanced my understanding)

rather than a two-way discussion. As a result, I was unable to gain any insight into Maldivian SH policy context from that interview.

I was fortunate (and dogged) enough to be invited to the multisectoral meeting held regarding the dissemination of preliminary findings of the Maldives DHS 2009 in February 2010. This was 6 months after my fieldwork had started. It allowed me to introduce myself and my research to a wide audience. I was approached by four people after the meeting, most expressing interest in this research. In addition to a lot of networking, I managed to recruit some more key informants, allowing me to integrate a set of people who had been exposed to the DHS' preliminary findings.

Interview protocols

The interviews, each lasting about 1 hour, were semi-structured, allowing a flexible interview process, and assisted by an interview guide. Different interview guides (Appendix E) were followed depending on the key informant's level and type of participation with the SH policies. These interview guides were continually refined in an iterative process, included (and were not limited to) the following themes:

- **General questions (all key informants):** attitudes towards youth SH policies, programmes, services; perception of current youth behaviour and experiences
- **Policy Actors protocol:** policy process of project/strategy involved in, outcome, perceived strengths and weaknesses, perception of progress
- **Service Providers protocol:** services provided at facility, procedures, perceived strengths and weaknesses, attitude towards facility, perception of progress; hypothetical scenario questions
- **Religious experts' protocol:** process regarding contribution to policy, influences derived from other countries with similar contexts, religious stance on SH issues.

If individuals belonged to both levels (some service providers were involved in the policy process), both protocols were applied. Each interview was begun after respondents had read the information sheet, clarified how they would be cited, and signed the informed consent form (Appendix F). Interviews were typically begun with some broad questions about their work, often establishing enough rapport

during the interview that they volunteered more information about their careers and educational backgrounds by the end of the interview. Before closing the interview, confidentiality was assured and thanks offered. All interviews were audio recorded with permission, kept password protected, and then transcribed in Dhivehi by myself, a copy of which remains available to the interviewee upon request.

3.2.2. *In-depth interviews*

The purpose of conducting in-depth interviews with youth was to generate data for:

Objective 2: Describe youth sexual health experiences

Objective 3: Identify whether there is mismatch between official sexual health data, policies and services and youth experiences of sexual health

Objective 4: Analyse the reasons for these differences between official sexual health data, policies and services, and youth experiences of sexual health

The in-depth interviews (IDIs) are the main source of data about youth experiences, perceptions, and attitudes. The use of this in-depth technique was to generate comprehensive accounts of youth experiences of SH and the influences that shape them.

Sampling technique

Considering the absence of such narratives of youth SH, whilst making the best use of time and resources and to ensure that an information-rich sample is chosen, the sample was purposively selected using Patton's *maximum variation sampling* strategy (1990). This strategy was chosen as it would allow me to identify common themes that cut across a diverse sample of Maldivian youth- "any common patterns that emerge from great variation are of particular interest and value in capturing the core experiences and central shares aspects or impacts of a program" (Patton, 1990, p. 172). In the first instance, I identified main criteria to construct an information-rich and diverse sample- geographical variation, gender, marital status, age, level of education, living arrangements.

- ***Geographical variation:*** The decision to examine and compare urban and rural areas was a straightforward one. An urban area in the case of the Maldives would be Male', the capital city, and a rural area would be one of the atolls. However, the differences between Male' and other atolls are vast in terms of living standards, accessibility to health care, opportunities for education and employment. There is little doubt that many of the variations in youth experience of SH can be attributed to institutional differences between Male' and atolls, but this would not shed much light on sociocultural differences. For this reason, it is common practice in Maldivian research to sample from two atolls for a rural sample, one from the north and one from the south. In addition to geographical differences where southern islands are much larger with bigger communities and more connected to each other, inherent and embedded Maldivian beliefs point to social class differences between the northern and southern atolls. It is due to these probable contextual and sociocultural differences that I decided to choose one northern and one southern atoll as rural sites (Male' as the urban site) – for sociocultural coverage, not as an attempt for geographical coverage or compare regional differences.

The selection of atolls was purposive, guided by time and resources. The Maldives is geographically widespread with some islands sparsely populated. The atolls were first selected based on risks involved in conducting fieldwork there (due to political unrest in 2008 in some atolls) and then shortlisted based on the total population size in order to ensure an adequate sample of youth could be drawn with minimal travel between the islands in that atoll. Atoll site selection was done in three stages:

1. Atolls assessed for safety and risk based on knowledge of political unrest and ability to ensure personal safety. Each atoll was assigned either Green (i.e., safe), Amber (depends on island, thus will be chosen only if it makes for an especially good research site), Red (unsafe). 13 atolls (from a total of 20) were assessed to be completely safe: 9 from the Northern region, 2 from the Central region, and 2 from the Southern region.

2. The 13 safe atolls were ranked by total population size. The same ranking holds when considering youth (aged 15-24 years) population and the top 5 based on population size were shortlisted
 - 2.1. Kaafu Atoll (K) (Central region)
 - 2.2. Raa Atoll (R) (Northern region)
 - 2.3. Haa Alif Atoll (HA) (Northern region)
 - 2.4. Laamu Atoll (L) (Southern region)
 - 2.5. Shaviyani Atoll (Sh) (Northern region)

3. The shortlisted five atolls were examined for feasibility as a research site. Considerations included share of total population of islands (to minimise travel between islands), population density of islands, and social infrastructure. Priority was given to selecting an atoll from the northern and the southern region each, given the possible sociocultural differences between the regions. Selecting one from the Central region was decided to be unnecessary as Male' (the third field site) is in the Central region.

Following this selection process (details of which can be found in Appendix G), the final selection of sites were:

- 3.1. Laamu Atoll (L): Southern region, rural
- 3.2. Raa Atoll (R): Northern region, rural
- 3.3. Male': Central region, urban

In order to reach maximum variation in sampling, the following criteria were identified and applied for respondent selection from each of the three research sites. This allowed better coverage of typical members of the target group within the timeframe and resources as well as to illuminate interesting comparisons for the analytical phase because each sub-category would have exposed the individuals to different sociocultural and religious influences.

Gender (male vs. female)

Marital status (married vs. unmarried): This distinction is central to this research because the current policy on SH is such that SH services are legally provided to married individuals only.

Age (18-20 years vs. 21-24 years): For purposes of better coverage of the age range, it was necessary to split the target group, and the divider was set after considering the mean age of marriage. The mean age at marriage in Maldives, as of 2000, is 21.8 years for women, and 25.7 years for men (Gender Info, 2007). Thus, those in sub-category (b), particularly females, are likely to have experienced pressures to enter marriage or can provide insights to sociocultural and religious that might be different to younger individuals.

Level of education (Up to O' levels vs. A' levels and diploma vs. Degree and above): In addition to allowing inferences about level of education, skills, awareness, and socioeconomic status, this category, in the Maldivian context, can also be used to gauge exposure to different lifestyles and sociocultural and religious influences because it is common for students to relocate to Male' (usually for A' levels and diplomas) or abroad (usually for Bachelor's degrees and above).

Living arrangements (living with family vs. living away from family): Traditionally, Maldivians, even after reaching adult ages, do not move out of the family home unless they are entering marriage, in which case one partner moves to the other's family home. However, given the limited opportunities for higher education and employment in the island communities, adolescents and youth are often sent to Male'. Male' is often too costly and crowded to allow the entire family to relocate there, so youth are usually sent to live with relatives or family friends. This often entails exposure to different sociocultural influences and less supervision over their social life than they would have had if living with their family, making this distinction useful for participants in Male'.

In addition to ensuring an information-rich sample, identifying the above criteria had two further advantages: First, it allowed me to estimate how many interviews need to be conducted to achieve the desired maximum variation. Selecting one male and one female respondent based on marital status, age, level of education and living arrangement equals 18 interviews per site. As IDIs were conducted from three field sites in Maldives- Male' (the capital), Raa Atoll (a northern atoll) and Laamu Atoll (a southern atoll) - a minimum total of (18 x 3 =) 54 interviews were necessary to ensure maximum variation. Secondly, identifying the criteria also assisted in minimising selection bias in respondent recruitment in cases where snowball

sampling (via informants) techniques had to be employed. This was necessary on occasions where door-to-door selection proved unfeasible in larger islands with sparsely populated areas, numerous vacant buildings, and forests.

Pilot study

Upon arriving in the field, I conducted four interviews with youth as a pilot study for the in-depth interviews to test the interview guide, particularly, question phrasing and appropriateness of language. I also employed cognitive interviewing techniques which is described by Beatty (2007) as “administering draft survey questions while collecting additional verbal information about the survey responses, which is used to evaluate the quality of the response or to help determine whether the question is generating the information that its author intends (Beatty & Willis, 2007, p. 288). For this I asked my pilot study respondents to articulate or ‘think out loud’ about how they interpreted the questions, how they constructed their answers, and how easy or difficult they felt they were. Using this method, I was able to refine the interview guide by adjusting question order, removing questions that were repetitive, revising phrases and words that were too critical (e.g., asking ‘is it okay?’ instead of ‘is it acceptable?’). Moreover, I had audio recorded each of the pilot interviews so that I could reflect on and improve my interviewing skills, such as keeping a good pace, and noting tone changes. I maintained records of the revisions, circulating them to my supervisors.

Interview guide

Despite the pilot study, I noted during data collection at the first field site, Laamu atoll, that the interview guide was not comprehensive enough. I found respondents very willing to talk about certain issues that I had considered would be too sensitive, such as abortion. I tried my best to think on my feet and continue without guiding questions but felt that I could push them to talk more. In light of this, I modified the interview guide, adding more questions to ensure I was prepared to discuss any related issue that might arise. During this refinement process, I maintained a commentary of how well/badly each question worked (see Appendix H) in order to improve interview guide development. Despite the on-going refinement, care was taken to ensure that the same core questions were administered to each of the respondents, so that comparisons can be made in the analytical phase. The

modifications made in-between field sites were mainly regarding phrasing to clarify ambiguities, revising leading questions, and removing unnecessary questions.

The research instrument included questions on the following themes:

- Attitudes: SH awareness programmes, sex education, SH services, sexual activity, relationships, marriage, abstinence, abortion
- Perceptions: magnitude of youth sexually active, age at sexual debut, differences between now and 5 years ago, social acceptance of sexual activity, risk of STIs, STI cases, abortion cases
- Knowledge: of SH issues, contraception, accessing contraception, STIs, STI transmission, accessing treatment, unwanted pregnancies, abortion
- Experience: living in the city/atolls, living with/away from family, being male/female, being married/unmarried, friends, community, family
- Hypothetical questions: What if scenarios, exploring what they would do if an unmarried friend was sexually active, or pregnant, or got an STI
- Religiosity: own beliefs, importance of religion, why, role of religion in own life, religiosity of peers

The interview process was very informal. Once I identify a potential respondent- on the street, or by visiting houses- or if one is identified for me by contacts in the community, I checked whether they fit the sampling criteria (making sure I was not oversampling based on some criteria and that I had balanced numbers of ever-married youth and never-married youth, male and female, etc.), and offered them information on the research before asking if they were interested in participating, making sure to highlight that it would be entirely confidential. If they agreed, I offered to let them choose a time and place for the interview, most respondents typically agreeing to conduct it there and then. All interviews were conducted in a private, quiet, and informal setting such as a park or public seating areas near the beach. If respondents hesitated at the audio-recording aspect, I offered them the option of using fake names, and some respondents accepted this offer. Only four youth among all (n=61) approached opted to not participate, finding the audio recording aspect too daunting.

Interviews did not begin until the information had been read, explained, and they had signed the consent form (see Appendix I). Each interview was typically begun with questions about their lives- where they grew up, family, friends, jobs, education. Many respondents asked me questions in return, once about my marital status, twice about my age, but most often about education- where I was studying, what it was like, and some wanted information on how they too can apply for higher education. I gave them as much information as I could. This introductory chat proved to be an effective way of relaxing the respondents, and allowed us to enter an easy banter.

Each interview lasted approximately 50 minutes. If there were interruptions such as people approaching us or phone calls for the respondent, the interview and audio recording was paused. Before closing the interview, I thanked them for their participation, explained the next steps in my research, and invited further comments or questions. Quite a few respondents thanked me for listening to them, and commenting on how much they appreciated being asked their opinions. Many wished me luck, and a few told me I was doing well by addressing youth SH issues.

Respondent profiles

Figure 5 overleaf compares the background characteristics of the IDI respondents from each of the three field sites. I had taken care to recruit equal numbers of males and females from each site, with the exception of Male', simply because I discovered at the end of the interviews that none of the males were ever-married. Thus in order to achieve theoretical saturation, I recruited one additional male based on his ever-married status. As the figure shows, more women were married than men in all the sites. Also, men generally attained higher levels of education than women, the difference being starker in Laamu atoll, the site observed to be most rural among the three. Although the themes did not differ much, my perception in the field was that Raa atoll youth were more aware of SH issues than Laamu, and did not discuss feeling restrained by the island as much. Other specific characteristics such as religiosity will be discussed with the relevant results in Chapter 5.

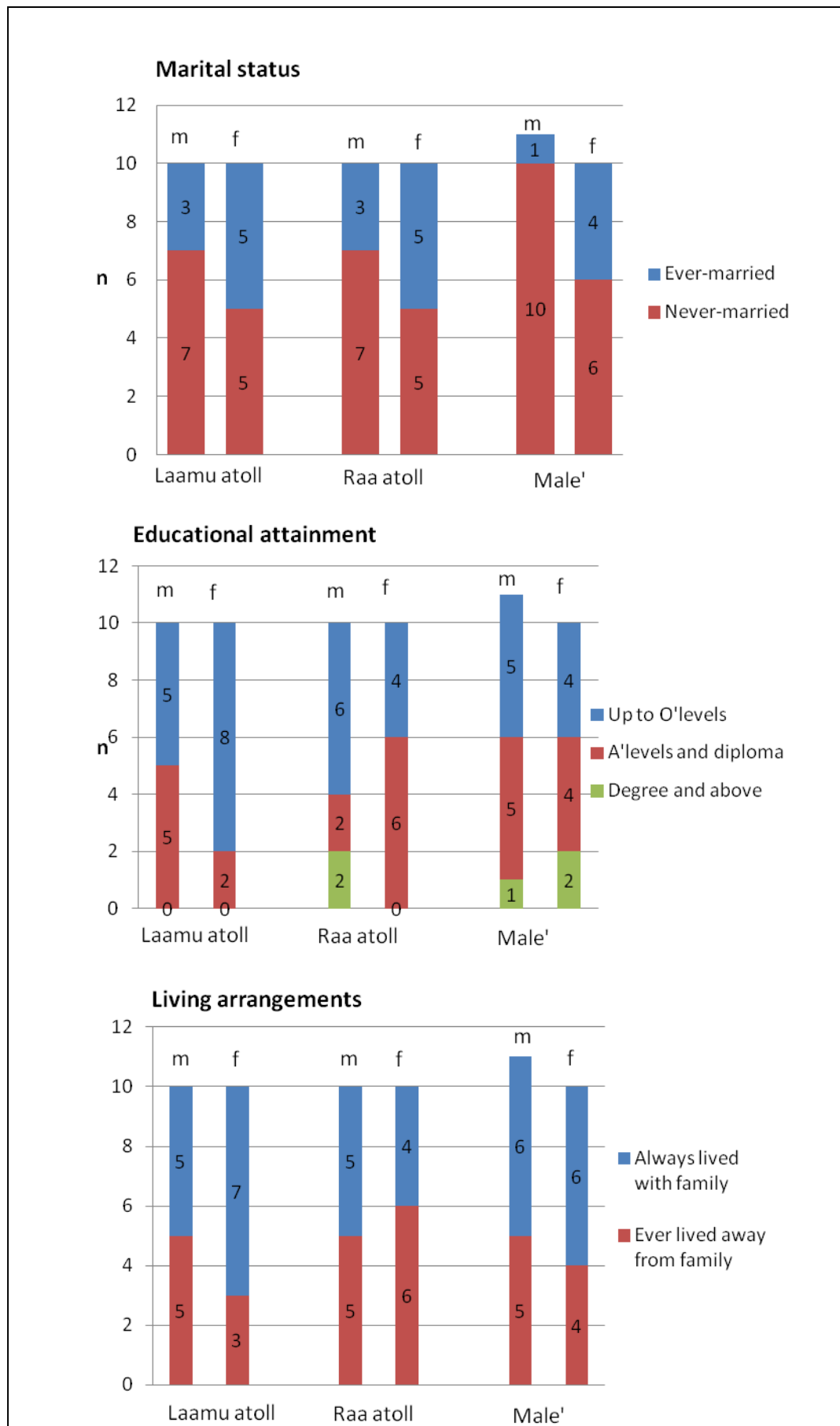


Figure 5: Background characteristics of IDI sample (youth aged 18-24 years, n=61)

Fieldwork experience

The overall fieldwork experience can be described as being a mix of positive and negative experiences, the positive outweighing the negative by far. The positive experiences can be largely attributed to the interactions with youth as they were an unexpected mixture of sincerity, vulnerability and humour. The welcoming nature of communities contributed a lot, as well as people's willingness to assist with anything. The opportunity to travel around the Maldives was also very pleasant.

The negative experiences can be attributed to unwanted attention and monetary issues. Being a newcomer in the islands resulted in a lot of unwanted attention on my research. I was aware that broadcasting that I was conducting research on a sensitive subject such as premarital sexual activity would complicate matters for both me and the respondents. So I made the decision to minimise the explanation I offered to curious community members, by saying it was a study on youth health. Soon after commencing interviews, it became apparent that the communities were so small and prone to gossip that my respondents would likely be questioned about the interviews later. Thus I began to alert respondents to this, and told them that they were at liberty to tell curious folk anything they wished, as I would never reveal anything to confirm or contradict them.

The second factor responsible for the negative experiences is depletion of funding resources. In addition to the late arrival of secured grants, the costs of transport (e.g.: fuel prices) and living had risen since my pre-field budget calculations. This led to a delay in commencing data collection from the second field site (Raa atoll), and limited travel within that atoll, which meant I was able to sample from four islands instead of five.

3.2.3. Secondary analysis: Maldives DHS 2009

The purpose of secondary analysis of the Maldives Demographic and Health Survey 2009 is to triangulate findings from the IDIs (see 3.2.2) and the web survey (see 3.2.4) for:

Objective 2: Describe youth sexual health experiences

Objective 3: Identify whether there is mismatch between official sexual health data, policies and services and youth experiences of sexual health

Objective 4: Analyse the reasons for these differences between official sexual health data, policies and services, and youth experiences of sexual health

About Maldives DHS 2009

The Demographic and Health Surveys, implemented by ICF Macro and funded by USAID, are recognised worldwide as sources of nationally representative and internationally comparable data on population, health, HIV and nutrition (www.measuredhs.com). The fact that it was conducted in the Maldives, where such data are rare and poorly disseminated, marked a milestone in openness to research, as well as the use of data in policymaking and services. Moreover, the fact that this survey collected data from unmarried youth as well as married youth about SH issues such as sexual activity, contraception, and STIs, made this especially relevant to my research.

The Maldives DHS 2009 was implemented by the Ministry of Health (then named ‘Ministry of Health and Family), funded by the Government of Maldives, UNFPA, UNICEF, and WHO, with technical assistance from Macro International (MOHF & ICF Macro, 2010). The project suffered some setbacks due to funding complications and field staff dropouts which delayed data collection by a few months (MOHF & ICF Macro, 2010). Subsequently, the analysis phase for this thesis was delayed till April 2011, preliminary results getting released in February 2010, and the dataset only released for public access on the Measure DHS website in December 2010.

Link between this research and Maldives DHS 2009

The news of Maldives DHS 2009 that arrived a month before I arrived in the field meant that having established contact with the Ministry of Health research team, I was granted access to the draft research tool, which was in the translation phase at the time.

The research instruments contained questions on sexual activity, age at sexual debut, knowledge of contraception, STIs and services, and attitude towards SH service provision to unmarried individuals. After extensive review of the research instrument, the quantitative phase of my methodology (determining distribution of the SH phenomena according to the Sequential Exploratory Strategy explained in 3.1) was modified, substituting the survey with secondary analysis of the Maldives DHS 2009 dataset.

Negotiating access

The process of negotiating access to the dataset was both obstructed and resolved by timeline issues. The concurrency of the Maldives DHS 2009 and my research is essentially a positive aspect because their data and mine would be from the same time period. However, the duration between DHS data collection (January - October 2009) and release (December 2010) of dataset was lengthy, and there was a chance that I would not be able to access the dataset in time to incorporate the data into my research. Thus I sought to gain access to the dataset prior to its public release.

I commenced negotiations with the Ministry of Health in June 2008 via email, with limited success. I continued to attempt this after arriving in the field, meeting with the research team, and by keeping constant correspondence with them. Although the verbal responses I received were very positive and reassuring, nothing could be put on paper, the reason being that data collection was still on-going, and it would be difficult to estimate when the dataset could be ready. Once data collection was completed, the new obstacle was data cleaning and preparing the pre-release dataset. I was unable to persuade access despite getting assurances from Macro International that they were ready to release it to me as soon as the Government of Maldives gave permission, even by email¹. I was able to gain more momentum and support following the multisectoral meeting on Maldives DHS 2009 preliminary findings in February 2010. However, this brought in competition from other agencies (including the Centre for Community Health and Disease Control) also vying for access to the pre-release dataset. This understandably added weight to the decision to allow

¹ Personal correspondence with Dr Ann A. Way (Director, MEASURE DHS Project, ICF Macro) on 22 June 2009

access pre-release data to anyone, and introduced new concerns about data censorship and right to information. Thus, my access was again postponed on grounds of having to renew procedures and committees regarding data release. This position was maintained without progress until December 2010, when the Maldives DHS 2009 dataset was released for public access on the Measure DHS website, at which point I acquired it without need for further contribution from the Ministry of Health or the Government of Maldives.

Sample characteristics

The Maldives DHS 2009 collected data from individuals via three questionnaires- Ever-married Women's Questionnaire (age 15-49 years), Ever-married Men's Questionnaire (age 15-64), and Youth and Young Adults' Questionnaire (for never-married individuals aged 15-24). From each of the datasets, I selected respondents aged between 18 and 24 years to allow comparability with my youth in-depth interview sample- as discussed elsewhere, the decision to exclude respondents under 18 had a pragmatic basis in that it would have raised issues of parental consent to interview underage young people about sexual issues. Further to the limitations of this sample discussed in sections 3.2.4 Web-based Survey and 7.1 Limitations, Table 3 compares the total MDHS sample with the MDHS age 18-24 subset I selected for secondary analysis. As the table shows, the subset selection preserved the gender and urban-rural proportions, while reducing the difference between ever-married and never-married individuals. Although not expected to have a significant effect, sample weights were taken into account in the analysis of MDHS data.

<i>MDHS total sample by background characteristics</i>			<i>MDHS ages 18-24 subset by background characteristics</i>			
n	%		%	n	weighted %	weighted n
<i>Gender</i>						
2754	24.8	Male	24.9	707	25.7	704
8344	75.2	Female	75.1	2134	74.3	2037
<i>Marital status</i>						
8858	79.8	Ever-married	57.8	1643	54.8	1501
2240	20.2	Never-married	42.2	1198	45.2	1240
<i>Type of place of residence</i>						
1785	16.1	Urban	17.1	487	36.6	1002
9313	83.9	Rural	82.9	2354	63.4	1739
11098		Total		2841		2741

Table 3: Comparison of MDHS total sample with subset selected (by age 18-24) for secondary analysis

3.2.4. Web-based survey

The purpose of the web-based survey is to triangulate findings from the in-depth interviews (see 4.2) and the secondary analysis of Maldives DHS 2009 (see 4.3) for:

- Objective 1: Describe the context of sexual health data, policies and services for Maldivian youth
- Objective 2: Describe youth sexual health experiences
- Objective 3: Identify whether there is mismatch between official sexual health data, policies and services and youth experiences of sexual health
- Objective 4: Analyse the reasons for these differences between official sexual health data, policies and services, and youth experiences of sexual health

The web-based survey was incorporated into this research after it had started as a methodological experiment to test modality effects of administering behaviour- and attitude-based surveys on sensitive issues to young people in face-to-face interviews versus self-completion via the web. The validity of some results of the Maldives DHS 2009, particularly those on sexual behaviour, has been questioned, together

with possible under-reporting because of an unwillingness of respondents to disclose behaviour considered illegal. Thus, the web survey was conducted to:

- explore whether or not the mode of survey administration affects responses
- explore whether or not item attributes (e.g. question wording, response categories, etc.) affects responses
- investigate young people's behaviour, experiences, attitudes, perception, and knowledge regarding SH in Maldives

Sampling and coverage:

Although representativity was not sought- or possible, given the lack of a sample frame- the web survey needed a wide coverage of the Internet population of Maldivian youth in order to yield useful results. The box below shows an excerpt from the web survey development notes that summarises the various sampling strategies that were considered.

Target group: Maldivian youth aged 18-24 years, married and unmarried, male and female, living in Male', islands, and abroad

How do I select them?

Sample frame: none available. The National ID card number database is one option but that will probably deter people from participating

Survey request and reminders by email: while this has proved to be the most effective way to improve response rates (Umbach, 2004), I did not have access to an adequate list of email addresses nor did I think this would be the best way of reassuring people about anonymity given that this is a sensitive issue.

Most studies dealing with sensitive issues and young people (e.g., smoking, risk taking behaviour) administer the web survey in a formal setting, such as a school (Denscombe, 2006) but this option was not available to me

Self-selection: Very common approach in web based surveys but there is no way to be sure how much of the respondents represent the target population (Zhang, 1999). This is done by posting invitations or adverts or links to the survey on popular websites. This might include social networking sites such as Facebook, Twitter, and blogs.

Volunteer panels: a volunteer panel of eligible respondents is compiled by appealing on popular websites, encouraging participation in a study (Couper, 2000). This option had potential to work using social networking sites mentioned above

How do I reach the target population?

Despite increasing internet usage among Maldivians (World Bank data indicates that Internet users per 100 people has risen from 2.2% in 2000 to 28.3% by 2010 in the Maldives (World Bank, 2011)), there will be an element of coverage error, i.e. the ‘internet population’ of Maldivian youth will not be representative of the target population. This could lead to underrepresentation of those with limited financial resources (Zhang, 1999), and I would presume this would indicate underrepresentation of youth from the atolls. However, conversations with youth suggests if a young person in Maldives has access to the Internet, then they will at least have made an appearance on one of the social networking sites, particularly Facebook- this is supported by a study of young people’s internet usage comparing India, Nepal and the Maldives indicate that Maldivian youth spent more time on social networking sites than youth in India and Nepal (Singhal, Shiraani, & Adhikary, 2009). In addition to this, it has been found possible to involve typically hard-to-reach internet users (Andrews, Nonnecke, & Preece, 2003).

However, some background research on ways to administer a survey on the social networking site Facebook reveals that in order to embed a questionnaire there, it needs to be done via a Facebook application. I reviewed these applications and concluded that they do not have the necessary functionality for this research (see Section 5 Tools). While a Facebook embedded survey has been ruled out as a feasible option, it can be used as general platform for the web survey. A Facebook Group or Page could be set up to generate interest for the survey, used as a departure point for the survey (i.e. ‘click on this link to take the survey’), allow discussions and troubleshooting, as well as releasing results when available. It should be noted that this would require a lot of monitoring to ensure sustained interest.

How do I ensure this is the target population?

As yet there is no way to screen unintended respondents (Zhang, 1999) and there is no technical solution to this either (correspondence with Matt Lingard, Teaching and Learning Centre staff at LSE).

Non-target group: The answer lies in involving the non-target groups as well. While this adds a lot to ‘noise’ in the data and thus to data cleaning, it is a feasible way to minimise unintended respondents

Age: I chose not to draw attention to the fact that my target group are people aged 18 to 24 years. This was because it might have the unintended consequences of making people lie about their age to become a part of the desired age group just out of curiosity about the survey. So, I allowed every Maldivian identifying themselves as ‘youth’ to participate. However, the first screen of the web survey contained (in addition to thanks, brief information and confidentiality assurances) a question asking for their age (or year born). Once someone provides this information and click submit, they were directed to one of the following:

generate new data on youth SH, to capture the distribution of issues raised in the in-depth interviews.

Therefore, the web survey of this study consisted of 4 versions of questionnaires. Table 4 below summaries the differences between the questionnaire versions and the number of mutually exclusive respondents each was administered to (details of survey questions are provided in Appendix J).

Web Survey questionnaires:	Version 1	Version 2	Version 3	Version 4
	MDHS original			MDHS modified
	(unmarried)	(married male)	(married female)	
Aim	-test survey modality effects			-generate data -test item effects (question/answer wording, response categories)
Replicates	MDHS <i>Youth and Young Adult Questionnaire</i> for never-married individuals aged 15-24	MDHS <i>Ever-Married Women's Questionnaire</i> for ever-married females aged 15-49	MDHS <i>Ever-Married Men's Questionnaire</i> for ever-married males aged 15-64	None. Includes modified questions from MDHS and the <i>National Survey of Sexual Attitudes and Lifestyles 2000</i> , and own questions
Web survey administered to	never-married male & female 18-24 years	ever-married female only 18-24 years	ever-married male only 18-24 years	ever- & never-married male & female 18-24 years
N (total=480)	211	12	25	232

Table 4: Summary of questionnaires built-in to Web Survey

For *Version 4: MDHS modified*, questions from the MDHS were modified based on five problems that I identified as a result of analysis of the youth IDIs with the MDHS questions. Firstly, some phrases used in the MDHS questions were unclear and ambiguous. For example, the MDHS question on sexuality education referred to 'human reproduction and sexuality' being taught in schools. Analysis of the youth IDIs showed that a lot of youth assume this referred to the human reproduction unit taught in Biology, which did not include STIs or contraception. Thus, for Version 4, for example, the phrase 'human reproduction and sexuality' was substituted with 'contraception and sexually transmitted diseases' to check whether specifying

components of sex education (such as STIs and contraception) made a difference to the responses.

Secondly, some MDHS questions contain response categories that could potentially force an invalid response in the absence of a 'don't know' response category. For example: *Have you ever had sexual intercourse? YES / NO*. If a respondent was uncertain about what is considered sexual intercourse, which the youth IDIs suggested might be the case, then a DK response category is needed. Some key attitudinal questions in the MDHS offered too many ways for youth to respond ambiguously. Example: *Contraceptive services should be available to unmarried couples. AGREE / DISAGREE / IT DEPENDS / DON'T KNOW*. This raises several questions. Firstly, the response 'it depends' raises the question "It depends on what?" What constitute contraceptive services is also unclear. Does a 'don't know' response mean they do not know whether contraceptive services should be made available to unmarried couples or that the respondent does not know what contraceptive services constitutes? If a respondent felt that such services should be made available to unmarried individuals and not just couples, should they answer 'disagree'? Questions such as these need appropriate response categories, and the MDHS modified version made use of different response categories to those used in the MDHS.

Thirdly, the Maldives DHS 2009 censored some issues from unmarried youth by not asking them the same range of questions that were asked of married individuals of the same age. These included very key questions such as asking them whether or not they have ever experienced symptoms of STIs, and whether or not they would be able to get a condom. This omission reflects the agenda of the research commissioning agencies, highlighting issues that they do not consider as relevant. Version 4 therefore asked the whole range of questions to all respondents, both married and unmarried.

Finally, some questions in the MDHS touch upon, but do not follow up in any depth, on a range of critical SH issues for youth. One such issue is abortion, which was mentioned once in the MDHS with no follow-up questions. Abortion was an issue

that was raised frequently in the in-depth interviews with youth, so Version 4 included more detailed questions on issues such as abortion.

Tools

The web survey tool was selected after identifying a number of requirements that needed to be met in order to conduct an online survey young Maldivians found interesting, important, and easy to complete. In addition to technical requirements such as the features for random allocation (to randomly allocate respondents to MDHS original or MDHS modified version), blocking individuals from doing the survey more than once, allow complex question skipping patterns so that random allocation and answer-specific allocations (directing married men in MDHS original version to the relevant questionnaire) worked in the background invisible to respondents, I also gave priority to tools that met certain aesthetic requirements. These included features that allowed me to adapt response options to fit the question (e.g., radial buttons, drop-down selection, text boxes) and to customise backgrounds, fonts, and even the link to the survey (see Appendix L for selected screenshots). Furthermore, I required the tool to be secure (i.e., inaccessible to third parties phishing for information), that it allow easy retrieval of data in Excel or SPSS formats, and for all this to be available for a set budget.

From a pool of 10 different online survey tools (namely, Bristol Online Surveys, Survey Monkey, Zoomerang, Google forms, Vantage Point, Question Pro, Survey Methods, Poll-Daddy, Survey Gizmo, and Facebook-based applications), I discarded those that did not meet the criteria and selected Survey Gizmo. The web administrators for this tool then allowed me free access to an already low-cost survey subscription package, and were extremely helpful with technical troubleshooting during the course of the survey.

Implementation

The Web Survey was launched on 31st March 2011 and was live for 6 months, until 30th September 2011. The main method of attracting participants was primarily via the Facebook Page set up for the Survey. I also used the Facebook Advertising feature for a total cost of £60 over the 6 months, which improved exposure of the survey exponentially. Facebook Insights (a feature that enables you to track the

reach of your Page) indicate that at its peak during July-August 2011, the web survey Facebook Page attracted an average of 60 unique visitors and 80 views every day. To date, the Page has 797 fans. To keep them engaged during the course of the web survey, I posted polls regarding attitudes and perception towards youth SH issues which received responses from an average of 50 people. See Appendix L for screenshots of WS and the Facebook Page.

Outcome

Table 5 below shows the age, gender, residence distribution of Web Survey respondents, and how they compare to the 18-24 years subset of the Maldives DHS sample.

<i>MDHS youth (18-24yrs) sample by background characteristics</i>						<i>WS youth (18-24yrs) sample by background characteristics</i>						
Male		Female		Total	%		%	Total	Male		Female	
E-m ¹	N-m	E-m	N-m						E-m	N-m	E-m	N-m
<i>Current age of respondent</i>												
0	149	149	149	447	15.7	18	10	50	1	29	1	19
5	116	94	145	360	12.7	19	14	68	0	40	1	27
7	88	172	96	363	12.8	20	21	102	1	52	8	41
17	82	246	90	435	15.3	21	18	87	5	44	12	26
23	70	288	59	440	15.5	22	14	65	6	23	16	20
42	38	337	39	456	16.1	23	13	63	13	23	10	17
43	27	338	17	425	15.0	24	9	45	6	21	7	11
<i>Type of place of residence</i>												
						Abroad	20	96	3	45	4	44
13	134	175	165	487	17.1	Urban (Male')	69	333	24	161	38	110
124	436	1331	463	2354	82.9	Rural (Islands)	11	51	5	26	13	7
137	570	1506	628	2841	100%	Total	100%	480	32	232	55	161
4.8	20.1	53.0	22.1	100%		%		100%	6.7	48.3	11.5	33.5
24.9		75.1		100%		% gender		100%	55		45	
					57.8	% E-m	18.1					
					42.2	% N-m	81.9					

Table 5: Comparative distribution of MDHS and Web Survey respondents by age, gender, and type of place of residence

¹ E-m: Ever-married; N-m: Never-married

As evident in Table 5, there are three major differences between the distribution of the Web Survey sample and the MDHS sample which I take into consideration when interpreting the results. Firstly, the age distribution- the MDHS sample is evenly distributed with 12.7% as the smallest proportion (19 years) and 16.1% as the largest (23 years). The Web Survey sample is distributed between 9% (24 years) and 21% (20 years). Secondly, urban youth (those living in Male') are over-represented in the Web Survey sample- 69% compared to 11% rural youth (those living in other islands). The inverse is true for the MDHS sample- there are significantly more rural youth (83%) than urban youth (17%). Moreover, the Web Survey sample contains Maldivians living outside of Maldives, whereas MDHS was sampled only from those based in the Maldives. Finally, while the proportion of male and female respondents are almost evenly split in the Web Survey sample, the MDHS sample over-represents females, particularly ever-married females who account for over half of the sample (53%). The limitations introduced by these skewed samples limit the conclusions that may be drawn from analyses- these are discussed with the results in Chapter 5.

Although there is no other study I can use to verify this, I would suggest that the Web Survey sample distribution most likely reflects the Internet population of Maldivian youth aged 18-24. The low proportion of rural youth (11%), the slightly bigger proportion of males (55%), and quite significantly bigger proportion of never-married youth (82%) is indicative of this. As will be discussed later, these differences in distribution of the MDHS and WS sample limits how much they can be compared to each other, and I discuss these implications when presenting the findings in Chapter 5.

3.3. Data analysis

3.3.1. Qualitative data analysis

Audio recordings from the KI interviews and the IDIs were transcribed and coded by myself using Nvivo software and analysed using discourse analysis. Discourse analysis, derivative of the social constructionist position, was done over two phases- the first phase is searching for thematic patterns and checking for variability and

consistency; and secondly, tentative hypotheses were formed and checked against the data in an iterative process (Gill, 2000).

Analysis becomes complicated when considering differences between data that would be generated from IDIs and KI interviews. KI interviews focus on content ('what' questions) (Silverman, 2006) as it was necessary to gain insight into what goes into SH policymaking and the extent to which religious and sociocultural influences enter that process. The use of interview data to answer 'what' questions is a contested issue, and it is argued that that practice belongs to positivism rather than constructionism (Silverman, 2006). However, that argument is met with claims that 'what' questions and 'how' questions (questions about form) can be combined within constructionism and that "the standpoint from which the information is offered is continually developed in relation to on-going interview interaction" (Holstein and Gubriam 1997, quoted in Silverman 2006, p.122). The KI interviews in this research are a combination because they also explore key informants' perceptions and experience of how they engage(d) with the SH policymaking process and how they negotiate(d) the surrounding religious, political and sociocultural influences.

Nonetheless, a distinction was made for the analysis stage. The topological framework for policy analysis (Lejano, 2006) is not suited for the IDI data, given that IDI respondents (i.e. youth) have had no role in the process that established (through policymaking) and implemented (through service provision) the SH environment in Maldives. Thus, IDI data was analysed separately from KI interview data.

By setting out characteristics of IDI respondents (marital status, age, etc.) and letting that guide sampling criteria selection, some choices about analytical themes were already made during the data collection process, such as the focus on marital status, including living arrangements as selection criteria. These themes were expanded and refined in an iterative process as fieldwork progressed.

Along with these themes, two interlinked phenomena (Rapley 2004, cited in Silverman 2006) also informed the constructionist analytical framework for the IDIs:

- *Identity work*: the respondent is presenting themselves as a "specific type of person in relation to this specific topic" (Rapley 2004: 16)

- *Cultural stories*: “...the interview-talk *speaks to* and *emerges from* the contemporary ways of understanding, experiencing, and talking about that specific interview topic” (Rapley 2004: 16)

Similar to using different analytical approaches to the two seemingly similar qualitative sets of data, there are differences to the way in which I use IDI and KII quotes¹ in the thesis. I use quotes from IDI data to show variation or similarities of youth narratives across different sites and background characteristics (such as gender or marital status), and in some instances I provide several quotes to show extent of a similar attitude (e.g., how commonly abortion is mentioned first in response to questions about unwanted pregnancies). I use quotes from KII data mainly to show different accounts of experiences that are somewhat shared between key informants (e.g., policy and programme planning discussions, providing services concurrently in Male’) and to show the different ways in which they deal with common influences (such as religious influences). With both KII and IDI data, I have made an effort to draw quotes from variety of sources than rely heavily on articulate interviewees- however, some sources were used more than once with KII quotes, given the small number of key informants (n=17) even fewer representing each institution. In most quotes, I have deliberately included the question that prompted the response, where appropriate, in order to show how the evidence was produced.

3.3.2. *Quantitative data analysis*

Datasets from the MDHS as well as the web survey were analysed using SPSS for descriptive statistics to assess prevalence of attitudes, followed by significance testing (Chi-square tests) to test for relationships between factors including age, attitudes, religiosity, education, and living arrangements.

3.4. **Ethical considerations**

Ethical approval was obtained from the LSE’s Research Ethics Committee who concluded that the appropriate ethical safeguards were in place for this research. Ethical approval was not required from the Maldivian authorities. The ethical safeguards assured prior to fieldwork, and adhered to throughout, are in Appendix M.

¹ Quotes were translated into English by me. Anonymised Dhivehi transcripts are available on request

3.5. Challenges and Limitations

This section describes overarching challenges and limitations of the methodology- limitations specific to individual research decisions are discussed throughout the thesis.

Language: Language issues were anticipated as a challenge for the interviews. Regarding key informant interviews, older generation Maldivians might not be very fluent in English, and with in-depth interviews some youth participants might feel less inhibited to discuss in Dhivehi. As I am fluent in my native tongue, Dhivehi, I was prepared to conduct the interviews and the analyses in Dhivehi (and translate the parts I would include as evidence in this thesis), thus minimising the loss of meaning in analysis. However, few interviews were entirely in Dhivehi, as almost all respondents (key informants and youth) spoke a mixture of English and Dhivehi. Thus this challenge was limited to the transcription phase alone, and did not affect the analysis as I am fluent in both languages and able to maintain meaning.

Quantitative data: Considering the usual high quality data from DHS studies, prior to receiving the dataset, a lot of weight was placed on the Maldives DHS 2009 data, the gaps it would fill, and the role it would play in this study. However, it was apparent from the preliminary findings that evidence from the KIIs and youth IDIs would challenge several aspects of the findings, such as low levels of reported premarital sexual activity. Although that is in itself interesting and was subsequently reflected in this research, and further tested using the web survey, the web survey cannot fill the gap for quantitative SH data on Maldivian youth as it was not a representative sample study.

Key informant data: While data from young people were triangulated by using three different methods to approach the same data (in-depth interviews, secondary analysis of Maldives DHS 2009, and web-based survey), the same could not be done for data from key informants. Difficulties in getting them to devote time to provide data and their elite status limited the research methods appropriate to them. However, every effort was made to minimise this limitation by extensive document review and cross-checking with other key informants.

Evaluation of services: The services provided for young people, namely the Youth Health Café and the Adolescent Unit (Reproductive Health Centre, IGMH) have had very few evaluations done. This limited the information that can be drawn upon in this research to accounts from service providers, which are bound to be very subjective. Again, extensive document review assisted in minimising this limitation.

3.6. Conclusion

Having detailed the methodology of this research, in the following two chapters I provide the results- first presenting results from the policy and services perspective (Chapter 4) followed by data from youth (Chapter 5).

Chapter 4 Maldivian SH Policy & Service Context

This chapter addresses Objective 1 of this research and establishes the Maldivian youth SH policy and service context. Based on policy reviews and key informant interviews with policymakers, service providers, and other stakeholders, the analysis is presented in three parts. First I provide an overview of how the SRH policies and services in Maldives have evolved in the past 30 years. Secondly, I draw upon milestones in Maldivian SRH evolution to establish the topology of the different stakeholders involved in Maldivian SH policy and services, identifying their roles in shaping Maldivian SH, their relationship to each other, their strengths and limitations. Finally, I describe contemporary youth SH services in the Maldives.

As discussed in Chapter 2, the analysis of Maldivian SH policy and its contributors uses the social constructionist approach to Social Problems Theory, also drawing upon social constructionist elements of analysing the cycle of social problems (J. W. Schneider, 1985). This conceptual framework is particularly applicable to Maldivian SH for its attention to both the definition of a social problem and the identification of those who define it as a social problem. Social Problems Theory lends itself well to an actor-centric analysis, although the corresponding term within this framework is ‘problem participant’ - a term that will be used in this chapter, referring to SH-related institutions (which are the unit of analysis) although individual differentiation will be acknowledged where applicable. This chapter’s analysis is based in part on policy review, which identified seven problem participants: UNFPA Maldives, Ministry of Health, Youth Ministry, Society for Health Education (NGO), Education Ministry and Schools, Clinicians, and Religious Institutions. Each problem participant is analysed in the section following the overview of Maldives SRH.

4.1. Overview of SRH in the Maldives

The timeline (Tables 6-8) shows how the Maldivian SRH policy context evolved in Maldives over the last three decades since the SRH problems were identified. Youth-related SH developments are set within the context of other SRH milestones. Both are compared to the SRH-related data available at that time to explore the extent to which policies and strategies were potentially informed by data.

4.1.1. 1980s: Fertility control

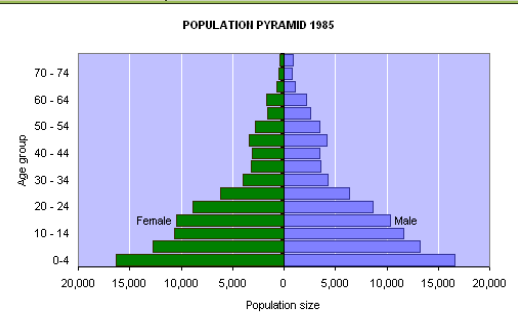
Year	Data	Youth SH	Other SRH
1980	<ul style="list-style-type: none"> Maternal Mortality Rate: 11.9/1000¹ Infant Mortality Rate: 120.7/1000 live births 	 <p>POPULATION PYRAMID 1985</p> <p>The population pyramid shows a wide-based structure with a significant number of children (0-14 age group) and a smaller number of elderly (65+ age group). The population size for females is generally higher than for males in the younger age groups.</p>	
1984-85	<p>1985 Census²</p> <ul style="list-style-type: none"> Total population: 180,088 Annual growth rate (exponential): 3.2 15-19 years: 11.55% of total pop. 20-24 years: 9.73% of total pop. 		<p>1984: Child Spacing Programme¹</p> <p>UNFPA assists Family Planning programme initiated with funding for Society for Health Education (SHE)³</p>
1987			<p>National AIDS Council (NAC) established and AIDS Control Programme launched⁴</p>
1988	<ul style="list-style-type: none"> Estimated Contraceptive Prevalence Rate among eligible (married) women: 3% 		<p>Child Spacing Policy¹ approved the following methods for child-spacing: “natural methods, barrier methods, Pills, Injectables, IUDs” (p.10). Female and male sterilisation permitted on medical grounds and voluntary requests, but validated by physician. Prohibits ‘menstrual regulations’ and abortion</p>

Table 6: Maldivian SRH in the 1980s

¹ (Regional Office for South East Asia WHO South East Asia, 1988)

² (MPND, 2005)

³ (UNFPA Maldives, 1994)

⁴ (UNICEF, 2006)

The foremost SRH-related social problem of the 1980s was fertility control and its impact on maternal and infant mortality. The Child-Spacing Programme project document identifies the Government of Maldives as initiators of the project-

...the Government introduced this project, funded by the UNFPA, executed by the WHO, and implemented by the Ministry of Health, to make modern child-spacing methods widely available on a voluntary basis so that married couples can achieve better control of their fertility. (Regional Office for South East Asia WHO South East Asia, 1988, p. 1)

The Child Spacing Policy is reported to have accompanied the Child Spacing Programme in 1984 (Regional Office for South East Asia WHO South East Asia, 1988) although UNFPA reports it did not come into effect until 1986 (UNFPA Maldives, 1994). As this Programme was the first time that fertility control had been encouraged officially in the Maldives, although fertility control and the use of contraception has been contested in Islamic doctrine (Musallam 1983 and Omran 1992 cited in Sargent 2006), the policy acted as a legitimising tool. The Ministry of Health was thus instructed by the government to be sensitive to the religious and sociocultural values in their approach to promote child-spacing (Regional Office for South East Asia WHO South East Asia, 1988). The government-approved project logo for this was also designed to reinforce this message (white crescent depicting Islamic faith) (Regional Office for South East Asia WHO South East Asia, 1988) and religious leaders were included in the outreach teams that travelled to atolls to conduct awareness sessions.¹

Despite this, there were some island communities that resisted family planning, saying it was a Western (and therefore ‘un-Islamic’) practice brought by Western organisations (namely UNFPA and WHO).² Fieldworkers from the NGO Society for Health Education (SHE) were particularly targeted for promoting Western practices as they were active in atoll outreach activities.³ The Child Spacing Policy was also instrumental in conveying that the child-spacing programme was state-sanctioned and initiated, despite the considerable involvement of international NGOs.

¹ KII01, KII15

² KII01, KII02, KII09

³ KII01, KII06

R: Everything is so... even to introduce contraception it was very difficult. They would not agree to... agree to... they just say it as abortion... even after the policy decision was made...

-KII02, MOH official-

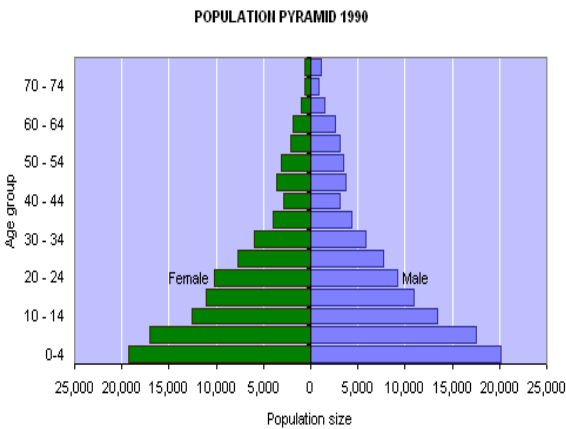
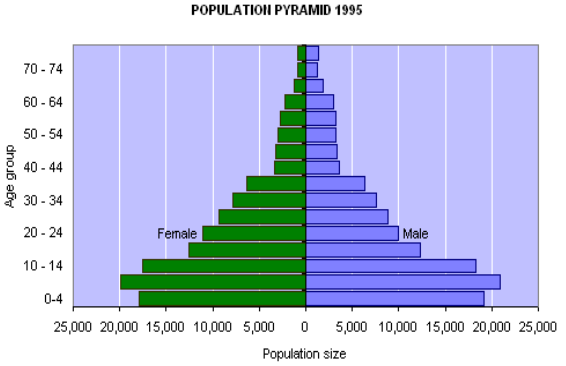
Three points emerge from this review of SRH issues in the 1980s. Firstly, the influence of religion in affecting policy formulation and programme planning in Maldivian SRH. Secondly, that the emergence of Maldivian SRH programmes was largely INGO and donor-driven. Finally, the importance that SRH policies appeared to be state-driven, even if this was not the case, in order to encourage public compliance.

According to Schneider's description of four stages in the cycle of Social Problems, the 1980s marks the first stage where a condition that needs to be remedied is identified by claims-makers urge action (J. W. Schneider, 1985). Spector and Kitsuse describe it as "collective attempts to remedy a condition that some group perceives and judges offensive and undesirable... Initial social problems activities consist of attempts to transform private troubles into public issues..." (1973, p.148, quoted in Schneider 1985). At this stage in this context, the claimants appear to be UNFPA, urging the need for family planning and child-spacing to achieve good reproductive health in the Maldives.

4.1.2. 1990s: Urban-rural differences

Maldivian SRH underwent three major changes during the 1990s. First was a redefinition of the social problem of Maldivian SRH. In the early 1990s, the focus of the SRH social problem shifted to urban-rural differences in sexual and reproductive health. This was shaped with considerable input from UNFPA and WHO. The UNFPA, instrumental in developing the Child Spacing Programme and for training the health personnel that delivered it, expressed continued difficulty (since their initial presence in Maldives in 1977) in ensuring that those in the outer islands were

benefitting from their support (UNFPA Maldives, 1994). The WHO attributed difficulties with the Child-Spacing Programme to geographical dispersion of the population combined with strict regulations on contraceptive distribution- two factors that are likely to be also responsible for the huge fertility decline between 1990 and 1995. Until 1990, Atoll Health Centre staff were only allowed to dispense oral contraceptives and condoms, while Island Health Post staff (the people present on every island) were not allowed to distribute any contraceptives (Regional Office for South East Asia WHO South East Asia, 1988). Thus, for many Maldivians the impact of the Child Spacing Programme was not apparent until 1990 (MOH 2001), when family planning services were first rolled-out to outer islands (UNFPA 1994). The 1990-1995 fertility decline is a prime example of the impact of family planning promotion in the atolls (and not restricted to only Male'). As the table overleaf shows, the Contraceptive Prevalence Rate (method or group unknown) in 1993 stood at 7% and doubled within the following 4 years, despite a lot of variability between islands that ranged from 4% to 32% (UNFPA Maldives, 1997).

Year	Data	Youth SH	Non-youth SRH
1990	<p>1990 Census (MPND 2005)</p> <ul style="list-style-type: none"> • Total population: 213,215 • Annual growth rate (exponential):3.4 • 15-19 years:10.36% • 20-24 years:9.11% 		<p>Provision of family planning services to outer islands (UNFPA Maldives, 1994)</p> <p>1st KAP (Knowledge, Attitude, Practice) survey on family planning conducted with financial assistance from UNFPA and WHO (Niraula, 2010) Data unavailable</p>
1992-93	<ul style="list-style-type: none"> • 1993: Contraceptive Prevalence Rate (method or group unknown): 7% (UNFPA Maldives, 1997) 		<p>1992: International Planned Parenthood Federation (IPPF) active through SHE (UNFPA Maldives, 1997)</p>
1994	<p>“...large numbers of illegal abortions...” (UNFPA Maldives 1994:7)</p> <p>“...contraceptives widely accessible to married couples, although there still were problems related to accessibility” (MOH, 1999a, p. 22)</p>		<p>UNFPA 1st Country Programme 1994-1997 (UNFPA Maldives, 1994). Noted difficulties due to low national expertise and human resources. Funding allocated towards training personnel, extending maternal and child healthcare, and family planning services to all 200 inhabited islands (UNFPA 1994).</p> <p>National Programme of Action aims to increase CPR from 10 to 20% by 1995 (UNFPA Maldives, 1994). Policy document unavailable</p>
1995	<p>1995 Census (MPND 2005)</p> <ul style="list-style-type: none"> • Total population: 244,814 • Annual growth rate (exponential): 2.7 • 15-19 years:10.17% • 20-24 years:8.59% 		

1996	<p>Health Master Plan 1996-2005 (MOH, 1995)</p> <p>“The number of adolescents who get sentenced for pre-marital sex (sex outside of marriage,) is an indication that adolescents are sexually active. According to 1995 data, 280 persons (29.7%) were sentenced for offences related to sex outside of marriage. Although this figure relates to all ages, current trends indicate a majority of these to be within the adolescent age group” (p.24)</p> <p>“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. Unofficial information from the community indicates that there have been deaths due to unsafe abortions.” (p.24)</p>	<p>Health Master Plan 1996-2005 reports that ‘adolescent health’ has only been addressed within the framework of maternal and child health, and has not been differentiated as focus area within the health sector (MOH, 1995)</p> <p>Although the inclusion of population education in secondary education to increase awareness of SH needs, “the methodologies used in educating young people on issues related to sexual and reproductive health need to be more attractive to young people so that they could take responsibility for their own health and actions” (MOH, 1995, p. 24)</p>	<p>Health Master Plan 1996-2005 proposes goals for addressing family planning, safe motherhood, and STIs (MOH, 1995)</p>
1997-98	<p>1997: “...CPR stood at 7 per cent in 1993, but is estimated to have increased to about 15 per cent at present. There is, however, a great deal of variation in the indicators. CPR for instance varies from 4 to 32 per cent in different islands” (UNFPA Maldives, 1997, p. 3)</p>		<p>1998: UNFPA 2nd Country Programme 1998-2002</p> <ul style="list-style-type: none"> -strengthen services established under 1st CP, -Capacity-building -Establishing a multisectoral approach in promoting population and RH issues (UNFPA Maldives, 1997)
1999	<p>Reproductive Health Baseline Survey 1999 (CIETinternational, 1999)</p> <p>-CPR for modern temporary methods: 23%</p>	<p>UNFPA Country Support Team in Kathmandu, Nepal and the Maldivian Education Ministry develop a resource book for students in 11th and</p>	<p>Health Report 1999 (MOH, 1999a)</p>

<p>-Unmet need for modern contraception among married women aged 15-49 years: 42%</p> <p>“Respondents who have never been married are only half as likely to be aware of at least one modern method of contraception compared with respondents who are or who have ever been married” (p.22)</p> <ul style="list-style-type: none"> • Household respondents who do not know of any signs of STD: 65% • Household respondents who have not heard of AIDS: 99% <p>Adolescents (15-19 years, via focus groups) reported to have high levels of knowledge on AIDS and contraception</p> <p>“Several groups mentioned their belief that STDs can ‘lead to AIDS’. This perhaps reflects the high-profile education programme about AIDS, which seems to have made nearly everyone aware of AIDS” (p.50)</p> <p>“Since Maldivians tend to marry early, a large component of adolescents and youth are sexually active. Despite strong religious proscription of extra-marital sex, there is growing evidence that many adolescents are sexually active” (UNFPA, 2006, p. 90)</p>	<p>12th grades (typically aged 16-18) (MOE & UNFPA Nepal, 1999). Information of the resource book’s utility, success or evaluation cannot be found. Titled <i>What Young Maldivians Want to Know About – Population, Reproductive Health and Family Life</i>, includes the following components:</p> <ol style="list-style-type: none"> I. Population of Maldives II. Adolescents’ Reproductive Health Issues in Maldives III. Human Development IV. Reproductive Health and Sexuality V. Family and Marriage in Islam VI. Society, Culture, and Gender 	
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Table 7: Maldivian SRH in the 1990s

The second major feature of Maldivian SRH in the 1990s is the composition of its problem participants. Up until 1995, INGOs were the major driving forces in shaping Maldivian SRH. The NGO SHE also became a key participant by conducting their own family planning activities with funding assistance from the UNFPA (UNFPA Maldives, 1994) and by becoming the local partner to the International Planned Parenthood Federation (IPPF) in 1992 (UNFPA Maldives, 1997). By formulating the 10-year Health Master Plan in 1996 (MOH, 1995), the Ministry of Health advanced from its role as an implementation agency to a more important participant in SRH policy development. This Master Plan led to the availability of more data, most notably, the Reproductive Health Baseline Survey (1999) which provided data on knowledge, perception and prevalence of contraception and family planning services in Maldives (CIETinternational, 1999).

This availability of nation-wide data illuminated the third major feature of Maldivian SRH in the 1990s, the diverging trajectory of policies from data. Previous policies may be described as both ambitious (for example the National Plan of Action in 1994 aimed to increase Contraceptive Prevalence Rate to 30% by 1995) and neglectful (e.g. a 5-year delay between RH services provision to urban areas and rural areas). However, these earlier policies could not be contradicted by data, because there were none (Table 7). The Health Master Plan 1996-2005 contains reports of premarital sexual activity, unsafe sexual practices, and unsafe abortion among adolescents but restricts strategies to raising awareness on SH needs in schools.

The 1990s marks stages two and three of Schneider's description of the Social Problems cycle. Stage two is characterised by government institutions recognising the claims and identifying "an organisation charged with doing something about the putative conditions" (J. W. Schneider, 1985, p. 212). In the Maldivian context, the Ministry of Health recognised and routinized reproductive health during the 1990s, promoting accessible family planning and maternal health services throughout the country (UNFPA Maldives, 1994).

However, stage three of the Social Problems cycle begins when official acceptance of claims lead to a 'new generation' of the Social Problem definitional activities (J. W. Schneider, 1985)- towards the late 1990s, there was growing awareness of sexual

health issues such as unsafe abortions and premarital sexual activity (MOH, 1995, 1999b). As Fuller and Myers posit, “[i]f the people are not problem-conscious, they will not behave as if there were any problem. They will not debate the condition as a problem nor will they organize to do anything about it” (Fuller & Myers, 1941, p. 26). The admission made by the MOH in the Health Report that ‘adolescent health’ has only been addressed within the framework of maternal and child health, and has not been differentiated as focus area within the health sector (MOH, 1995) indicates that youth sexual health has been identified as social problem.

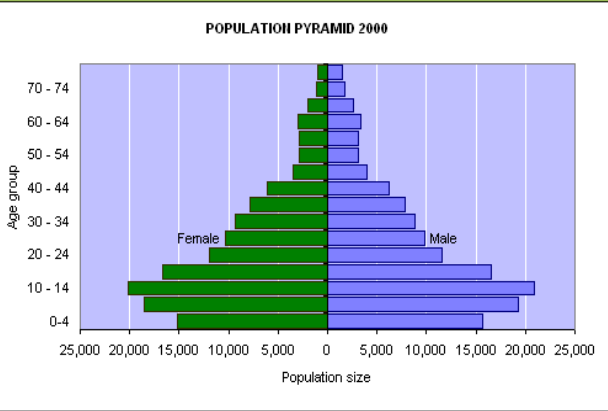
4.1.3. 2000s: Adolescent Reproductive Health

Youth SH was first identified as a social problem in 2000. However, the term Youth SH was rarely used in policy documents (CDE, 2003; MOH, 2004b; MPND, 2007; UNFPA Maldives, 2003a). All participants interviewed agree that using the term ‘reproductive health’ rather than SH encouraged support and endorsement from communities as well as decision-makers -- the quote presented below is one such example. Moreover, there is a consistent use of the word ‘adolescent’ which appears to have directed policies and research to in-school young people (CDE, 2003; MOH, 2004b; MPND, 2007; UNFPA Maldives, 2003a).

R: It is actually sensitivity, to be honest... We have been trying to do this for ages... adolescent or sexual health... sexual reproductive health... for adolescents it's often ASRH... If it's a regular mainstream project its ... it'll be about 'reproductive health'

-KII02-

SH policies continued to consistently reflect commitment to promoting awareness (MOH, 2004b; MPND, 2004, 2007) despite persistent reports showing the need for services to deal with STIs, unwanted pregnancies, and unsafe abortions (NCB, 2003; Thalagala, 2008). Similarly, there are numerous strategies targeting HIV/AIDS despite low incidence and high levels of knowledge of HIV/AIDS and low knowledge of other STIs (CDE 2003; BBS 2008; MDHS 2009).

Year	Data	Youth SH	Other SRH
2000	<p>2000 Census (MPND, 2005)</p> <ul style="list-style-type: none"> • Total population: 270,101 • Annual growth rate (exponential):2.0 • 15-19 years: 12.32% • 20-24 years: 8.71% <p>• Mean age of marriage rising: women: 21.8 years; men: 25.6 years (UNFPA, 2006)</p> <p>• 2.65% of the adolescent female (10-19 years) had given birth to at least one child (UNFPA, 2006)</p> <p>A Situational Assessment of HIV and AIDS in the Maldives for the Year 2000 (UNFPA, 2006) notes “the rapidly increasing young population, mobility, exposure to foreign lifestyles and long separation from families place higher vulnerability to the risk of HIV” and that “a proportion of young people were found to experiment with sex before marriage. Further, parents and relative do not teach anything about sex, and sexuality or related issues to their children” (UNFPA, 2006)</p>	<p style="text-align: center;">POPULATION PYRAMID 2000</p>  <p>Department of Public Health offers to conduct SH information sessions in Male’ schools. One private school agrees (others’ responses unknown). Students demonstrate low knowledge but great interest (KII17)</p>	

2002	<p>Independent Assessment of the Level of Fertility in the Maldives: Results of a Survey (MPND, 2002) confirms fertility is declining & picking up momentum</p>	<p>National Youth Policy (MYS, 2002) notes youth health as one of 9 issues: [Unofficial translation] “The most serious issues affecting the health of young men and women are because of their habits and lifestyles. Low consumption of healthy food, smoking, and drug abuse may be noted in particular. Also the importance of family planning” (MYS, 2002, p. 17). Among the strategies:</p> <ul style="list-style-type: none"> - <i>Promote awareness about HIV/AIDS and other STIs</i> - <i>Promote awareness about nutrition, family planning, and early marriage</i> (MYS, 2002, p.33) 	<p>Strategic Plan for Prevention and Control of HIV and AIDS 2002-2006 (UNICEF, 2006)</p>
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2003	<p>Rapid Situation Assessment of the Drug Abuse Situation in Maldives highlights unsafe sexual practices and early sexual debut among high-risk youth (NCB, 2003)</p> <p>Reproductive and Sexual Health of Adolescents in the Maldives conducted by private consultancy (CDE, 2003) finds high levels of knowledge of HIV/AIDS among adolescents</p> <p>Market Research on Condom Prevalence and Promotion (UNFPA Maldives, 2003b) shows need for brand variation in condoms to encourage condom use and:</p> <ul style="list-style-type: none"> - “People under 19 years of age, with 6% of the market, falls into the least significant user segment. Interviews with pharmacists indicate that the low per cent of the latter segment of users would be an incorrect representation as most of them would most probably be unmarried and, hence, unwilling to participate in the research due to legal implications. However, given evidence of increasing sexual activity outside marriage amongst adolescents and youth, the low condom prevalence rate among adolescents suggested by the findings of this research is cause for concern” (UNFPA Maldives, 2003b, p. 4). - “Suggestions were also made to introduce delivery service of condoms and to lift restrictions on the sale/distribution of condoms to unmarried people” (UNFPA Maldives, 2003b, p. 7). 	<p>Adolescent Sexual and Reproductive Health Project and Life Skills Education Project (UNFPA Maldives, 2003a). Involved Life Skills education in selected schools to increase awareness on adolescent SRH issues, equipping them with necessary life skills to lead a healthy life (UNFPA Maldives, 2003a). Also piloted a youth-friendly RH clinic (the Youth Health Café) which provides advice and contraceptives to youth (UNFPA Maldives, 2003a)</p> <p>Profile of Adolescents and Young People in the Maldives (UNFPA, 2006) states that “knowledge and access to information and services on how to prevent unwanted pregnancy is, however, limited” and that “there is a total lack of qualitative and quantitative information on actual adolescent’s sexual behaviour” (UNFPA, 2006, p. 60)</p>	<p>UNFPA 3rd Country Programme 2003-2007 focusing on RH, gender, population and development. (UNFPA 2002). Also funded the ASRH Project (see left column) and the Reproductive Health Quality of Care Project aimed at strengthening the quality of RH services (UNFPA Maldives, 2003c)</p>
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2004	<p>Reproductive Health Survey (MOH, 2004c)</p> <ul style="list-style-type: none"> • Contraceptive Prevalence Rate for all methods : 34% • (increased preference for modern methods since 1999) • Unmet need for all contraceptives among married women of reproductive age: 39% (was 42% in 1999) • Knowledge about STI transmission: 79% (was 57% in 1999) • 48 women aged 15-19 years had given birth to at least one child • Mean age of marriage: women: 18.4 years; men: 22.3 years • Youth sexually active before marriage: 8% • Two-thirds of the 8% had had their first experience before the age of 18 • HIV Prevalence among 15-24 year old pregnant women: none (UNFPA Maldives, 2004) 	<p>Population Policy (MPND, 2004) identifies Goal 14: Provide population education to children, adolescents and adults</p> <p>Reproductive Health Survey (MOH, 2004c) is the first ever Maldivian study to explore premarital sexual activity. However, the report itself cautions against generalising to the whole population due to the low representation of youth from urban areas.</p> <p>Adolescent Unit established at the Reproductive Health Centre at state hospital in Male’, planned to provide holistic health services and referral for young people. (KII14)</p> <p>SHE (NGO) establishes a Youth Kiosk to provide young people with counselling and SRH information (SHE website, 2011)</p> <p>ICPD+10 and Beyond: Progress, Achievements and Challenges in the Maldives 1994-2004 identifies priority actions that includes “[a]ddressing the needs of adolescents and youth through the provision of information and services, promoting responsible behaviour through strengthening life skills education in schools and out of school youth and carrying out awareness campaigns through media on issues of drug use, unsafe sex, gender based violence etc. and their implications” (UNFPA Maldives, 2004, p. 5)</p>	<p>Population Policy (MPND, 2004)</p> <p><i>Goal 1: Reduce population growth rate to a sustainable level by 2020 and achieve stable population growth by 2050</i></p> <p><i>Goal 2: Reduce fertility levels to near replacement over the next 20 years</i></p> <p><i>Goal 3: Reduce maternal mortality rate to under 100 per 100,000 live births by the year 2010</i></p> <p><i>Goal 4: Reduce infant mortality rate to under 15 per thousand live births by 2010</i></p> <p><i>Goal 7: Promote awareness on reproductive health and responsible parenting</i></p> <p>Health Report 2004 states that prevalence or incidence of STIs were unknown as proper surveillance had not been undertaken (MOH, 2004a)</p>
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2005	<p>Restoration of comprehensive quality reproductive health services and rights among populations affected by the tsunami uncovers reports of increasing pregnancies, including unwanted pregnancies, as women and girls were placed in high-risk conditions due to the poor & communal living conditions following the Tsunami (UNFPA 2005)</p>	<p>National Reproductive Health Strategy 2005-2007 (MOH, 2004b) identifies adolescent sexual and reproductive health as a thematic area, with the goal to “improve the sexual and reproductive health of adolescents (10-19) and young people (15-24) in the Maldives.</p> <p>Objectives:</p> <ol style="list-style-type: none"> 1) 50% of adolescents and youth (10-24 years) have access to age appropriate information related to SRH 2) ASRH Life Skills Education provided to at least 75% of adolescents/young people in selected schools in Male’ 3) Develop and pilot youth-friendly services on SRH” (p.13) <p>Family Planning Unit (FPU) established at state-hospital in Male’ primarily attending to sexual and gender-based violence cases but has been reported to offer emergency contraception during treatment of rape cases.</p>	<p>National Reproductive Health Strategy 2005-2007 (MOH, 2004b)</p> <ul style="list-style-type: none"> - <i>Safe motherhood and new-born care</i> - <i>Family planning</i> - <i>STIs and HIV/AIDS</i> - <i>Gender based violence</i> - <i>Partnering with men in sexual and reproductive health</i> - <i>Reproductive morbidities (including infertility and cancer)</i> <p>Youth Voices study (MYDS, MPND, & United Nations Task Force On Adolescents And Youth, 2005), a nation-wide youth-participatory study exploring ‘the main challenges of young Maldivians’ focuses on employment, education, family, recreation, and religion.</p>
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2006	<p>2006 Census (MPND, 2006)</p> <ul style="list-style-type: none"> • Total population: 298,968 • Annual growth rate (exponential): 1.69 • 15-19 years: 13.3% • 20-24 years: 11.6% 	<p>7th National Development Plan 2006-2010 (MPND, 2007) identifies the need to promote awareness of RH among adolescents</p>	<p>7th National Development Plan 2006-2010 (MPND, 2007) identifies the right to quality RH services</p> <p>Situational Analysis on HIV/AIDS in the Maldives reports a cumulative of 13 HIV/AIDS cases among Maldivian nationals, recommends forming multisectoral strategies to combat youth vulnerability to HIV/AIDS, and policies addressing sex work and male to male sex (NAC, MOH, & UN Theme Group on HIV/AIDS, 2006)</p>
2008	<p>Behavioural and Biological Survey conducted for high-risk groups including youth. Results showed high levels of premarital sexual activity</p> <p>Qualitative study of induced abortion in Maldives conducted via SHE, assisted by IPPF reports “induced abortions were found to be common events among females in Male’ and most of those could be considered to be obtained in unsafe circumstances. The discussions indicated that abortions were more common among unmarried youths than among married couples” (Thalagala, 2008, p. 2)</p>	<p>Adolescent Unit at RHC in state hospital discontinued due to low human resources and lack of funding to develop capacity of staff (KII14)</p> <p>SHE discontinues Youth Kiosk (KII12)</p>	
2009	<p>Maldives DHS (MOHF & ICF Macro, 2010)</p> <ul style="list-style-type: none"> • Unmarried women (15-24 years) who have had sexual intercourse: 3.2% • Unmarried men (15-24 years) who have had sexual intercourse: 9.8% 	<p>Maldives Demographic and Health Survey is the first nationally representative study to explore premarital sexual activity</p>	<p>Family Court introduces regulation requiring all couples intending to marry to attend a one-day Marriage Awareness Programme that has one session on SH issues such as STIs and contraception (MOJ, 2011)</p>

Table 8: Maldivian SRH in the 2000s

The 2000s saw the introduction of three SH services for young people- the Youth Health Café, Adolescent Unit at the Reproductive Health Centre of the state hospital in Male', and SHE's Youth Kiosk. However, the late 2000s also marked a period that highlighted lack of policy support and commitment to youth SH as two of these three services were discontinued due to a lack of trained personnel and funding.

By comparison, married couples are provided with family planning information and services at all medical facilities, some health posts in rural areas conducting active outreach (MOH, 2004b). In 2007, the Family Court introduced a regulation requiring all couples intending to marry to attend a one-day Marriage Awareness Programme that has one session on SH issues such as STIs and contraception (MOJ, 2011).

During the 2000s, stage three of the Social Problems cycle continues with more social problem definitional activities undertaken following acceptance of claims by a government institution (J. W. Schneider, 1985). Since 1999, youth sexual health was characterised by a need to create awareness among young people about STDs and HIV/AIDS- this is evidenced by the RH Baseline Survey attempts to examine levels of awareness (MOH, 1999b) and the development of a resource book for students aged 16-18 (MOE & UNFPA Nepal, 1999). However, UNFPA's ASRH Project including the pilot youth SH clinic indicates that youth sexual health is being redefined to also include service provision in addition to information provision. Stage four of the Social Problems cycle is described as the point where claimants express discontent about working within the system (official bounds) and attempt to find alternatives (J. W. Schneider, 1985). In the Maldivian context, stage four is not apparent from the review of policy and programme documents but in the next section, I use in-depth exploration of the problem participants to show that some participants (e.g., clinicians, UNFPA Maldives, MOH) circumvent the official regulations restricting youth sexual health.

4.2. Youth SH problem participants

In this section, I analyse policy review and key informant data to establish the way in which Maldivian SH problem participants are inter-related. First I analyse each participant in terms of their role in shaping Maldivian SH, the ways in which they exert their influence, and identify their limitations.

I do not include young people among the youth SH problem participants because as the previous section's analysis of the youth SH in the Maldives have shown that youth themselves have not played a role in either stage in the cycle of social problems. In contexts such as Malaysia, young people representing NGOs often play the role of claims-makers where claims and grievances about a situation (e.g. Restricted services) are made, urging action to remedy it (Ercevik Amado, 2009). Although involvement of youth in SH policy and programme planning is recommended by youth SH guidelines (PAHO & WHO, 2000; UN, 1994b, 1999a; UNFPA, 2004, 2006; UNFPA website, accessed 29 May 2012; WHO et al., 2006), there have not been any notable involvement of or contribution from young people in the context of the Maldives. Disconnect between young people and other components of Maldivian youth SH (such as policies, services, and data) is one of main points I discuss in Chapter 6.

4.2.1. UNFPA Maldives

UNFPA has been an active participant in Maldivian SRH for nearly 20 years, with a field office established in 1994, in conjunction with the first Country Programme 1994-1997, although it had previously assisted the Maldivian government with the census in 1977 (UNFPA Maldives website). In the most recent (4th) Country Programme, from 2008-2010, UNFPA Maldives is identified as providing support for a range of issues including gender equality, reproductive health and family planning, maternal and child health, through service provision, capacity building, research, advocacy, and programme development (UNFPA Maldives website)

UNFPA Maldives' role was initially as a donor agency and its biggest contribution to Maldivian SRH was through the Adolescent Sexual and Reproductive Health and Life Skills Project (ASRH) launched in 2003, with a contribution of US\$ 250,000 from UNFPA and MRF 318,750 from the Government. The 4-year project was aimed at addressing adolescent SH issues through awareness campaigns and teaching Life Skills to adolescents and youth (10-24 years), in and out of school (although only 4 schools were selected for the pilot stage). The project also involved piloting a youth-friendly RH clinic in Male' which provided advice and counselling services to youth regarding SH issues (UNFPA Maldives, 2003a).

The previous section described the challenges of defining youth SH as a social problem- difficulties that included unclear definitions of young people (e.g., adolescents), of SRH (e.g., sexual health or reproductive health), and the religiously and socioculturally sensitive nature of youth SH in the Maldives. Despite these challenges, the ASRH project was successfully negotiated and approved for implementation. However, UNFPA Maldives was able to exert considerable influence rooted in their individual employees. It was headed by a Maldivian citizen¹ (UNFPA Maldives website, 2010), an advantage for bargaining and competitive aspects of agenda-setting, due to an increased ability to garner support and form alliances with other groups (Howlett & Ramesh, 1955). In addition, some UNFPA members held familial connections to the political elite of the Maldives (Colton, 1995; Rasheedha, 2004).

I: So initially...

R: Yes it was UNFPA who took the initiative... but I don't know if we were imposing this on them but... the need was there...we always consulted others... I myself didn't feel we should be imposing foreign organisation's...you know. It needs to be for the country and that country's youth... so we thought like that...

I: Did they cooperate... was it difficult to get them on board?

R: It was difficult in a way... always issue-wise... but it was difficult to take the work forward... and I know on the other side there were trained people who understood the issues... so we had to organise... it was probably because of difficulties like that.. .it is going very slow... but consistent... we do progress but not at the speed we wanted to

-KII11, UNFPA Maldives official-

In addition to lack of public support, UNFPA Maldives also had difficulty in maintaining partnerships with other SH participants on Youth SH issues.

¹ KII11

I: So Youth [Ministry] tells the UNFPA to...like that?
 R: No not like that either. Of course it was our idea they expect us to do the work... something like that... there was no one to take ownership and work towards a result
 I: Ownership is key isn't it?
 R: There's absolutely no ownership... and on many programmes... adolescent sexual health programme... I led UNFPA before hoping that the national ownership would be there and then they could replicate it or span ...2 aspects for adolescent... life skills education plus these services... we haven't got either one of the two in the mainstream... Now it's like 7 years. So I think it's an ownership issue there... in everything... the sensitive nature... maybe before... now it's even worse because now religious groups and opposing groups ...so now we probably have to do something big... someone who dares to take risks... that things like this are things you have to work with young people... so we can't do it unless we find these kinds of people

-KII02-

The ASRH project was a joint effort between the Ministry of Education, Ministry of Youth and Sports, and SHE with in-kind contributions from the Ministry of Health. The MOH provided the technical expertise (i.e., clinicians and nurses) to staff the youth-friendly SH clinic that was to be piloted as part of the project (UNFPA Maldives, 2003a). However, UNFPA Maldives participants point to a lack of ownership by local participants. The team involved with the conception of the project reiterate that UNFPA Maldives' role would be minimised once implementation began, and national ownership would lead to expansion of services. However, after 7 years, UNFPA continues to actively lead on matters such as: negotiating access to schools for Life Skills educators; procurement of clinical equipment for the YHC; and, mediating arrangements for clinicians between MOH and the Youth Ministry.¹

This highlights a major limitation of UNFPA Maldives- they are very restricted in making connections at the grassroots level and therefore unable to do much at implementation and delivery levels. For example, they were unable to encourage progress on one main component of the ASRH project - Life Skills classes (components of which include contraception and STIs) in schools because of a lack

¹ KII02

of commitment by the Education Ministry in ensuring that schools actually conducted these classes.

R: Maybe it's because schools don't support it... it's not a priority for them... maybe they don't inform the parents well... and UNFPA isn't involved in finding out what the problem is on the ground...and we don't have an entry point in schools... it's the school's principal who has to implement it

-KII02-

So although UNFPA Maldives played a key role in 'creating' and defining youth SH as a social problem and subsequently 'owns' it, they are limited in their ability to advance the issue.

I: Was there an evaluation?

R: There were a couple of evaluations... I can give them to you later... I told you last year I did... I looked at that then. I have that information I can share that with you. So in that... it was the same old issues... that it was relatively good, that in the initial work we achieved this, that there are difficulties... I don't think anybody said let's scrap the whole thing and I was hoping they would because if it's not working... by now we have put in a lot of effort actually and the time is also now... so I have been thinking if actually the government side... that UNFPA should let go now, we've done this, maybe it's not so successful and maybe we should just do more work

I: So you really think that has been the cause don't you...that outside//

R: //but that might be just my perspective because it was something we were so involved in...having seen that...maybe that's why I get this feeling... I don't know how other people who were in there or were in the Ministry feel about why something like this didn't...

-KII13, UNFPA Maldives official-

4.2.2. Ministry of Health

SH problem participants from the Ministry of Health (MOH) include officials from policymaking levels from the ministry itself, as well as officials from the Centre for Communicable Health and Disease Control (CCHDC; formerly the Department of Public Health), the National AIDS Programme, the Decision Support Unit, the IGM Hospital (government hospital), and the Reproductive Health Centre of IGMH. MOH became increasingly active in Maldivian SRH policy planning in the 1990s, while in preceding years their role was more involved in service delivery (MOH, 1995; Regional Office for South East Asia WHO South East Asia, 1988). Their influence is based on their ability to lend validity to programmes and gain acceptance from communities, a challenge for UNFPA Maldives. However, this is linked to a major limitation of MOH, which as a government body, is restricted in the policies it can pursue.

- R: So it's the contraception issue that you're taking?
 I: Yes that and STIs
 R: What we need to promote now is triple... one is HIV AIDS preventions ... two, child family planning... the third thing is STIs... if we do it like this, outside...how do I say this... outside of wedlock in Maldives probably...
 I: So broadcast//
 R: //the problem so far has been... for anything the government does... government policies having something against the religion would make it a problem. On the other hand NGOs...
 I: Hmm... it's only SHE right?
 R: At the moment there's only SHE right, for something like this... so now the only way we can do this now is... Journey¹, they also distribute condoms... Yes they do... like that... and this Youth Café' also distributed... places like that... but the Youth Café' distributing it could cause problems because Youth Ministry and Health Ministry are also in it
 I: So as removed as possible from government
 R: Actually for this kind of controversy... religious controversial issues, social issues should be handled... in my opinion... the best people are the NGOs. Maldivian NGOS are too weak... in the long term, its NGOs...

-KII06, MOH official-

¹ It's an NGO run by former drug-dependant people, for drug-dependant people. No other respondent mentioned this and I could not make contact with the NGO due to time constraints

MOH is heterogeneous; governments or governmental bodies are rarely monolithic “that is, one single-minded body that speaks with one voice and works towards just one set of goals” (Birkland, 2005, pp. 14-15), but it makes it particularly complex within a large organisation like MOH to incorporate value systems of individuals involved in policy planning. Consider the following example of heterogeneity examined through the lens of one youth SH issue: condom provision to unmarried youth.

Two levels of heterogeneity were identified by KIIs, each contributing to, and interacting with, each other. Technical experts – those perceived to have a good grasp of the magnitude and health implications of youth SH issues – were identified in particular as wanting to address youth SH.¹ This could be the provision of condoms to sexually active unmarried youth because of increasing reports of unsafe premarital sexual activity since 1995 (see Health Master Plan 1996-2005 excerpts quoted in section 4.1) (MOH, 1995). By contrast, morally and religiously inclined individuals with little technical expertise were reported to have considerable policymaking power, despite their lower awareness of the issues, attributed to both ignorance and denial of youth SH issues.²

R:	...and emergency contraception is available only under certain criteria... that too is something we had to fight so hard to put in the Reproductive Health Policy
I:	When was that?
R:	Around 2004...5...around then. Emergency contraception can be given, for example in a rape case or something like that... if it's not rape, then to a married couple... And for this too people who were very senior, even the senior-most gynae [gynecologist] also strongly opposed this but then there were some people who said of course we would do this...they said it very openly too... but senior people... they were ready to walk out of discussions... yes!...to introduce this. That's if we want to introduce it from policy level... there is this sort of mentality
I:	So there is a split over everything isn't there. Some people see the need and// ((interrupted))

¹ KII01, KII02, KII04, KII08

² KII02, KII08

R: //I don't think there is anybody who doesn't see the need
 I: To do or not to// ((interrupted))
 R: //Its denial actually
 I: If its denial then isn't it more difficult//
 R: //to overcome yes... That's what I feel okay...
 I: If there were people who would know what is happening//
 ((interrupted))
 R: //Let's say for example... exclusively in reproductive health
 issues. Somebody like that says that emergency
 contraception is not suitable for Maldivian society, sex ed is
 not something allowed by our religion... if they have this
 mentality, nobody would say they don't know but they
 would rather say they are denying the facts... the question
 here is who will champion this. At what level? And then we
 need to think about look at other countries... how do they do
 it in strict Islamic countries...

-KII08, MOH official-

A second level of heterogeneity divides individuals based on their experience with controversial public policy decisions. On the one side (mostly comprised of respondents with reported experience of participating in Cabinet-level discussions) are those that consider it would be naïve to allow condom distribution because of the uproar they anticipate as a result.¹ The other side (mostly comprising respondents who reported grassroots-level interaction with youth and frustration with current youth SH programmes) considers it a weakness and a sign of self-interest to consider political and societal repercussions to self and society when making public health policy decisions.²

I: And something else I notice a lot is the sometimes it's referred to as youth reproductive health and sometimes it's referred to as sexual health. Did you have a distinguishing feature then?
 R: We... well we used it as one term... obviously for Maldivian cultural and religious stuff... I think adolescent reproductive health had most people's buy-in. When sexual health comes up it's... there were a lot of sensitivities... because of sex outside marriage... there were issues like that
 I: Was it felt
 R: It was felt in the discussions. For example, at that time people like [person A] from [Health Institution X] had a very

¹ KII01, KII02, KII03, KII06, KII07, KII09, KII11, KII13, KII17

² KII08, KII13, KII14, KII02, KII08, KII13, KII14

different attitude. Very uncomfortable... but people in [Health Institution Y] like [person B] he was very open about it... and [person C] people like that... maybe the difference is because we knew the realities didn't we... and even if ideally the situation would be like this, the figures do show pregnancy, abortions do happen... all of these things do happen... we even brought up the issue in surveys... but I know that if the negative reaction is too extreme, we won't be able to do anything...

-KII11, UNFPA Maldives official-

It was apparent from the interviews that MOH actors (including the quotes above), despite being the top level in the health sector,¹ did not (or did not consider themselves to) hold decision-making power. Decisions were made at the Ministerial level, while MOH actors were limited in their capacity to act as technical advisors to the Ministerial decision-makers.² This, in turn, results in a lot of time and effort having to be spent on promoting and advocating youth SH strategies *within* MOH.³

Advocacy within MOH takes place mainly at two points. First, those dealing with data collection and programme planning have to promote youth SH in order that it gets tabled in senior staff meetings within the Ministry.⁴ Given the heterogeneity in opinions on youth SH strategies this is often an arduous task where a resolution is often a cautious decision. For example, consider the first time unmarried Maldivian youth were asked about their sexual activity in a survey. The decision to include the topic in the *Reproductive Health Baseline Survey* (MOH, 1999b) was contested among MOH senior officials on the basis of sociocultural sensitivity and required considerable advocacy and negotiations by research unit officials.³ Addressing the issue was only allowed when a compromise was reached to include it in a separate self-selected self-completion questionnaire.³ As a result of this cautious decision, the response rate (12%) was an extremely low in the capital island (MOH, 1999b) and ultimately reduced the reliability of the data.

¹ KII01, KII02, KII03, KII06, KII08, KII09, KII11, KII13

² KII01, KII06, KII09

³ KII01, KII08, KII09

⁴ KII08

R: And I remember actually in 2004 when we were going to do the Reproductive Health Baseline Survey we decided that to some extent to look at behaviour actually sexual behaviour... we need to assess it to find out what are the risk factors, how... it's not enough to just do awareness. And there were actually a lot of huge issues then, a lot of well, high level policy people were totally against doing that

I: In the survey?

R: Yes even in that there is a lot of resistance so what happens is... well I have always raised the question how can we do this programme... some people are people who hesitate to even explicitly say contraceptives even when we are talking about different methods. So what happens is if at that level... how do we implement the programme if this is the mentality of people at the high levels? These are big issues faced in advancing these programmes. So when at first we wanted to assess this we had to struggle a lot. In the Ministry of Health then policy or planning, no like health info research would come under planning. So during planning when we were trying to write the questionnaire we actually had a lot of resistance. But even so at the lower level there was quite a lot of support like to do this in focus group discussions for example, to do it. Eventually it was decided to do a blind study... 15 to 25 youth unmarried youth, to bring them get them somewhere and to give a close questionnaire, there won't be names or anything. So we did it like that. And that was the first attempt to collect that kind of data. So we found that there actually were factors that we should be concerned about... unprotected sex. There was a lot of it. A lot of things like that. And later in the RSA I think there was a lot of it among drug users, a lot of sexual behaviour problems. So sexual health is now a very serious public health hazard, to be honest... So... and we don't know when there will be an epidemic or not, we don't know. We can't sit in denial like this... even still there's some resistance to talk about this... so it's a very critical issue

-KII08, MOH official-

The second point where advocacy is undertaken by MOH actors is when directed at ministerial level decision-makers. The main barrier to this is the short tenure of cabinet ministers, who tend to be political appointments without specific technical expertise.¹ Given the political instability of the Maldives from 2004 onwards

¹ Such technical expertise is drawn upon from the senior most technical expert in the health sector, the Director General of Health Services. (KII01, KII06, KII08)

(Niraula, 2010), government leaders and institutions frequently experienced shuffles and reorganisation.

Narratives from those most actively involved in advocating for youth SH to MOH officials and the Cabinet, show that these short tenures affect progress in policies and services for youth SH in two ways. Firstly, agenda-setting, ownership and commitment require time, something that decision makers often lack. Individuals who remain in power for a relatively short period of time tend to focus on high impact policies that do not detract from their political capital or popularity. Advocating for youth SH would not fit those requirements, given the sensitivity of the issue. Secondly, each new Ministerial appointment requires that advocacy efforts for youth SH advocacy have to begin anew. Tactics and proposals for advocacy have to be tailor-made to suit each minister's personal beliefs, value systems, and attitudes.¹ Once their support has been achieved, advocacy has to be repeated for all cabinet-level leaders.

R: They [policymakers] keep on changing. Now we're finding it very difficult we're having to start the whole thing. Yeah and a lot of development we start from scratch again. But then I think that is how... we have been so used to sort of similar type of people for a long time so we didn't really feel that policies... that they are equitable socially sensitive policies that we are deciding on so it was easy for technical [people] to work also but now it's a big challenge to do that. And then technical people will get frustrated and we keep on telling them [policymakers] showing them advise them blah blah blah... an hour meeting and that's it and they go out thinking about something else so it doesn't really impact, does it?

-KII09, MOH official-

The second route is external advocacy; appealing for public support for a cause in order to use public pressure for the issue to be tabled with decision makers. This is most commonly achieved through the use of the media, which in the case of youth SH creates a circular situation. Media regulations in the Maldives are stringent regarding youth SH; mentions of condoms, for example, are not allowed in case it is

¹ KII08

construed as condoning premarital sex.¹ Those involved in IEC mention this constraint and report having to rely on double entendres and other indirect messages-² Advocates do not have free reign to promote youth SH because of limitations policymakers can lift, but policymakers are unlikely to be swayed unless there is considerable public pressure.

Clinicians

Clinicians, while part of MOH, are different from other MOH participants, because some of them have dual roles through contributing to policy planning and providing technical expertise within MOH, as well as having grassroots access to young people. This enables them and other MOH participants to ‘medicalise’ Youth SH during the definitional process, which is effective in legitimising social problems (J. W. Schneider, 1985).

Contraception for unmarried individuals is a contentious issue among SH problem participants because it is associated with premarital sexual activity. However, data from key informant interviews indicates that once contraception is medicalised by associating with HIV/AIDS prevention, condom promotion is allowed.

R: No it's not said as straightforward as that in the policy... policy says to give it to people with high risk behaviours. But it comes through as... not really for sexually active... and the thing is if you need policy acceptance you need to link it to something justified or acceptable, then that will be okay. HIV is okay, they are able to justify it to themselves ‘okay we are doing this for particular reasons’ ...it's not for sex but to prevent this really dangerous disease

-KII09, MOH official-

Given their access to youth in medical settings, clinicians have considerable leeway within current policies. Clinicians in governmental, non-governmental, and private

¹ KII06

² A condom promotion campaign against HIV circumvented media restrictions by using the Dhivehi slogan *HIV ah huras alhalmaa* which translates to ‘Let’s use *huras* against HIV’ where the Dhivehi word *huras* means ‘barrier’ as well as ‘condom’ (KII01). This is discussed in more detail in section 6.1.3

services are regularly approached by unmarried youth for medical help, and those in governmental services are obliged to report them to the government.¹ However, in 2006, clinicians at the biggest state hospital made the conscious decision not to do so, while still providing records of STI incidence.²

R: Most times we see, when they come, when they end up pregnancy, out of wedlock pregnancies or any form of pregnancies. At that point I don't... clinicians don't feel it is the right time to talk about sexual health issues because then the girl gets stigmatised. We try as much as we can to not even ask if she is unmarried or married. That's something we in the department very clearly decided to do... to consistently never ask people if they are married or unmarried or what happened. Those things will be sorted in another way. Generally the rule says... from the government from a long time back... to report if it's an out of wedlock pregnancy. We have stopped reporting

-KII13, Clinician-

In 2009, this decision was put into the spotlight when information was leaked to the Human Rights Commission resulting in a report of non-marital pregnancies received at the government hospital in Male'.³ Following a media flurry, this led to governmental action wherein the Ministry of Health and Family, containing the newly (2008) merged MOH and Gender and Family Ministry, issued a directive for the hospital to release these records to the Police. The records were released, but no action was taken. Thus, while clinicians can influence youth SH by providing services to an extent, their activities are still restricted by policy.

I: So the protocol now it to not report?
 R: We were told just the other to report all the cases we haven't been sending
 I: Really?
 R: It's because of that recent incidence, isn't it? There was an 18 year old girl who was not married and got pregnant and people were talking and since she was barely 18 this was

¹ KII06, KII09, KII13

² KII13

³ KII06, KII13

taken up by the Gender Ministry. Gender Ministry took it up and then the Human Rights Commission got involved and then the Police... and then it was on TV and it was made out like a big advertisement. And the things she had discussed with the doctor, there wasn't even any confidentiality and the Police were reporting she had discussed with the doctor. So if these things go to that level, it will be difficult for us, right?

I: So then they told you to...

R: Yeah they told us to report all the cases we had up until that point, of 18 year olds who were pregnant... to check those who tested positive for pregnancy... if they were unmarried or legally married... well, it [marriage before 18] won't be legal... legal within religious concepts but illegal in this country... so yes they took the list of all those people

I: And they were cases that had been finished?

R: They've even taken cases from over 6 months ago. SO it depends on what these people are thinking at that time... Suddenly they might think to themselves 'I'll do something clever today'...

-KII06, MOH official-

4.2.3. Youth Ministry

Prior to 2003, the Youth Ministry's role in Maldivian SH was minimal; the Youth Policy 2002 demonstrates little attention and commitment to youth SH (see Youth Policy excerpts in section 4.1) (MYS, 2002). In 2003, the ASRH Project identified the Youth Ministry as an agency in charge of implementing a Youth Counselling Unit and a youth friendly SH clinic (both housed in the Youth Centre in Male') as well as conducting Life Skills classes to out of school youth. Their considerable role at the implementation level led to a number of employees at both the policy planning level and the service delivery level receiving training and field experience in a short period of time.

R: There was a group... we call them master trainers... the master trainers were trained... several training locally with technical assistance, we brought them... overall period of, if I can remember, of two or three years of... every year they had sessions and they had to like, practically, give lots of lessons and they had to log them. They had to take something like 100 sessions plus different levels of trainings

before becoming master trainers. These groups would be very capable actually, in this country...

-KII02-

This combination of training and field experience resulted in the Youth Ministry being shaped as champions of youth SH and experts on youth behaviour. Although the Life Skills¹ classes were packaged to indicate that they were teaching life skills such as handling peer pressure, leadership, and healthy lifestyles, it was generally understood among Youth SH problem participants that this was primarily a tool for disseminating information about contraception and STIs (i.e., sexuality education).

Another major influence of the Youth Ministry was their links to youth NGOs and associations from the atolls as well as their contribution regarding infrastructure. Under their jurisdiction there are 13 multi-purpose Youth Centres in different regions of the Maldives (MHRYS website, 2012). This allowed them a bargaining advantage over other Youth SH participants that can be used to shape Youth SH. However, this is countered by lack of support from policymaking levels within the Youth Ministry, leading to slow progress of youth health issues, insufficient human resources, low training opportunities, and inadequate funding allocated.

- I: So overall what would you say... are you happy with the progress, it's been a while now
- R: Not really. Progress is... because our staff turnover rate is very high so even since before we haven't had the progress we wanted
- I: Is it that it's slow?
- R: It's not that it's slow... there are many factors here for example our staff issues, because of our situation...
- I: You mean capacity?
- R: Yes people who are trained plus limitation plus... now our services go on until around 10 o'clock but if we want to bring out more staff then... youth usually come around in the evenings... so there are a lot of constraints like this for us to continue... so some kind of adjustment is needed... we have to fit it somehow
- I: Yeah

¹ 'Life skills-based SRH education' is also used commonly in global SRH circles.

R: Even with staff we can't have shifts... we're talking about two three staff and for our sessions we bring technical ... so a lot is about funds

-KII05, Youth Ministry official-

4.2.4. *Society for Health Education (NGO)*

Established in 1988, the Society for Health Education (SHE) is the longest running NGO in the Maldives and targets health education and service delivery with a focus on promoting women's health and rights (IPPF website, website accessed 15 March 2012). IPPF, of whom SHE has been a full member since 1999, identifies SHE as the only non-governmental organisation involved in RH programmes and that it has a good relationship with the government of Maldives (IPPF website, website accessed 15 March 2012).

SHE is a formidable actor among governmental and international bodies and derives most of its influence from individual members, notably a founding member who was the First Lady of the Maldives at the time (Rasheedha, 2004). A key achievement is their successful lobbying to legalise abortion in pregnancies where the foetus is diagnosed with thalassemia, the only instance abortion is permitted in the Maldives (UNDP & DESA, 2002).¹

Although SHE's engagement with youth SH has been less active than its commitment to reproductive and maternal health, they report that they have "been able to penetrate the conservative mind-set of people towards the importance of family planning, reproductive and sexual health" even though "[w]hen FPC [Family Planning Centre] started in SHE, Maldives was a society where sexual and reproductive health and rights always faced challenges from conservative political and religious forces" (SHE website, website accessed 15 March 2012). SHE opened a Youth Kiosk in 2004 to provide counselling and information on youth SH although

¹ "Abortion is prohibited in the Maldives except for certified medical reasons. The consent of the spouse is required. Abortion is reportedly permitted where thalassemia is diagnosed. Thalassemia is a fatal genetic blood condition that is carried by 20 per cent of the population and affects one child in every 250" (UNDP & DESA, 2002, p. 1)

it has been inactive since 2008. Their medical services in Male' are still approached by young people seeking to avoid disclosure of their marital status (see 4.3.3).¹

SHE does not exert a lot of influence over policy planning, largely due to the fact that they are the only NGO working on youth SH issues (MOH, 2004b; UNFPA Maldives, 2003a; Regional Office for South East Asia WHO South East Asia, 1988).

4.2.5. Education Ministry & Schools

The Education Ministry's involvement with youth SH began with health education sessions in 1997 for classes above grade 7 (13-14 year olds),² followed by the compilation of a resource book for 11th and 12th grade students (16-18 years) with technical assistance from UNFPA Nepal in 1999, and lastly optional sessions provided by then Public Health Department (now the CCHDC) in 2000.³ Information on extent or impact for either of the classes were not available. The Education Ministry developed a larger role in youth SH in the ASRH project, where it was in charge of delivering the Life Skills programme in schools (UNFPA Maldives, 2003a). The Education Ministry played an active role in developing the courses and adapting them for schools in Maldives, but was much less successful in actually promoting its use in schools.⁴

Three selected schools in Male' were approached to take part in delivering the Life Skills courses as a pilot (UNFPA Maldives, 2003a). Of those schools involved – both primary and secondary - there was a supportive response from students but opposition from parents.⁵ The backlash from parents revolved around the issue of contraception.⁶ This led to wariness from teachers and schools about further involvement, and the Life Skills programme lost the cooperation of schools.⁴

¹ KII12

² KII01

³ KII17

⁴ KII02

⁵ KII02, KII07, KII17

⁶ KII10

- I: In this school package, contraception is also// ((interrupted))
- R: //it's not. There is no mention of condoms or anything like that. And well, parents are very... parents are very bothered by it. Rightfully so, right? For example... someone who is innocent... well some of them are at least innocent. But facilitators come and tell us after taking sessions about how wild things were... But in the school package we don't... but if it comes up in discussions yes. The one we took for parents, we taught anger management, and for the kids [inaudible]
- I: So when talking about contraception and things like that, you said some people say this [inaudible]... was this the prevailing thinking at that time?
- R: Education Ministry... the Education Minister at that time got phone calls... if things like condoms were mentioned, parents call the Education Minister. Isn't that the sort of thing we do here... and we have to make life easy for them [Ministers] as well, don't we... so that's why we assured the parents in a group that we won't talk about things like that... but if they are interested, here are the numbers, here's how to reach us...

-KII07, Youth Ministry official-

4.2.6. *Religious Council*

The main reason for using the term *Religious Council* is because since this research was begun, the religious body with the power to influence policies changed from the Supreme Council for Religious Affairs to the Ministry of Islamic Affairs with the government change in 2008 (see also Section 2.4.2 for review of religious influence in the Maldives). Their role in policymaking would have changed but since this research builds narrative on retrospective accounts of SH policies and strategies from before 2008, this redefinition does not affect this study in that sense. The precise role of the Religious Council in SH policymaking meetings has been difficult to define. Other key informants report that different representatives from Religious Council attended meetings- only one individual was identified as having played a role in promoting family planning in the islands. Now retired, the information I gathered from interviewing that individual could not inform the study of the SH policies or strategies but rather provided me with background to SRH issues in Islam. As a

result, the Religious Council is not represented among the key informants, but their role is gathered from other key informants' accounts.

Religious leaders from the Religious Council played a major role in getting island communities to accept family planning. The uproar following UNFPA's establishment in Maldives and their contraceptive promotion campaigns¹ was resolved only when religious leaders accompanied health workers and declared their blessing for this campaign. The role of the Religious Council in youth SH is encouraged by other participants, and they are consistently invited to policy planning and awareness sessions.² Their influence is rooted in their expertise to judge what should and should not be done (in terms of strategies and service provision) in Islamic societies, and their influence is characterised by their considerable vetoing power. Given the absence of Religious Council among my key informants, I am unable to further characterise their role in youth SH policies. I reflect on this limitation in Chapter 7.

4.2.7. Topology of participants

Table 9 summarises the main problem participants of youth SH in Maldives, giving an overview of their type of participation, influences, contribution to youth SH, and their limitations.

¹ KII01, KII09

² KII04, KII09, KII11

SH policy Problem Participant	Type of participation	Influence & contribution	Limit
UNFPA Maldives	Biggest donor Major participant in policy planning	-Individual-based bargaining power -Funding -Lends reliability -Foreign expertise	-Low public acceptance -Cannot own programmes; must have exit strategy
MOH (including CCHDC, AIDS Unit)	Major participant in policy planning. Used to be just implementing	-Lends validity to programmes because high public support if state-sanctioned	-Heterogeneous -Inconsistent commitment at top decision-making level
Clinicians	Major in policy planning and implementation	-Can medicalise problem -High grassroots contact -Individual-based -More elbow room within policy	-Ultimately answerable to policies and regulations -Piecemeal work because at individual's discretion
Youth Ministry	Minor in policy planning Major in implementation	-Recognised as experts in youth -Gatekeepers to out-of-school youth	-Lack of support from decision-making level -Low resources
NGO (SHE)	Minor in policy planning Major in implementation	-Derived by individuals -Backed by IPPF -Can bring spotlight -High public acceptance	-Low human resources -Not enough political clout
Education Ministry & Schools	Minor in policy planning Major in implementation	-Gatekeeper to Life Skills in schools	-Limited by PTA & public
Religious Council	Major on policy planning and implementation	-Has considerable veto power in policymaking -High public support and trust	

Table 9: Youth SH policy participants in the Maldives

In addition to establishing and describing the topology, it is important to map the relationships between the problem participants. Analyses of the KII show that there are 3 main inter-relationships that have dominated, and continue to shape youth SH in Maldives:

UNFPA Maldives leaves Youth Ministry in charge of Youth SH

Despite playing a catalytic role in establishing youth SH in Maldives, UNFPA Maldives was not in a position to ‘own’ youth SH given low public support for the issue. The Youth Ministry’s status as champions of youth SH and experts on youth behaviour led to UNFPA Maldives gravitating to the Youth Ministry as potential national owners of Youth SH, a move that some KIIs now question:

- R: ...they weren’t a strong Ministry were they, Youth [Ministry]...even before. So there would have been those issues... they have a big Youth Centre but even that was not really utilized very well, were they
- I: But Health Ministry was strong and still is... technically... like technical level
- R: So maybe one of the mistakes, if you will, is to do it under Youth [Ministry] maybe they didn’t have the capacity to take anyway
- I: Maybe Youth [Ministry] was too vague. Like they say, what does Youth [Ministry] do... sports...?
- R: Yes and they mostly focus on youth NGOs to do some...
- I: Youth NGOs//
- R: //it’s mostly sports really, right. And to name it [Ministry of Youth and] Sports... And also the Youth Centre is a strange place but I don’t know how much was linked to Youth Ministry but there too were internal issues... Yes so it’s difficult to say...

-KII11, UNFPA Maldives official-

The lack of policy support, human resources and funding within the Youth Ministry created difficulties for UNFPA Maldives to hand over ownership. Thus even after 7 years, UNFPA continues to actively lead on matters such as negotiating access to schools for Life Skills educators, procurement of clinical equipment for the YHC¹, and mediating between the Youth Ministry and MOH, having alienated the latter by their choice of national owner of youth SH.

- I: So Youth Health Café was a pilot [study] and the Life Skills thing... how is that working out?
- R: It started off with great difficulty but... 2004 if I remember correctly, we opened it at first... we tried to have doctor

¹ KII02

then... for young people to come and consult about various issues but at policy level, for example Health Ministry and IGMH [state hospital] did not see it as a priority. We wanted doctor... like a duty roster... doctors to come... that turned out to be a big task for them [MOH and IGMH]... it became a huge issue actually. And just... they sent some because we had begged them [MOH and IGMH] and they got fed up and they sent some [doctors]... I can't say they didn't send... So they sent some but couldn't continue. So the UNFPA had to always go to Health Ministry and remind them and IGMH... that's not a sustainable system, I would think. So in the end Youth Health Café was... because they didn't have that support they started to call... they couldn't get doctors and things like that happened so what they [Youth Health Café] started to do was to pay doctors a salary to get them to come. But still it's not sustainable because usually they... doctors aren't people who come to work for a small amount of money. And in addition to that, the doctor has to be... every doctor had to... the people at Youth Health Café preferred only certain doctors... someone accepted by the kids. So that did not materialise after a while and then it stopped and physically the place was also shifted. It's now at a place on Majeedhee Magu [name of a main road in Male'] but it doesn't work anymore... the counseling stuff, sessions and things they don't have them anymore I think... it's not functioning. Now youth Ministry is talking about bring it back to Youth Ministry...I mean Youth Centre, Social Centre... bring it back there and start the doctor service ... younger kids come more often if there's support like that... but at policy level it's not integrated... but in reports, when noting successes, everyone writes about this place [Youth Health Café], that it's there.

-KII02-

Youth Ministry and MOH disagree on youth SH services

Subsequent to UNFPA Maldives' recognition of Youth Ministry's expertise in youth SH, Youth Ministry challenged MOH about the most appropriate ways of delivering SH services to young people. The two services differed in where the services were placed- the YHC is a separate from any other medical services, and the RHC Adolescent Unit was housed in the main state hospital (IGMH) in Male'.

Argument for integrated services

R: Adolescent health services are... actually healthcare providers have to provide a range of services for adolescents

in a friendly... For example, an adolescent goes to casualty or the emergency room... he needs to be treated as an adolescent, knowing what his or her problem will be like. You don't just treat only the complaint they come with... you have to understand adolescent problems and give care for all of the problems and referrals [to other doctors] is a part of it... You can have adolescent health clinics but if within health care facilities like IGMH... the Adolescent Unit in the Reproductive Health Centre... not to just sing its praises because I worked there... the services there were very comprehensive... it was a really good service, it was planned as a very comprehensive package of services, very complete... it was how it was planned I mean...

... For example, say they don't want to mingle with pregnant people, they don't have to mingle with them, there were things for evening times and we started by giving information, all health-related information an adolescent needs and we did screenings and checked their vaccinations... and we had a vaccination component we focused on so we gave them vaccines and we screened them... there might be visual problems or hearing problems or mental problems there could be anything... parents won't know to identify it by themselves.. And the kids don't know how to explain it... they can notice it but to explain it... so to identify it within a referral system... and also there could be major issues, in this country anemia is a big problem at all ages and in that age it's something they are prone to, so they need to be screened for that... that programme [RHC Adolescent Unit] was developed focusing on all of that

-KII03, MOH official-

Argument for separate services

R: People do go...adults... youth won't go that's why we started this service here... IGMH has always been that like... it's not very friendly, people go there if they don't have a choice... if it's for STIs or even anything else, youth won't go there, that's why there was a need to start services here

-KII04, Youth Ministry-

I: The Reproductive Health Clinic at IGMH has an adolescent unit...

R: They have it there but they [youth] won't go to a mainstream place where everyone goes. That's why it should be separated for them [youth]... there... you go there and you have to wait in queue for an hour... what kid would go there? Paying 200 Rufiyaa for private places [clinics] is... So

in an environment like that, youth friendly services are not adequate, so there is a need to have something for them [youth]... the country is not yet ready to integrate these things

-KII02-

This then, resulted in uncoordinated split of resources, namely clinicians who had to be released by MOH to provide services at the youth-friendly clinic run by UNFPA Maldives and the Youth Ministry. This made functioning of the YHC dependent on the commitment of individual clinicians, and the RHC Adolescent Unit run by MOH was understaffed, and neither service was able to function to their full extent.

Education Ministry resists UNFPA Maldives' Life Skills classes in schools

Although it was generally reported by Youth SH participants that Life Skills classes in schools failed because of parents' protests, some held the opinion that the resistance was from the Education Ministry. KIIs speculated that the Education Ministry played too much of a gatekeeping role as resistance to ASRH project's proposed strategy to incorporate Life Skills education into the school curriculum

R: Actually we just didn't get the policy support at that time
 I: What was their problem?
 R: There was no support because you know, the society... in this country all the education expectations are based on ... people who get seven A's or nine A's get everything. And for kids... for example [to conduct Life Skills classes] in Grade 10, there's no way we can even ask. Even for [Grade] 8 or 9 we even try to approach them [Schools] they now say we can't give away their English classes, we can't give away this other class. So it went like that and got really difficult

-KII02-

R: So we were thinking about where to base it [Life Skills component of ASRH project] and I think we went and based it at Education Ministry. And we took the youth component
 I: So in schools... when you gave it to the Education Ministry//
 R: //Yes but what happened at the Education Ministry at that time was... in schools there was a lot of... their curriculum was very... I mean teachers get very concerned about the students' results, don't they... So at that time they... I remember the letter we sent to the Education Ministry then...

we said to put it [Life Skills classes] in the syllabus, to put it in the subjects. But we got it to go after the last class... Now it's not going on anywhere... It's stopped. From what I remember, more than 200 people were trained for it

-KII07, Youth Ministry official-

4.3. Services

This section described the only formal services targeting youth SH in the Maldives. Apart from one assessment report on the ASRH project, there have not been any publicly available evaluation reports (it is not clear whether they exist) for the services listed. This greatly limits triangulation of the review below, and as an effort to counter this, I draw on interview data from key informants (including those who were and were not involved in that particular service) and from in-depth interviews with youth in order to describe the services as fully as possible.

4.3.1. Youth Health Café

The implementation of the Youth Health Café (YHC) met with numerous obstacles. In addition to difficulty in arranging health professionals for the clinic, the YHC also found it difficult to attract clients.¹ The reason for this was thought to be because the clinic was housed in the Youth Centre in Male', a building located in the outskirts of the city.² The Centre itself was the location of many sports venues, and this was thought by policymakers to be an attractive feature.³ However, low levels of new clientele prompted relocation to a central area on the other side of Male'.⁴ The relocation failed to attract new clientele and because it was felt that it was not worth the difficulties in maintaining a clinic outside the Youth Centre- the YHC was again moved back to the Youth Centre.¹ In 2004 it was felt that there was a need to go out and convince youth to visit the clinic, an unsuccessful approach.³ The reach of the YHC tends to be very limited, mainly to friends of youth volunteers and employees.⁵

¹ KII01, KII04, KII05, KII13, KII17

² KII04, KII05, KII17

³ KII17

⁴ KII04, KII05, KII11

⁵ KII13

However, YHC officials report a good response on their help-line and radio programmes discussing SH issues.¹

R: Before that I was first working at the Youth Health Café when it was opened at the Social Centre... I worked there twice a week at that time. And when I go, they don't get many youth dropping in either. Most people who come there is a friend of a friend of someone who works there... they come like that

-KII13, Clinician-

Soon after its establishment, the YHC was labelled by Male' community as a condom dispensary, and was not well-received by the public.² Actors present at the time recall receiving calls from members of the community with negative comments (see Chapter 6, Section 6.2).² The YHC maintains that it does not distribute condoms but rather makes them available for the clinicians to distribute at their discretion.³ Only two out of 61 youth interviewed for this study mentioned knowing about the YHC (see Chapter 5).

4.3.2. *Reproductive Health Centre (RHC) Adolescent Unit*

The Reproductive Health Centre at the government hospital in Male' (Indira Gandhi Memorial Hospital) includes an Adolescent Unit. This service was established in 2004⁴ after much advocacy at MOH programme planning level by policy individuals with considerable power derived from long service in the medical profession as well as familial links.⁵ The establishment and implementation of the Adolescent Unit has been described as an uphill battle, with support and resources being pledged on paper, but little evidence in practice.⁶ Lack of human resources, training opportunities, and fiscal compensation for out-of-hours' work were highlighted as the main reasons for its slow progress, leading to a discontinuation of this service in 2008³. Their reach is limited to interactions with students and parents in school

¹ KII04

² KII05

³ KII04, KII05

⁴ KII01

⁵ KII03

⁶ KII03, KII14

health fairs, and most of their current work involves ensuring that vaccinations are up to date. However, none of the 61 youth interviewed for this project reported knowing about the RHC Adolescent Unit, even though they stated they would probably go to that hospital if they faced an SH issue (see Chapter 5).

4.3.3. *Youth Kiosk*

The Youth Kiosk run by (and housed at) the NGO Society for Health Education (SHE) was established in 2004 to provide counselling and SH information and services to young people (SHE website, 2011). However, it no longer functions, and instead services are provided alongside their contraceptive clinic, a service utilised by married couples. Thus they provide information or contraceptives to youth regardless of marital status, and questions are not asked, contrary to the protocol in the RHC. In spite of this, very few youth seem to be aware of this service point- only one among the 61 youth interviewed for this research mentioned the SHE services (see Chapter 5).

- I: So... and you're happy with the number of people who approach here?
- R: No I would have liked more people to come but I think still people are as a bit reluctant and also with these religious extreme ...beliefs coming in getting more stronger among the youth and even the educated we ... they are I think more hesitant to come thinking that we would ask that question thinking they might have to answer that question thinking they might be turned out without providing services. It is very sad but whenever I give information even in public or even... I do say that we give services as well of course we don't provide abortion because it's illegal in our country we don't do anything that is illegal as such. So we even provide ECP [Emergency Contraceptive Pill] also which is emergency contraceptive Pills ...they should come more often. I mean... compared to the number who are sexually active... with the number [of people] who come for the EC Pills are few. Yes but is it only increased because I think people are still not so aware that this is available and they would be given this.

-KII12, SHE-

4.3.4. FPU

The Family Protection Unit (FPU) is also based at the government hospital in Male' and provides medical assistance in cases of gender-based violence, child abuse, and sexual violence.¹ Established in 2005, the FPU recognises their low human resources, and limits their services to providing assistance within the hospital grounds, liaising with the Police as well as the Child and Family Protection Services to pursue cases outside the hospital. One of their major hurdles involved getting approval to stock and release emergency contraceptive pills- the debate revolving around whether or not it would facilitate abortion. None of the youth interviewed for this research named the FPU as an SH service (see Chapter 5).

4.4. Conclusion

In this chapter I have traced the evolution of SRH issues in the Maldives, showing that recognition of most SRH issues (such as population control, family planning, etc.) were largely based on data, except for youth sexual health issues which was not recognised until the 2000s despite informal but persistent reports of nonmarital sex and unsafe abortions among youth. Examining the problem participants of SH policy, their influences and limitations, and their interrelationships revealed three key features- firstly, policy participants of youth SH in the Maldives have remained unchanged since youth SH was recognised as a social problem; secondly, their subsequent interrelationships, alliances and disagreements are longstanding; and lastly, these interrelationships have had a major effect on the current state of SH-related services for youth. In the next chapter, I examine Maldivian youth SH from youth's perspective, which would allow me to explore whether there is disconnect between official policies, services, and data and SH experiences of Maldivian youth.

¹ KII13

Chapter 5 Sexual Health of Youth

In this chapter I explore Maldivian youth's SH issues, comparing the official data that is available to policymakers and service providers (provided largely by MDHS) to youth narratives provided by in-depth interviews (n=61) and the web-based survey (WS). These two sets of data - official quantitative data and youth narratives from IDIs and the WS - are compared in parallel, under 6 broad themes of SH - sexual behaviour, contraception, STDs and HIV/AIDS, unwanted pregnancy, abortion, and sex education. For each theme, I explore young people's reports of their SH experiences, attitudes and perceptions, both their own and that of their peers, drawing from quantitative and qualitative evidence. Using these multiple data types, to examine the ranges of evidence help us to better understand the SH of Maldivian youth. In particular, I consider whether different sorts of data provide reinforcing or conflicting descriptions of youth SH.

5.1. Sexual behaviour

Sexual behaviour encompasses the broad range of issues raised in youth narratives. I focus in detail on two sub-themes that emerged as most salient from the perspective of Maldivian youth: premarital sex and sexual experiences besides intercourse. Other issues that were raised much less frequently, including rape and sexual abuse, promiscuity, prostitution, homosexuality, and infidelity are not considered in detail. This is not to deny their importance but given the limited times it was raised by interview respondents I decided to focus on those things that were discussed the most.

5.1.1. *Premarital sex*

The 'premarital' aspect of sexual activity is central to this research - unmarried Maldivians are theoretically excluded from SRH policies and SRH services because it is illegal for them to be sexually active. The first ever data on premarital sexual activity were provided by a self-administered component in the 2004 Reproductive Health Survey (MOH 2004) which showed 9% of unmarried youth aged 15-24 reported having had sexual intercourse before marriage. The MDHS 2009 is the

second study (and the first nationally representative study) in Maldives to provide data on premarital sexual activity (Table 10).

MDHS (18-24yrs)						WS: MDHS Original version (18-24yrs)				
Male		Female		Total		Total	Male		Female	
E-m ¹	N-m	E-m ²	N-m				E-m ²	N-m	E-m ²	N-m
<i>Ever had premarital sex</i>										
82	466	1226	586	2360	No	130	5	62	18	45
35	100	134	42	311	Yes	118	7	68	7	36
117	566	1360	628	2671	Total	248	12	130	25	81
				3.6	% MISSING	0				
29.9	17.5	9.9	6.5	11.6	% Yes	48.0	58.0	52.0	28.0	44.0
19.8		8.9			% Yes by gender		53.0		41.0	

Table 10: MDHS and WS data on premarital sex among youth 18-24 years

These MDHS data suggest that premarital sexual activity is not very common among Maldivian youth with just 11.6% of 18-24 year olds reporting sex before marriage. Level of primary abstinence among never-married youth in South/Southeast Asia is typically higher than in other regions (Khan & Mishra, 2008), indicating that the MDHS data fits the regional profile. However, compared to regional countries such as Indonesia (86.7% and 38.9%) and India (72.2% and 24.4%)³, the Maldives has the highest proportion of unmarried youth aged 15-19 and 20-24 (94.5% and 41.4% respectively) reporting never having sex (Macro International website, 2012).

It is important to note that the MDHS did not ask any direct questions about premarital sex to ever-married respondents, this information was derived by comparing reported age at first marriage and age at first intercourse. These figures might be affected by memory bias as they might have recalled either age incorrectly. There is also a possibility of interviewer bias because the data entry field in the questionnaire

¹ E-m: Ever-married; N-m: Never-married

² Ever-married respondents' premarital sexual intercourse was calculated by comparing age at first marriage and age at first intercourse. 'No' includes those who answered 'at first union'

³ Corresponding data unavailable from DHS in Sri Lanka, Pakistan, or Bangladesh

contains the option ‘first time when started living with (first) wife/husband’ which some interviewers might have read aloud¹, thus providing respondents with an easy- and legal- response option. The illegality of premarital sexual activity might also prove less important to youth who are already married, leading them to report it more freely than their unmarried counterparts.

The gender differences in reported levels of premarital sex among MDHS never-married respondents are striking, with significantly ($p < 0.05$) more never-married men reporting premarital sex than their female counterparts. This raises two questions. Firstly, is it that young men are less reluctant than young women to report premarital sex? Interview data suggests that this might be the case as most interviewees stated that young women would (and do) face more negative social repercussions (such as labelling, taunting) if they are known to be sexually active (discussed in 6.2.2). Secondly, it also raises the question of who these young men are having sex with. There is no data in the MDHS that could give an insight to this. There have been anecdotal reports of sex workers² but there has not been any data on this either.

Results from the Web Survey, however, suggest rather higher levels, with almost half of youth respondents (48%) reporting premarital sex (Table 10). However, it is also important to note that even though the WS has no missing data as opposed to 2.3% missing cases in the MDHS data, the MDHS sample is much larger sample ($n=2741$) than the WS ($n=248$)³. In addition to sample size differences, the WS sample is a non-representative, self-selected sample- youth from various socioeconomic backgrounds were not represented and also, youth who chose to participate in a survey called *Maldivian Youth Sexual Health and Lifestyle Survey* are likely to be those unhesitant to answer questions about sexual issues. Therefore a higher level of premarital sex reported in the WS was expected, albeit interesting.

¹ “[W]hen doing this probing, be certain not to assume that the first time she had sex was at the time of her first marriage. If she says her first time was when she started living with her (first) husband/partner, record it as such by circling ‘95’ [first time when started living with (first) husband]” (ICF Macro, 2012, p. 91)

² KII05, KII07

³ Missing data for all tables and figures will be clearly indicated, discussed, and I do not include them when calculating percentages.

The data reported here are based on responses to exactly the same question wording as the MDHS. Similarly, ever-married WS respondents were not asked whether or not they had had intercourse prior to marriage, and this was calculated from their age at first marriage and age at first intercourse.

Gender differences in the reporting of premarital sex persist in the WS sample although not statistically significant (p -value = 0.125), with over half of the male respondents- married and unmarried- reporting premarital sex. However, the biggest difference between the two samples is between never-married females, with just 6.5% reporting premarital sex in the MDHS survey compared with 44% of never-married women in the Web Survey. In addition to the afore-mentioned effects of WS sample limitations, this difference could be explained by women's likely hesitancy to divulge premarital sexual activity to others because of the negative (and illegal) connotations in Maldives. Respondents in the MDHS would have had to verbally admit their premarital sex in a face-to-face interview with another Maldivian, whereas Web Survey respondents were assured of anonymity.

The reporting of premarital sex was also strongly reflected in the in-depth interviews. Interviewees were not asked outright whether they had had premarital sex, and I avoided any use of 'us/them' distinction. For most of the interviews, the phrases constructed between myself and the respondent tended to make reference to 'those who do it before marriage' (*'neendhe mikanthah hinngaa kudhin'*) and 'those who wait' (*'madu kuraa kudhin'*). These phrases are not devoid of connotations either, but this cannot be avoided; the category of 'those who wait' is more positive than the other, as the unspoken understanding was that it was 'good' and expected to delay sex until marriage.

Most respondents would place themselves in one category (using 'them' or '*emeehun*' for one group and identifying with the other), allowing me to infer whether or not they had had premarital sex, but it is only an inference. These implications of belonging to one group were not happenstance as the issue of premarital sex was discussed over a number of questions. Respondents had numerous opportunities to alternate between using 'us' and 'them' or to clarify, confirm or reject their narratives. Just five respondents from 61 felt that they had to

state whether or not they had had premarital intercourse. Four of the five were female - one was currently married, and reported having had sex at a young age and before marriage; whereas the remaining three stated that they had not had sex. The fifth was an unmarried male respondent who mentioned his sexual activity as something he did even though he prayed; implying that he felt that the two activities were contradictory. Although few respondents stated this as explicitly as said respondent, as I discuss more in depth in *6.2.1 Religious influences*, the disconnect between religiosity and attitudes towards premarital sex was apparent in many youth narratives. Overall, male respondents were more comfortable than women to imply that they had had premarital sex, while women were more likely to distance themselves from those who have premarital sex.

A man being sexually active before marriage was reported by both men and women as unsurprising and somewhat expected. Contrarily, most interviewees felt it would be surprising to learn a female friend was sexually active before marriage. However, the majority of respondents clarified that the surprising aspect would be more about *knowing* their unmarried female friend was sexually active, rather than her *being* sexually active. This reinforces the finding that women are more hesitant to reveal their sexual activities than men, although there are urban-rural differences. Urban women referred to peer pressure and popularity associated with being sexually active and unmarried, which rural women did not refer to.

5.1.2. *Sexual intercourse and sexual activity*

MDHS questions use the term ‘sexual intercourse’, however in nearly all of my in-depth interviews I was asked for clarification about what I meant by ‘sex’? The words I used in Dhivehi- *jinsee gulhun*- did not specify if it was intercourse, and as is often the case among Maldivians, resorted to English - I either confirmed “yes, all the way” (*ekee*) or supplied “fully” (*full koh*). The English term ‘sexual intercourse’ might have been clearer, but during the piloting phase it became apparent that the term was considered too formal and clinical for in-depth interviews.

What do Maldivian youth include or consider when they talk about ‘sexual intercourse’ or answer questions about it? The in-depth interviews suggest that ‘sexual intercourse’ does not include penetrative oral or anal sex - youth who

referred to those sexual activities identified them explicitly. Respondents appeared to understand ‘sexual intercourse’ as referring to penile-vaginal penetrative sexual intercourse, excluding all other forms of sexual contact.

Three key informants also made an unprompted distinction, distinguishing between sexual intercourse and other sexual activity when discussing their perceptions of youth. Thus, it seems generally understood that in mainstream discourse and discussions about youth sexual activity or behaviour, it is sexual intercourse that is being referred to and is of interest from a policy and service perspective. However, this shows that there is a gap in thinking around other forms of sexual activity, especially if, for example, anal or oral sex is excluded from peoples’ thinking about sexual intercourse. There is evidence from the US that young people engage in oral sex in order to avoid pregnancies and to keep their vows of abstinence exposing themselves to risk of STI transmission (Dailard, 2003; Remez, 2000).

The fact that in my in-depth interviews there was extensive need for clarification suggests that the distinctions between penile-vaginal penetrative sexual intercourse and other sexual activities is significant in youth narratives.

I:	So now if you had to think of Male’?
R:	If considering people in Male’ they would have done some...
I:	Done some...?
R:	Had some kind of experience
I:	Oh I mean sex... fully
R:	Oh full sex... then I wouldn’t say majority but there will be a minority

-R08, unmarried, male, rural-

If youth attach a different set of values to penile-vaginal sex compared to other sexual activities, then this might affect levels of reporting in response to questions about sex. I tested this in the Web Survey (Figure 6):

MDHS Original version administered to 51.7% of Web Survey respondents

Have you ever had sexual intercourse?

MDHS Modified version administered to 48.3% of Web Survey respondents

Have you ever had full sexual intercourse?

Have you ever had any other sexual experiences (e.g. oral sex) with another person?

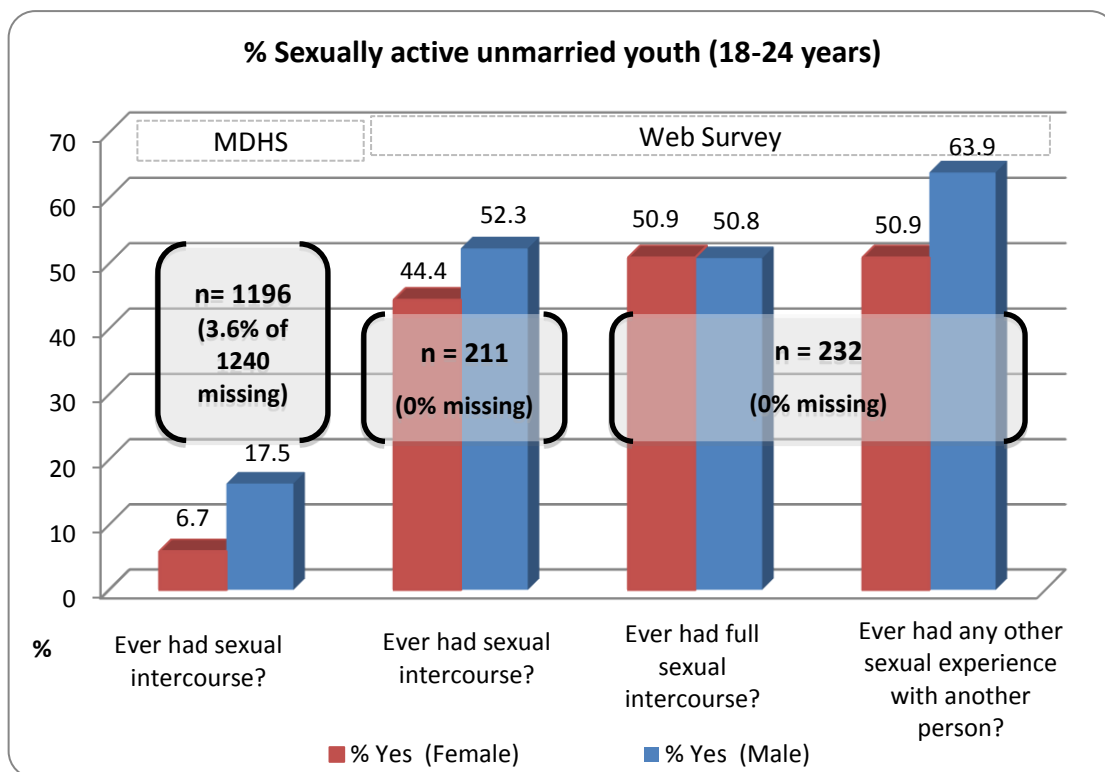


Figure 6: Comparison of MDHS and WS data on % sexually active unmarried youth aged 18-24 years

Comparison of MDHS and WS data show three important findings. First, a much larger proportion of youth report premarital sexual intercourse in the web-based survey compared with the MDHS face-to-face interview- the limits of this comparison, as discussed in the previous section, need to be recognised because the WS sample is not representative and lacks coverage of youth from different socioeconomic backgrounds. Secondly, the term ‘sexual intercourse’ is unambiguous to youth respondents, both male and female, with similar proportions in the MDHS Original version of the Web Survey, and when modified to ‘full sexual intercourse’ in the MDHS Modified version of the Web Survey. That is, asking them whether they have had sexual intercourse or full sexual intercourse does not seem to matter, as long as it is asked in a private and anonymous setting. Finally, the data suggest that young people, especially men, are sexually active - that is, they engage in other

sexual activities even if they do not report sexual intercourse. Reported levels of the proportions of youth who have had sexual intercourse do not necessarily capture all youth sexual activity.

The focus on sexual intercourse in official data and mainstream discourse could lead to underestimations of sexually active youth which in turn affects programme planning for awareness campaigns and service provision. There are potential negative health effects of this underestimation as it fails to acknowledge that according to interview data, there are incorrect beliefs that STIs are not transmitted during anal or oral sex, a lack of awareness about the dual protection afforded by condoms (which could decrease likelihood of condom use during anal sex), combined with a fear of repercussions from unwanted pregnancies. The quote below is an example of how a young person might consider oral sex with someone he suspects could be AIDS infected but considers himself safe as long as he does not have sexual intercourse with them.

I: Do most people, most people your age know to that level?
[Only AIDS]
R: Actually to that level, yeah. Well now, to put it like this, people our age who hang around at street corners, the way we think is that for example if it's a *partey* girl [street name for a girl who's addicted to drugs], don't do it with her. She might have some disease, right. But it's ok to get her to blow you and send her away.

-M13, unmarried, male, urban-

5.2. Contraception

Two key themes relating to contraception emerged from the qualitative narratives: contraceptive knowledge and use, and access to contraceptive services.

5.2.1. Contraceptive knowledge and use

Levels of contraceptive knowledge are high according to the MDHS, with just 2% of unmarried youth aged 18-24 years unaware of a method of contraception. In-depth interviews with youth corroborate MDHS findings- young people report knowledge

of condoms as a contraceptive method, though not all were aware it could also protect them from STIs. In the IDIs, respondents speculate that very few of their peers would not know any contraceptive methods, with most citing friends and the Internet as sources of information, rather than via any formal awareness campaigns such as the Life Skills workshops or the limited seminars runs by Island Health Centres. Reliance on the Internet and peers for information can potentially pose problems in terms of the accuracy and completeness of the information.

However, when contraceptive knowledge is considered alongside contraceptive use, it seems that there is a stark contrast between knowledge of contraception and use of contraception does not necessarily transfer to practice (Figure 7).

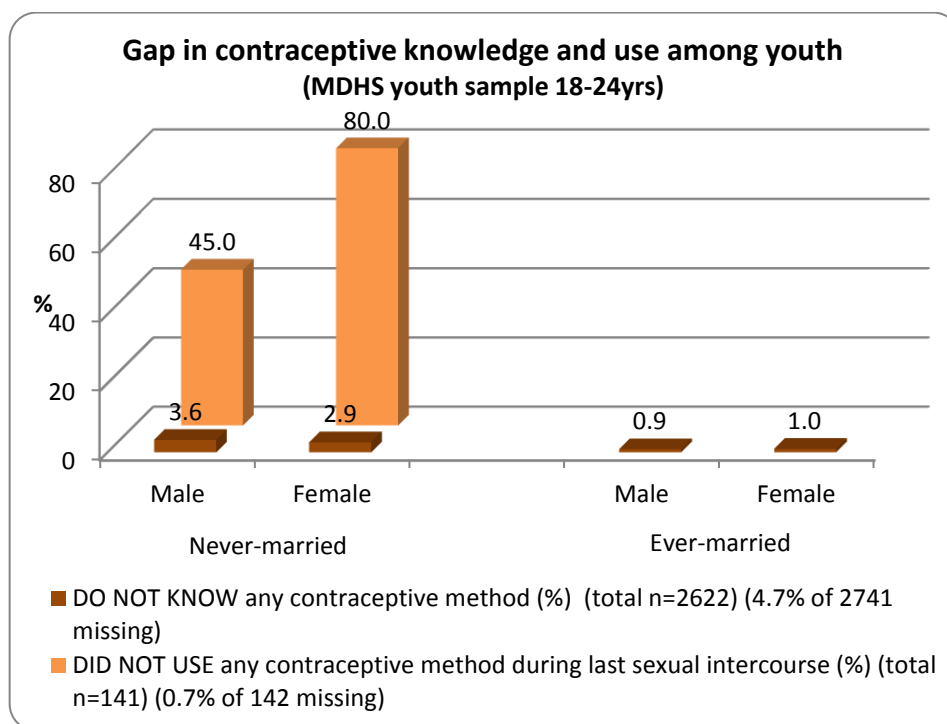


Figure 7: MDHS data comparing contraceptive knowledge and use among youth 18-24 years

The MDHS question on contraceptive use was administered only to never-married respondents who reported premarital sex (142 respondents out of 1240) which drastically widened the difference in sample size of the two questions. Moreover, because MDHS specifically asked about sexual intercourse, this means that answers to this question will not capture youth who engage in, for example, anal sex without

a condom. The vulnerability of youth to STI transmission indicated by the MDHS data is, though considerable, most likely an underestimation because of the exclusion of non-penile-vaginal penetrative sex.

Although the sample is not very robust- the contraceptive use question had only 141 respondents, and it was not administered to ever-married youth- the difference between contraceptive use and knowledge is striking. I offer two possible explanations for this- either that many young people do not *want* to use contraceptives, or they do want to use contraceptives but are unable to obtain them.

With specific reference to condoms, the lack of popularity of this contraceptive method is well established in Maldives. In 2003, UNFPA Maldives commissioned market research on condom prevalence and promotion, and showed a prevailing opinion among youth that condoms decreased sexual satisfaction (UNFPA Maldives, 2003b). Findings from my in-depth interviews reinforce the unpopularity of condoms:

I:	Do you think most people know condoms...condoms... most know that using condoms... they can protect themselves... they know, right?
R:	Hm
I:	That's at least something I guess
R:	Yeah
I:	It worries me that //
R:	//but there are many who don't use [laughs] condoms
I:	People who don't use? Yeah?
R:	Yeah there's lots...Most people will say they don't use at all
I:	Why? Do they say?
R:	Don't know [um] what can I say- I too didn't use it at all [um] sex yeah and... I got married in 2005 right but even before that I was with him for ages and even then didn't use it at all
I:	What if you'd gotten into trouble//
R:	//in my whole life I used it only once- it wasn't good enough
I:	That's what it is with most people isn't it
R:	It's not comfortable right? For the woman it's some kind of irritation sort of thing...and that's just me that's what happens to me
I:	Most people say that's what happens?

R: Even for the man they actually don't get the comfort they want
 I: Hm
 R: So it's not something I like and... so I didn't use it and after getting married you actually shouldn't [well] have that much guarantee with the man... trust I mean but even so I don't use it and I know it's a bad thing

-M12, married, female, urban-

Similar negative perceptions about condoms were reflected in other interviews, although most did not explicitly discuss their own sexual behaviour. Most people discussed condoms in relation to speculation about their peers; they perceived almost all would know about the preventative aspect of condoms but had heard that intercourse was unsatisfying if a condom was used.

It is clear that it is not a matter of being aware of condoms, but rather young people's disinclination to use condoms that might explain low levels of condom use. Comfort and satisfaction from sexual intercourse seem to be high among the priorities for youth, irrespective of their knowledge and acceptance of the potential health risks. The majority of youth are confident about their ability to arrange an abortion in the case of an unwanted pregnancy (see 5.4 *Unwanted pregnancy and abortion*), meaning that if unplanned pregnancy is perceived as a manageable and *only* risk of not using condoms, then it is unlikely they will forego sexual satisfaction for condom use. I discuss this in detail later in the chapter.

5.2.2. *Access to contraceptives*

Current Maldivian law and regulation states that contraception should be provided or sold only to people who are currently married. Here, I examine the data regarding young people's ability to obtain contraception. Discussions about different actors' perspectives on this policy are covered in Chapter 6.

MDHS questions on contraception ask whether respondents know where they can get condoms and whether they could get a condom for themselves if they wanted. These questions, however, were only administered to married people. Unmarried respondents were instead asked about their contraceptive knowledge and their

intention to use (and which method) when they were married. This selective application of questions reflects the illegal status of premarital sexual activity and regulations that make contraceptive services unavailable to unmarried people.

MDHS data show that high levels of ever-married men and women (98% and 89.1%, respectively) know where to get condoms from, with most people identifying pharmacies. The reporting of pharmacies as the primary source of condoms was corroborated in the Web Survey.

In the MDHS data, the proportion of respondents who feel that they themselves could get a condom if they wanted, was slightly lower, 94.6% of ever-married men and 83.6% of ever-married women, implying that some people would be dependent on another person to get a condom, although the MDHS questionnaire does not investigate who. It was a common speculation in the key informant interviews that unmarried youth were dependant on their married friends or relatives for condoms. However, unmarried youth interviewees reported being able to easily buy condoms from pharmacies, and less than 5% of unmarried Web Survey respondents identified ‘married relatives or friends’ as a source of condoms¹

% Youth (WS MDHS Modified version n=232)		Sex of respondent			
		Male		Female	
Where can a person in Maldives get condoms?		E-m ²	N-m	E-m	N-m
Location	<i>Any island</i>	50.0		38.2	
	<i>Certain islands</i>	21.3		17.3	
	<i>Male'</i>	50.0	45.1	73.3	45.0
	<i>Only outside of Maldives</i>	5.0	2.0	3.3	5.0
	<i>Don't know any location</i>	0.0	4.9	0.0	21.3
Sources	<i>Hospital or health centre</i>	45.0	43.1	33.3	30.0
	<i>Clinic</i>	30.0	27.5	30.0	25.0
	<i>Pharmacy</i>	90.0	97.1	93.3	83.8
	<i>Don't know any sources</i>	5.0	1.0	0.0	8.8

¹ This Web Survey question contained a limitation- I was unable to make the options ‘married relatives and friends’ and ‘any relative or friend’ mutually exclusive. Therefore, respondents were able to select both and 42 (23% of never-married respondents) selected both. The data reported above are from respondents who selected one and not the other. The same goes for ‘any island’ vs. ‘certain islands’ responses.

² E-m: Ever-married; N-m: Never-married

	Ever-married	Never-married
<i>from any relative or friend</i>	4.0	6.6
<i>from married relatives or friends</i>	6.0	4.9
<i>Any island</i>	44.0	44.5
<i>Certain islands</i>	20.0	19.2

Table 11: WS data on young people's (18-24 years) access to contraception

The Web Survey asked respondents where youth thought they could obtain condoms (Table 11). The proportion of never-married women who said they did not know any sources is considerable (8.8%) compared to other groups. Most women reported it would be possible to get condoms in Male', compared with men who reported it would be possible on any island. This again possibly reflects the hesitancy women display about their sexual activity as Male' was described by nearly all in-depth interviewees as a place that afforded anyone anonymity, so they would unlikely to be recognised if they bought condoms. In-depth interviews with youth raised the issue that almost all pharmacies are staffed by foreign staff (from Bangladesh, India or Sri Lanka) that would not be able to identify them as being unmarried, making pharmacies accessible for condom supplies.

The Web Survey sheds light on 2 important aspects neglected by the MDHS. Firstly, the WS shows how never-married youth perceive the accessibility of condoms. Secondly, it indicates laxity in regulations to restrict condoms to unmarried people because - pharmacies do not check whether or not the purchaser is married. As one key informant explained selling condoms is a commercial venture, so it is not in the interests of pharmacies to reduce sales.

Questions in the MDHS about whether contraceptive services should be provided for unmarried people reveal a lack of consensus, with 53.2% of never-married youth agreeing that they should be made available. However, there was a statistically significant ($p < 0.05$) gender difference- while more unmarried men agreed that such services should be provided, more unmarried women disagreed. I attempted to test this question in the Web Survey but also modified the question to include more response options, changed the phrasing, and administered it to both married and unmarried youth.

The results of the Web Survey were unexpected. Youth who strongly oppose the provision of contraceptives to unmarried people outnumber those who feel more moderately about it and those who strongly support it (Figure 8).

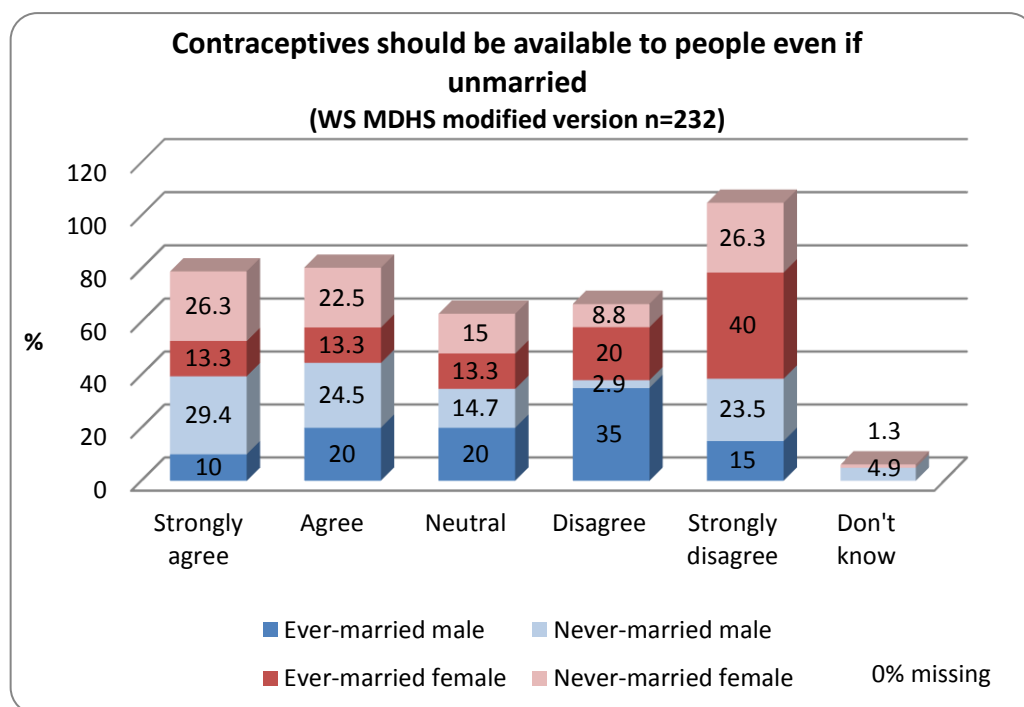


Figure 8: WS data on attitudes towards providing contraception to unmarried people

The MDHS did not explore the attitudes of married men and women regarding the provision of contraceptives to unmarried youth - although it was not possible to ascertain statistical significance given the distribution of attitudinal responses, my Web Survey data indicates that this is a group with strongly held opinions.

Two mutually reinforcing reasons contribute to an explanation for these responses: religiosity and assumptions about contraceptive access leading to increased sexual activity. Religiosity is a dominant theme that emerged from in-depth interviews as being strongly related to attitudes towards sexual activity. This stems from the belief that premarital sexual activity is *haram* (forbidden) in Islam, which also forms the basis for the illegal status of the act in the Maldives because Maldivian law is based on the *Shari'a* (Islamic Law). In the majority of IDIs, young people expressed a concern that providing contraceptives to unmarried people might send the message

that premarital sexual activity is acceptable. However, it should also be noted that almost all IDI respondents reported religion as being ‘somewhat’ to ‘very’ important to their lives, so their reported opinions being in line with religious rules is unsurprising. The quotes below illustrate how IDI respondents from each of the three sites tended to state religious rule-aligned opinions.

I: According to regulations, pharmacies are not supposed to sell condoms and things to unmarried people. But some people think it should be allowed to, because then only can they [unmarried people] take precautions. And other people think we should keep it [regulation] as it is because if it's permitted, then we are promoting it. What do you think?

R: Well I think we should keep it... actually make it more strict than this... by giving these to unmarried people... well, that's just saying 'yeah, go on like this'

I: That it's okay, eh?

R: Yeah we're giving you an opportunity, why don't you kids go and do this... even if it's not verbally, its sending that kind of message

-R05, unmarried, female, rural-

I: ...and some people think that we should sell [condoms] without checking if they are married or not married because then only can they take precautions and other people think if we allow it... that if it is allowed, then we're making it easier.. What do you// ((interrupted))

R: //if it's sold to people who are not married then its saying 'you should do it' isn't it? In my opinion if you're not married then... it should be only if you're married... there are rules to this, right, not just to any person...

-L14, unmarried, female, rural-

I: technically they are supposed to check. For that as well, there are 2 sides. Some people say, they shouldn't be checked and that we should provide [condoms] even if they are not married// ((interrupted))

R: //'cos they are gonna do it anyway

I: And other people say if you permit that then// ((interrupted))

R: //then that's promoting it, isn't it?

I: Yeah? What do you think?

R: I agree and disagree with both of them

I: ((laughs)) Elaborate

R: ((laughs)) Okay. Like yeah it's true they're gonna do it anyway so we should give it [condoms] to them, if we don't

diseases and stuff will increase, pregnancies will increase, abortions will increase. But on the other hand, if we give it then we're promoting it! [We're saying] 'Do it, its ok, we'll give you protection and everything

-M03, married, female, urban-

Because of the strength of the issue of religiosity in in-depth interviews, a question on religiosity was included in the WS where most respondents reported religion as being currently very important to them. Is reported religiosity, therefore, associated with negative attitudes towards the provision of contraception for unmarried people (Figure 9)?

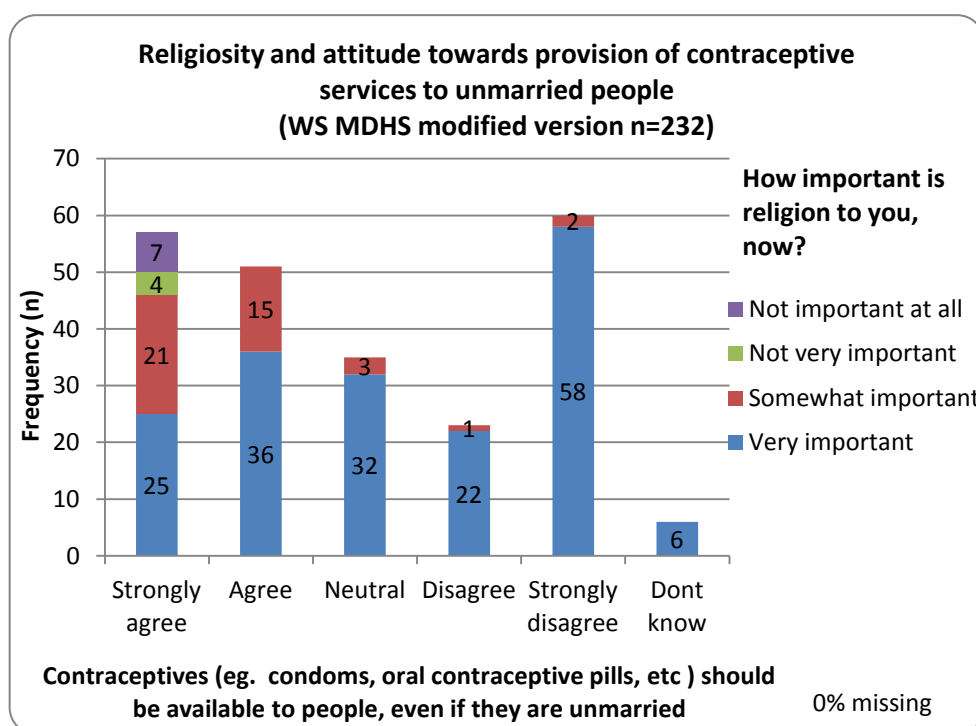


Figure 9: WS data on youth attitudes towards religion and towards provision of contraceptive services to unmarried people

Chi-square tests reveal that there is a statistically significant relationship between reported importance of religion and attitude towards providing contraception to unmarried youth ($p < 0.05$). However, this test was not based on a very robust sample—even after combining some categories (e.g. ‘Strongly Agree’ and ‘Agree’), 4 cells (50%) cells had expected counts less than 5. A guideline attributed to W.G. Cochran

states this must be less than 20%- if not, the validity of the test is decreased (Shiner & Barham, 2010). The low cell count is due to the tendency of most respondent to state religion is important to them, which could include a desirability bias as all Maldivians are raised to love and practice our religion. Nonetheless, the figure above shows that those who strongly oppose making contraceptives accessible to unmarried people have tended to be youth who state religion is very important to them.

R: I would say that [providing condoms to unmarried people] would just be supporting them to do this... in all honesty its [premarital sex] God has pronounced *haram*, right? It will just be supporting it, an encouragement to those youth, of that I am sure because like... it's saying 'do whatever you want'

I: Hmm so you think we should keep it like this right?

R: we should just provide it to people who are married, right

I: Only to them, right? Okay. But what about the diseases? Like, a lot of diseases will spread if they [unmarried people] don't use condoms and things...

R: Then just don't do it [have sex]. Simple, right?

-R09, married, female, rural-

5.3. STIs and HIV/AIDS

The study of STIs and HIV/AIDS in this research does not extend to its incidence or prevalence, but is rather an exploration of what young people know of STIs and how that knowledge affects their SH experiences and behaviour. This 'health' aspect of the research made it easier to establish rapport with, and gain acceptance from, community members in field sites. I encouraged youth respondents to do the same (i.e., emphasise that the interview was about diseases and their health) if people later enquired about their participation. As a researcher, it was more acceptable to be talking about sexually transmitted infections and diseases than it was to talk about the sexual activity itself.

During the youth interviews, I felt this was the easiest issue to discuss, as it was the issue with almost no involvement of values and moral stances. With themes such as

sexual activity or abortion or even sex education, there are clear, polarised values attached. Even though as the interviewer, I avoided making any value-related statements, the ‘undesirable’ or ‘unacceptable’ position exists and the respondent places themselves in relation to that position in part by gauging where I stand. For example, a respondent may gauge that I am accepting of premarital sexual activity if I were researching such an issue, and may position himself as someone who is also accepting of premarital sexual activity. It is by discussing it in more depth that we approach a consensus, a mutually agreeable construct- for example, ‘premarital sexual activity is a thing that happens a lot’. Sometimes the construct we settle on does contain value-judgements (e.g. ‘premarital sexual activity is bad and I don’t do it’) because I made the effort to take their cue and reflect their stated opinions in order to encourage candidness and valid opinions and attitudes. In the case of discussing STIs and HIV/AIDS, I felt that this was one issue that did not require a lot of discussion and was easily constructed as something to avoid and take precaution against, and in almost all cases, something the respondent knew little about. Even though it was established that I would know more about STIs than my respondents, I did not ‘teach’ respondents. If asked, I made general comments (at the end of the interview) about the importance of knowing about STIs and how they could lead to poor health outcomes.

5.3.1. Knowledge of STIs and HIV/AIDS

A high level of knowledge about HIV/AIDS is a finding often reported in official data (CDE, 2003; MOH, 2004c; MYDS et al., 2005). Most recently, the MDHS showed that only 2.8% of youth aged 18-24 years had never heard of HIV/AIDS. Data from the in-depth interviews also supports that nearly all youth are aware of HIV/AIDS and attributed the knowledge to repeated exposure to AIDS awareness material on TV, radio and printed material. However, the in-depth interviews such as those excerpts presented below, indicated that in judging young people’s knowledge of STIs, it is imperative to investigate whether youth were aware of STIs besides HIV/AIDS.

I: Now thinking about STIs and things like that okay? Sexually transmitted diseases... how much do you know about it?

R: AIDS
 I: Anything else?
 R: I don't know ((laughs))
 I: Why AIDS// ((interrupted))
 R: AIDS is the most famous, everyone would know AIDS...
 HIV

-M20, unmarried, female, urban-

I: Do you know anything about STDs.... About those
 diseases... by sexual contact... do you know about it?
 R: I know AIDS. Others...
 I: Others?
 R: Don't know any
 I: So AIDS eh, is that from TV// ((interrupted))
 R: //Yeah from TV... and radio

-R05, unmarried, female, rural-

R: I mentioned before right, that people get labeled here very
 quickly? This is what happens to them [people who go to the
 doctor about SH concerns] too... they are labeled
 I: Is that why you said you wouldn't// ((interrupted))
 R: // Actually it was then that I even found out sexual diseases
 even existed... when I heard people talking about it... so we
 asked people for information about what happens, how do
 you get it, what are the types... because what we know is
 HIV as something big that happens... didn't know there were
 different types... actually, I still don't know the types..

-L10, unmarried, male, rural-

The quotes above were taken from interviews from the 3 field sites (2 rural atolls and urban Male') and are typical of most responses. The youth interview respondents who were able to name STIs besides HIV/AIDS speculated that they knew more than their peers, attributing their own knowledge to awareness seminars they had attended or because they had worked in a health-related institution or project. This low level of knowledge of STIs excluding HIV/AIDS is reinforced in the MDHS data (Figure 10).

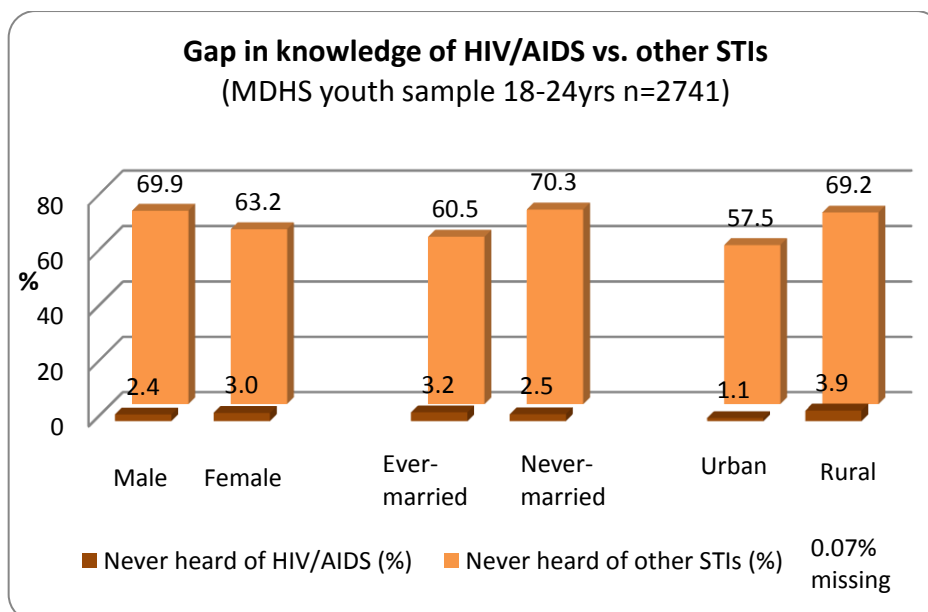


Figure 10: MDHS data comparing knowledge of HIV/AIDS and other STIs among youth (aged 18-24)

Levels of knowledge of STIs besides HIV/AIDS are low regardless of marital status, gender, and urban-rural divides. There is a statistically significant difference ($p < 0.05$) in knowledge of other STIs between never-married youth in urban and rural areas. One explanation could be that more youth in urban areas are likely to have easier and more frequent access to the Internet - a service youth most commonly identify as a source of information.

From a service-provider's perspective, youth workers and NGOs report having greater youth participation in awareness sessions in the atolls because the small size of the communities allows easier participant recruitment and follow-up. Recruitment techniques for sessions in Male' do not include door-to-door visits or public announcements from the local health centre but rather are usually through schools or offices or word-of-mouth.

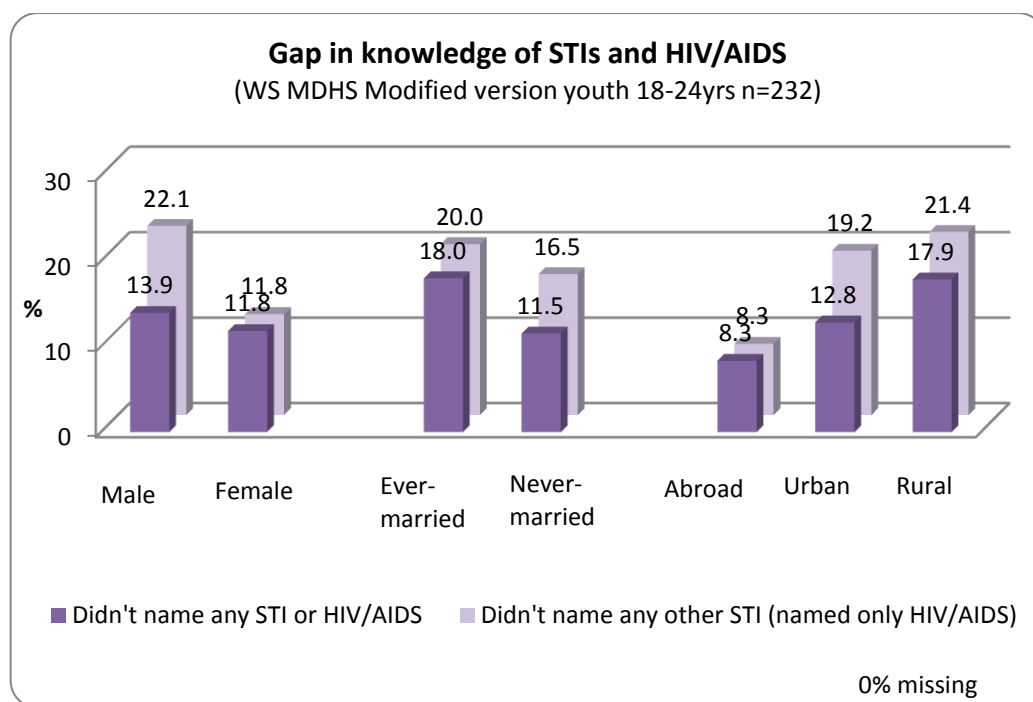


Figure 11: WS data comparing gaps in knowledge of STIs and HIV/AIDS

In the Web Survey, I utilised a different approach to explore knowledge of STI and HIV/AIDS, administering the following question to the 232 respondents allocated to the MDHS Modified version:

Do you know of any diseases or infections that can be passed on through sexual activity? Name as many as you can in the box. Don't worry about getting the spelling right. If you don't know, just write 'don't know' in the box

Figure 11 compares the background characteristics of respondents who were able to name only HIV/AIDS to those who were not able to name any STI or HIV/AIDS. These results indicate that the knowledge differences between Male' youth and island youth are smaller when considering proportions of youth who can name other STIs besides HIV/AIDS. The biggest proportions of youth who cannot even name HIV/AIDS or any STI are those that reside in the atolls- however, atoll (rural) youth were very poorly represented in the WS sample (11%), therefore these inferences are limited. Although not comparable to the MDHS results, it appears that contrary to the MDHS data, more ever-married youth than never-married youth are unable to demonstrate knowledge of STIs or HIV/AIDS. This is surprising considering court-

ordered information sessions, made mandatory for newly married people since 2007. However, there are no data on the proportion of couples that attend these sessions.

5.3.2. Experience of STIs and HIV/AIDS

One major gap in the MDHS as well as other sources of official data is that there is no data on the incidence of STIs or HIV/AIDS among unmarried people. The MDHS administered questions only to ever-married respondents about whether or not they had had any disease as a result of sexual contact. The proportion of people who responded yes to this question was very low (1.5% of ever-married men, 2% of ever-married women). However, these results are interesting compared to the responses from a further two questions that asked whether they had had an abnormal discharge from their genitals, and whether they had had a sore or ulcer near their genitals (Figure 12).

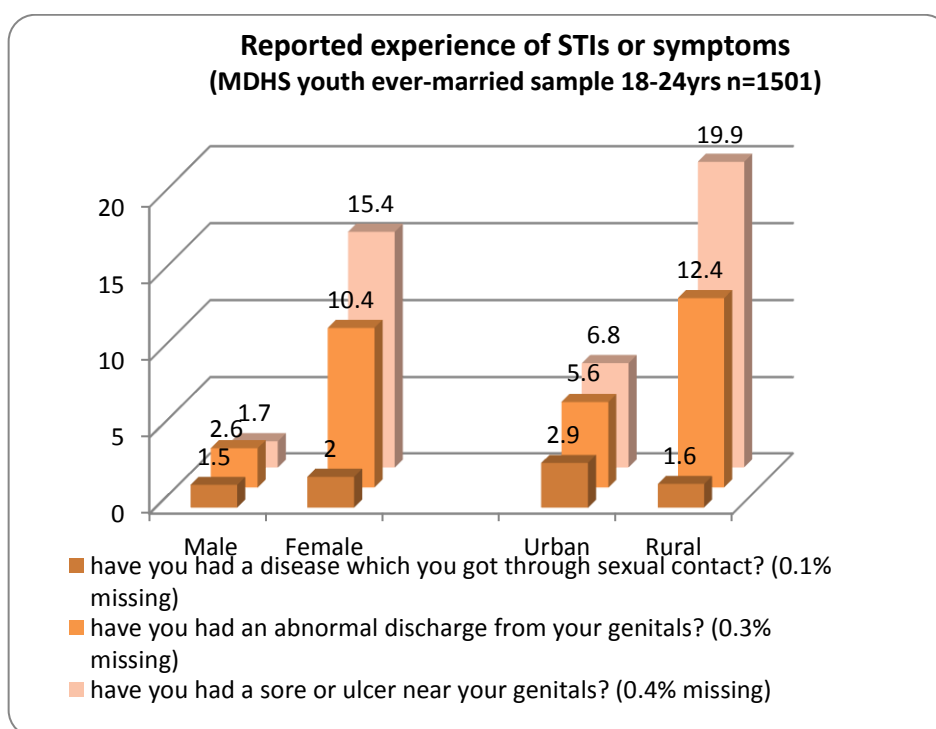


Figure 12: MDHS data on reported experience of STI symptoms among ever-married youth (aged 18-24) in the last 12 months

Although small proportions of ever-married youth stated that they had had a disease that they got through sexual contact, much larger proportions experienced symptoms that could be linked to cases of sexually-transmitted infections. Combined with the low levels of knowledge youth have regarding STIs, this indicates that the incidence

of STIs by and among youth may have been underestimated. This data is consistent with in-depth interview data nearly all youth report that they had not experienced STIs or had heard of anyone among their peers who had. Only 11 out of 61 respondents said they had heard of typically one or two cases of STIs or even of people experiencing STI-like symptoms. A likely explanation is that youth are unaware of their own STI status- this could have been countered if the MDHS had administered the same three questions to unmarried youth. It was not possible to include it in the Web Survey given the need to keep it short as well as reflect the MDHS question order and avoid introducing priming effects in order to generate comparable data.

Key informants working in the health sector, however, report that it would be possible to estimate STI incidence among unmarried youth based on doctors' reports but that these estimates would be inaccurate for two reasons. Firstly, there are no standardised reporting mechanisms that would allow a reasonable estimate of STI incidence among unmarried youth because the data often-times did not identify marital status. The prevailing view among health-sector key informants, both at policy level and service-provision level, is that neglecting to collect the marital status data worked in unmarried people's favour. This is because legally, unmarried people should not be able to access SH services as it is illegal for them to be sexually active. Thus, service-providers maintain deniability by not recording marital status (See Chapter 4 for further discussions from service-providers' perspectives). The second reason that current records would yield inaccurate estimates of STI incidence among unmarried people is, health experts speculate, because only a small proportion of youth seek health services, possibly as a result of lack of awareness about symptoms or about services available to them.

5.3.3. Access to medical help for STIs

Of the ever-married MDHS respondents who said they had experienced STI-like symptoms, there were a small proportion of respondents (16.7% of women and 31.8% of men) who report that they had not sought any kind of advice or treatment regarding their symptoms. Among the MDHS never-married respondents, 92.4% said they did know of a place they could go to get treatment if they think they may have an STI. This is despite the fact that it has never been officially recognised that

unmarried youth might require STI treatment and such a service availability has not been publicly communicated. This finding reinforces key informant reports about unmarried youth accessing services by not having to give their marital status. However, pursuing either of these options based on this particular MDHS result needs to be cautious- the MDHS question was not administered to never-married respondents who did not know about HIV/AIDS or any STIs- thus it was administered to only 367 respondents (from a sample of 1240).

The WS incorporated some questions, including both MDHS questions and modified questions, about STI treatment (Figure 13).

MDHS (interviewer to verbally administer question only, and record response)

521	Do you know where a person can go to get treatment if they think they have a sexually transmitted disease?	YES 1 NO 2	→ 601
522	Where can they go? Any other place? PROBE TO IDENTIFY EACH TYPE OF SOURCE AND CIRCLE THE APPROPRIATE CODE(S). IF UNABLE TO DETERMINE IF HOSPITAL, HEALTH CENTER OR CLINIC IS PUBLIC OR PRIVATE MEDICAL, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE)	PUBLIC SECTOR INDIRA GANDHI MEMORIAL HOSPITAL A GOVT. REGIONAL HOSPITAL B GOVT. ATOLL HOSPITAL C GOVT. HEALTH CENTER D GOVT. HEALTH POST E COMMUNITY/FAMILY HEALTH WORKER OTHER PUBLIC G _____ (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE HOSPITAL/CLINIC H PHARMACY I PRIVATE DOCTOR J OTHER PRIVATE MEDICAL K _____ (SPECIFY) OTHER SOURCE SHOP L OTHER X _____ (SPECIFY)	

Web Survey (question and response options visually presented on screen)

If a person in Maldives had a disease or infection transmitted through sexual activity, where can they go?
Please select either yes, no, or don't know for each one.

Any of these places? *

	Yes	No	Don't know
Indira Gandhi Memorial Hospital (IGMH)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ADK Hospital	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Regional or Atoll Hospital on an island	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Health Centre or Health Post on an island	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A clinic in Male'	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A clinic on an island *	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Health service or doctor abroad (out of Maldives)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Or another place?

Figure 13: Comparison of MDHS and WS question on STI treatment services

The sets of questions differ in two important aspects that need to be considered before comparing the data. The first aspect is regarding the proportion of never-married youth who state they do not know where they can access help if they need STI treatment.

Based on the MDHS (n=366) and WS (n=182) data, it is difficult to discern any background characteristics of unmarried youth who do not know any options for help regarding STIs. Overall, 6.8% of MDHS respondents reported they did not know, while 8.2% of WS respondents gave the same response. Considering the response option differences between the questions, I would argue that it would have been much more difficult to respond with 'don't know' to the Web Survey question than to the MDHS question. The question format in the Web Survey question requires the respondent to repeatedly say they don't know. In fact, the visual setting of the question shows the respondent that responding *yes*, *no*, or *don't know* would all require equal amounts of time, effort and clarification. Therefore, the MDHS question might have allowed exaggeration of the 'don't know' result whereas the Web Survey question would have not.

The second aspect to consider before comparing the data deals with the places identified by respondents (Table 12: darkest shade indicates highest value in each column, lightest indicating the lowest). MDHS respondents were not prompted whereas WS respondents were presented with a list of places and they had to decide,

for each place, whether treatment was possible there. Thus, WS respondents were given the opportunity to make a judgement about each of the places- their ‘no’ responses would indicate places from which unmarried youth felt they could not obtain STI services. It should be recognised that this data lacks the clarity of the MDHS question on access to contraceptives where there was a follow-up question that asked whether or not they themselves (the respondent) would obtain the service at the place they report the hypothetical person in the question could obtain that same service.

Unmarried youth's report of where they can get medical help regarding STIs		Sex of respondent		Total Yes	No	Don't Know
		Male	Female			
MDHS (n=366)						
<i>Do you know where a person can go to get treatment if they think they have a sexually transmitted disease? [If yes] Where can they go?</i>	IGMH	83.3	82.5	76.8		
	Private hospital/ clinic	50.0	43.9	42.9		
	Atoll hospital	20.0	30.7	24.0		
	Regional hospital	33.3	34.4	31.7		
Web Survey MDHS Modified version (n=182)						
<i>If a person in Maldives had a disease or infection transmitted through sexual activity, where can they go? Please select either yes, no, or don't know for each one</i>	Health services or doctor abroad (out of	82.4	87.5	84.6	0.5	14.8
	ADK Hospital	79.4	82.5	80.8	3.3	19.2
	IGMH	75.5	80.0	77.5	5.5	17.0
	Regional or Atoll Hospital on an island	45.1	35.0	40.7	13.2	46.2
	Health Centre or Health Post on an	32.4	26.3	29.7	18.1	52.2
	A clinic in Male	64.7	71.3	67.6	4.9	27.5
	A clinic on an island	30.4	30.0	30.2	17.0	52.7

Table 12: Comparison of MDHS and WS question and responses on STI treatment services¹

Some unmarried youth felt that clinics or health centres on islands were not places a person could go to for help regarding STIs- 18.1% said no to ‘Health Centre or Health Post on an island’ and 17% said no to ‘a clinic on an island’. However, these two were also the options most respondents felt they did not know about. This indicates that while a majority of the unmarried youth respondents did not know whether or not they would be able to obtain STI services on an island, a lot of youth felt that they would not be able to do so. This is then compared to the proportion of respondents that said a person could get help from a clinic in Male’ (67.6%). It

¹ The darkest shade indicates the highest value in each column, the lightest indicating the lowest

should be reiterated, however, that Web Survey respondents consisted of a much larger proportion of youth based in Male' (69%) than those from islands (11%), meaning knowledge about island facilities will be lower. Similarly, MDHS respondents consist of 63.5% from the atolls and 36.5% from Male'- a distribution much closer to general population distribution, given better sampling (than WS sample) - which might be why island-based facilities are the third most mentioned option for STI treatment in the MDHS data.

The majority of MDHS respondents felt a person could obtain STI treatment from the state hospital (Indira Gandhi Memorial Hospital IGMH) in Male' whereas more WS respondents report the main private hospital (ADK) in Male'. The proportion of youth who consider private clinics an option are not much less than those who mention hospitals- a similarly close split was reflected in the in-depth interviews as well. Some respondents felt the crowds and queues in Male' hospitals would allow a person to be anonymous or even claim they were there accompanying another person. Other respondents felt small private clinics in Male' were numerous enough that they could sneak into one without attracting much attention. Atoll respondents reported having fewer options- those with easy access to the regional hospital said they would opt to get treatment there, but those on islands that have Health Centre or Health Post facilities said they would have to travel to the island with the Regional Hospital, the arrangement of which would require them to tell- or lie to- at least their family members about the reason for the trip.

As the Web Survey data indicates, nearly 85% of unmarried youth feel they would have to go outside of the Maldives to seek STI treatment. This could be because of the low confidence they have in the Maldivian health services- an opinion expressed by many interview respondents and key informants- and an extension of the common practice among Maldivians to obtain most health services in neighbouring countries where it is reportedly cheaper. Alternatively, it may be linked to the perceived low STI prevalence that led respondents to believe STI treatment is not available locally. In either case, it is fair to say the response option 'abroad' has little explanatory power and worsened the applicability of the modified question exploring access to STI services.

5.4. Unwanted pregnancy and abortion

Prior to MDHS 2009, there were no publically available data on either unwanted pregnancies or induced abortions among unmarried youth. Despite this, key informant interviews suggest that at policy planning and service-provision level, it is well known that these rates are high among unmarried youth (it is unclear whether this level is higher than among ever-married youth, as it was not discussed). Almost all key informants state that there is very little that can be done about it, as it would be impossible for the Islamic state to provide any medical assistance for abortion, and state that it is a major milestone for such data to be collected in the nationally representative MDHS.

5.4.1. Experience of unwanted pregnancies and abortion

Results from the MDHS are shown below, alongside data from the Web Survey that administered the same questions in the MDHS Original version.

MDHS (n=139)			Web Survey (n=104)	
Never-married male	Never-married female		Never-married male	Never-married female
<i>Sometimes a woman becomes pregnant when she does not want to be. [FOR FEMALES]: In the past, have you ever become pregnant when you did not want to be? [FOR MALES]: In the past, has a woman with whom you were having sex ever become pregnant when you did not want her to be?</i>				
3.1 (3)	22.0 (9)	% Yes (n)	4.4 (3)	13.9 (5)
96.9 (95)	78.0 (32)	% No (n)	95.6 (65)	86.1 (31)
2.1% (3 of n=142)		% Missing cases (n)	50.7% (107 of n=211)	
% Yes by Current residence (n)				
		Abroad	14.0 (2)	17.0 (1)
0.0 (0)	9.0 (2)	Urban / Male'	2.0 (1)	15.0 (4)
6.0 (3)	35.0 (7)	Rural / Atolls*	0.0 (0)	0.0 (0)
% What happened with the (last such) pregnancy? (n)				
0 (0)	77.8 (7)	Pregnancy continued	0.0	0.0
100 (3)	11.1 (1)	Had abortion	100.0 (3)	100.0 (5)
0.0 (0)	11.1 (1)	Had miscarriage	0.0 (0)	0.0 (0)
0.0 (0)	0.0 (0)	Don't know	0.0 (0)	0.0 (0)

Table 13: MDHS and WS data on unwanted pregnancies and abortions among youth (aged 18-24)

The first point to note regarding the data presented in Table 13 is the substantial portion of missing cases for this question in the Web Survey (50.7%). This was because there were skipping pattern errors that sometimes skipped some respondents or erroneously administered the wrong abortion questions to some respondents (it needs to be based on gender and experience of unwanted pregnancies). Since this would have introduced several biases, I decided to not include cases where the question was administered incorrectly, leaving a sample of only 104. The MDHS sample for this question is also small (n=142) given that it was administered to never-married youth who had reported sexual intercourse, meaning that any explanation drawn from this question, is drawn from very small samples for both data sets (see '(n)' given in each cell in table above). Nonetheless, the MDHS had only 2.1% missing cases, while the WS had 50.7%.

Both sets of data indicate a lower proportion of unmarried women report experiencing unwanted pregnancies than indicated in IDI and KII narratives. MDHS respondents may have been hesitant to reveal this to the interviewer, even more so than revealing that they had engaged in premarital sexual intercourse. Data from the in-depth interviews indicate that while being sexually active might be seen in a positive light by some peers, becoming pregnant as a result of premarital sex is unanimously considered shameful.

As an aid to explore respondent's attitudes towards unwanted pregnancies and abortion, in-depth interviewees were given a series of 'What If?' scenarios.

Scenario 1: What if you found out that an unmarried friend of yours was sexually active?

Scenario 2: What if an unmarried friend told you they think they had an STI?

Scenario 3: What if an unmarried friend told you she was pregnant?

The majority of respondents reported they would not be surprised if they were faced with Scenario 1, and most went on to say it had happened to them. The response to Scenario 2 was generally ambivalent, as most youth said they would just encourage their friend to go to a doctor. Probing about where they would seek treatment

revealed deeper issues of accessibility, such as their financial ability and freedom to travel to another island to avoid ‘leaks’ about their health status. In contrast, Scenario 3 elicited the most value-laden responses and almost all respondents mentioned religion at that point.

I:	Okay say for example a friend of yours comes and tell you ‘I am pregnant’. What would you do?
R:	Well I wouldn’t say anything... To drop [abort] is another sin upon sin right? -R06, unmarried, female, rural-
I:	Another friend okay... this time a friend comes and says ‘I’m pregnant’. What do you do then?
R:	You mean illegitimately?
I:	Hm
R:	If that happens I would mostly try to guide her to the right way. I wouldn’t force... I mean recommend doing an abortion -R08, unmarried, female, rural-

Discussion about unwanted pregnancies immediately led to discussion of abortion in in-depth interviews. Although I had decided, during the piloting phase, to exclude abortion from the interviews, it became apparent in the first few interviews that youth were very much exposed to the issue of abortion. I deliberately avoided mentioning abortion in the in-depth interviews, but when I followed up on the Scenario 3 question with “Say the friend came to you for advice, what would you say?” all respondents answered with reference to abortion.

I:	Say for example, again a friend of yours... this time she says she’s pregnant... what would you do then?
R:	If that happens eh? If that happens I will certainly not tell her to abort -L14, married, female, rural-
I:	Alright so what if a friend came to you and said she was pregnant? What then?
R:	Then... it’s already in there so then... the question is ‘do you want to have it or not’ right? I would advise... not to go for

abortion... but how would she raise the child... I guess I would advise her to go for abortion

-M08, unmarried, male, urban-

I: Another friend comes and says to you 'I think I'm pregnant'. What do you do then?

R: I would definitely not tell her to abort it

-R12, unmarried, female, rural-

I: Ok so another friend comes and tells you she is pregnant? What would you do then?

R: Well, to do an abortion or anything like that, I wouldn't encourage her or even help her.... Well, I'll tell her to tell her mother, to tell her parents...

-M14, unmarried male, urban-

Having encountered a range of attitudes regarding abortion in the in-depth interviews, I included an attitudinal question in the Web Survey MDHS Modified version (Figure 14).

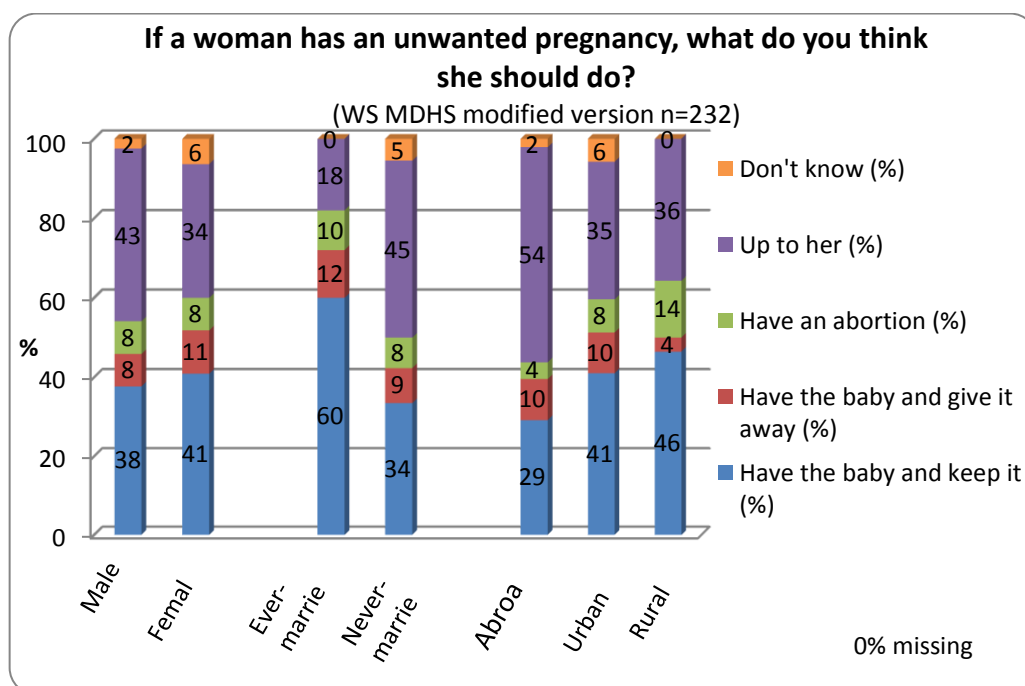


Figure 14: WS data on youth (aged 18-24) attitudes regarding how women should deal with unwanted pregnancies¹

¹ n=5 resort-workers included in 'Atolls' group

The results loosely reflect youth narratives from the in-depth interviews. A considerable proportion felt the choice was up to their friend and very few said they would advise her to have an abortion. Although the response categories were based on common responses in interviews, I recognise, in hindsight, that my response categories are problematic. Even though most interviewees responded to ‘unwanted pregnancy’ questions in terms of abortion, the reverse does not work- it is unlikely that people would recommend abortion, even if they would support a woman’s decision to abort. It is possible that the ‘up to her’ response category contained responses from those who would support a decision to abort. Therefore, there were validity issues with this question. Nonetheless, the proportion of youth who said it would be the woman’s decision may be indicative of a perspective among some youth where they perceive they have- or perhaps that they should have- options regarding unwanted pregnancies.

In in-depth interviews, most youth speculated the best course of action would be to carry the pregnancy to term, and avoid *faafa egge machchah faafa*- i.e., to ‘commit sin upon sin’. It was clear that youth perceived abortion to be much closely linked to their religious beliefs than premarital sexual activity. Their stance did not seem to be reflecting pro-life arguments regarding abortion- there was almost no discussion of the foetus as a life. Instead, it seemed to be because Islamic doctrine regarded it as a sin. Two out of 61 respondents mentioned that they thought that Islam allowed pregnancy termination within the first trimester.

Regardless of their attitude towards abortion, the majority of youth interviewees agree that abortion is extremely common among unmarried youth. 21 respondents reported knowing of up to 5 cases of abortion among unmarried peers, four respondents report knowing of 5-10 cases, and nine reported knowing of more than 10 cases.

R:	Yeah people do talk about it but you know... but these days I mean... I can say that a lot of the girls tend to do abortion and
I:	How many cases of abortion have you heard?
R:	Many

- I: 50?
 R: Yeah it could be more than that
 I: 60?!
 R: not really, it's like... I didn't really see them doing that or it's not that they came back and told me that I did the abortion... it's not like that but I have...
 I: Okay so how many from ...people who you know... among them, about how many would there be?
 R: yeah it will be more than 20 seriously
 I: that's loads eh, so it is pretty common
 R: yeah it is common
 -M17, unmarried, male, urban-
- I: Do you hear about babies being dropped [aborted]?
 R: Well... recently a friend was also... by accident... she got pregnant... we didn't talk to her, we didn't even want to...
 I: Do you think it is common
 R: It's common now yeah... what happens now is there are these pills to drop [abort] so it's become an easy thing
 -L13, married, female, rural-
- I: You hear about it eh? What do they usually do? I mean, do they give birth or abort or...?
 R: More friends in [neighboring island], most friends there, it happened to them, to a few of my friends... I mean, there's a lot of youth who... when I was living there, it happened to a few friends and they took some kind of pills and aborted... I know they did. The other, those who gave birth... there was one girl who gave birth while in school... she didn't go to classes after that
 I: Hm. So those pills they take to abort... is it easy to get them in this island?
 R: That... I don't know about this island...
 I: In [neighbouring island]
 R: I don't know about it on this island... I've only heard of one
 I: And on [neighbouring island]?
 R: Oh there I knew a lot because well, I lived there for 9 years in school there... so I knew about it [abortions] there...
 I: Yeah... so was it easy to get it [pills] there?
 R: the pills... that time, they got it because it was... what's his name... there was a guy then, he got it somehow
 I: the friend's boyfriend?
 R: Her younger sister's... ((Laughs)) her younger sister's boyfriend. Yeah he got it that time... he sent some later too
 I: Yeah?
 R: Yeah... I don't know how they got it [pills] after that
 -R16, unmarried, female, rural-

5.4.2. Access to abortion

The quotes above reveal a further aspect about abortion- that it is considered an ‘easy fix’ to an unwanted pregnancy. When asked if they knew how people got abortions, 40 of the 61 respondents were able to describe to me different ways of inducing abortion, the most common of which was consuming pills, usually in combination with another medication. Exactly half of the in-depth respondents said they would be able to acquire these abortion-inducing pills. It is unclear whether or not they were referring to emergency contraception as I did not want to introduce new information to the discussion. Another common option reported by youth respondents and key informants was surgical abortion, though this is limited to those financially capable to travel abroad, usually to Sri Lanka or India.

- | | |
|----|--|
| I: | Okay but what about 5 years ago, we had peer pressure then too |
| R: | Yeah there was... there wasn't that... everybody wanted to do it or everybody wanted to experience because some people like... there is that fear, if I do something I might get something or I might be pregnant or whatever... but now that fear is not even there because they get these medicines and all those things abortions and stuff so there no... there's no fear I think in do those things |
| I: | Like, even if something happens to me there are things I can do... there's no fear because they think like that? |
| R: | Yeah, that there's another option because if I get an STI too I can just take some medicine, if I get pregnant, go abroad... some place like [Sri] Lanka and I can get an abortion... so there are different options they could choose so they are not afraid to do |

-M18, unmarried, male, urban-

Interview data suggests that easy access to abortion counters young people's fear of unwanted pregnancies, which could be linked to low use of contraception.

5.5. Sex Education

Currently in schools in Maldives, information about contraception, STIs and HIV/AIDS, and sexual behaviour is taught in the Life Skills classes- these are information sessions given in school-based settings (12-18 years) delivered during

non-school hours and taught by facilitators trained under the Life Skills Project.¹ It was introduced as part of the ASRH project and involved 4 schools (selected primary and secondary schools based in Male') in their piloting phase. The project was not formally rolled out to schools as the project stalled at a debate on whether or not to make Life Skills part of the curriculum (also see Section 4.2). Nonetheless, some schools sporadically request that these classes, usually a condensed version, be taught to selected grades or classes². It is entirely possible for Maldivian youth to have progressed through the 10 years of primary and secondary education with no in-school sex education.

5.5.1. Getting sex education

The MDHS results indicate that 72.7% of unmarried youth were taught about human reproduction and sexuality in school. Consider this date compared against proportions of the same sample of youth who reported low levels of knowledge of a key SH issue- STIs. This suggests that it is worth exploring what is included in human reproduction and sexuality education in schools. If we consider levels of SH knowledge according to whether youth received any human reproduction and sexuality education in school, we can see the following trend (Figure 15).

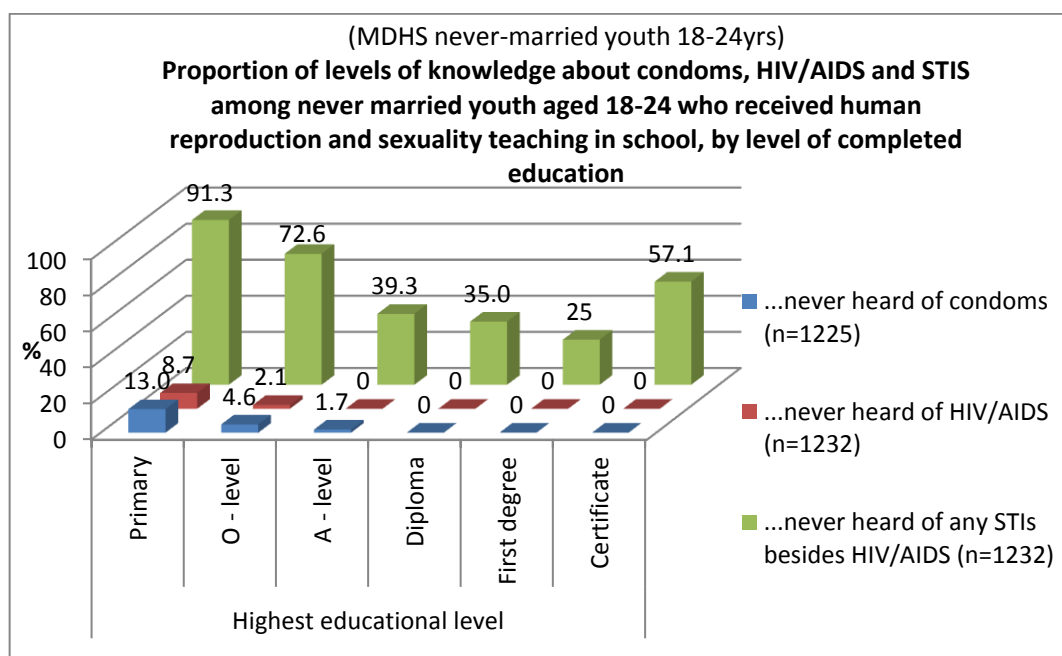


Figure 15: MDHS data on gaps in human reproduction and sexuality lessons in school among youth (aged 18-24)

¹ KII10, KII17

² KII07

Although all those with first degrees, diplomas and certificates have heard of condoms and HIV/AIDS, it is likely that knowledge was gained after O-levels.

When IDIs were questioned about whether or not they were taught about ‘sexual health or reproductive health’, the majority of respondents said that they had not received this education, often followed by speculation that it might be because they did not do Biology. Respondents who did Biology in school confirm that their lessons did not include information on contraception or STIs but did recall HIV/AIDS being mentioned, though not in detail. They, however, suggest that human reproduction was one of the topics but that it was focused on reproductive systems and organs.

I:	Hmm okay. Now thinking about STDs and things like that
R:	Hm
I:	How much do you know about STDs?
R:	Not that much... well, only what I learnt
I:	Where did you learn it from?
R:	In CHSE [A-level school in Male’ teaching ages 16-18]
I:	No I mean those things [STDs]
R:	Oh those things... in Grade 7, and then in secondary [school] too... in every... in every grade, I mean, primary, secondary, higher secondary [schools]... in everything there’s a bit about AIDS
I:	Is it just AIDS? Other STDS...
R:	Other STDS...
I:	Haven’t heard eh?
R:	No I haven’t heard...
	-M04, unmarried, female, urban-

Although the MDHS data suggests wide coverage of sex education, the analysis above raises two important points. Firstly, it is possible MDHS respondents may have misunderstood ‘human reproduction and sexuality’ to refer to human reproduction systems taught in Biology, rather than more general learning about contraception and sexuality. Secondly, it is important to be cautious in interpreting the coverage of ‘human reproduction and sexuality’ education in schools as it appears that it does not necessarily correspond to awareness of STIs other than HIV/AIDS.

5.5.2. Attitudes towards sex education

The MDHS administered a further two questions to never-married youth to explore their attitudes towards sexuality education. However, the lack of clarity as to what this includes means that these data cannot be taken to indicate respondent's attitudes towards teaching information on contraception, HIV/AIDS, and STIs in schools. A modified version of this question was included in the Web Survey MDHS Modified version, testing not only respondent's perspectives on sex education but also the age at which they feel sex education should commence.

The majority of respondents from the MDHS (94.6%) and from the WS (95%) consider that sex education should be taught in schools. When asked at what age these lessons should start, the biggest proportion of MDHS respondents (33.8%) and Web Survey respondents (23%) suggest 15 years. This is one instance where the official data and youth data correspond.

Key informants who did not think sex education should be taught in schools had the option of explaining why. Most stated that teaching sex education in schools would make young people more curious at an age they would want to experiment. Some respondents differentiated between teaching about contraception and about STIs—they support teaching about STIs but think that once taught about contraception, it makes young people aware of ways they can be sexually active without fear of repercussions. This is similar to reasons why some youth believe contraceptives should not be allowed to unmarried people, that their provision would lessen their fear of repercussions, removing one of the reasons why some unmarried youth refrain from having premarital sex.

I:	Do you think everyone should be taught this like
R:	Yeah my point is not everyone... ok? Not everyone. Especially ... I think O level students [typically aged 16] don't really need this... maybe after O levels... I think that could be good or maybe... you know, for... maybe you know... Social Studies, Biology... in science there might be so...
I:	Okay

R: but my best point of view is... after O levels
 I: Before that... you don't think young people will need it? And why do you think just// ((interrupted))
 R: Science really... not really Biology
 I: Okay... but there might be people who study Commerce who need this information...
 R: Yeah
 I: So you don't think they should be taught this?
 R: I mean [not] before O levels... After O levels you can't access [youth] eh?
 I: why do you think O level... Why do you think from O levels?
 R: ((laughs)) you know, my point of it is... you know, especially... you know... we call them kids. They do... you know... [Their] minds can't really read into... I mean this is like if someone says 'yeah this is this, this is that'... [They will say] 'Well let's believe'... They do have childish minds
 I: So if we teach them you think...
 R: Misuse [information] again... mislead
 I: okay
 R: Misinterpret
 I: Okay so they are the ones [mentioned before] who'll take it as 'they're telling us to have sex' and do this?
 R: Yeah they might... which is something that is happening... you know

-M17, unmarried, male, urban-

5.6. Conclusion

In this chapter, I explored whether youth SH experiences have been fully captured in publically available data by comparing such official data (Maldives DHS 2009) with youth perspectives using both quantitative (Web Survey) and qualitative (In-Depth Interviews) data. The comparison has shown that on the aspect of premarital sexual activity, official data has tended to under-estimate the proportion of sexually active youth by failing to distinguish between sexual intercourse and other sexual activities. Youth data suggests that a majority of youth have premarital sex, with larger numbers likely to be broadly sexually active. With regard to knowledge of contraceptive methods, official data tends to highlight high levels of knowledge without acknowledging the extremely low levels of contraceptive use- however; this is understandable given how official data shows low levels of premarital sex. Official data and youth narratives both indicate that unmarried youth are aware of

where to obtain contraceptives, and this research disproves the previously held belief by officials that unmarried youth are not dependent on their married friends or relatives for contraceptives. MDHS data shows that 53.2% unmarried youth are in favour of contraceptive services being made available to unmarried youth. Although data from this research show a similar lack of consensus, it was interesting to find that those who strongly oppose it have tended to consist of youth with high levels of self-reported religiosity. With regard to sexually transmitted infections, official data fails to highlight that although the majority of youth are aware of HIV/AIDS, most are unaware of any other STIs. Youth narratives also indicate extremely low knowledge of other STIs. The proportion of youth who received sex education may have been exaggerated in official data due to inadequate question definition. However, official data and youth narratives both indicate that youth think sex education should be taught in schools, most recommending after reaching age 15.

In the following chapter, I explore the evidence presented in these last two chapters, examining why there are divergences between young people's perspective and official perspective of youth SH in the Maldives.

Chapter 6 Religious and Sociocultural Influences

In the preceding two chapters, I examined Maldivian youth SH from policy (Chapter 4) and youth (Chapter 5) perspectives. Building on these and drawing together the evidence from the MDHS, web survey, youth and key informant interview and policy review, this chapter sets out to achieve three things. Firstly, to describe whether and how the different components of youth sexual health in the Maldives- policy, services, official data and young people's SH experiences- are mismatched. Secondly, I explore influences that have shaped and continue to shape these mismatched relationships examining the pathways of their influence on SH policies, services, data and youth experiences. Finally, I revisit the research question- *To what extent, and why, is there a mismatch between official Maldivian sexual health policies, services, and data and the lived experiences of youth in the Maldives?*

6.1. Disconnected relationships

Three components in global sexual health programme guidelines comprise the basic standards for achieving good sexual health for youth. They include (1) addressing sexual health issues of young people at a policy level; (2) providing youth appropriate services and information about sexual health; and (3) encouraging young people's participation in developing these policies and services (PAI, 2002; UN, 1994a, 1999a, 1999b; UNFPA, 2009b; UNFPA website, accessed 29 May 2012; WHO, 2010; WHO et al., 2006). Using these three components I developed a simple diagram showing ideal relationships between youth SH experiences, policies, services, and data (Figure 16), compared to a diagram showing how these relationships actually manifest in the Maldives (Figure 17).

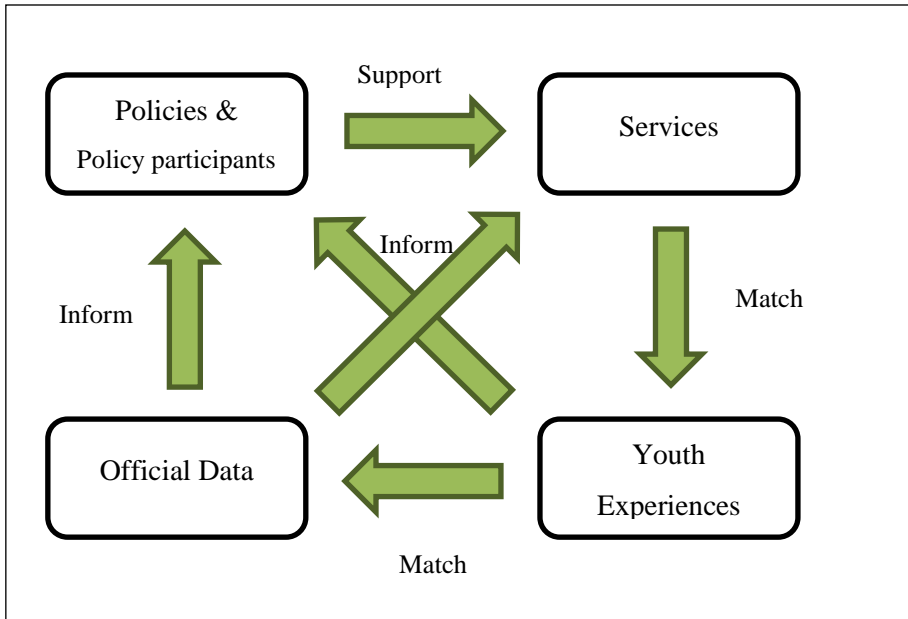


Figure 16: Ideal relationships between Maldivian youth sexual health experiences, policy, services, and official data

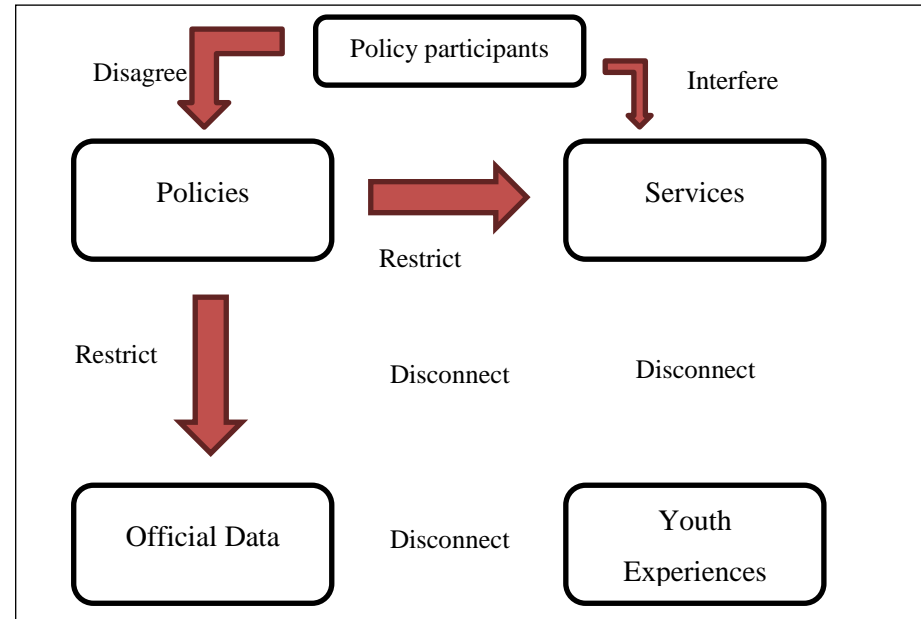


Figure 17: Actual relationships between Maldivian youth sexual health experiences, policy, services, and official data

1

¹ Author's own diagrams

Figure 17 displays three major characteristics¹ of the relationships between youth SH experiences, policies, services, and data in the Maldives. Firstly, the disconnect between youth experiences and officially sanctioned data and services. Secondly, the restrictive influence of policies on officially sanctioned data and services. Lastly, the disagreement between policy participants and the policies. I next discuss each of these in turn.

6.1.1. Disconnect between youth experiences official data and services

I identify four main specific points of divergence to contribute to understanding the factors shaping current youth SH in the Maldives.

Incidence of premarital sexual intercourse

The first is regarding the incidence of premarital sexual intercourse among youth. MDHS indicated that it was at 12% among youth aged between 18 and 24, whereas the Web Survey showed that over half of the respondents reported premarital sexual intercourse. Since the preliminary results of the MDHS were released while I was conducting key informant interviews and youth interviews in the last field site, (Male'), I was able to get feedback about the figures.

I:	A survey done recently showed that youth aged between 15 and 24... people who're not married when they were asked... 3 per cent among girls and 9 per cent among guys said they had never had sex... before marriage. What do you think?
R:	who've done it?
I:	Hm
R:	9 per cent males have done it and females 5 per cent
I:	3
R:	3 female?
I:	Yeah. Do you think// ((interrupted))
R:	//you mean before getting married
I:	I mean for example, if you take 100 girls, unmarried girls, among 100 of them 3 girls would have had sex and the rest would be virgins
R:	It will be the exact opposite! ((Laughs))

¹ The minor characteristic shown in Figure 17 is the way in which policy participants' interrelationships interfere with services. This was discussed in Chapter 4, section 4.2.7

I:	The opposite eh?
R:	For sure! ((Laughs))
	-M21, married, male, urban-
I:	It was done very recently... and when the preliminary result came out it showed among 15 to 24 year olds, among never-married women 3.5 per cent, among men 9.8 per cent have had// ((interrupted))
R:	//Sex before marriage?
I:	Do you think that's accurate?
R:	No I don't think that's accurate I think it's much more than that percentage... I think that they would not tell... because they are afraid they'll be labeled, that their secret will be out in public and because we live in such small communities... yes even by mistake if it is out they might think... or we'll see and we'll mark which ones have answered this questionnaire... so that is why they don't...
	-KII12, SHE (NGO)-

Evidence that I collected shows that there is a general belief that premarital sexual activity was underreported in the MDHS. One possible explanation offered by service provider KIs was that MDHS respondents may have misunderstood what was meant by 'sexual intercourse'¹, an aspect I later tested with control and treatment groups in the Web Survey. However, these analyses (Section 5.1.2), showed that most respondents found the term 'sexual intercourse' unambiguous. This suggests that survey modality is important, with unmarried youth uncomfortable revealing their sexual activity in a face-to-face interview with another Maldivian. As highlighted in the key informant quote above, the small size of the communities has a significant impact on privacy or perceived privacy.

Incidence of unwanted pregnancies and abortion

Unwanted pregnancies and induced abortions among unmarried youth are similarly culturally sensitive issues with reported low incidence in the MDHS- one never-married woman and 3 never-married men from a total of 139 reported having (or their partner having) an abortion. However, it is unclear whether youth were less willing to report unwanted pregnancies because of the face-to-face mode as I was unable to test for modality effects with those questions in the Web Survey.

¹ KII13, KII17

Questions on unwanted pregnancies and abortion were included in the Web Survey but there were skipping pattern errors that sometimes skipped some respondents or erroneously administered the wrong abortion questions to some respondents (it needs to be based on gender and experience of unwanted pregnancies). Since this would have introduced several biases, I decided to not include these potentially low quality data. Nonetheless, the WS data showed that among a predominantly urban sample of youth, the proportion of unwanted pregnancies leading to abortions are more common than the official data would suggest. This is supported by both youth respondents and key informants.

- I: Have you heard of many people who have got pregnant out of marriage?
 R: ((nod))
 I: How many would you say?
 R: Some have been pregnant and abort... and have gone through with abortion maybe like 5, 6 of my friends? Classmates...
 I: Got pregnant?
 R: Got pregnant... And there are some of them who went to [Sri] Lanka and had abortion
 I: Okay. And... did anyone give birth?
 R: Hm. One has a very healthy baby boy

-M18, unmarried, female, urban-

- I: Is abortion a big problem?
 R: Abortion is a big problem right. Actually in this country, internally... locally they attempt it a lot. But it's when it gets serious and is brought to the hospital that's... That's an issue, isn't it? A lot of people will die because they don't get timely care. And okay well it might not be recorded as maternal death but like sepsis or bleeding... they won't give that history, personally I think, that abortion was attempted... They do go abroad for abortions... I saw this abortion study done by someone the other day [the study done by SHE, see Section 4.1.3]... yeah so lots and lots of people go abroad for it [abortion]

-KII09, MOH official-

Sex education coverage

The coverage and availability of sex education was possibly over-estimated in the MDHS because of ambiguous terminology ('human reproduction and sexuality' which most students study in Biology). This was further evidenced by high proportions (72.7%) of MDHS respondents who reported having had sex education in school who were unable to report any knowledge about STIs besides HIV/AIDS. However, most key informants speculate that a lot of youth would have had sex education, both in and out of school. This is in reference to the Life Skills classes provided under the Adolescent Sexual and Reproductive Health project, the success of which is often lauded among proponents but not verified by evaluations¹.

- | | |
|----|--|
| I: | So overall you're happy with the progress? |
| R: | Very, actually... how do I say, over a short period of time we had created... I would say... model programmes that can be used in this region [South Asia]. Our Life Skills... everyone in this region say that it's very... that it fits, that it's very thought out... [I am] happy with that [Life Skills package]. And we... for the peer education [approach], everyone in the region were saying 'how will we do that'... there was a lot of interest. And at that time we created... marginalized [groups], if it's Nepal [it is] thousands... millions. But our good fortune is that we [population] are few... So if we provide change to 12 kids, if their lives are changed, they moved on to help others... so like I said, yes, it was very very... in the process we created a lot of young people who want to work in this field... |
| | -KII07, Youth Ministry official- |
| I: | Do you get that kind of information in schools? |
| R: | In [School A, for A levels, typically aged 16-18]... there was something in Primary [typically aged 7-13], there were some sessions |
| I: | Yeah? Which school were you in? |
| R: | In Primary, I was in [School B] [one of the schools selected for Life Skills pilot phase], for Secondary in [School C].... Were there sessions there? I don't recall... but there were some in [School A]... |
| I: | In Primary... what was... was it during class hours or separate sessions? |

¹ KII10, KII07, KII17

- R: They were separate sessions, girls separate, boys separate... they taught us separately
- I: What sort of things were you taught?
- R: From what I remember, like body parts and things like that, when we were in Grade 6 and 7 [typically aged 12-13]
- I: So the basic things?
- R: Yeah the basic things
- I: At any stage were you taught about diseases?
- R: When talking about Sexually Transmitted Diseases they always talk about AIDS... in school, in some subjects they'd mention things like that but not separate information like that... and well, about Sexually Transmitted Diseases, its very limited... they just taught the names, AIDS was the only one we focused on...
- I: Yeah
- R: And well I don't know anything about how it spreads... at that point, its 'stop!'
- I: Yeah? Was contraception taught at all... condoms?
- R: No we weren't taught about condoms

-M04, unmarried, female, urban-

Availability of contraception and STI-related services

Although contraceptives cannot be legally provided to unmarried people, most key informants believe unmarried youth are able to obtain contraception, either from pharmacies or married friends.

- I: So if something like that [get an STI or nonmarital pregnancy] happens, what can they [unmarried youth] do?
- R: in any case, in this society... in today's society... they will get service from all service facilities... even if they don't necessarily ask if they [youth] are married, they [service providers] will try to find the person's partner, if it's an STI... to check how they got it... if it's an infection
- I: So they don't really ask this [marital status] now, right? In a government facility?
- R: That... no they won't ask whether they are married... just about how... about people they've done this with and advise them [patient] to tell them [partner] about it and how to treat it... that's actually the policy. To go out and find the partner and bring them... that's not done. And for pregnant women... there wouldn't be any hospital or clinic where they wouldn't get services... but there are people who don't go

I: that's just...

R: that's just labeling, because of that

I: But they would be able to go [to seek services], right?

R: they would

I: Hm

R: Well almost 80 90 per cent [births] are now attended... in Male' its 100 per cent, in the islands it's around 98%... [Births] at health facilities... so it's covered, isn't it?

I: Yes... so the youth are also going there

R: There

I: So to clarify how it is in the policy... even if people are unmarried, services are provided to them... they don't even have to be asked [about marital status] according to the regulation?

R: That... there is a regulation... but the data... I mean, during registration, it will be known... They will ask the husband's name. There are reasons for that, not to label people... the purpose is to provide them [husband] with information... about pregnant women... because it's not only the woman's [responsibility]... to provide the husband with information, that is the purpose.

-KII01, MOH official-

Analysis of MDHS and key informant interviews suggests a prevailing assumption that STI-related medical assistance is available to young people throughout the country. However, the services mentioned by key informants are localised in Male', marginalising access for youth from other islands (Chapter 4, Section 4.2). Youth narratives also suggest a concern among island youth about privacy and confidentiality if utilising island health centres, which undermines key informants' claims that services are readily available to youth throughout the country.

R: They don't give condoms either... in this island

I: Yeah? They don't give it?

R: In [neighbouring island] they just give it

I: Is that because they can't tell who is not married or...

R: I don't know, they'll just give it when you ask for it

I: But over here they don't eh?

R: Over here you have to go see someone... to go to someone called [person X]... and then he would... well, [talk to] Island Chiefs and... like that

I: So you have to get it through [person X] eh?

R:	Well most youth won't have the nerve to go... for example, people my age won't have the nerve to go... he [person X] would know... like if they are married...
I:	the person at the pharmacy?
R:	it's a foreigner at the pharmacy, he would say go and see [person X], that he has it...
I:	Yeah?
R:	They still won't dare to go...
-R07, unmarried, male, rural-	

6.1.2. Restrictions from policies

The second major characteristic of the relationship between Maldivian SH components is the restrictive influence of policies, which partly explains the mismatch between official data, services, and youth experiences. Current policies on SH issues do not acknowledge the incidence of sexual activity outside of marriage. As a result, survey instruments for unmarried individuals are censored; the Maldives DHS instrument for unmarried youth does not include crucial questions that were administered to married youth of the same age. These questions include those on experiencing STI symptoms (unmarried youth were asked only if they were aware of STI symptoms) and whether or not respondents knew where to get condoms (unmarried respondents were asked whether they knew of different contraceptive method and their intention to use these once married). However, this censorship of DHS data is not unique to the Maldives- in 2004 Bangladesh DHS, sexual behaviour data were collected from ever-married women only, and family planning data in 2002-2003 Indonesia DHS, 2002 Jordan DHS, 2005 Egypt DHS were based on data from ever-married women only (Khan & Mishra, 2008).

Prior to the MDHS 2009, there had been only one survey that examined sexual activity of unmarried youth- the Reproductive Health Survey 2004. Key informants involved in survey development report having had tough negotiations with senior policymakers to be allowed to survey this issue and permission was granted only upon reaching a compromise to make the unmarried youth component a separate, voluntary, self-administered survey¹. This led to extremely low response rates (only

¹ KII08

12% in Male' where over 40% of the youth population reside) which in turn greatly reduced the reliability of the data (MOH, 2004c) (See also 4.2.2 MOH).

Similarly, services face severe restrictions due to current SH policies regarding unmarried youth. Service providers at the Reproductive Health Centre at the biggest state hospital in the country are required to ask marital status of patients before attending to sexual health complains and later report them to the authorities.¹ Although some clinicians refuse to report,² the hospitals are at risk of being ordered to provide those records at a later date.³ The Youth Health Café does not face as severe restrictions given UNFPA's partial ownership of the service and they are not required to record or report marital status of patients.⁴ However, media restrictions on advertising and promoting condom use bar the YHC from identifying themselves as a sexual health medical service for unmarried youth.⁴ This in turn severely limits their reach and popularity among youth.

6.1.3. Discontent of policy participants towards policies

The third major characteristic of relationships between Maldivian SH for youth is marked by the dissent policy participants feel towards current youth SH policies. This is evident in all three levels of participants involved in youth sexual health: service provision; programme planning; and, policymaking.

Service providers disagreed with the requirements imposed by the current policies regarding unmarried patients seeking sexual health treatment, and state that these limit health-seeking behaviour of youth.

R:	Generally the rule says... from the government from a long time back... to report if it's an out of wedlock pregnancy. We have stopped reporting
I:	So you consciously decided that?
R:	We consciously felt we did not have to do this... that if we do this it does more harm than good. Once a girl becomes pregnant we have to look to give a good outcome to mother

¹ KII13, KII06, KII14

² KII13

³ KII06

⁴ KII04, KII05

and child... [Inaudible] away from attendance to care and away from inspiring confidence in the system

-KII13, Clinician-

R: ...for abortions what we now get from service provider side is... before- we will have to again validate that from [records]... previously there was a statement from the higher... *Mathee Majlis* [Religious Council] for the child... it was for the child. Not the mother. For the child, it says if a life-threatening or a very disabling condition is found, that we can abort. So the issue we are facing now is we get the same situation... you are able to detect life threatening and disabling... but it's too late... but still you know, but still you can't... and the gynecologists take up that issue. But yes we don't have a... it doesn't allow us. And then the mother, when the mother's health is affected at what point do we do it? And medically per se... we have to do everything we can to save a life... some gynecologists are reluctant to do that... we will kill the baby. But for that, my personal belief is medically it's justified to save a life but some people... in their... they don't do it. And they tell the Ministry to decide

-KII09, MOH official, Clinician-

R: We need to think a little about these things... about 5 or 6 years back in [Island A] there was a young girl... an illegal unmarried pregnancy and she gave birth at the hospital, that case... someone died or maybe she gave birth at home... it was a case like that... anyway the hospital records showed she gave birth there... it became a huge problem then and the then Minister [of Health] said cases like that need to be reported to the Police... an unmarried pregnancy at the hospital... so we were told to do that then as well but how much do we report or not report, we didn't know... well we [clinicians] are very... it's not something we support... if that is the case that girl won't come to the hospital... then they will just come to die... they will be in too serious a condition...

I: unsafe abortions like that, do you hear that less now compared to then... if coming here is too...

R: after this they will be even more reluctant, right?

-KII06, MOH official, Clinician-

Key informants involved in programme planning reported dissatisfaction with strict regulations restricting research, promotion of services for unmarried youth, and sex education, and having to work around them.

- R: To broadcast we don't really... we can't do anything to promote condom promotion but contraception can be discussed on TV and radio... it is discussed and there's no problem... there was something [criticism] but we didn't hear anything like that later on... we did find it a bit difficult the first time we tried to do a poster... because we felt it was needed for that [awareness campaign]
- I: Around when was that, the poster...?
- R: 2003... 4... around then
- I: Ah so that was when you were in DPH [Department of Public Health]. And what... was it you who made the decision?
- R: Actually, that decision was made by the then DGHS [Director General of Health Services]
- I: Hm
- R: It was discussed at that level
- I: Who were the ones who said it shouldn't be done?
- R: The religious side...
- I: Hm
- R: Then we thought of how to convey the message... there are so many different words we can use... for example, what SHE did... with a Global Fund project... 'Let's use *huras* against HIV' [*huras* means 'barrier' and also 'condom' in Dhivehi]
- I: ((laugh)) Nice!
- R: So we use words like that and do it somehow...

-KII01, MOH official-

Lastly, key informants that contribute to policymaking- even those representing government institutions- reported frustration at facing barriers that restrict formulation of effective youth SH policies.

- I: Is it difficult... to advocate youth sexual health?
- R: It's very difficult
- I: Why? Is it denial// ((interrupted))
- R: It's very difficult. The thing is now... the other day we had this [meeting] about HIV... everybody believes there is a need but how we do it, that we don't agree. Even at the

policy level there are some people advocating liberal approaches , we should give them information, we need to empower them’ ... and then there’s ‘we are sort of facilitating them to do wrong things’... how do we get the balance? Even now the Islamic Ministry says... in the things [programmes] we do for HIV, also tell them to be abstinent. For example. So we say ‘use condoms’ but then they want it to also say ‘but the best thing is abstinence’. They would like to put some religious messages into it but that will make it confusing... we have to do some formative research before we even do that. So mostly the difficulties are coming from a cultural angle... because of some communities. Recently it’s been a little... initially you couldn’t even say condoms but now we can... there are some ads... but even for that there’s a lot of resistance, criticism actually... from some people, like in a poster, because the navel was showing...

I: navel?

R: it’s around here as well, HIV posters... a girl’s navel is showing

I: the ‘*huras alhamaa*’ [see previous quote] poster was really good... so you have to do things like that?

R: Yeah... and for this one [poster] they say that’s showing her *a’ura* [Islamic teachings say these are parts of the body that must not be naked for others to see]... I mean *come on!* Now we are getting to the point... I mean look, if we are trying to access the youth target group, it should be to grab their interest... there’s a big battle between this

-KII09, MOH official-

I: Okay, regardless of whether we addressed it or not, we have got here, so would you say you’re happy with the progress?

R: Progress for what?

I: For youth sexual and reproductive health

R: For youth sexual and reproductive health... we haven’t done anything significant so... I can’t say whether I’m happy or not until I know what is the government’s policy... I don’t know what that [the policy] is... the government decides with many political, social and religious factors but... broadly we have been saying that there is a requirement to address this but how you address is entirely up to the government to decide... and sexual health is not something you can work on individually without policy, in a 100 percent Muslim country. So if we’re looking at progress then we would first need to identify where are we heading, what do we want out it... it is after that can we address what is that we have progressed and not progressed in

-KII13, Clinician-

The quotes above show how youth SH policy participants from service provision, programme planning and delivery, and policymaking levels feel dissatisfied with the existing policies- or in the case of the latter quote, the absence of a clear policy- regarding youth sexual health in the Maldives.

6.2. Influences

Thus far I have established that there is a mismatch between Maldives SH components characterised by a disconnect of youth experiences from official data, services and policies- a feature that may be partly attributed to the restrictive nature of current policies that are, in turn, not supported by majority of SH policy participants. This then raises questions about the influences that have led to these mismatched relationships between SH policies, services, and official data and youth experiences.

The influence of religion on governance varies depending on interlinked factors that include School of Islamic Jurisprudence and the strength and role of religious institutions. Applying that to the context of policymaking in the Maldives, while there were explicit laws stating that the constitution will be based on the *Shari'a* (Islamic Law), belonging to the *Sunni* sect meant that religious institutions did not have much influence (as *Shi'a* countries) to promote compliance and punish non-compliance. My analysis suggests that this was only partly correct- religious influence is evident in policies and personal beliefs but lacks the power to promote compliance and punish non-compliance. Where religious influence is lacking, compliance is promoted and non-compliance is punished by sociocultural influences that do not necessarily have a religious basis. I discuss each of these points below.

6.2.1. Religious influences

Religion is often cited as a major contributing factor to youth sexual health in the Maldives- it is done so in official documents (MOH, 1999a, 2001, 2004a) as well as in interviews with key informants and young people. Based on my analysis, I suggest that the influence of religion on Maldivian youth SH is exerted via two different paths.

Religious influence on SH policy

The influence of religion on policy explains the restrictive nature of Maldivian youth SH policies on data and services because of the policy silence on premarital sexual activity is attributed to the fact that premarital sex is illegal under the *Shari'a* and prohibited in Islam. Moreover, it also explains the lack of support for the policies from policy participants. Analysis of key informant data shows there are three different ways in which policy participants deal with this religious influence on SH policy.

Some policy participants believe the key is to minimise the attention drawn to their programmes.

I: What about the other strategy [of the ASRH project] ... the services, did you get any resistance?

R: Oh definitely. We were not allowed to distribute condoms for example ... and unmarried kids are mostly those who can't go to the hospital with these issues... Even so, one of the doctors who worked there at the time was very youth-friendly... he would just keep condoms in a basket. But that wasn't a strategy of the whole service... even in the Youth Center it was very conservative...

-KII02-

R: Fortunately we ... we didn't... we weren't big on publicity. And back then there wasn't much publicity on this. So if we were running a programme like... we had a programme for sex workers... very few people would be aware of it. So we didn't tell anyone, we just did it. So it wasn't a big issue then

-KII07, Youth Ministry official-

I: Do you think people know that you do this? [That clinicians will not report]

R: We don't want people to know. What happens is, they are not supportive... the other thing is, we don't report that we do this, and the way we thought about this is... even if we don't report, there are other systems through which the government can find this information. So we don't have to report

-KII13, Clinician-

But, minimising attention to programmes often diminishes the programmes' potential impact as fewer young people know about them. Other participants suggest that involving religious experts in programme planning, as is done currently, does not have a negative impact as long as religious experts are approached in a certain way.

- I: So what are you planning to change in the new Health Act?
 R: We have been thinking to make it [condoms]... not as something so restrictive... Like before, it had to be with a doctor's prescription... not like that... loosen that a bit
 I: that will have a huge effect
 R: Yes, then it will be an over-the-counter... even now, the religious side hasn't complained, has it? Sure they did it when condoms were first sold but it's still sold, isn't it? If there is support for it, they will stop objecting... we can remove this restriction
 I: there are ways to remove it eh?
 R: Yes... let's not ask them [religious experts] about something that is forbidden... that's what I think
 I: Yes and you mentioned before// ((interrupted))
 R: //ask them what they think we should do, ask how they can help
 I: So most times they are cooperative aren't they?
 R: [inaudible] will recommend
 I: So it doesn't go well if we ask them 'can we do something religion forbids' eh
 R: That's right, ask them how they can help and to help if they can... ask them like that and it will work
 I: Can it go forward without their okay?
 R: It can but to keep the peace...
 I: We don't really want to do that then eh?
 -KII01, MOH official-
- I: So it's very much linked to religion, isn't it?
 R: It's because it's about sex... but you can't not mention it either right... what I believe is... this time at UNFPA...
 I: So how do you do it, do you write to the Islamic Ministry or do you ask some individuals informally or...
 R: When we first started it there was Sheikh [Person A]... and we always try to get someone who gets along with youth... Sheikh [Person A] took the sessions in a fun way... so actually like I said before it's about this style... there are some who are a bit extreme, we don't involve them much... but it's not like we are doing anything forbidden in this work, right?

-KII04, Youth Health Café-

The third strategy policy participants report as a way to deal with religious influence has not been attempted, mainly because of the close embedded relationship between religion and policies. Nonetheless, it is mentioned as an option to explore if involving religious experts fails.

- I: But how can this [youth sexual health] be tackled then?
People who don't want to talk about it won't talk about it
- R: So what we actually have to do now is... someone has to start working on championing this. We have to find them. But who's going to talk about it? For things like this, there are moderate religious scholars. There are people who will believe in this. And people we can use to educate more people. Maybe they don't yet know the extent of these [sexual health] problems. So we need to sensitise them. There might be reluctance but if you push this persistently you can do it. But you should choose who you talk to. Then the next question is, should we use religious people? Why should we, really? Let them preach. Right? But health professionals do know that this is a very serious social issue... they know the consequences... if they know it then will we not facilitate ways to bypass these obstacles? These things need to be discussed at policy level
- I: So there's a lot of big decisions to make isn't there
- R: There are. And who will take those decisions? So far there has not been any strong decision made on this. That's what I think
- I: But at some point the religious council does come in, don't they? That's what has happened in this issue so far right?
- R: Yes they do. But usually for example if we make policies as a collective, all the stakeholders are involved. So if that is the case and everyone in this issue is involved, the religious people are also involved... But as we are trying to make this collective decision, and it gets vetoed because there is a religious mentality... that's not acceptable. There are people who work from the social side and from the health side... their eyes are open to these things... they know these things. If that is the case then they should be able to influence this decision. If we try to do that then this can work. For example in the Reproductive Health Survey. People who were at the Ministry of Health kept pressing that this should happen that this should be there... *some* data. But even after that data wasn't collected in the way we wanted nor has there been any difference because of that.

-KII08, MOH official-

I: So if we do that, do you think... is that a better way of... I mean there are many lessons learnt, should we choose them based on that aspect [religious aspect]? How they [other countries] would handle it? Do you think that would be a way forward?

R: Well, for example with religion, what I think is... it doesn't matter if the religious point of view is there. Or if there's a modern view of it. What is important is to address what is important to that country in a way that is suitable to them.

-KII13, Clinician-

These quotes show the various ways in which policy participants deal with religious influence in youth SH policies and programmes. The differences in opinion as to how much value should be attached to the religious influences contributes to dissent between the policy participants, which in turn affects service and programme delivery as discussed in section 4.2.7.

Religious influence on youth SH experiences

The second way in which religious influence is exerted on youth sexual health in the Maldives is via young people's religious beliefs regarding sexual health.

R: And the other thing is, a lot of people still think... they believe we are still a 100 per cent Muslim country... that people are so good and well-behaved. Which doesn't happen, in reality... only on paper... all Islamic countries have this... this is not some special place

-KII08, MOH official-

R: The reason why we can't give any of these services is because we are a 100 per cent Muslim country. That's the problem- the people don't have to be Muslim, the *country* has to be Muslim

-KII06, MOH official-

The quotes above capture the difference between religious influence on policy and that influence on young people. Although being Muslim is intrinsically related to being Maldivian- every Maldivian is born Muslim, and apostasy is extremely rare

and not tolerated¹- youth report varying degrees of religiosity. I included a measure on the importance of religion in the Web Survey administered to youth which revealed the following results.

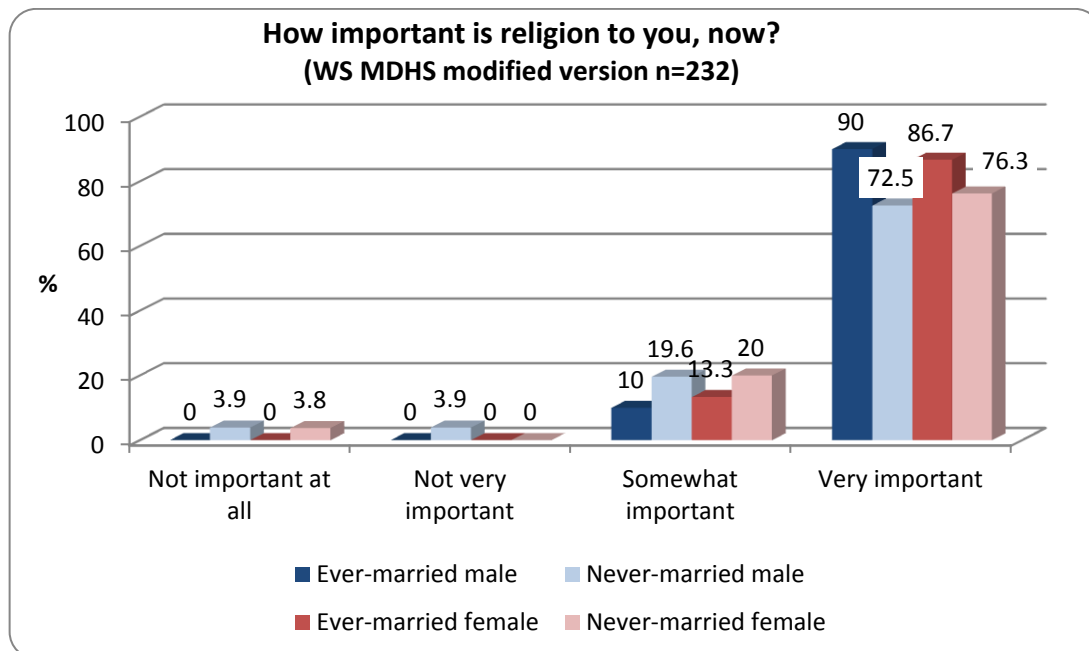


Figure 18: WS data on reported importance of religion among young people (aged 18-24)

The results show that most respondents report that religion is very important to them. Although not directly comparable, data from the in-depth interviews with youth was slightly different where most interviewees reported being ‘somewhat close’ to religion rather than ‘very close’ to religion. I did not probe religiosity questions very much in the interviews because I did not want respondents to associate the topic of the interview- sex- with religiosity and then adjust their answers. There is a statistically significant relationship between reported importance of religion and attitude towards providing contraception to unmarried youth ($p < 0.05$)². But do religious attitudes affect sexual behaviour?

¹ News article 1 June 2010: “A Maldivian man who publicly declared himself an apostate during a speech by Islamic speaker Dr Zakir Naik on Friday evening has repented and offered a public apology on Television Maldives (TVM)” (Robinson, 2010)

² 4 cells (50%) of cells had expected count less than 5. As discussed in 5.2.2, this is due to small number of respondents stating religion is not important to them, and it also decreases the validity of these tests.

Chi-square tests reveal that the relationship between religious attitudes and sexual intercourse (p-value = 0.455)¹ is not statistically significant - young people who state religion is very important to them also engage in premarital sexual activities and intercourse. This is supported by the interview data as well. When discussing reasons for having premarital sex, respondents rarely mentioned religion- their responses identified premarital sex as opportunistic (“because their parents are not there”), accidental (“because they get carried away”), expected (“it’s the next step in the relationship”), and experimental, among others.

R: Actually this force [to have sex] comes from the boy’s side
 I: he forces the girl?
 R: No I mean like... ‘If you don’t do this with me, I don’t want to do this, I’m going to leave you, it’s because you don’t love me’... forcing her by saying things like that

-M11, unmarried, male, urban-

R: the people who wait [until marriage to have sex], why do they wait?

I: Yeah

R: Hmm... how do I say, they just don’t have a chance... they’re not in relationships... maybe they can’t go out... the chances increase when you’re in a relationship

-R10, unmarried, male, rural-

I: So you said the people who wait [until marriage to have sex] are just good, right? Good in what way? Religious, for example?

R: Yeah they could be religious. But there are those who are just waiting for a chance, they just don’t get a chance... maybe their mother told them to meet and talk [to the boyfriend] here ((gestures to house))... you definitely can’t do anything in this light

-L14, married, female, rural-

On the other hand, when identifying reasons why some people do not have premarital sex, many youth responded in relation to religion, saying it was because they were ‘good’ and ‘religious’ (‘good’ did not always mean ‘religious’- as

¹ 4 cells (50%) of cells had expected count less than 5

evidenced in the latter quote above, the respondent meant ‘good’ as in obey the mother’s orders). This could indicate a link between religiosity and abstinence but it could also indicate a social desirability where they feel they are expected to denounce premarital sex and label it ‘bad’. The latter is supported by respondents who reported being religious but also reported having premarital sex.

The data indicates that although religion influences young people’s reported attitudes, it does not seem to be reflected in their sexual behaviours. Therefore it appears that the influence of religion on youth experiences is very different than the influence of religion on policy. This explains the disconnect between youth experiences and other components of Maldivian youth SH: religious influence shapes policy and subsequently, services and official data, but it does not shape youth sexual health experiences in the same way.

I: So most of the time, the people who oppose it, is it the religious issue they are taking or...?
 R: It’s the value system. Our value system could be religious... just strong beliefs that they [sexually active youth] are just bad kids, ‘how bad is that girl, very immoral’... values like that are more than, I think... it’s not just religion, though it is a part of it...

-KII07, Youth Ministry official-

6.2.2. Sociocultural influences

Analysis of interview data from youth and key informants indicates that the factor that promotes compliance and punishes non-compliance- to religious and legal rules, for example, premarital sex- is sociocultural in nature because it is rooted in the insular nature of small islands characteristic of the Maldives.

Insular, adj. and n.

A. adj.

1.

a. Of or pertaining to an island; inhabiting or situated on an island.

b. Physical Geogr. Of climate: Of the moderate or temperate kind which prevails in situations surrounded and tempered by the sea.

2. *Of the nature of an island; composing or forming an island.*

3.

a. *transf. Detached or standing out by itself like an island; insulated.*

b. *Bot. 'Situated alone, applied to galls which occur singly on a leaf'*

c. *Pathol. insular sclerosis.*

d. *Anat.*

4.

a. *Pertaining to islanders; esp. having the characteristic traits of the inhabitants of an island (e.g. of Great Britain); cut off from intercourse with other nations, isolated; self-contained; narrow or prejudiced in feelings, ideas, or manners.*

b. *Palaeogr.*

B. n.

An inhabitant of an island; an islander.

(Oxford English Dictionary)

Although not the sole source of sociocultural influences, the effects of insularity-geographically and socioculturally- are amplified in small islands (Royle, 2001). With over half of the inhabited islands sized between 1-39 hectares and populated by less than 1000 people (DNP, 2012), Maldivian island communities are extremely small and characterised by an inward-looking culture that exerts considerable social pressure and boundaries within which young people must exist.

Although premarital sexual activity is illegal in the Maldives, nearly all youth respondents identified legal repercussions (such as being reported or arrested by authorities) as far less serious than social repercussions- these include being labelled, taunted, gossiped about and consequently bringing shame on family, kicked out of home, and become socially isolated. These forms of informal societal punishment are of immense concern to Maldivian youth given the nature of small island life. Based on youth narratives, it was possible to discern how avoidance of societal punishment has led to hidden youth with SH needs.

Youth interview respondents were given a series of hypothetical ('what if?') scenarios about a hypothetical unmarried friend of theirs who has been sexually active (followed by scenarios of a friend who had contracted an STI, and another

who had an unwanted pregnancy) and is concerned about people finding out. Presented below are a few translated excerpts of responses.

I: What if the neighbours found out... people on this island... would it be a big deal?

R: It'll be a very big deal

I: Yeah? What would they do?

R: That... what happens is... it would be difficult for her to go out... to face other people, it would be difficult right? What happens is... a lot of people would taunt and mock her... she'd get a lot of people's ridicule for it

-L19, married, male, rural-

I Say the neighbourhood, or the island community found out, would it be a big deal?

R: ((nod))

I: What would happen?

R: Her whole image would be destroyed completely. In islands... well, one person might chatter about it and then it will be all over the whole island... and they would talk about it constantly... and they would talk in a very... a degraded person... I mean she'll be like a very immoral person... everyone will see her that way... she'd be labeled

I: Would they say it to her face?

R: They might say it to her face too, like say she was on the street and they might just say it to her as she passes... But like to walk up to her and scream about it... they wouldn't do that but people in this island... well people in this island are very nosy... you know... they would talk... and if they hear something like that they might build it up as they go on

I: Hmm... make the story worse

R: Yeah they might exaggerate... that she got pregnant and she aborted the child... they make up stuff like that

-R14, married, female, rural-

R: If that happens they will taunt her, from then on they'll all know she's no longer virgin

I: That's how they'll taunt her eh

R: Yeah. Now that she's not a virgin anymore she'll be loose...

-M13, unmarried, male, urban-

I: What if the neighbours...or the island people found out... that she's done this... even once... what would happen?

R: there ARE some people who are dating girls like this... the whole island knows... and he knows... and even knowing it, he's decided to get married

I: Yeah? Around the island... if everyone knows then they'd talk about it eh

R: Yeah... well what happened in this island was... I mean... there were these photos leaked... of this girl... and the guy was crazy about her, he was ready to marry her, it was set... and then it was like the whole island, the whole world... like she was humiliated in the whole island

-R07, unmarried, male, rural-

Being found out or labelled by their community can be catastrophic to some youth, often making it difficult to remain on that island. However, one major feature of islands is 'isolation' which refers to the need for a dedicated journey to leave (or visit) the island (Royle, 2001) - a feat that is difficult to the average unmarried Maldivian youth without financial assistance. Family or parents were found to be inconsistent avenues of help in youth narratives. Some young people expect their parents to disown or kick them out of their homes if they were found to be sexually active or pregnant outside of marriage. Thus, parents and families must also act within the sociocultural boundaries maintained collectively by the island community.

R: Reputation is a very big deal isn't it? Like, something the son/daughter does can affect the mother or the father's reputation right? They are losing their [literal translation: worth] dignity among people... and no one will buy anything from their shops

-M10, unmarried, female, urban-

I: What if the neighbors found out? What would happen?

R: it would be shameful... for parents, right?

I: Will it be more shameful for the parents than to her?

R: To her too... it'll be shameful for both of them. She'll lose her dignity in the community... she'll be worthless... that'll probably happen. And parents too will get a lot of blame... that it's because they can't control them...everyone would say that, won't they? This person's kid behaves like this... that it's because they don't look after him/her... that they can't look after their kids... why would they have kids if they can't even look after them. Thing like that...

-M12, married, female, urban-

Young people were very cognizant of how their sexual behaviour reflects on their family. This creates added pressure for youth to conceal their sexual behaviour, even at the expense of their own health.

- I: Would you go see a doctor? Or would you again be scared in case people find out?
 R: Then people will know, right
 I: Is that an uncool thing to happen, getting found out for that?
 R: Then that'll be the story going around the entire Male'!

-M13, unmarried, male, urban-

- I: Do you hear that in this island, girls getting pregnant and dropping the baby [aborting]?
 R: Stories like that... some time ago... something like that
 I: That they do this?
 R: They do it... when she got pregnant while in school, she wrapped herself [stomach] in cloth and later... her mother and them... well, she delivered in the bathroom and the baby... when they found her the baby had died they say... I don't know if the baby was killed... There's no facility like that in this island, I mean you can't get pills like that but I guess you could drink something like bleach but... she wrapped herself in cloth until she gave birth...

-R14, married, female, rural-

It is this need to avoid public humiliation that contributes to make abortion an option for unmarried women who find themselves with an unwanted pregnancy.

- I: Okay let's take one step further and say a female friend of yours comes to you and says she's pregnant and asks what she can do
 R: Oh with that, well... there's not much to do right... if she's pregnant... the thing is, it's very common isn't it... girls getting pregnant and getting an abortion... it's very common. If you can't get it done around here, then go to Male'... if you can't get it done in Male' then go to India
 I: Do you hear that a lot... on this island too?

R: As far as I know... there's a relative of mine who's arranged 3 abortions... like going to India for it...

I: Oh she got 3 abortions or...?

R: Arranged abortions

I: How... it got done more than once?

R: What happens is... oh I'm talking about the guy here... he helped 3 different girls to get abortions

-L19, married, male, rural-

I: Okay, say for example a friend of yours came and told you she was pregnant. What would you do?

R: If she says she's pregnant then... well I'm going to say what I think about this ok... I do actually know it's a bad thing but the way we think about it... we think to ourselves if... like, I get pregnant... then I'll immediately get some pills and quickly take it... I think I'll do something like that ((laugh)). So I think I'll tell my friend the same thing

-R14, married, female, rural-

I: Okay so a girl comes to you and says she's pregnant. What can she do?

R: Get her a pill

I: What kind of pill?

R: I don't know the name

I: What happens when you take it?

R: Um... like... the baby gets...

I: Aborted?

R: Aborted

I: How easy do you think it is to find it?

R: It's not so easy. I have to call many people and... it takes some effort

-M02, unmarried, male, urban-

It is worth noting that although not specific to island communities, that gender adds another layer to the sociocultural influence. Young men do not receive the same treatment if found out to be premaritally sexually active or to have fathered a child outside of marriage. Young women, though more likely to receive public humiliation, find it more difficult to negotiate leaving the island as families tend to control daughters more than sons. Young women are likely to find SH services less accessible than to men, as they perceive their actions are monitored and rumoured about, more than their male counterparts.

- I: Okay... would she be worried if, say for example, the neighbourhood people found out [about a female friend having premarital sex]?
- R: If it's a girl then... for example if it gets out to people on this island, everyone will talk about it... she will lose a lot of respect [or 'worth']... if it's a boy, if something like that gets found out, people won't talk about it that much
- I: Why is that?
- R: the difference is because... I don't really know how to explain it... it's because its girls... they just talk about girls a lot more

-L12, unmarried, male, rural-

The sociocultural influence due to small island insularity also extends to policies via policy participants. As noted by a Small Island Developing States (SIDS) expert:

Another public administration problem in SIDS is that people know each other well, and are related to each other (Briguglio, 1995, p. 1619)

As discussed in Chapter 4, participants in sexual health policies have remained largely unchanged and their interrelationships are characterized by longstanding issues and disagreements. In addition to this need to maintain good standing over time, the religious influence on policy makes some stances automatically 'right' and difficult to oppose.

- R: You know, for me the most amazing thing is, some... I'm not saying old but quite a lot of them [policymakers] still in private they accept you what we are talking about but in public they deny it. I mean they have another opinion. I mean there is something I think these are the things... that reluctance to accept this is happening to our youth
- I: and it has been a while, I mean... the first thing... I think it's been ten fifteen years... are you happy with the progress we've made in the last ten fifteen years or...?
- R: Well, at least we can talk about it like this; at least they are not going to arrest me

-KII12, NGO-

I: Is it that opinion [that it's against religion to give condoms to unmarried people] that's dominant still?

R: I don't know if that opinion is dominant... there ARE people of that opinion... even if one person shouts it then the rest of the people won't oppose it because it's something like that... if you say its religious then no one will have the guts to argue

...

I: Do you foresee any kind of policy change or will we stay like this?

R: No the reason why we haven't been able to change anything with reproductive health is not because we don't know how. There is just no will to face the religious people

-KII06, MOH official-

Similarly, service providers also face difficulties because of small island insularity- they report how their services get labelled and stigmatised which in turn deters young people from approaching their outlets.

I: You mentioned earlier that it took you about 2 years to get things started here [Youth Health Café]. During that, what was your experience?

R: To be very frank, we got called different sorts of names... this place is like *this*... because we talked about contraceptives and things, some people didn't do that... except they [critics] talk about it so much more now... so we received a lot of criticism// (interrupted)

I: //directed at you personally?

R: No no... that the Youth Centre is this sort of place, a lot of the members of the public, not young people even, grown up adults too... but later on we just tried... and we think it's becomes a programme parents and others accept...

-KII04, Youth Ministry official-

This section has shown that sociocultural influence stemming from small island insularity affects young people's SH experiences by creating a fear of social consequences of being found to be sexually active, which in turn deters them from taking precautions (e.g., buying condoms, even if they know where it might be obtained). Moreover, it shapes health seeking behaviour by deterring them from

seeking qualified medical assistance, leading them to unsafe options. The sociocultural influence due to insularity shaped SH policies in that it deters policy participants from challenging current SH policies and religious influences that are linked to them. Services are also shaped by this sociocultural influence that diminishes their acceptability among the communities and accessibility to young people.

6.3. Conclusion

This chapter has addressed the research question- *To what extent, and why, is there a mismatch between official Maldivian sexual health policies, services, and data and the lived experiences of youth in the Maldives?* Based on analysis of the four different types of data included in this research, I have established that the components of Maldivian youth sexual health- policies, services, official data, and youth experiences- are mismatched, the extent of which is evident in three main ways. Firstly, where ideally youth experiences should inform policies, services and be reflected in official data, there is a complete disconnect. Secondly, where policies should be ideally informed by data and create supportive enabling environment for services, current SH policies restricts collection of high quality appropriate data and drastically limits services. Thirdly, there is a lack of support for the current SH policies among policy participants who report being unable to influence policies based on their expertise in the field of youth SH in the Maldives.

Examining the reasons behind this mismatch within Maldivian youth SH, my analysis indicates two types of influences that explain the features that characterise this mismatch. I summaries the findings in Table 14:

	Religious influence		Sociocultural influence (via small island insularity)	
On SH policy, services, and official data	-strong influence on policies but not policy participants	-explains restrictive policy -explains lack of support from policy participants for policy	-strong influence on policy participants -strong influence on services	-explains lack of resistance to policy -explains low accessibility to youth
On youth SH experience	-weak influence on youth SH behaviour	-explains high incidence of premarital sex despite high religiosity -explains disconnect from policy, services, data	-strong influence on youth SH experiences esp. health-seeking behaviour	-explains low contraceptive use -explains high incidence of unsafe abortions

Table 14: Summary of religious and sociocultural influences on Maldivian youth SH

Having identified these influences, the difference between its effect on youth experiences and SH policies, services and data, and the pathways by which this influence is exerted, it is now possible to begin to identify ways of addressing this mismatch. For example, religious strategies will not affect the incidence of premarital pregnancies among youth but it is possible to improve contraceptive use and use of SH services using socioculture-based strategies addressing stigma attached to these services and people who approach them. Future work such as these and contributions are discussed further in the next chapter.

Chapter 7 Conclusion

In this final chapter, I first summarise the results of each objective, and then discuss the implications and limitation of this research, setting the findings within broader literature. I then explain the substantive, methodological, and policy contributions of this research, concluding with how it can be used for future work on youth sexual health.

This research set out to examine the following research question, and was guided by the 4 objectives:

To what extent, and why, is there a mismatch between official sexual health policies, services and data and the lived experiences of youth in the Maldives?

Objective 1: Describe the context of sexual health data, policies and services for Maldivian youth

Youth sexual health was not identified as a social problem in Maldivian policies until the early 2000s, nearly 20 years after family planning services were introduced to married couples, and at least 10 years after reports of unsafe abortions were referred to in official reports. Sexual health of unmarried youth - unintended pregnancies, unsafe abortions, STIs, sex education – continues to be a controversial issue in official records and narratives.

The relationship between Maldivian policy and official data is a circular one, given the reliance on large-scale quantitative state-commissioned research that constitutes the bulk of data used in policies. However, this reliance on certain sorts of data transfers the decision-making power about how to do data collection and which issues to investigate, to the policy and political arena and away from technical expertise. Issues are vetoed on the grounds of being too culturally sensitive or unacceptable; data on the prevalence of premarital sexual activity is one sexual health issue that has not been researched. The resulting lack of data then forms the basis for programmes and policies that ignore the prevalence of premarital sexual activity, locking data and policies in a vicious cycle. This renders a situation where

official SH data is often in short supply, is censored, and often has low validity in that it does not fully reflect the issues faced by the population of interest, in this case, Maldivian youth. Margolis (1997) reports a similar situation in demographic data on francophone Sahel region where unmarried women were not asked about their reproductive history or intentions leading to an apparent low demand for contraceptives. Similarly, Pakistan is criticised as among some Muslim countries that fails to collect data to estimate national burden of STIs, using religion as a “blind backup to support claims of cultural immunisation of the entire population from STIs” (Shafiq & Ali, 2006, p. 321).

SH-related policies in the Maldives censor culturally sensitive issues such as the sexual health of unmarried youth. Analyses of SH policy participants and the policymaking process revealed that these policies are largely shaped by the policy participants, their interrelationships, and their susceptibility to sociocultural influences. Firstly, youth SH policy participants in the Maldives have changed little since youth sexual health was first acknowledged 10 years ago, making the interrelationships between policy participants longstanding. The initiating role played by the UNFPA Maldives, their rapport with the Youth Ministry, the latter’s challenge to MOH as ‘experts’ of youth health have all contributed to the current state of youth SH policies and services. Secondly, the small size of Maldivian communities and even smaller pools of expertise make the individual policy participants susceptible to social pressures that are against supporting services targeting socially unacceptable behaviour (e.g. premarital sexual activity, abortion), which in turn, could lead to withdrawal of individual and institutional support for that policy. As Buse and colleagues explain, it is not advantageous to the policymakers and elected officials to champion groups that would accrue little political influence, such as women (2006), or unmarried and pregnant teens (A. Schneider and Ingram, 2009). These two factors combine to make youth SH policies difficult to negotiate and change.

As a result of the inconsistent and fragmented nature of institutional support, youth SH services have not been based on, or reflect, youth sexual health needs. The Youth Health Café, a joint effort between UNFPA Maldives, Youth Ministry, and MOH, remains understaffed due to a lack of consensus between the two Ministries.

As a result, medical assistance is often unavailable, and the service remains limited to one site. The Adolescent Unit at the state hospital, introduced as an alternative to the Youth Health Café, was discontinued due to lack of funding and human resources, both attributed to lack of policy support. The Youth Kiosk run by the NGO SHE was similarly discontinued, and although the NGO continues to provide services to youth if approached, they are under-utilised. Lastly, the Family Protection Unit based at the state hospital in the capital, attends to unintended pregnancies in cases of sexual violence but their reach remains limited to Male'. This research concludes that SH services for youth remain limited, under-utilised, and under-funded as they do not have adequate institutional and policy support.

Objective 2: Describe youth sexual health experiences

This study shows that premarital sexual intercourse is common among Maldivian youth, with greater numbers engaging in other non-penetrative sexual activities. This was supported by qualitative and quantitative data, as Remez (2000) points out, young people often consider oral sex as being abstinent, making it difficult to capture in survey data. Contraceptive use is low, and is linked to a widespread belief that condoms decrease sexual satisfaction rather than a lack of access to or knowledge of condoms. Despite legal prohibitions, unmarried youth do not find it difficult to obtain condoms and are less dependent on their married friends or relatives than previously documented (UNFPA Maldives, 2003b).

Unsafe sexual intercourse among unmarried youth is further influenced by their attitudes towards STIs and unintended pregnancies. Nation-wide campaigns have led to high levels of knowledge on HIV/AIDS but very low awareness of other STIs. The emphasis on AIDS awareness, including information on its low incidence in the country, also contributed to many youth identifying AIDS as a worst-case but unlikely scenario, which in turn has led youth to underestimate the risk and effects of other STIs. Furthermore, in the absence of information about other STIs, young people's reliance on peers leads them to underestimate the incidence of other STIs as they have not heard of any related peer experience. Reports of STI cases among peers were low (compared to reports of unintended pregnancies and abortion) - this is believed to be a result of extremely low awareness of STIs and its often asymptomatic nature. Concerns about the risk of a sexually transmitted infection are

therefore low. This is congruent with studies that reported how youth respondents believed HIV/AIDS was more common than any other STI (Jones and Haynes, 2006).

Young people's attitudes towards unintended pregnancies are shaped by their access to abortion. Although illegal in the Maldives, unsafe induced abortion is common among unmarried youth. Most youth can readily name a number of ways of inducing abortion (most commonly mentioned methods include consuming a concoction of medications and injections) and are confident in their ability to arrange an abortion, frequently more confident than their ability to obtain contraceptives. Thus, an unintended pregnancy is considered easily fixed by abortion. This notion is more prevalent among urban youth for two reasons. First, it is easier to access abortion-inducing medication or injections in urban areas. Secondly, most urban youth are of higher socio-economic status than rural youth, which increases their ability to travel abroad for medical abortions, which is also reported to be quite common. These urban-rural differences are generally consistent with abortion trends in developing countries (Guttmacher Institute & WHO, 2012).

Young people rate the risk of STIs and unintended pregnancies to be considerably less serious than the social consequences of getting 'found out' as being sexually active or pregnant outside of marriage by their community. Social consequences include stigma and isolation from the wider community, and sometimes from their own family. This concern is more prevalent among rural youth as they live in smaller communities where stigma is inescapable, reputation of self and family are highly valued, and people tend to be more conservative. Young women are further disadvantaged given gender bias and stereotypes where unmarried women are stigmatised for being sexually active while being sexually active is somewhat acceptable for, and sometimes expected of, unmarried men. These findings are in line with the systematic review by Marston and King (2006) that showed similar gendered double standards prevalent in many settings- sexual experience is desirable among young men but undesirable among young women, as is carrying or buying condoms, because it implies sexual experience.

Objective 3: Identify whether there is divergence between official sexual health data, policies and services and youth experiences of sexual health

This study shows there have been considerable divergence between official SH data, policy and services and the lived experiences of youth sexual health. Three points of dissonance are identified in particular. Firstly, the extent of premarital sexual activity among youth is underestimated in official data, often neglected in policy and programme planning, and inadequately catered for by services. Under-reporting in national data on sensitive subjects is uncommon- Hasnain and colleagues (2005) speculate huge under-reporting of HIV/AIDS cases in several Muslim majority countries (particularly in the Middle East or South East Asia) because of the unacceptability of many sexual activities. Moreover, Buse and colleagues (2006) argue that a selective attention to data is usually present in SRH policymaking and politics, as evidenced by the persistence of abstinence-only programmes in the US.

Secondly, HIV/AIDS is given disproportionate focus in programmes and very high priority in policymaking despite similar sociocultural sensitivities as sexual health and evidenced high levels of awareness among youth. It appears that Glasier and colleagues' (2006) contention about STI programmes being side-lined by HIV/AIDS programmes is evident in the Maldivian context. However, this needs to be further investigated with respect to the influence of donors for their role in agenda-setting and programme planning. Thirdly, the overwhelming sociocultural influence on sexual health seeking behaviour among youth is unacknowledged in policies, service provision, and data collection.

Objective 4: Analyse the reasons for these differences

An overarching key finding of this research is that sociocultural and religious factors heavily influenced policymaking, service provision and youth experiences. However, while religious factors were found to be limiting, sociocultural factors appeared to be even more restrictive. Contrary to most theocratic states, the SH policymaking process in the Maldives is shaped by policy actors and institutions whose strengths have more sociocultural basis than religious expertise. For example, restrictions in service provision are attributed less to religious concerns, and more to sociocultural sensitivity combined with a lack of policy commitment and ownership of the issue. Data gathered from young people also demonstrate that religiosity plays

a smaller role in their SH decisions than sociocultural pressures rooted in small island life.

The varying nature of religion and religious influence supports my postulation that religion is socially constructed. The restrictive nature of religion that is encountered in youth sexual health policy on promoting condom use is not apparent in HIV/AIDS campaigns that promote condom use. There is something about the nature of HIV/AIDS or among the policy circles within which it is deliberated that allows the moral issue of promoting condom use among unmarried individuals to be overlooked. The differing approaches taken by SH policy participants with regard to religious experts- whether to involve, disregard, or circumvent- reflects a manipulation that would not be possible if religion (e.g., the Islamic stance on premarital sex) was a stable and universal element, prescribed to in the same way by all participants. Similarly, the way in which young people invoke religion with regard to abortion as opposed to premarital sex is also selective, showing that religion is more malleable than is often conceptualised.

7.1. Limitations

There are four main limitations this research that I would address if this study were to be replicated. Firstly, triangulation of data to verify key informant accounts was limited, largely because of the unavailability of independent evaluations and research on Maldivian SH services and policies. Secondly, policy participants from religious institutions were not represented. This was mainly because I was unable to arrange interviews due to time constraints- I was unable to identify religious experts involved in SH policies and programmes until much later in the fieldwork phase and it was difficult to pursue access to them after leaving the field. In future research, I would make it a priority to pursue access to religious actors because while I was able to explore other actors' approach to religious boundaries on sexual health, I was unable to shed light on how religious actors approach sexual health. More exploration of religious actors' experiences with SH policy could potentially frame religious influence on policy as more reciprocal than how I have depicted it based on current findings.

Regarding what I would improve in the youth component of this research, I would allocate more time and resources to conduct repeat interviews with youth to establish more rapport so that they felt comfortable enough to discuss their own sexual experiences instead of needing hypothetical scenarios. The last limitation I identified is related to sample of youth respondents for interview and web survey. The sampling strategy for the web survey diminished the quality of the data- in future research, I would explore more ways to reach island-based youth who were under-represented. As Baumer and colleagues report, socioeconomic differences often play a key role in shaping sexual behaviour among young adults (Baumer & South, 2001) and had island-based youth been well represented in my survey sample, the conclusions I draw would have a more nuanced view of urban-rural differences. Conversely, Male' (urban) youth consisted of a third of the interview respondents which may have emphasised the insularity effect of small island communities- some respondents reported how living in Male' afforded anonymity because of the dense population. The final limitation is that I could not include individuals younger than 18 among my youth respondents- I made the decision to exclude them as it would have raised ethical complications, such as parental consent. However, given the reports of the drop in age at first sexual intercourse, it is clear that I may have excluded a group with serious sexual health needs.

7.2. Substantive contribution

As the first in-depth study focusing on sexual health of youth in the Maldives, this research makes considerable contribution to knowledge on youth sexual behaviour and attitudes, and the factors that shape their sexual health experiences. Four findings are highlighted in particular as substantive contributions: incidence of premarital sexual activity, deterrents to safer sexual practices, attitude and access to abortion, and fear of social repercussions.

While other qualitative studies have reported that premarital sexual activity occurs in the Maldives among groups identified as 'high-risk' (NCB, 2003; UNDP Maldives, 2009), this is the first to establish that premarital sexual activity not only occurs but is probably relatively common among youth from a variety of backgrounds in the Maldives. The quantitative data collected from the web-based survey, though not

representative, challenges the low incidence of premarital sexual intercourse shown by the 2009 Maldives DHS, suggesting the levels to be much higher, and that even more youth are engaging in other sexual activities, if not penetrative intercourse.

In-depth investigation about youth sexual practices reveal that low contraceptive use is due to a combination of factors as opposed to limited knowledge of contraception or of where to obtain them- this study shows that lack of STI information lead youth to misjudge the risk and effects of STIs by comparing it to HIV/AIDS which they perceive as highly unlikely in their community. This, combined with the widespread belief that condoms decrease sexual satisfaction, makes the risk of STIs as an insufficient deterrent to use a condom. Jones and Haynes (2006) report similar findings from a UK context- youth have more awareness of HIV/AIDS than of STIs and often name HIV/AIDS as the most common disease in the country because of how much they hear about it relative to other STIs. They suggest that knowledge of STIs had little effect on sexual behaviour because even knowledgeable youth seem to have low perception of risk regarding STIs (Jones & Haynes, 2006). It would be interesting to see if this effect is present in the Maldivian context as it could inform current strategies that depend heavily on improving awareness.

In addition to perceived low risk of STIs, risk of unintended pregnancy is also an insufficient deterrent to practicing safer sex because abortion is considered as an easy fix. Building on the SHE (NGO)-supported study (Thalagala, 2008) that revealed the occurrence of unsafe abortions in Maldives, this research shows that unsafe abortions are not only common but almost as easy to obtain as condoms. This research emphasises the need to address knowledge among youth about the risks unsafe abortions, and has policy implications about the need to reduce demand for unsafe abortions as well as urging discussions regarding access to safe abortions.

Lastly, this research highlights the overwhelming fear of social repercussions young people, especially women, experience and how it contributes to sexual ill-health. Learnt and reinforced by peer experiences, young women expect stigma and isolation from community and family if they were to be 'found out' to be sexually active or pregnant outside of marriage. For some youth, this is a deterrent to premarital sexual intercourse, directing them to other sexual activity (such as oral or anal sex), which,

combined with low knowledge of STIs, replaces the risk of unintended pregnancy with risk of STIs. However, Furby and Beyth-Marom (Furby & Beyth-Marom, 1992) reject the perception that young people take decisions that have detrimental effects and are too 'risky'- they emphasise that what is 'risky behaviour' should be studied with respect to sociological structures.

Despite the high risk of STIs, youth narratives indicate that their fear of social repercussions would deter some from seeking medical help. This study highlights the prevalence of sociocultural pressure on young people, especially women, and how it does not serve to police socially 'unacceptable' behaviour but rather restricts their health-seeking behaviour. Michels and colleagues (Michels, Kropp, Eyre, & Halpern-Felsher, 2005) have also shown the salience of social consequences among young people in the US, suggesting that more in-depth research needs to be done on sexual decision-making among youth and the role of their perception of social risks and health risks.

7.3. Methodological contribution

The methodological contribution of this research is the evidence from the web-based survey that used many of the same questions as the 2009 Maldives Demographic and Health Survey. Although the DHS are internationally-accepted standardised questionnaires that make tremendous contributions to high-quality data on a wide range of issues, the Maldives DHS failed to capture the extent of key sexual health issues of youth. I contend that this is largely because youth respondents did not feel comfortable revealing sensitive information in a face-to-face setting.

This research showed a substantial modality effect on survey response. Analyses of the web-based survey using the same questions as the DHS showed much higher levels of reporting on key issues that drastically changed the representation of youth sexual behaviour. Reporting of premarital sexual intercourse, for example, was significantly increased in the web-based survey which effectively removed the sociocultural pressure of reporting a socially unacceptable, illegal, and 'immoral' activity in a face-to-face setting. This would not be possible in surveys administered

in a face-to-face interview mode, even if enumerators were highly trained, as small communities afford little privacy and almost no anonymity.

A secondary methodological contribution can be made from analyses of modified DHS questions administered in the web-based survey. Certain questions in the Maldives DHS survey instrument were tested in this research for clarity and accessibility to young people- for example, questions on sexuality education phrased as *human reproduction* elicited much higher responses than when phrased as *contraceptives and STIs* and clarifying *sexual activity* as *full sexual intercourse*, differentiating it from *other sexual activity (like oral sex)* lead to significantly different levels of responses. The responses gathered from the web-based survey were supported by the youth narratives from the in-depth interviews, and questions the validity of some questions used in the DHS survey instrument.

This research shows there is a significant modality effect for questions about SH, incorporated in the DHS methodology. This finding is supported in research by Cooksey and colleagues who administered sexual behaviour questionnaires to religious youth using hand-held devices. They reported improved quality in data compared to face-to-face studies which they attribute to the devices giving respondents more privacy and anonymity (Cooksey, 2008). If the DHS methodology incorporated methods such as these and addressed the potential validity issues in the DHS instrument, it could improve not only response rates but also quality of the data.

7.4. Policy contribution

This research contributes to SH policy in the Maldives by identifying key influences shaping youth sexual health- religious influences and sociocultural influences. Effects of these influences include the mutually reinforcing relationship between data and policy which reduces the validity of data and diverts focus of the programmes; the lack of collaboration among the various institutions which hinders service provision; misidentification of sociocultural pressures as religious pressure which renders sexual health taboo; and susceptibility of policymakers to sociocultural influences that result in inconsistent and fragmented institutional support, which in turn limits the progress of youth sexual health in the Maldives.

In order to address these barriers, it is recommended that, in the first instance, youth sexual health be identified as a public *health* issue, severing links to immorality and undertaking strong advocacy to communicate this message to Maldivian communities. This is supported by other research that challenges the exclusive focus on changing youth attitudes, knowledge and ‘risk’ behaviour and recommend that more focus be put on the sociocultural contexts that shape youth sexual health outcomes (Aggleton, 2006; Shoveller & Johnson, 2006).

Although Schneider’s (J. W. Schneider, 1985) 4-stage heuristic model of the social constructionist approach to Social Problems Theory allowed me to break down the policy process of defining and redefining youth SH, its analytical powers were limited. As discussed in Chapter 4, Maldivian youth SH is in the fourth stage where claims-makers (such as the UNFPA Maldives and MOH) insist on the difficulties of working ‘within the system’ and attempt alternative approaches (e.g., clinicians refusing to report nonmarital pregnancies to authorities). However, identifying the current stage does not assist in identifying how, as I recommend above, youth SH in Maldives be redefined as a public health issue. To this end, in retrospect, it would have been informative to use, in conjunction, Anne Schneider and Helen Ingram’s social construction of target populations from Policy Design Theory literature (A. Schneider & Ingram, 1993; A. Schneider & Sidney, 2009). They suggest that there are four ideal types of target populations with positive or negative images and varying political power that affects policy actors’ decisions to support policies-

“*Advantaged* groups are perceived to be both powerful and positively constructed, such as the elderly and business. *Contenders*, such as unions and the rich, are powerful but negatively constructed, usually undeserving. *Dependents* might include children or mothers and are considered to be politically weak, but they generally carry positive constructions. *Deviants*, such as criminals, are in the worst situations, since they are both weak and negatively constructed” (A. Schneider & Ingram, 1993, pp. 335-336, italics added).

I wonder if there is a conflict in the way Maldivian youth requiring sexual health attention are perceived by the policy actors- perhaps MOH and UNFPA Maldives consider them as *Dependants* while the Religious Council perceive them as *Deviants*- that might explain the impasse in Maldivian youth SH policy. There is potential explanatory power in applying these elements in conjunction with the social constructionist approach to Social Problems Theory, which could potentially lead to more policy contributions.

A further contribution can be made to sexual health policy research in similar theocratic countries. This research supports findings from other SH research reporting how the intrinsic nature of Islam makes sexual health issues difficult to address in Muslim contexts. This stems from reluctance to acknowledge illicit sexual practices in official policy, reluctance to collect and report such data, and is amplified by sociocultural stigma attached to these issues (Hasnain et al., 2005). However, review of different Islamic countries with varying levels of religious influence on policies have shown that religion is not necessarily a restrictive factor but can be supportive, depending on the sociocultural context (WHO, 2006). This research has shown that in the context of the Maldives, religious influence is currently a restrictive factor shaping SH policy. Moreover, it has shown that an appreciation of how religion and religious influence (on policy and behaviour) is socially constructed can lead to more nuanced understandings of the impact of Islam on youth SH. Further research on measuring religious influence in different Islamic contexts is necessary, which in turn could facilitate knowledge sharing between Islamic countries in how to incorporate religious influence in strategies to improve youth sexual health.

7.4. Future work

In many ways, this research represents a beginning. Youth sexual health remains under-researched in the Maldives. The findings of this research indicate that key issues of youth sexual health such as unintended pregnancies, unsafe abortions, and STIs have been under-estimated in official data. This alone warrants further, large-scale representative research before policy decisions are made based on those official data. With regard to policy, this research highlights that the religious sensitivities

related to sexual health are first, rooted in religious influence that is often manipulated or disregarded, and second- enforced by sociocultural influences, both of which may be overcome. The extent sociocultural influences on sexual health in island-state contexts are also researched and under-theorised, and countries such as the Maldives would greatly benefit from further research on this aspect. Further research could also focus on more in-depth study of the ways in which religious influence is exerted sexual health policymaking, not only in the Maldives but in other Islamic countries as well.

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Appendices

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Appendix A: Timetable

<i>Month / Week</i>	<i>Target</i>	<i>Location</i>
2007-08	Major Review- upgraded to PhD	London
2008-09	Michaelmas term: Fieldwork. Postponed due to political unrest Lent term: Interruption of study	Maldives
2009-10	Michaelmas & Lent Term: Fieldwork	
July 2009	Travel to Maldives	Male'
Week 3	<u>IDs</u>	
Week 4	1. Finalise field site, arrange lodging, transport 2. Inform Atoll office and island office if necessary	
August 2009	3. Practice interview and revise guide	
Week 1	<u>MDHS data</u>	
Week 2	1. Meet MOH officials to secure data release	
	<u>KIIs</u> 1. Meet UNFPA official for info on potential KIIs 2. Compile/complete KI list 3. Make contact with KIIs 4. Schedule interviews	
RAMADAN	<u>IDs</u>	Male'
August 2009	1. Data collection at field site 1: Male'	
Week 3	<u>KIIs</u>	
Week 4	1. Conduct KIIs	
September 2009		
Week 1		
Week 2		
September 2009	<u>IDs</u>	Atoll
Week 3	1. Data collection at field site 2: Atoll	
Week 4	<u>MDHS data DELAYED</u> 1. Check progress of MDHS.	
October 2009	<u>IDs</u>	Atoll
Week 1	1. Data collection at field site 3: Atoll	
Week 2	2. Complete IDs. Tie up loose ends 3. Coding and preliminary analysis	
October 2009	<u>MDHS data DELAYED</u>	Male'
Week 3	1. acquire MDHS dataset	
Week 4	2. preliminary analysis of MDHS	
	<u>KIIs</u>	
	1. Conduct KIIs	
November 2009	<u>KIIs</u>	Male'
December 2009	1. Complete KIIs 2. Coding and preliminary analysis	
2010-11	Data transcription, coding and analysis	London
2011-12	Write-up	London

Appendix B: Glossary of Islamic terms

Fatwa	Legal ruling (plural is fatawa) based on religious interpretation
Hadith	Deeds and collected sayings of the Prophet Muhammad. A primary source of Islamic Law
Holy Quran	The Book. A primary source of Islamic Law
Ijma	Consensus. A secondary source of Islamic Law
Qiyas	Analogy. A secondary source of Islamic Law
Shari'a	Islamic law. Divine Law for Muslims
Shi'a	One of the Schools of Islamic Jurisprudence
Sunni	One of the Schools of Islamic Jurisprudence

Appendix C: Islamic Countries' matrix

Table 1 of 2: Selected Islamic countries with indicators on religion and government SRH policies (Note: data used for review in 2007)

Country or territory	% Muslim ¹	State Religion ¹	main School of Jurisprudence ²	GRI ³	GFI ⁴	SRI ⁵	Population size ('000) ⁶	% popn. under age 15 ⁶	Level of concern about size of working-age population	Adolescent fertility rate ⁷	Level of concern about adolescent fertility ⁶	Access to contraceptive methods ⁴	Grounds for abortion ⁸	HIV Prevalence among adults 15-49 (%) (2005) ³	Level of concern about HIV/AIDS ⁴
Iran	90% or more		Shia 89%	9.17	8.83	10	71 208	27	major concern	20	major concern	direct support	1	0.2	major concern
Jordan	90% or more	Islam	Sunni 92%	8.61	8	6.67	5 924	36	major concern	25	not a concern	direct support	1 2 3 5	no data	major concern
Maldives	90% or more	Islam	Sunni % unspecified	10	7.5	2.67	306	32	major concern	23	major concern	direct support	1 2	not in PAI	major concern
Pakistan	90% or more	Islam	Sunni 80%	9.17	7.77	10	163 902	36	major concern	36	major concern	direct support	1 2 3	0.1	major concern
Turkey	90% or more	Secular	Sunni % unspecified	6.94	5.47	10	74 877	27	major concern	37	minor concern	direct support	1 to 7	no data	major concern
Egypt	90% or	Islam	Sunni 90% of	8.61	7.93	9.33	75 498	33	major	39	minor	direct	1	<0.1	minor

¹ ("not proclaimed" = govt. avoids naming a state religion but recognises some religions as official. "Secular" used only if explicitly stated).

² (as % of Muslim population unless stated otherwise) Source: U.S. Department of State (2007). International Religious Freedom Report 2007

³ GRI: Govt. Regulation of Religion index6 (0-10 low is less regulation) Grim, B. J. and R. Finke (2006).

⁴ GFI: Govt. Favouritism of Religion index6 (0-10 low is less favouritism) Grim, B. J. and R. Finke (2006).

⁵ SRI: Social Regulation of Religion index6 (0-10 low is less regulation) Grim, B. J. and R. Finke (2006).

⁶ Population Division of the United Nations Secretariat (2007). World Population Policies.

⁷ Adolescent fertility rate (per 1,000 women, aged 15 -19) (2005-2010) Population Division of the United Nations Secretariat (2007). World Population Policies

⁸ Grounds on which abortion is permitted: (1) to save the woman's life; (2) to preserve physical health; (3) to preserve mental health; (4) rape or incest; (5) foetal impairment; (6) economic or social reasons; (7) on request. Population Division of the United Nations Secretariat (2007). World Population Policies

	more		total population						concern		concern	support			concern
Morocco	90% or more	Islam	Sunni 99% of total population	6.94	7.1	8.67	31 224	29	major concern	19	minor concern	direct support	1 2 3	0.1	major concern
Bangladesh	70% - 89%	Islam	Sunni 80% of total population	8.61	7.27	9.33	158 665	34	major concern	124	major concern	direct support	1	<0.1	major concern
Indonesia	70% - 89%	"extends official status to 6 faiths"	Sunni?	6.94	6.77	9.33	231 627	28	major concern	40	major concern	direct support	1	0.1	major concern
Kuwait	70% - 89%	Islam	Sunni 70% of total population	8.06	7.27	8.67	2 851	23	minor concern	13	minor concern	direct support	1 2 3 5	no data	minor concern
Lebanon	70% - 89%	??	Sunni & Shia each 28%	6.94	7.43	7.33	4 099	28	minor concern	25	minor concern	direct support	1	0.1	major concern
Albania	70% - 89%	secular	Bektashi (a Shia order) 25%	0.56	2.13	1.33	3 190	25	minor concern	16	minor concern	direct support	1 to 7	no data	major concern
Malaysia	50% - 69%	Islam	Sunni % unspecified	8.61	8.67	8.67	26 572	30	minor concern	13	major concern	direct support	1 2 3	0.5	major concern
Burkina Faso	50% - 69%	secular	Sunni % unspecified	0	0	0	14 784	46	minor concern	126	major concern	direct support	1 to 5	2	major concern

Table 2 of 2: Selected Islamic countries with indicators on religion and youth SRH (Note: data used for review in 2007)

Country or territory	Percent Muslim ¹	State Religion ¹	main School of Jurisprudence ²	% Population age 20-24 ³	Age-Specific Fertility Rate ⁴	Age at First Sex (f) ⁵	% N-married (F) ever had sex ⁶	% N-married (M) ever had sex ⁷	% Ever married (F) aged 15-19 ⁸	% Ever married (M) aged 15-19 ⁹	Mean age at marriage (f) ¹⁰	Mean age at marriage (m) ¹¹	% Married before 18 (f) ¹²	% (f) giving birth by 18 ¹³	% Births to (f) <age 20 attended by skilled personnel ¹⁴	HIV Prevalence, 15-24 ¹⁵
Iran	90% or more		Shia 89%	25.4	19.5	no data	no data	no data	18	3	21.1*	24.5*	30	no data	no data	0
Jordan	90% or more	Islam	Sunni 92%	20	26	no data	no data	no data	6	2	24.7*	27.8*	11	5		no data
Maldives	90% or more	Islam	Sunni % unspecified	21.9	62	no data	no data	no data	no data	no data	19.1*	23.2*	no data	no data		no data
Pakistan	90% or	Islam	Sunni 80%	21.4	69	no	no data	no data	21	6	21.7*	26.5*	24	no	no	0.1

¹ ("not proclaimed" = govt. avoids naming a state religion but recognises some religions as official. "Secular" used only if explicitly stated).

² (as % of Muslim population unless stated otherwise) Source: U.S. Department of State (2007). International Religious Freedom Report 2007

³ Proportion of Population age 20-24 (%) (2005) PRB-UNFPA Country Profiles for Population and Reproductive Health 2005

⁴ Age-Specific Fertility Rate per 1,000 Women, 15-20 (2005) PRB-UNFPA Country Profiles for Population and Reproductive Health 2005

⁵ Median Age at First Sexual Intercourse, Female, 25-49 (2005) PRB-UNFPA Country Profiles for Population and Reproductive Health 2005

⁶ Unmarried females 15-19 who have had sex (%) (2006) PRB The World's Youth 2006 Data Sheet

⁷ Unmarried males 15-19 who have had sex (%) (2006) PRB The World's Youth 2006 Data Sheet

⁸ Ever married ages 15-19 Female (%) (2006) PRB The World's Youth 2006 Data Sheet

⁹ Ever married ages 15-19 Male (%) (2006) PRB The World's Youth 2006 Data Sheet

¹⁰ Mean Age at Marriage, Female (2005) PRB-UNFPA Country Profiles for Population and Reproductive Health 2005

¹¹ Mean Age at Marriage, Male (2005) PRB-UNFPA Country Profiles for Population and Reproductive Health 2005

¹² Women married before 18 (%) (2007) Population Action International (2007). A Measure of Survival-Calculating Women's Sexual & Reproductive Risk.

¹³ Women giving birth by 18 (%) (2006) PRB The World's Youth 2006 Data Sheet

¹⁴ Births to women <age 20 attended by skilled personnel (%) (2006) PRB The World's Youth 2006 Data Sheet

¹⁵ HIV Prevalence, 15-24, Total (2005) PRB-UNFPA Country Profiles for Population and Reproductive Health 2005

	more					data								data	data	
Turkey	90% or more	Secular	Sunni % unspecified	18.4	40.5	no data	no data	no data	12	no data	22*	25*	23	8	83	no data
Egypt	90% or more	Islam	Sunni 90% of total population	20.9	42	no data	no data	no data	10	2	21.6*	26.4*	17	8	69	no data
Morocco	90% or more	Islam	Sunni 99% of total population	20.6	24	no data	no data	no data	11	1	22.3	27.2	16	8	66	no data
Bangladesh	70% - 89%	Islam	Sunni 80% of total population	20.3	120	no data	no data	no data	48	3	18*	25.5*	69	46	13	0
Indonesia	70% - 89%	"extends official status to 6 faiths"	Sunni?	19	53.5	18.6*	no data	no data	15	3	21.6*	25.2*	24	12	58	0.1
Kuwait	70% - 89%	Islam	Sunni 70% of total population	15.4	23.5	no data	no data	no data	5	0	23*	26.3*	22	no data	no data	no data
Lebanon	70% - 89%	??	Sunni & Shia each 28%	18.4	26	no data	no data	no data	4	no data	no data	no data	no data	no data	no data	no data
Albania	70% - 89%	secular	Bektashi (a Shia order) 25%	18.6	16	no data	7 (all teens)	5 (all teens)	10	0	no data	no data	16	4	no data	no data
Malaysia	50% - 69%	Islam	Sunni % unspecified	18.1	18	no data	no data	no data	5	1	23.5	26.6	8	no data	no data	0.4
Burkina Faso	50% - 69%	secular	Sunni % unspecified	20.6	158	17.5	24	25	32	1	19*	27.6*	52	27	55	6.9

Appendix D: Theocracy review

This section reviews four countries: one selected purposively (site of PhD research); and, 3 selected on the basis of the proportion of their population that is Muslim (Iran > 90%, Indonesia 70-89%, and Malaysia 50-69%).

Historical events play a large part in explaining contemporary situations, for example, the Iranian Islamic revolution in 1979. The challenge of describing the situation in Iran is one of the reasons why a narrow set of guiding questions was chosen for this review. Some countries, such as the Maldives have poorly-documented historical pasts, and this set of questions is an attempt to capture the present-day situation in each country and the present influences exerted by religious institutions, whether or not they have historical roots.

For each country, I include discussions on religious influence and also on the SRH context. Selected SRH indicators are in the table below- notably, some indicators have no data available. The necessary element to demonstrate in this part of review is the level of support for SRH issues in these countries, and the absence of data is interesting in and of itself.

	Adolescent fertility rate ¹	Level of concern about adolescent fertility ¹	% Women married before 18 years ²	% Births to women age <20 years (2005-2010) ¹	% Births to women age <20 years attended by skilled health personnel (2006) ³	Grounds on which abortion is permitted ^{1,4}
Maldives	No data	Major concern	No data	6	No data	1, 2
Iran	24	Major concern	30	6	No data	1
Malaysia	15	Major concern	8	10	No data	1, 2, 3
Indonesia	24	Major concern	24	3	No data	1

Youth-specific SRH indicators for selected Islamic countries

Maldives

¹ Births per 1000 women aged 15-19 (2005-2010) (Population Division of the UN Secretariat 2007)

² Population Action International 2007

³ Population Reference Bureau 2006

⁴ Grounds on which abortion is permitted: (1) to save the woman's life; (2) to preserve physical health; (3) to preserve mental health; (4) rape or incest; (5) foetal impairment; (6) economic or social reasons; (7) on request

Religious influence: The Maldivian population is 100% Muslim, Islam is the state religion, and Maldivians are prohibited from practicing other religions (U.S. State Department, 2010). The Supreme Council for Religious Affairs became the Ministry of Islamic Affairs in 2008- it regulates religious affairs by being the authority in accrediting Imams and approving the content of religious teachings, which are regularly communicated to the public at Friday prayers and through the media (U.S. State Department, 2010). Institutional influence is evident in the education sector as there are religious schools (with Arabic as the language of instruction), in addition to all other schools where Islamic instruction is mandatory for Maldivian pupils (U.S. State Department, 2010). Although there are no tensions specifically attributed to a *Sunni-Shi'a* divide, the School favored by the Maldivian government is implicit in its Constitution which stipulates that the President and the Cabinet of Ministers must be *Sunni* Muslims, (Government of Maldives, 1997). The 2008 constitution further stipulated that members of parliament and the judiciary must also *Sunni* Muslims, and that Atoll chiefs must be Muslims (Government of Maldives, 2008).

SRH situation: Maldives has very poor data availability on SRH, a trend that continues across approximately 30 SRH indicators accessed from a range of international databases (e.g. PAI, 2007; Population Division of the United Nations Secretariat, 2007; PRB, 2006). The absence of youth-relevant data is unsurprising as youth SRH is under-researched in the Maldives. Country-level annual health reports and SRH strategies suggest that data do exist. It seems, then, that the issue lies in reporting to international health organisations.

Iran

Religious influence: Iran is a self-declared theocratic democracy (Mehryar et al., 2007). Muslims account for 98% of the total population (U.S. State Department, 2007) and 89% of those follow a particular brand of Shi'ism (Marcinkowski, 2008; Tremayne, 2006).

Iran is similar to the Maldives in that the legal system is based on the Shari'a (U.S. State Department, 2007), but as strict adherents to the Shi'a School, the head of state is the supreme religious leader, and is supported by senior theologians who oversee the decision-making process (Mehryar et al., 2007; U.S. State Department, 2007).

The practice of policymaking in accordance with *fatawa* (religious rulings; *fatwa* is singular, *fatawa* is plural) issued by the theologians in aspects of education (Mehryar et al., 2007; U.S. State Department, 2007) and health (Mehryar et al., 2007; Obermeyer, 1994; U.S. State Department, 2007) entail a considerable influence exerted by the state religion. This probably has more impact on religious minorities such as the Sunnis and those of the Baha'i faith who reportedly face restrictions such as exclusion from universities and government employment in addition to restrictions on functioning as a community (U.S. State Department, 2007).

SRH situation: Frequent references are made to Iran as a success story in family planning (Mehryar et al., 2007; Obermeyer, 1994; Roudi-Fahimi, 2004). Family planning and contraception was deemed acceptable within Islamic tenets by *fatawa* declared by the religious leaders in 1989 (Mehryar et al., 2007) following Iran's struggle to cope with its growing population (annual growth rate reaching 3.4% in 1986) (Hoodfar & Assadpour, 2000). Recognising the unmet need for SRH care for unmarried youth, service providers (public and private) have reportedly been instructed not to enquire about marital status when approached for SRH health care (Mehryar et al., 2007).

Despite an increase in age at first marriage (Mehryar et al., 2007), 30% of women are married before age 18 (PAI 2007), calling into question the voluntary entry into sexual relationships. Liberal religious leaders have failed to reach a consensus on legalising abortion in the first 4 months of pregnancy, and it remains illegal unless the woman's life is in danger (Mehryar et al., 2007; PAI, 2007; Population Division of the United Nations Secretariat, 2007).

Malaysia

Religious influence: Islam is practiced by 60% of the Malaysian population, and the constitution identifies Islam as the state religion. Religion in Malaysia is similar to Maldives in the prominence of the Sunni School among Muslims. Unlike Maldives, other religious practices are permitted- 19% practice Buddhism, and 9% Christianity (U.S. State Department, 2007). However, the discord is not between different groups of different religions but rather between the Sunni authorities and the Shi'ite

community (Marcinkowski, 2008). Like Malaysians, Ethnic Malays are classified as Muslim at birth, and hence religious identity is inextricably linked to national identity for at least 55% of the total population in Malaysia (U.S. State Department, 2007).

The Islamic Centre of Malaysia is the over-arching body that regulates religious activities (Marcinkowski, 2008), and its influence is exerted in the education sector as religious instruction is compulsory in public schools (Marcinkowski, 2008; U.S. State Department, 2007). Values that discourage deviations from the state-prescribed interpretation of Islam are routinely communicated to the public (U.S. State Department, 2007), warning them of ‘deviationist teachings’ that also included Shi’ite materials (Marcinkowski, 2008)

Compliance is promoted by the Government’s provision of more financial assistance to Sunni Islamic institutions compared to other groups (U.S. State Department, 2007). Non-compliance is punished through restrictions placed on Shi’a practices that include preventing erection of a Shi’ite mosque (Marcinkowski, 2008).

SRH situation: The environment in Malaysia seems fairly liberal when it comes to SRH issues, a significant indication of which is the fact that they were able to host the Coalition for Sexual and Bodily Rights (CSBR) Institute- the first international forum to discuss sexual rights in Muslim societies (Ercevik Amado 2009). In addition to the comparatively low proportion of women married by age 18 (8%), a UNFPA initiative aimed at addressing adolescent SRH is in place (UNFPA, 2005).

Indonesia

Religious influence: Although described as a secular state (Sciortino, Marcoes Natsir, & Mas’udi, 1996), Indonesia is home to the largest number of Muslims in the world (Marcinkowski, 2008; Roudi-Fahimi, 2004), accounting for 88% of the total population (Roudi-Fahimi, 2004; U.S. State Department, 2007).

Despite a Sunni majority and a large Shi’ite community, there are no reported occurrences of explicit discord between the two groups (U.S. State Department, 2007). The Shi’ite community seems to be benefiting from the post-Suharto

democratization process and Indonesia is referred to as the center of Shi'ite revival. The present political climate provides opportunities for Shi'ism by allowing Shi'ites to erect and congregate in their own mosques rather than state-run mosques- a stark difference from Malaysia (Marcinkowski, 2008).

Islamic influence is dispensed through independent religious organizations: *Majelis Ulama Indonesia* provides consultancy to the government by issuing *fatawa* which are incorporated into the policymaking process as guiding principles, rather than legally binding rules (U.S. State Department, 2007). *Nahdhathul Ulama* exerts its influence through the sheer size of its membership and presence in the rural areas, and *Muhammadiyah* remains influential by virtue of its access to the mass media, as well as school and hospitals throughout the country (Sciortino et al., 1996).

With access to policymakers, rural areas, and the general population through media, as well as a hand in the education and health sectors (Sciortino et al., 1996), the institutional influence exerted by Islam in Indonesia is strong and it is able to communicate its values and promote conformity (Marcinkowski, 2008). Restrictions such as limited business hours during Ramadan and the passing of strict Shari'a-based regulation on Muslim attire for all women (though localized in some regions only), affects minority religious groups (U.S. State Department, 2007) and can be considered as punishment for non-conformity.

SRH situation: Like Iran, there are varying views among the prominent religious organizations in Indonesia regarding the issues of abortion and on provision of contraceptives to unmarried people (Sciortino et al., 1996). While acknowledging this can be important, it does not change the fact that the current reality faced by Indonesian women and adolescents present them with very limited choice when it comes to SRH issues.

Appendix E: Key Informant interview protocols

OUTLINE

- INTRODUCTION
 - Thank you
 - Thank you for agreeing to meet with me today.
- Introduce myself
 - As I mentioned before, I am a PhD student at the London School of Economics in the UK, and this interview is part of my research. Just to tell you about my research...
- Purpose of interview
- Confidentiality
- Duration
 - This interview should take about 1 hour
- Audio recording
 - I'd like to tape this session because...
- Invite questions
 - Before we begin, is there anything you would like to ask?
- Signature of consent
 - Are you willing to participate in this interview? [Obtain signature] [PRESS RECORD]
- INTERVIEW
- CLOSING
 - Additional comments?
 - Is there anything else you would like to add?
 - Who else?
 - Can you think of anyone else I could interview?
 - Next steps
 - There's a study that's going on now, the Maldives Demographic and Health Survey, which is going to generate some data on some of the youth issues we just spoke about. It would really interesting to discuss some of that data with you- could I come and see you again, sometime in October?
 - I'll be analysing the information you and others gave me and will be reporting it in my PhD thesis. I'll be happy to send you a report of my findings if you are interested. This may take some time as my research involves collecting other kinds of information as well.
 - Thank you
 - Once again, thank you very much for you time [stop recording]

INTERVIEW PROTOCOL TO FOLLOW

Different KI groups	Includes	General qns (in black)	Respondent-specific qns (in colour)
Service Providers	doctors, nurses, counsellors from govt. clinic, private clinic, NGO	yes	yes

Policy actors (excl. religious council)	Health Min, Youth Min, UNFPA	yes	yes
Religious council	Policymakers	Yes (different order)	yes
Project-related informants (for insight on how research fits with policies, how it was commissioned, complications re data collection, reporting, funding, etc.)	Researchers involved in Health Reports & RH Survey 2004 (x1), Adolescent SRH 2003 (x1)	yes	yes
Other grassroots level actors with high interaction with youth	Youth NGO, school counsellor, imam (x1)	yes	no

INTERVIEW GUIDE

[Insert RESPONDENT-SPECIFIC QNS: RELIGIOUS LEADERS ONLY]

Defining RH and SH

I mentioned that my research is about sexual and reproductive health. First of all, I'd like to ask, do you think there's a difference between SH and RH?

What is the difference?

Do you think this distinction is important?

To policymaking?

To devise strategies?

At service provision level?

I mentioned that my research is about sexual and reproductive health. What do you think is included when I say 'reproductive health'?

What do you think is included in 'sexual health'?

Married vs. unmarried?

Do you think being married or unmarried makes a difference when it comes to SH and RH?

What about specifically in Maldives?

~~Youth. Married proportion? Age at first marriage? Why?~~

~~We have a large youth population in this country. Thinking of people aged between 18 and 24 years, would you say most of them would have never been married?~~

~~At what age do you think most young men tend to get married in Maldives?~~

~~Why do you think they marry at that age?~~

~~At what age do you think most young women tend to get married in Maldives?~~

~~Why do you think they marry at that age?~~

~~Percception of magnitude and trend~~

~~Do you think sex among unmarried people is something that happens in Maldives?~~

~~Do you think it's a recent trend?~~

~~How common do you think it is?~~

—————~~How did you arrive at this conclusion?~~

Socially acceptable? Recent trend? Why?
 Do you think it's accepted in Maldivian society today?
 Is this different from before?
 Why do you think it has changed?

[Insert RESPONDENT-SPECIFIC QNS: SERVICE PROVIDERS ONLY]

For/against providing services to unmarried? Why?
 Some people argue that there needs to be SRH services for unmarried youth whereas other people say this would mean premarital sex is being condoned. What do you think?
 Why?

Magnitude of SRH problems
 Would you be able to say how many youth face these kinds of problems?
 Is that based on your experience as a ---- or...?
 Do you know of any official information about this?

[Insert RESPONDENT-SPECIFIC QNS: PROJECT-RELATED KIs ONLY]

Discuss SRH? Is it socially acceptable?
 There is a shortage of data, and health authorities have said the subject is too sensitive to discuss in Maldives. What is your opinion about this?
 Do you think this is something people talk about amongst themselves?
 Do you think it's socially acceptable to talk about SH issues, even among unmarried people?
 Was it the same before, say 10 years ago?
 Why do you think this is the case?

For/against providing information
 Some people argue there needs to be more awareness about this on TV and radio and magazines. But others say if you give information about it, it would be the same as encouraging youth to have premarital sex. What do you think?
 Why?

Is Sex Ed ok? At what age? Do you think they do already?
 At what age do you think it's alright for youth and adolescents to be taught about SH in school?
 Why do you say this?
 Do you think they teach it in school?
 Do you think they should?

[Insert RESPONDENT-SPECIFIC QNS: POLICY ACTORS ONLY]

Opinion of current regulations. Good fit with situation? Do you think people abide by it?
 Do you know about the current law about youth who have sex before marriage?
 What do you think about it?
 DO you think a lot of people follow this law?

There are a few strategies and plans that touch on the subject of SH. Some of the recent ones include Health Master Plan 2006-2015, the National Development Plan 2006-2010, and also the RH Strategy 2005-2007. Are you familiar with these?

Awareness. Important? Effective? Why?

Looking at the youth-relevant strategies, it seems to me that there are two main approaches. First of all there is awareness raising

How important do you think this is?

Are you aware of some of the campaigns?

In your opinion, how effective do you think they are?

What is the reason behind this?

Services not for unmarried? Why?

Secondly, there is the provision of services. As far as you know, are these services currently available to married and unmarried youth?

Do you think an unmarried person be able to legally access contraceptives?

Access medical help related to STIs?

Why do you think this is?

What other factors?

[END]

[RESPONDENT-SPECIFIC QNS: SERVICE PROVIDERS ONLY]

What if (1): provide contraception? Why?

Now thinking of yourself as a service provider at this clinic, what if someone comes here for help, for example, wanting to buy condoms/Pills. You're pretty certain they are not married. Does this matter?

Why/Why not?

Would you ask them, to make sure?

What if you think they have lied?

How often? How easy? Other places easier? Why?

Do you come across this quite often?

Do you think it's common practice to get condoms and pills at clinics like this?

Do you think it's easy?

Are there some easier than others? [Probe: for example, private clinics? Pharmacies?]

Why do you think there's a difference?

What if (2): provide medical help? Why?

What if someone came to the clinic and they needed medical help and from the sound of it, it seems like an STI. And you're pretty sure they're not married, Does this matter?

Why/Why not?

Would you ask them, to make sure?

What if you think they have lied?

How often? How easy? Other places easier? Why?

Do you experience this quite often?

Do you think it's easy to come here for help?

Are there some easier than others?

Why do you think there's a difference?

Confidentiality an issue? Why?

Some previous studies have highlighted that people hesitate to come to clinics in case the nurses or doctors here tell other people about their problem. Do you think this is a valid concern?

What makes you say this?

What if (3): Regulation saying refuse to provide services/help to unmarried. Why?
Assuming there was a regulation at this clinic saying unmarried people can't be given medical help for STIs etc. What would you feel about that?
Why?

[RESPONDENT-SPECIFIC QNS: PROJECT-RELATED KIIs ONLY]

Too sensitive to research? Why?

Do you think there is a shortage of data when it comes to youth SRH?

Why do you think this is the case?

It has been said in health reports that it's because the subject is too sensitive to research in Maldives, Would you agree?

Why do you think this is?

Do you think if someone did a survey, young people would answer truthfully?

Why wouldn't they?

In your experience?

In your experience with ---- did you find that this was the case?

Response rates? Compared between male' and atoll? Younger and older participants?

Why do you think this was the case?

Research just on knowledge? Why not attitudes or behaviour?

The age group you studied was...?

As I understand, that study covered knowledge of contraception and STIs, including HIV/AIDS?

Some studies on explore attitudes. Do you think it might be useful to know about youth attitudes towards SH issues?

Did yours?

Why/Why not?

How about behaviour?

Why/Why not?

Is it possible to study sexual behaviour of youth in Maldives?

Why/Why not?

Research commissioned?

Can you tell me about how that study got started?

Was it commissioned? By?

Why was there a need for it at that time?

Funding?

Technical assistance?

Data and recommendations

Was the data as you expected?

Do you feel as if were an accurate representation of your subject matter?

How did you formulate your recommendations?

What were the factors you had to consider?

If they weren't there, what would you have recommended?

Were your recommendations followed?

Why not?

[RESPONDENT-SPECIFIC QNS: POLICY ACTORS ONLY]

Strategies. Familiar? Involved?

There are a few strategies and plans that touch on the subject of SH. Some of the recent ones include Health Master Plan 2006-2015, the National Development Plan 2006-2010 [CHECK], and also the RH Strategy 2005-2007. Are you familiar with these?

Were you involved in the formulation of any of these?

What was your role?

Awareness. Important? Effective? Why?

Looking at the youth-relevant strategies, it seems to me that there are two main approaches. First of all there is awareness raising

How important do you think this is?

Are you aware of some of the campaigns?

In your opinion, how effective do you think they are?

What is the reason behind this?

Services not for unmarried?

Secondly, there is the provision of services. Are these services currently available to married and unmarried youth?

So to clarify, would an unmarried person be able to legally access contraceptives?

Access medical help related to STIs?

Why

Why do you think this is?

When was this decision made?

By whom?

RH Strategy: 'address legal barriers'. Other instances? Involved?

One of the strategies in the RH Strategy 2005-2007 was 'to address legal barriers to provision of RH services and products to adolescents and young people'. So this issue has been given some attention. Were you involved with this?

Are you aware of other attempts or policymaker-level discussions?

Were you involved?

Policy process: Who? Why? How? When?

Could you talk me through it?

What did it involve? Discussions with...?

Was there data? Official or unofficial (anecdotal)?

Who provided it?

Need highlighted how?

Need highlighted by whom?

How was it received? I.e., who opposed, who supported? And why do you think?

Who else was involved?

This was around when?

How long did the process take?

Is the length typical?

Was the process typical? [In case the priority directive came from above, like for drug policy]

Sensitive?

It has been mentioned in reports that youth SH is a sensitive subject. What do you think about that?

Was this felt at all, during the policy process?

Do you remember who raised this sensitivity issue?

Why do you think they did that?

Did you agree with this?

Context

Also, thinking back to that time, the year----, can you remember any other issue that was a priority to the government?

What else was going on at that time? [Depending on year, probe 'drugs issue? Political instability? Religious issues? Tsunami? Child protection? Volunteer anecdote 'I would've been away at the time so I can't imagine....' or 'I was working at the -- - so I remember that we were dealing with ---']

Was it the same group of stakeholders involved in those or...?

Do you think that might have affected this policy at all? [probe; I know how you have to consider timing when it comes to making decisions that might upset some people, so if only one overhaul can be made, there's usually space for only one, and others have to be mild changes']

If that other had not been so pertinent at that time, do you think the policy outcome of this would have been different?

Different how? And why?

Outcome

So the outcome of that was ----

Were you happy with it?

Were most stakeholders happy with the outcome?

Strategy appropriate to data back then? Good enough data? Now?

You mentioned that this was formulated in ---- By the end of that process, did you feel like it was an appropriate strategy/action given the data at hand at that time?

Did you think more data would have made a difference or did you think that data was a good representation of Maldivian society at that time?

Do you think that has changed?

Good fit with society. Then? Now? Why?

So overall, would you say that policy was a good fit with the society at the time?

What makes you say that?

Since that policy is still in effect, would you say it is still a good fit with the society today?

What makes you say that?

[RESPONDENT-SPECIFIC QNS: RELIGIOUS LEADERS ONLY]

Which policies come to you? Why? E.g.?

Typically what kinds of policies require the attention of the religious council?

What is the reason behind it?

Can you tell me some examples?

Process? Talk me through it

Can you talk me through the process?

Do they send it in writing or is there a meeting?

Who else will be present?

How does it proceed? I.e., do they present their case or...?

What steps do you take then?

Are you expected to decide on the matter or provide your opinion?

What/who do you consult?

Youth SH? Talk me through it

Were any issues on youth SH brought to your attention?

What was the matter exactly? Was it about services or...?

Can you recall when this was?

Who approached you?

Who else was present?

Can you talk me through the discussions?

What were their arguments?

What were your responses?

What was your decision/opinion?

What did you base that on?

Lessons from other countries? Important? Why?

Were you told or did you consider what other countries do on these types of issues?

Do you think it is important to do so?

Which countries would you derive examples from?

Why?

After the meeting? Approval? Changed? Overturned?

Is your decision approved by someone else?

Who?

Was this the case with youth SH?

Do they come back to appeal?

With any of the cases like this, have there been any instances where you have changed your mind regarding the decision you?

When that has happened, what has tended to be the reason behind it?

Has your decision ever been overturned?

Other instances?

Were there other instances where your counsel has been sought regarding youth health issues?

[Begin GENERAL QNS. But follow this order (1) about whether current policy/regulations are a good fit with situation, (2) For/against providing info; (3) Sex Ed; (4) Acceptable to discuss SH; and then begin Gen Qns from the youth proportion qns]

Appendix G: Site selection for in-depth interviews with youth

Atoll	Filter 1: Safety ¹	Filter 2: Population size			Top 5 among all safe atolls	Region	Selected (top atoll from each region)
		Population ²	% share of total popn.	Population 15-24 years ²			
HA	Green	13,495	4.5	2,807	3	Upper North	
HDh	Red	16,237	5.4	3,458		Upper North	
Sh	Green	11,940	4.0	2,672	5	Upper North	
N	Green	10,015	3.3	2,133		North	
R	Green	14,756	4.9	3,171	2	North	Raa
B	Green	9,578	3.2	2,154		North	
Lh	Green	9,190	3.1	2,140		North	
K	Green	15,441	5.2	4,778	1	North Central ³	Male'
AA	Green	5,776	1.9	1,399		North Central	
ADh	Amber	8,379	2.8	2,182		North Central	
V	Green	1,606	0.5	355		North Central	
M	Green	4,710	1.6	943		Central	
F	Green	3,765	1.3	804		Central	
Dh	Amber	4,967	1.7	1,095		Central	
Th	Red	8,493	2.8	1,805		South Central	
L	Green	11,990	4.0	2,741	4	South Central	Laamu
GA	Amber	8,262	2.8	1,642		Upper South	
GDh	Red	11,013	3.7	2,041		Upper South	
Gn	Green	7,636	2.6	1,653		South	
S	Red	18,026	6.0	3,626		South	

¹ Assessed based on knowledge of political unrest & ability to ensure personal safety. Key to colour code: Red= unsafe, rule out; Amber= Depends on island; Green=safe

² Source: Census 2006 Analysis report

³ Kaafu Atoll (K) was not selected because it is the atoll in which Male', the capital city and the third field site, is situated.

Appendix H: Youth in-depth interview guide

Notes after field site 1: Laamu

Comments in RED. Have identified questions that didn't work. And those that did, have said whether they were 'ok', 'good', or 'great' (ever the scientist).

INTRODUCTION

1. Thank you

Thank you for agreeing to meet with me today.

2. Introduce myself

As I mentioned before, I am a PhD student at the London School of Economics in the UK, and this interview is part of my research. Just to tell you about my research [Insert text]

3. Purpose of interview [Insert text]

4. Confidentiality

[Insert text]

5. Duration

This interview should take about 1 hour

6. Audio recording

I'd like to tape this session because...[insert text]. Encountered 2 people who were put off by the fact that I would record it. I told them it would be really difficult for me to write their answers and said that in case, I cannot interview them. One of them came back later, and said that she was ok about it now :S

Not sure if it's good practice but after seeing an R hesitate, I offered to let them use a different name during the interview. They signed their real name etc. in the consent form.

7. Invite questions

Before we begin, is there anything you would like to ask? Have been forgetting this step

8. Signature of consent

Are you willing to participate in this interview? [obtain signature] [PRESS RECORD]

INTERVIEW

CLOSING

1. Additional comments?

Is there anything else you would like to add? Some of the more reserved R's have been really forthcoming with this question!

2. Next steps

I'll be analysing the information you and others gave me and will be reporting it in my PhD thesis. I'll be happy to send you a report of my findings if you are interested. This may take some time as my research involves collecting other kinds of information as well.

3. Thank you

Once again, thank you very much for your time [stop recording]

Objectives for IDIs (from RQs)

1. Examine youth attitudes towards SRH
2. Is it socially unacceptable in Maldives to discuss sexual activity before marriage?
3. Is it socially unacceptable in Maldives to be sexually active before marriage?
4. Is it socially unacceptable in Maldives to seek sexual health services before marriage?
5. Examine perceptions regarding SRH problems in Maldives
6. Examine attitudes towards provision of SRH services to unmarried youth
7. Explore legal and religious influence on young people's experience relating to SRH
8. Explore socio-cultural influence on young people's experience relating to SRH

INSERTED → First of all, can you tell me a little bit about yourself. [used this bit to get on record their age, marital status, education level- info I would need later on. Also asked where they grew up, and other details that put them at ease.]

what comes to mind when I mention Reproductive health and sexual health. Can you guess what the difference between them is? [not sure why I'm asking, since very few were able to give an answer, but nonetheless, answers I did get were interesting..]

[2. Is it socially unacceptable in Maldives to discuss sexual activity before marriage?]

Sensitive to discuss?

There have been a few studies focusing on young people, and a recent survey asks young people about their sexual health. EDIT → There have been very few studies focusing on youth sexual health in Maldives, and the reason for that is said to be that people would not think its ok to talk about this.

Do you think its generally ok to talk about sexual health issues, like contraception and sexual activity? ok

Do you talk about it with your friends? Family? ok

DO you think it makes a difference if you're not married? ok

Would it be fairly normal/typical for one of your friends, a girl/guy your age, to talk to you about having sex? ok

[1. Examine youth attitudes towards SRH]

For/against providing information

Some people argue there needs to be more awareness about sexual health (ie, contraception, STIs, safe sex) on tv, radio and magazines. But others say if you give information about it, it would be the same as encouraging youth to have premarital sex. What do you think? Good. At first I had some trouble phrasing it in Dhivehi- a few times I would've sounded like I was clearly the side that wanted to promote awareness. I quickly caught it and changed the phrasing.

Why? good

What do you think is the main difference between these two groups of people? This question did not work at all. It can't be because of the way I phrase it in Dhivehi, because it doesn't work in English either. They don't understand what I'm asking and I end up having to probe so much that I suggest something and they just say yes,

Is Sex Ed ok? At what age? Do you think they do already?

INSERT → In some countries, SRH is taught in school.

Do you think they teach it in school here? The way I first phrased it made it sound like I was a very poorly-prepared researcher and I was looking to the R to give me the answer to this qn

Do you think they should? good

At what age do you think its alright for youth and adolescents to be taught about SRH in school? good

Why do you say this? good

What if: consequences. Social? Legal? Other?

What if a friend of yours, the same age as you, came to you to talk about having sex. EDIT → Say ~~it was the first time that friend had sex,~~ and she was very worried that her family might find out. For this qn, I am always first asking about a hypothetical friend who is a girl. I found that this was easily implied while interviewing female R's but when it came to male R's it caused a bit of a confusion, so there was a bit of stumbling in the earlier interviews.

Do you think there's a reason to be worried? good

What do you think will happen if the family finds out? good

INSERT → probe: what is the worst thing that will happen to her?

Get kicked out?

What about other people in the community? Great! I got the feeling that consequences of community finding out were very different from when the family finds out. I'm thinking of asking them to compare, and say which would be worse, and why.

What if your friend was a guy, does it make a difference? Great! The answer to this is a resounding 'yes!' but when I ask why, they are not able to articulate why. They vaguely say something along the lines of 'that's how it's always been'.

INSERT → As you know, under the current law premarital sex is a punishable offence. Have there been instances where people have been reported by other people? Arrests?

Is it something that would worry youth, like that hypothetical friend we just talked about?

I'd like to insert something that would get them to compare these different consequences. Pro: it will get them talking a bit more about it, really get into the hypothetical scenario. Con: this looks like the sort of thing I should look into, during analysis. Is it stupid to ask R's this? I wonder if I'll be told to go ask the R's for my research questions too, while I'm at it.

Perception: age at first sex?

What do you think is the age most people have sex? Great!

Think of people in this community great

What about those in Male'? good

In resorts? This question did NOT work at all! Most people are not able to speculate. And the way I find myself phrasing it is "...Think of youth who work in resorts, and those who might have grown up there... *bright spark* of course, they don't allow under 18's to work in resorts anymore.. so..." The only reason I'm asking this is to find out differences if people grew up away from family. Why can't I ask them that? Whether it makes a difference?

Why is there a difference? Good

INSERT somewhere. Shouldn't be hard, since 'family' is mentioned in some answers → Growing up away from parents- do you think it makes a difference?

[3. Is it socially unacceptable in Maldives to be sexually active before marriage?]

How common? Trends

Do you think its fairly common for people your age to have sex before marriage? Great! I LOVE this question. But EDIT → Thinking of people your age, do you think most would have had sex even though they are not married?

What proportion? [the proportion question is not as complicated when pitched in Dhivehi, and most were stating a percentage before I even asked]

Do you think this is a recent trend? Great!

Why do you think this has changed? good

What about people you age living in Male'?

Profile

REMOVE → Do you think its mostly people your age who have sex outside of marriage, or do you think older people do that as well? Could not recall why I was asking this question so I dropped it

Why do you think this is the case?

Do you think there's a difference between young men and women? ok

Why do you think this is the case? ok

Do you think there's more or less in male'? good

Why do you think this is the case? good

EDIT → You mentioned that about xx% would have had sex before getting married. Now thinking of the remaining xx%, why do you think they wait? What do you think is the difference between people who have sex before marriage and those people who don't? Great! This qn works very well

Acceptable?

Do you think its generally accepted these days that people are having sex before marriage? Good but Dhivehi phrasing needs some work. I used the equivalent of 'acceptable' but I kept getting answers like "noo.. not THAT, but still.." so I'm looking for a word equivalent to 'less than acceptable'. On a hunch, I said to an R "So not acceptable but..." which got them talking a bit more, so I think I'll leave this question like that

Is it accepted here, in your community? good

Has it always been like that? Why do you there's been a change?

INSERT → What about in Male'?

INSERT → Does it make a difference if two people are in a relationship, though not married? [Think this question will work interestingly]

[4. Is it socially unacceptable in Maldives to seek sexual health services before marriage?]

What if: STD

Do you know about STDs? Great. Great because they answer readily, even though its almost always '..um.. a little'. Its so very alarming, how little they know, and how little importance they give it. Would you believe that one R asked "like cancer, right?" and I nearly fainted. I thought about taking some leaflets on STDs to give to R but that will be a dead giveaway to R's family and friends re R's participation in a

study, the topic of the study, and wonder why the interviewer thought a leaflet on STDs would be useful to the R.

What if your friend came to you for advice, and was worried that she might have caught an STD?

What would you advise? *ok*

What can she do? *Repetitive?*

Where can you go for medical help? *ok*

Even if your friend was unmarried? *ok*

What if: pregnant

What if a friend of yours, an unmarried girl your age, got pregnant.

What would you advise? *Great!*

What can she do? *Great!*

Where can you go for medical help? *Great!*

[5. Examine perceptions regarding SRH problems in Maldives]

Have you heard of other people having this kind of problem? *Great! This invitation to sort of gossip seemed to put most ppl at ease, so I brought this in early sometimes. This wasn't just for rapport; it was interesting to see that each R was able to say at least 3 people they knew of. Indicates how big news it is, in a small community? Or how common it is?*

What do they usually do? *Great!*

Have you heard of girls who have had sex outside of marriage and have become pregnant? *Great!*

Mention abortion as see fit.

VERY tempted to ask which they think is a worse consequence- getting pregnant or getting an STD.

[6. Examine attitudes towards provision of SRH services to unmarried youth]

For/against providing services to unmarried? Why?

Some people argue that there needs to be SRH services for unmarried youth whereas other people say this would mean premarital sex is being condoned. What do you think? *Great!*

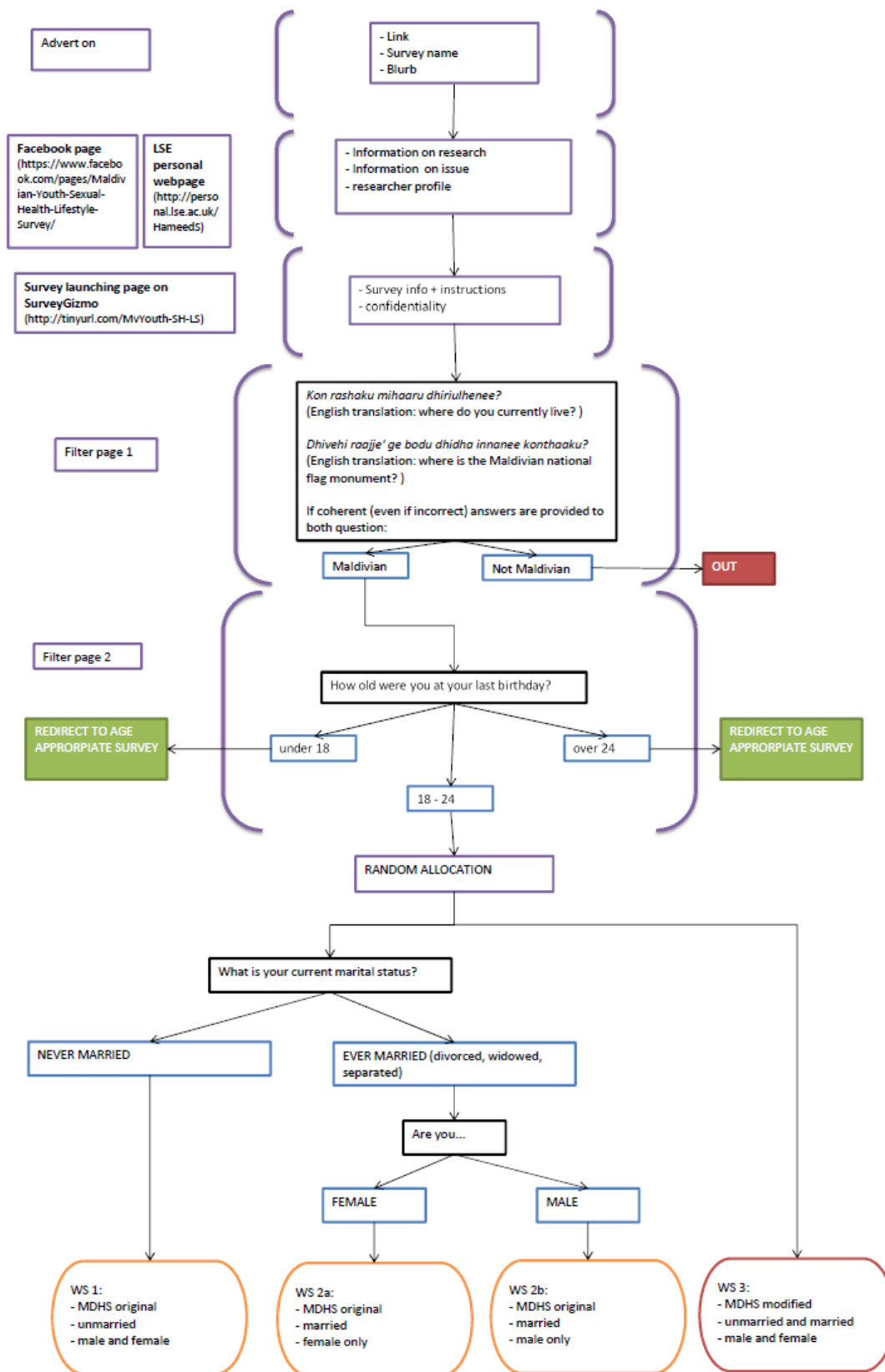
Why? *Great!*

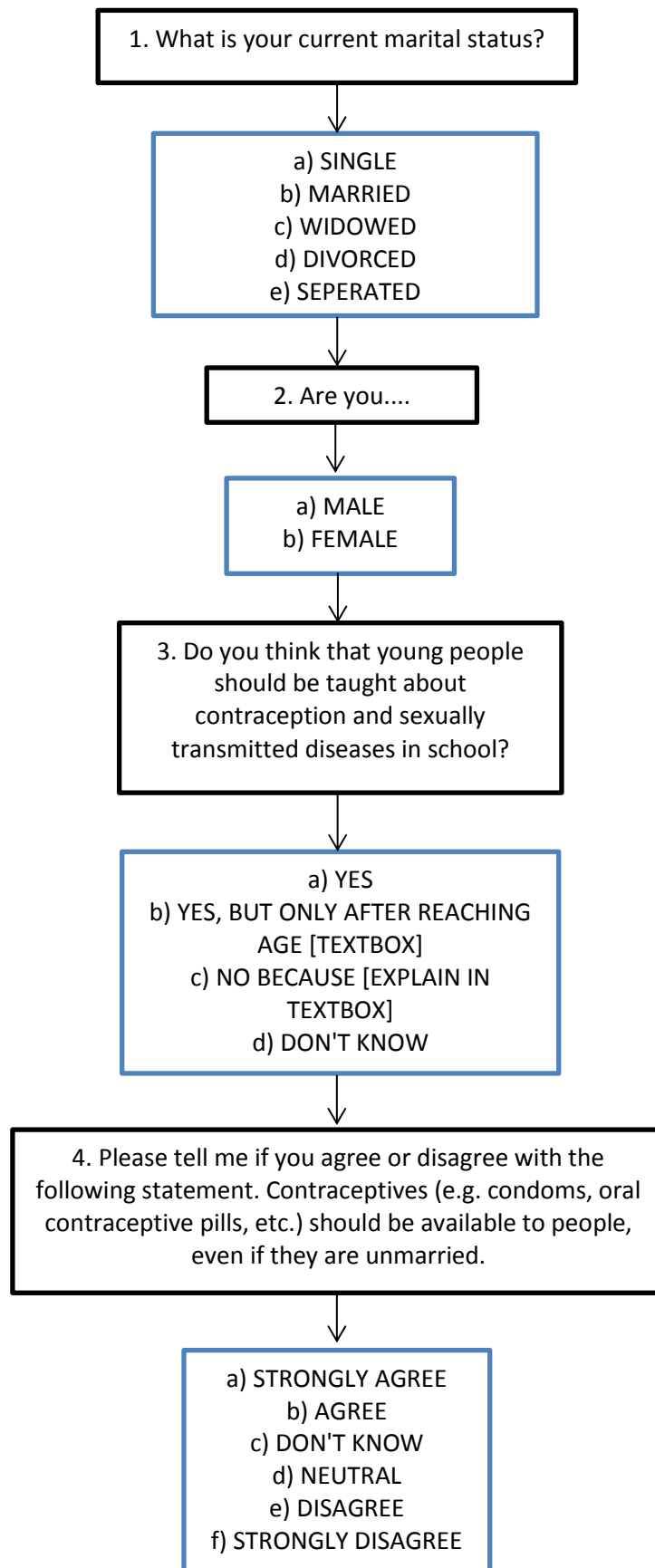
What do you think is the main difference between these two groups of people? *Again, didn't work. I think it's all to do with my phrasing. Will work on this*

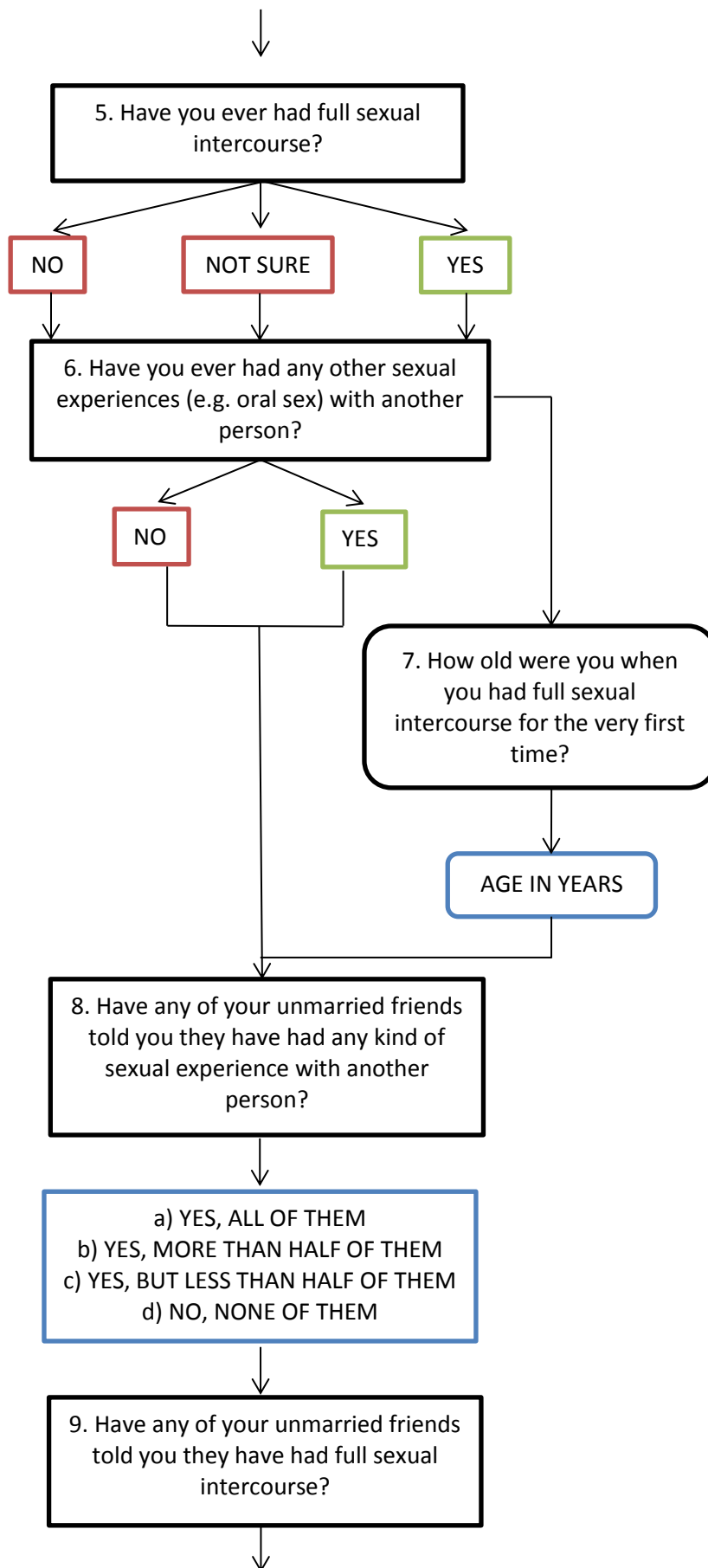
[7. Explore legal and religious influence on young people's experience relating to SRH]

[8. Explore socio-cultural influence on young people's experience relating to SRH]

Appendix J: Web survey instrument



WS 3: MDHS modified questionnaire (others available on request)



- a) YES, ALL OF THEM
- b) YES, MORE THAN HALF OF THEM
- c) YES, BUT LESS THAN HALF OF THEM
- d) NO, NONE OF THEM

10. Do you agree or disagree with the following statement: It is becoming more common in the Maldives for couples to have full sexual intercourse even before marriage

- a) STRONGLY AGREE
- b) AGREE
- c) DON'T KNOW
- d) DISAGREE
- e) STRONGLY DISAGREE

11. If a woman has an unwanted pregnancy, what do you think she should do?

- a) HAVE THE BABY AND KEEP IT
- b) HAVE THE BABY AND GIVE IT AWAY
- c) HAVE AN ABORTION
- d) UP TO HER
- e) DON'T KNOW

12. If someone you know in the Maldives wanted to get an abortion, where can they go? SELECT ALL THAT APPLY

- ANY ISLAND
- CERTAIN ISLANDS
- MALE'
- ONLY OUTSIDE OF MALDIVES

FROM WHICH OF THESE LOCATIONS?
- ANY ISLAND
- CERTAIN ISLANDS
- MALE'
- ONLY OUTSIDE OF MALDIVES

FROM WHICH OF THESE SOURCES?
- HOSPITAL OR HEALTH CENTRE
- CLINIC
- PHARMACY
- FROM ANY RELATIVE OR FRIEND
- FROM MARRIED RELATIVES OR FRIENDS
- DON'T KNOW
- OTHER (EXPLAIN IN TEXTBOX)

↓

14. Do you know of any diseases or infections that can be passed on through sexual activity? Name as many as you can in the box. Don't worry about getting the spelling right. If you don't know, just write 'don't know' in the box

↓

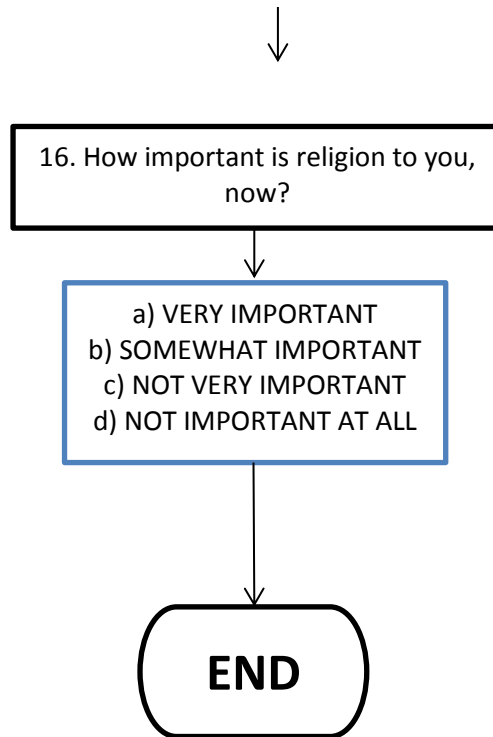
[TEXTBOX]

↓

15. If a person in Maldives had a disease or infection transmitted through sexual activity, where can they go? Please select either yes, no, or don't know for each one.

↓

a) IGMH
b) ADK
c) REGIONAL / ATOLL HOSPITAL ON AN ISLAND
d) HEALTH CENTRE /HEALTH POST ON AN ISLAND
e) CLINIC IN MALE'
f) CLINIC ON AN ISLAND
g) HEALTH SERVICE OR DOCTOR ABROAD (OUT OF MALDIVES)



Appendix K: Web survey information provided to prospective respondents

(Short introduction on Facebook Page and web page)

If you're a Maldivian who is over 15 years old, please check it out. Click here for the survey: <http://tinyurl.com/MvYouth-SH-LS>

There will be about 10-15 questions and I swear it will not take you more than 5 minutes to finish it. You might want to do the survey when you're by yourself because some questions would be about your personal experiences and opinions, and I want you to feel comfortable in expressing them. Here is an example:

Please tell me if you agree or disagree with the following. It is becoming more common in the Maldives for couples to initiate sexual intercourse before marriage.

Agree

Disagree

PS: Check out the tabs on your left for more information about the research, the researcher, and about the survey.

About the issue: youth SH in the Maldives (on Facebook Page and web page)

Reproductive health involves family planning, getting pregnant, maternal health care, and child care. Sexual health involved contraception (like condoms), not getting pregnant, sexually transmitted diseases (STDs), abortion and abuse. (Even though the last one is of the most important issues, I don't think I'm currently equipped to handle it, so I don't go into it that much in this research).

The issue here is, young people are sexually active but they don't know a lot about being safe. They don't know a lot about what can happen to them if they have unsafe sex. And lastly, they don't know a lot about what they can do when something happens. Don't you think that's dangerous? I do.

What makes it even more dangerous is that there is very little information about this in Maldives. So some people think youth know what they should and shouldn't do. Some think youth have the information. Some think youth know where to get the information and help.

It's when you look at this issue from both sides that you realise that there is a need for information, so I'm trying to provide some of it so that policymakers and service providers can help youth better, and youth can help themselves better. One of the main reasons why there hasn't been a lot of research on this issue is because, as you can imagine, it is a sensitive topic because of our religion. However, I believe there are ways to address youth sexual health and still respect and adhere to our religion, because Maldives is not the first country to be faced with this kind of situation.

About the research (on Facebook Page and web page)

This is a PhD research exploring the sexual health of young people in Maldives.

The largest part of the research involved in-depth one-on-one discussions with youth from various backgrounds. I spoke to them about their attitudes regarding the current

sexual health situation of Maldivian youth, their perceptions of how other youth like them are experiencing related issues, and their opinions about what they would like to see happen regarding sexual health education, awareness programmes, and services in Maldives.

Next, I interviewed policymakers, service providers, NGOs, and other stakeholders because one needs to examine both sides of a situation. They told me about the current policies and strategies, what has worked, what they have tried to make work, and the challenges they face.

Thirdly, I examined data from the first Demographic Health Survey (DHS) of Maldives because it is the first time a standardised survey (it is a very big deal among population studies researchers) was conducted across the entire Maldives, and asked young people (even unmarried ones) key questions about their sexual health and lifestyles.

The fourth part is this web-based survey. My discussions with youth were conducted in three places (Laamu atoll, Raa atoll, Male') because of time and funding limitations. Also, studies like Maldives DHS are conducted according a sampling technique that selects a certain number of people. So the numbers are limited, right? Most of you would not have encountered either research. I want to do this web survey now to open it up to more Maldivian youth- I learnt from my fieldwork that you guys are a passionate and intelligent group who care about what happens to your fellow youth.

When I finish collecting and analysing all this data, I'll be more than happy to share it with you. If you are particularly interested, do email me and I'll keep in touch. But I have to warn you, I won't be able to share any findings until early next year because it's going to take me a while to do this!

About the researcher (on Facebook Page and web page)

Yes it's important that you know who is doing this research. My name is Shaffa Hameed, 27 years old, female. Born and raised in Male', Maldives. I've been very lucky to get chances for higher education. As soon as I finished my O levels at Aminiya, I was able to go abroad for my undergraduate degree. Then I got back and worked at NNCB for a little while, and helped out with the tsunami psychosocial support volunteer work. Then I got accepted into a Masters programme so I went and did that for one year. After finishing that, I got back to Male' and worked at the Ministry of Gender and Family. I then got accepted into this PhD course so I returned to studies.

If you want to see a more official kind of summary about my research and educational background, click on this link that is part of the university I'm studying at now- the London School of Economics and Political Science. Do have a look if you want to make sure this is for real :)

If you're interested in knowing more about the research, do drop me an email or a Facebook message. However, I can't really tell you results yet because I haven't got all of the data yet. I should point out that I wouldn't know if you do take part in this

study because everything is collected anonymously (i.e., there're no names or anything that can identify you).

Confidentiality (on Facebook Page and web page)

This is the most important part. Here is the down low:

Every bit of information you provide will be confidential. It will be visible and accessible to me and only me.

You will not be asked your name or email address or anything that can identify you. You will be anonymous. So even if I see the answers you give, I won't know who you are.

My survey tool has a built-in feature where it will block you if you try to take the survey more than once. This is to prevent fake responses. This still does not show me who you are, so you are still anonymous to me.

The information you provide will be used for this PhD research only.

There are no known risks for participating in this study- no one will know if you participated unless you tell them, and no one will know what answers you gave.

You are free to participate in this survey, and you are free to refuse to take the survey and just shrug, say 'whatever', and walk away. No hard feelings.

Thank you (on Facebook Page and web page)

Thank you so much for taking the time to do this survey. You have definitely made a contribution to this research through which I will endeavour to make a contribution to the sexual health situation of Maldivian youth.

Hopefully, this has highlighted some important health issues you or your friends might face. You can find a lot of useful links at this Facebook Page or <http://personal.lse.ac.uk/HameedS>. You can also leave feedback here and find updates on this research, so make sure you drop in from time to time!

Appendix L: Web Survey and Facebook Page screenshots

This screenshot of my web-based survey entitled Maldivian Youth Sexual Health and Lifestyle Survey on [Survey Gizmo](#) has been removed for copyright reasons.

This screenshot of the [Facebook Page](#) for my web-based survey entitled Maldivian Youth Sexual Health and Lifestyle Survey has been removed for copyright reasons.

Appendix M: Ethical considerations

Guidelines: The proposed research will adhere to guidelines and best practice outlined by the Social Research Association (also under the RESPECT Project). These include ensuring: the appropriate research methods are chosen; the research process does not involve unwarranted material gain or loss to researchers or participants; factual accuracy and avoid suppression or misinterpretation of data; reflection on consequence of research engagement for participants; data reporting and dissemination is carried out responsibly. Additionally, the candidate has received training on implementation, reporting, and research ethics of surveys and will endeavour to receive further training.

Participants: the research does not involve vulnerable groups. Participants are research are officials from the policymaking and service providing organisations (for key informant interviews) and young people aged 18-24 years (for the in-depth interviews). The survey participants are delimited by age- the lower boundary (18 years) marks the end of the legal definition of children, after which the individuals are legally recognised as being able to give informed consent.

Queries or problems: The researcher will be present in all data collection settings and will be prepared to respond to queries and problems or direct to possible answer sources if unresolved, at any point during the course of the study. E.g., direct respondents to helplines and advice centres, if asked.

Treatment of data: removing identifying factors from the questionnaire; restricting access to data collection and processing equipment

Potential participants: Potential participants will be informed that they will not benefit directly by participating but that indirect benefits are possible should the research findings influence policy or level of service provision. Moreover, it will be made clear to potential participants that they can refuse participation without reasons and withdraw (themselves and the data just supplied) from the study at any point with no adverse effects. Potential participants will be asked to give informed consent

by signing and dating the consent form, also confirming that they have received and read the information about the study.

Information about the research (written and oral. See Appendix H for written sheet): Prepared in an appropriate form and language for potential participants and it will be provided to each participant to obtain informed consent before commencing the interview.