

RESEARCH BRIEF

Universal Access to Sexual and Reproductive Health and Rights: Gaps in Policies in the Maldives

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Universal access to sexual and reproductive health and rights (SRHR) is among the global targets of the Sustainable Development Goals (SDG), reflected mostly under the goals for health and gender equality (<https://sustainabledevelopment.un.org/>). Prior to this, it was reflected in the Millennium Development Goals (MDG), specifically under the goal to improve maternal health (United Nations, 2000).

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| Box 1: Universal access to SRHR reflected in SDG and MDG goals |
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MDG 5: Improve Maternal Health

Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

Target 5.B: Achieve, by 2015, universal access to reproductive health

SDG

Target 3.7: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

Target 5.6: Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the ICPD and the Beijing Platform for Action and the outcome documents of their review conferences.

The original phrasing of MDG5 mentions reproductive health only, with sexual health being added for the SDG goal statement. In fact, universal access to even just reproductive health was not included among the MDGs at first (United Nations, 2001), and was not added as 5B until the World Summit in 2005 (United Nations, 2005). This was duly recognized as a mistake but the fact that universal access to SRHR was left out despite the global agreement in the historic 1994 International Conference on Population and Development in Cairo (United Nations Population Fund, 1994)—while HIV/AIDS, an obvious component of SRHR, was highlighted in one MDG—was heavily criticized (Glasier, Gülmezoglu, Schmid, Moreno, & Van Look, 2006). This is often attributed to lack of political commitment because it highlights “the more uncomfortable parts of sexual and reproductive health- i.e. sexual intercourse that is not for procreation and not only within marriage” (Glasier et al., 2006, p. 4). The Maldives is one prime

example—these “uncomfortable” aspects of sexual and reproductive health, such as sexual health of unmarried youth and adolescents, continue to be understated and under-researched (Hameed, 2012). In contrast, basic family planning services for married couples are widely available, maternal mortality reduced drastically, and strong HIV prevention and awareness programmes established (Ministry of Health, 2006, 2011, 2014, 2016b).

Another criticism of the MDGs was how its national-level implementation led to gaps in quality, accountability, and equality (Sen, 2014), all of which are arguable concerns in the Maldives. In addition to having a population of about 350,000 people across 188 islands (National Bureau of Statistics, 2014), the Maldivian SRHR policy and service context suffer tremendous religious and sociocultural influences (Hameed, 2012). With these many factors potentially impeding the country’s progress in the SDGs, it is imperative to examine policies and legislature for gaps and facilitators. This study is one such effort to analyze Maldivian SRHR policies and legislature to identify gaps and barriers to achieving universal access to SRHR in the country.

Methods

This study is primarily a desk-based review and analysis of policies and legislature related to sexual and reproductive health and rights issues in the Maldives. “Legislature” is used throughout the paper to refer to legally enforced and enforceable Acts, Bills, regulations made under the Acts, as well as the Constitution. “Policies” refer to government documents that provide a policy statement, stance, or guidance—this includes policies, master plans, plans, strategies, guidelines, and standards. Additionally, feedback was obtained through five individual interviews and roundtable discussion of draft findings among 27 relevant stakeholders (including individuals and organizations) in the field of SRHR in the Maldives. This information served to strengthen relevance and to ensure that the list of policies and legislature reviewed was a

comprehensive one (See Appendix for full list).

An important demarcation is that this analysis is of documentation—it is beyond the scope of this study to explore how well the policies are implemented, and it does not update, corroborate, or question any data on SRHR trends (for this, see Hameed, 2012, 2018).

Assessing Universal Access to SRHR

A 2008 World Health Organization (WHO) and UNFPA technical discussion on conceptual and practical considerations of achieving universal access to SRHR put forth a suggested definition of universal access to SRHR, which will be used for this study:

Box 2: Definition of universal access to SRHR (WHO, 2008, p.42)

The equal ability of all persons according to their need to receive appropriate information, screening, treatment and care in a timely manner, across the reproductive life course, that will ensure their capacity, regardless of age, sex, social class, place of living or ethnicity to decide freely how many and when to have children and to delay or to prevent pregnancy; conceive, deliver safely, and raise healthy children, and manage problems of infertility; prevent, treat and manage reproductive tract infections and sexually transmitted infections including HIV/AIDS, and other reproductive tract morbidities, such as cancer; and enjoy a healthy, safe and satisfying sexual relationship which contributes to the enhancement of life and personal relations.

The most widely used method of tracking the progress of MDG5b and SDG3 are provided in Table 1, alongside figures at the global, regional, and country level for the Maldives.

Table 1
Global Indicators for Tracking the Progress of Related MDGs and SDGs, With Figures at Global, Regional, and Country Level for the Maldives

| Indicator | Global | Regional¹ | Maldives |
|---|---------------|-----------------------------|-----------------|
| Contraceptive prevalence rate (women aged 15-49, married or in a union (%)) | 63.6 (2015) | 68.5 (2015) | 34.7 (2009) |
| Unmet need for family planning rate (women aged 15-49, married or in a union (%)) | 11.9 (2015) | 9.9 (2015) | 28.6 (2009) |

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|--|-------------|-------------|-------------|
| Proportion of demand for contraception satisfied (PDS) (women aged 15-49, married or in a union (%)) | 84.2 (2015) | 87.4 | No data |
| <u>3.7.1</u> Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods | 77.4 (2018) | 71.7 (2018) | 42.7 (2009) |
| <u>3.7.2</u> Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group | 43.9 (2018) | 32.1 (2018) | 12.9 (2014) |
| <u>5.6.1</u> Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care | 53.4 (2013) | 47.7 (2013) | No data |

¹ Asia and the Pacific for MDG indicators; Southern Asia for SDG indicators

Sources: <https://sustainabledevelopment.un.org/>; <http://mdgs.un.org/unsd/mdg/Data.aspx>

The global indicators themselves reveal little about the policy conditions that would facilitate or hinder this progress. Although there were suggestions and guidance in different documents on different thematic areas of SRHR, an all-encompassing framework for such a policy assessment could not be found. Therefore, a conceptual framework was derived from the policy-relevant indicators from the WHO/UNFPA technical consultations (Table 2), combining guidance from international authorities on SRHR.

Table 2

Indicators Measured by Policy Review to Monitor the Achievement of Universal Access to SRHR (WHO, 2008, pp. 13–14)

| <i>Sexual and reproductive health area</i> | <i>Indicator</i> | <i>Type of measure</i> |
|---|--|------------------------|
| General | National sexual and reproductive health policy (or strategy) | Yes/No |
| Family planning | Multi-year plan for procurement of each family planning product | Yes/No |
| STI/RTI/ reproductive morbidities | Policy on cervical cancer screening | Yes/No |
| | Policy on STI control | Yes/No |
| Sexual health | Law prohibits discrimination on the basis of gender identity, sexual orientation or physical and intellectual disability | Yes/No |
| | Law prohibits marriage for both men and women prior to age 18 | Yes/No |
| | Law requires full and free consent of the parties to a marriage | Yes/No |
| Sexual violence | Law prohibits sexual violence | Yes/No |
| | Law prohibits marital rape | Yes/No |
| | Strategy/plan to prevent and respond to sexual violence, including marital rape | Yes/No |
| Harmful practices | Law prohibits all forms of female genital mutilation (FGM) | Yes/No/NA |
| | Strategy/plan for abandonment of FGM (according to local need, informed by local research on cultural practices) | Yes/No/NA |
| | Existence of medical regulations against the practice of FGM | Yes/No/NA |
| Adolescent¹ sexual health | School-based sexuality education is mandatory | Yes/No |

¹ “WHO definition of adolescent (aged 10–19 years) applies. However, for certain sexual and reproductive health indicators for adolescents, usual data sources allow for obtaining data only for the age group 15–19 years; inclusion of the 10–14 age group depends on the contextual practices and decisions” (WHO, 2011, p.14)

The conceptual framework was derived from WHO’s (2008) suggested definition of universal access to SRHR (Box 2), the national-level policy-based indicators recommended by the WHO/UNFPA technical consultations (Table 2) and the policy conditions outlined in the WHO (2011) report on accelerating achievement of universal access to SRHR (Box 3).

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| Box 3: Policies as accelerators towards universal access to SRHR (WHO, 2011, p.10) |
| <p>Policies can act as accelerators towards achieving MDG Target 5B if they:</p> <ul style="list-style-type: none"> • Ensure the security and commodity of contraceptives and expand choices by: <ul style="list-style-type: none"> ○ Streamlining the process of registration and prequalifications for new methods (including emergency contraception); ○ Facilitating training for health providers; |

- Introducing regulation for tubal ligation, vasectomy and other long-term methods.
- Foster adolescent sexual health by:
 - Providing access to information on contraceptives;
 - Promoting use of condoms for dual protection.
- Prevent unsafe abortions by:
 - Harmonizing with human rights commitments;
 - Maximizing access to care the extent possible under local laws;
 - Engaging the private sector.
- Manage sexually transmitted infection services and structure by:
 - Encouraging the use of generic drugs to lower cost or providing free treatment;
 - Including prevention of sexually transmitted infections and management interventions within the minimal package of actions related to Target 5B (as a human right);
 - Promoting condoms for dual protection.

Results

Results of the policy analysis are organized into six thematic areas based on the ICPD Programme of Action and the WHO Global Reproductive Health Strategy (UNFPA, 1994; WHO, 2004), assessing whether Maldivian policies and legislature facilitate or restrict each of these:

1. Family planning
2. Maternal and newborn health
3. Unsafe abortions
4. RTIs, STIs, and other reproductive morbidities
5. Sexual health (including adolescent sexuality)
6. Harmful practices

The analysis highlights the gaps and recommendations for each of these priority areas across the four dimensions in the WHO definition of universal access to SRHR (WHO, 2008, p.42):

- a. that all persons have equal ability to access these services, based on need
- b. that the information, screening, treatment, and care are appropriate
- c. that they can access these services in a timely manner
- d. that they can access these services regardless of age, sex, social class, place of living, or ethnicity

Family Planning

WHO's suggested definition of universal access to SRHR states that all persons should be able to "decide freely how many and when to have children and to delay or to prevent pregnancy" (WHO, 2008, p.41), which includes family planning counselling, information, education, communication, and services. In the Maldives, an Islamic country, family planning is exclusive to married people, as child-bearing outside of marriage has legal, religious (*Constitution of the Republic of Maldives*, 2008), and sociocultural repercussions (Hameed, 2012).

Family planning (FP) has commanded much of policy and programmatic attention given to SRHR in the Maldives. Historically, concerns regarding fertility control and related impact on maternal and infant mortality led to the Child-Spacing Programme in the 1980s, led by the Government and supported by the WHO and UNFPA (Fulhu, 2014; Hameed, 2012; WHO Regional Office for South East Asia, 1988). This was faced with some public resistance as it was felt to be "un-Islamic" and religious leaders accompanying outreach efforts served to legitimize it (Hameed, 2012). During the 90s, the Government also provided incentives for population control—the "Population Shield" that was awarded to the islands that successfully curbed population growth (Fulhu, 2014). An opposing effect may have been indirectly incentivized by population-based service provision where an island's population size is among the factors considered for determining levels of health services (Ministry of Health, 2014) and schools to be

made available on an island. Although these may be longer-term demographic changes, the impact of these indirect factors and policy incentives from the recent past have the potential to affect service delivery and attitudes towards family planning.

The analysis revealed two policy barriers and two opportunities related to universal access to family planning services in the Maldives.

The first issue is generally applicable to all six thematic areas of SRHR in this review, but the gap is more evident in family planning where policies are more comprehensive than other areas. It is unclear whether family planning services are accessible to the migrant non-Maldivian residents throughout the country. The 2014 Census, the first time foreign migrants were counted, indicated that 63,637 migrants resided in the Maldives, and this is widely agreed to be an undercount (National Bureau of Statistics, 2014). The outgoing Health Master Plan 2006–2015 as well as the National Reproductive Health (RH) Strategy 2014–2018 both contradictorily state that the “Government of Maldives recognizes health as a *human* right and is committed to ensure access to primary health care to all *citizens* in an equitable manner at an affordable price” [emphasis added] (Ministry of Health, 2006, p. 9; 2014, p. 15) and includes gender and socioeconomic status as the only grounds for non-discrimination (Ministry of Health, 2006). The Health Services Act is similarly confusing in that it stipulates access to health services for citizens but later deem that no discrimination should take place based on factors including race or nationality (*Health Services Act 29/2015*, 2015). It is disconcerting that the only current policy on reproductive health, the National RH Strategy 2014–2018, makes no mention of migrant health or family planning needs (Ministry of Health, 2014).

The Health Master Plan 2016–2025 rectifies things somewhat by including foreign migrants among the vulnerable groups whose health concerns are critical to address (Ministry of

Health, 2014). The National Standards for Family Planning 2005 states that all clients have a right to receive FP services, regardless of factors that include ethnic origin (Ministry of Health, 2005). Despite this, as the new Master Plan acknowledges, the social health insurance scheme *Aasandha* does not cover migrants, making affordability another potential barrier to their access to FP services (Ministry of Health, 2014).

The second policy barrier to universal access to family planning relates to the mandatory conditions for providing male and female sterilizations as a permanent method of contraception. The National FP Standards stipulate that it is mandatory to obtain informed written consent of the patient as well as the spouse (Ministry of Health, 2005). While it is imperative to regulate this (WHO, 2011), especially considering that the most common form of modern contraception for women was sterilization (Maldives Demographic and Health Survey shows 10% of ever-married women, compared to 1% of ever-married men choosing male sterilization; (Ministry of Health and Family & ICF Macro, 2010), the mandatory spousal consent impinges on the person's autonomy and rights. According to international human rights standards, "legal provisions requiring the husband's consent for a woman to undergo sterilization [is] a violation to woman's right to privacy" (Office of the United Nations High Commissioner for Human Rights, 2016b, p. 2). It is worth noting that none of the other contraceptive methods require spousal content (Ministry of Health, 2005). However, the word "couple" is used throughout the FP Standards (Ministry of Health, 2005), indicating potential infringement on the individual's right to choose family planning.

Maternal and Newborn Health

Universal access to SRHR requires that all persons should be able to "conceive, deliver safely, and raise healthy children, and manage problems of infertility" (WHO, 2008, p. 41), thereby necessitating access to education and services for prenatal care, safe delivery, and

postnatal care, as well as prevention and appropriate treatment of infertility.

This is another aspect of SRHR where the Maldives has excelled—reports highlight the stunning drop in maternal mortality rate, identifying the 90% drop during the last 25 years as the biggest drop in the world (UNFPA, 2016, 12 October). The infant mortality rate (8 per 1000 live births) and under 5 years old mortality rate (10 per 1000 live births) are also maintained low, although neonatal death rates are challenging to lower without more specialized services (Ministry of Health, 2016b).

The analysis revealed one policy barrier and two warning signs. The policy barrier is the treatment of nonmarital pregnancies and how they do not satisfy the dimension of universal access by providing access regardless of age, sex, social class, place of living, or ethnicity (WHO, 2008). In addition to being a legal offense, the social repercussions of such pregnancies lead many unmarried people to terminate their pregnancies, usually in unsafe ways (Hameed, 2012; Thalagala, 2008; UNFPA Maldives, 2011). Unmarried pregnant women who do carry to term risk being reported throughout their pregnancy, but in cases they are not, policy gaps make them vulnerable to this at time of delivery.

Although there is no enforced policy obliging service providers to report nonmarital pregnancies (and subsequently many health professionals do not, as an internal understanding) (Hameed, 2012), vital registration procedures at birth highlight absence of father's name. The Health Services Act protects medical records but allowances are made for authorized persons or particular purposes (*Health Services Act 29/2015*, 2015)—this could potentially lead to identification in small island communities where nonmarital pregnancies are few.

The National Standards for Adolescent and Youth Friendly Health Services (AYFHS) describes strategies to tackle various health outcomes, one of which is “Unwanted Pregnancy”

(Health Protection Agency, 2013). While it states clinical services such as antenatal care and postnatal care that are on par with typical maternal and newborn health (MNH) services are to be offered (Health Protection Agency, 2013), some support services may breach the unmarried woman's rights. This includes home visits which could potentially violate the user's right to confidentiality and privacy; and premarital counseling (Health Protection Agency, 2013) which assumes their only way forward is to enter marriage, thereby pressuring their right to choose and consent to marriage.

The first of the warning signs is on the dimension of ensuring access to services regardless of place of living (WHO, 2011). Given that 54% of all deliveries take place in Male, despite the presence of six regional hospitals and 13 atoll hospitals, the policy and programmatic drive is to encourage utilization of these other facilities (Ministry of Health, 2014). Some strategies to achieve this is to make MNH services more comprehensive at the peripheral facilities, increasing the number of deliveries closer to home, and insisting that normal deliveries be carried out by non-specialists (Ministry of Health, 2014). Care should be taken to ensure that these strategies are not implemented in a way that restricts a person's right to access MNH services regardless of their place of living.

Second, the rate of C-sections has been repeatedly described as high (32% of all birth; (Ministry of Health, 2014, 2016a; Ministry of Health and Family & ICF Macro, 2010). This indicates potential gaps in MNH information being provided to the users—it may be possibly creating a perception that non-specialist care is perceived as inadequate no matter how comprehensive the services, or that specialist care is perceived to involve C-sections. Further research is warranted to ensure that comprehensive information is being provided, as well as stronger monitoring of decisions leading to C-section deliveries.

Unsafe Abortion

The prevention of unsafe abortion and the management of its complications is highlighted in WHO Global Reproductive Health Strategy (2004) as a priority area as well as one of the conditions of achieving and accelerating achievement of universal access to SRHR (WHO, 2011).

Although numerous qualitative studies have documented experiences and conditions that lead to unsafe abortions, meaningful quantitative data on unsafe abortions in the Maldives is not available reportedly due to sociocultural sensitivity in asking those questions (Hameed, 2012; Thalagala, 2008; UNFPA Maldives, 2011). Analysis of policies on preventing unsafe abortions reveals two key policy barriers.

WHO's policy guidance states that the prevention of unsafe abortions could be accelerated by harmonizing policies with human rights commitments (WHO, 2011). According to human rights mechanisms, "criminalization of health services that only women require, including abortion, is a form of discrimination against women" (OHCHR, 2016a, p. 1).

Maldivian policies restrict abortion except on certain conditions, the last of which is a recent addition, by way of a *fatwa* (religious ruling). The legal grounds for abortion are if there is a danger to mother's wellbeing; if the mother's body is too weak or not developed enough to sustain the fetus (before 120 days only); if the fetus was found to have a debilitating medical condition including thalassemia major and sickle cell major (before 120 days only); and if the pregnancy is a result of rape or incestuous rape (before 120 days only; Islamic Fiqh Academy, 2013).

Secondly, policies facilitative to unsafe abortion prevention need to maximize access to care the extent possible under local laws (WHO, 2011). Although, the National RH Strategy reports are unclear as to the strengthening links between family planning and post-abortion care,

care standards for abortion, or availability at different health service levels (Ministry of Health, 2014). The AYPHS Standards highlights “mortality and morbidity due to unsafe abortions” as a health outcome, but all clinical service descriptions state “admit and provide treatment according to the national guideline...” (Health Protection Agency, 2013, p. 32), referring back to unclear guidelines. Unless care standards and service availability are made known, the dimension of universal access to SRHR where all persons have equal ability to access services cannot be fulfilled.

RTIs, STIs, and Other Reproductive Morbidities

According to WHO’s (2004) suggested definition, universal access to SRHR should include services to “prevent, treat and manage reproductive tract infections (RTIs) and sexually transmitted infections (STIs) including HIV/AIDS, and other reproductive tract morbidities, such as cancer” (p. 41). The analysis reveals that these policies are generally facilitative, highlighting one barrier and one opportunity for accelerated progress.

The WHO (2008) guidance states the need for a policy on STI control—this was found to be partially present in Maldivian policies. While the previous Health Master Plan focused mainly on increasing knowledge about STI and HIV prevention (Ministry of Health, 2006), the new Health Master Plan 2016–2025 mentions safer sex and STI prevention (Ministry of Health, 2016a). This, however, is raised in reference to migrant youth (Ministry of Health, 2016a) indicating that there is still hesitation to formally acknowledge nonmarital and often risky sexual behavior among Maldivians. It appears to be the only instance where non-Maldivians have comparable access to services as Maldivians because any migrant found to be HIV positive is provided the same antiretroviral treatment under the Maldivian government program (Ministry of Health, 2011). It is recommended that safer sex and STI prevention initiatives be explicitly widened to include Maldivians, removing the discrimination based on nationality. A caveat

worth noting here is how all migrants applying to work in the Maldives are required to undergo health checks (including HIV testing) as part of their pre-employment procedure. If found to be HIV positive, they are denied work visas, without which they cannot legally enter the country for work purposes or they are required to leave if already in the Maldives (*Work Visa Regulation*, 2010).

It is apparent that, similar to many other countries, it is easier to promote HIV prevention than for dual protection (Glasier et al., 2006) or pregnancy prevention because of the latter issue's links to morality (Hameed, 2012). An interesting feature of the AYPHS Standards is how its regional higher-level facilities that are able to issue contraceptives to prevent unwanted pregnancies, whereas if it is for STIs and HIV prevention, even the lower-tiered health posts are permitted to issue contraceptives (Health Protection Agency, 2013). Likewise, information, education, and communication material on STI/HIV prevention are allowed for adolescents over 13 years of age but no such concessions are made with regard to providing information on preventing unwanted pregnancies (Health Protection Agency, 2013). It is recommended that the guidance on issuing condoms for pregnancy prevention be elevated to match that of STI/HIV prevention. Similarly, condom distribution guidelines for family planning purposes appear to be more stringent (registration is not mandatory, but maintaining a register is encouraged; Ministry of Health, 2005).

Sexual Health

Universal access to SRHR includes every person's right to "enjoy a healthy, safe and satisfying sexual relationship which contributes to the enhancement of life and personal relations" (WHO, 2008, p. 41). This includes sexuality and sexual health of adolescents and young people (WHO, 2008, 2011) who are often overlooked because of the non-procreative aspect of their sexuality that is still uncomfortable even in the global SRHR platforms (Glasier et

al., 2006). This corresponds to the WHO Global Reproductive Health Strategy priority area of sexual health, which is defined as:

...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 a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of 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)

By this definition, efforts to achieve universal access to SRHR need to also address sexual coercion, sexual violence, and harmful practices such as FGM—these harmful practices are discussed separately. Overall, sexual health (SH) has been difficult to address in Maldivian policies due to religious and sociocultural influences on policymaking and policy actors (Hameed, 2012). The analysis revealed four key policy barriers.

The first policy barrier relates to the dimension of all persons having equal ability to access these services (WHO, 2008). Although the Constitution affirms all citizens' right to health, the illegal status of nonmarital sexuality (*Penal Code, 2014; Sexual Offenses Act 17/2014, 2014*) imposes barriers on unmarried people's right to access contraceptive services. The National FP Standards obliges service providers to set aside personal beliefs and treat all users with respect and dignity, regardless of marital status (Ministry of Health, 2005). Similarly, the National RH Strategy recognizes contraceptive needs of unmarried sexually active couples (Ministry of Health, 2014); however, the consistent use of the word "couples" throughout the documents may impinge on an individual's right to SRHR (Ministry of Health, 2005).

The second policy barrier relates to the dimension of a person's right to access SRHR services regardless of age (WHO, 2008). While the previous Master Plan (2006–2016) included

strategies on adolescent and youth sexuality focused exclusively on providing information (Ministry of Health, 2006), the RH Strategy (2014–2018) stated attempts to institutionalize this information provision in schools (Ministry of Health, 2014), and the new Master Plan (2016–2025) made vague mentions of enabling youth to make “healthy choices” and “access to reproductive technologies” (Ministry of Health, 2016a, p. 39). This depicts extremely slow progress on acknowledging and addressing sexual health needs of adolescent and youth who make up nearly half of the Maldivian population (National Bureau of Statistics, 2014).

The third policy barrier is created by the Health Services Act that necessitates parental consent as well as the parent being informed of any health service being provided to individuals aged below 18 years (*Health Services Act 29/2015*, 2015). In addition to violating these individuals’ right to privacy and right to health, in cases of nonmarital pregnancy or sexual ill-health, this could also render young people more vulnerable to repercussions from the family that could include homelessness, restrictions to education, and pressure into entering marriage (Hameed, 2018).

Lastly, universal access to SRHR requires the presence of “law prohibiting discrimination on the basis of gender identity, sexual orientation or physical and intellectual disability” (WHO, 2008, p. 14). While the special SRHR needs of people with disabilities are acknowledged in the National RH Strategy (Ministry of Health, 2014), and the FP Standards require guardian’s consent only in permanent contraceptive methods (Ministry of Health, 2005), the Maldivian legislature criminalizes homosexuality (Penal Code Section 411 as well as the Sexual Offenses Act) and does not recognize different gender identities (*Penal Code*, 2014; *Sexual Offenses Act 17/2014*, 2014). This presents a fourth policy barrier to universal access to SRHR.

Harmful Practices

The analysis of policies and legislature related to sexual coercion, sexual violence, and

other harmful practices revealed four major policy barriers to achieving universal access to SRHR.

The WHO guidance states the need for laws that prohibit marriage for both men and women prior to age 18, and laws that require full and free consent of the parties to a marriage (WHO, 2008). Maldivian policies and legislature do not meet this requirement as the current Family Law allows the marriage of girls under 18 if deemed appropriate by the Court—this effectively allows child marriages as well as coercion of girls into marriage before they can legally provide consent (*Family Act 4/2000*, 2004). As long as this allowance persists, universal access to SRHR cannot be claimed.

The WHO (2008) guidance also necessitates that there be laws that prohibit sexual violence, laws that prohibit marital rape, and a strategy/plan to prevent and respond to sexual violence, including marital rape. Although the Domestic Violence Prevention Act (2012) was a tremendous achievement in criminalizing gender-based violence including intimate-partner violence, it was silent on marital rape, reportedly as a result of dissenting religious views (Hope for Women, 2012).

The Sexual Offences Act (2014) excludes spousal rape from its definition of rape (section 6), but later outlines specific circumstances where marital rape may be considered an offense—these include the couple being in stages of the marriage dissolution and the husband’s intention to transmit an STI (section 20; *Sexual Offences Act 17/2014*, 2014). Furthermore, section 130 (b) of the Penal Code has a rebuttable presumption that consent exists during spousal sexual intercourse (*Penal Code*, 2014), and the Sexual Offences Act states specific conditions in which consent may not be treated as existing, such as when consent is extorted with threats of bodily harm or fear of death (section 14; *Sexual Offences Act 17/2014*, 2014). Arguably, these

overlapping conditions narrow the grounds for marital rape and while they persist, they present policy and a legislative barrier to universal access to SRHR.

The third barrier relates to the right to access SRHR services that are appropriate to a person's need (WHO, 2011). In responding to gender-based violence, the AYPHS Standards recommends couples counseling, premarital counseling, as well as parental involvement (Health Protection Agency, 2013). Considering how one in five women experience violence at the hands of an intimate partner, and how in many instances the perpetrator is someone they know (Fulu, 2007), to involve a potential perpetrator in counseling or any service provision would be a gross violation of the user's right to health and to be free from harm.

The WHO guidance states the need for active discouragement of FGM in the form of a law that prohibits all forms of FGM, a strategy/plan for abandonment of FGM (according to local need, informed by local research on cultural practices), as well as medical regulations against the practice (WHO, 2008). Despite emerging reports of FGM being practiced in the Maldives (Hope for Women, 2012), none of the above policies are in place. This indicates the fourth policy barrier to claiming universal access to SRHR.

Discussion

In addition to identifying opportunities for future work, the above analysis has shown that, across the six areas of SRHR, there are barriers and gaps present in policies and legislature that impede universal access to SRHR in the Maldives. Some commonalities among the highlighted policy barriers are lack of consistency between policies and lack of clarity in policy statements. An example of lack of consistency includes the grounds for non-discrimination in some policies—these include ethnic origin or nationality (Ministry of Health, 2005)—but others give right to access to citizens only (Health Protection Agency, 2013; Ministry of Health,

2016a). An example of lack of clarity is where some policies protect an individual's right to access services regardless of marital status or age (Health Protection Agency, 2013; Ministry of Health, 2005), but others hinder or link it to criminalized behavior (*Constitution of the Republic of Maldives*, 2008).

It may be argued that lack of clarity and consistency makes quality assurance and accountability difficult. Consider the following hypothetical scenario that was discussed among stakeholders during the roundtable seminar. Although the FP Standards instruct service providers to not discriminate against users who are unmarried, a need for contraception is linked to nonmarital sexual activity, which is legally prohibited (*Constitution of the Republic of Maldives*, 2008). As a result, the FP Standards do not explicitly allow or disallow the service provider from providing contraceptive services—this entails a situation where the service provider can offer or refuse this service, and they may not be held accountable to either decision. In this scenario, the user is denied access to contraceptive services, which enhances their vulnerability to STIs, or unwanted pregnancy, both of which are concerns for public health authorities but they cannot compel the service provider, given the lack of clarity in policies.

An obvious resolution to this is to state with clarity—for the above hypothetical scenario, this would mean to state, in policies, that service providers are obliged to provide contraceptive services to individuals even if they are not married. To bring about such a policy change would entail challenging the current illegal status of nonmarital sexual activity, an aspect linked to *Sharia* (Islamic law) and religious belief. In a policy climate where religious influence is increasingly formalized as a part of policymaking (Hameed, 2012) and increasingly conservative views are prevalent (Hameed, 2016), it is highly unlikely that such a challenge would be won. This hypothetical outcome was commonly agreed by all stakeholders as likely and damaging to

the advancement of universal access to SRHR in the Maldives.

It appears then, that policy clarity is not always useful. In discussing alternatives to resolving the problem of ensuring universal access to SRHR (across the four dimensions of equal ability, appropriateness, timeliness, and non-discriminatory), nearly all stakeholders were in agreement that establishing legislature was likely to entail a more restrictive situation. The remaining viable alternative raised among the stakeholders was to strengthen standards among service providers through tighter monitoring mechanisms, combined with advocacy to change the conservative mindset, as well as establish policies which may be kept intentionally grey to protect the providers' rights as well as the users. But would this be a step towards or away from universal access to SRHR? This is just one example of the mixture of concerns faced by proponents of SRHR in the Maldives—the balance of striving for universal access within legal and religious boundaries while maintaining quality and accountability and addressing inequality.

This study has shown that major gaps remain, including issues related to the equal ability of all persons to access services, and discriminatory practices related to age, marital status, gender, and identity. Arguably, these are fundamental to universal access—equality and non-discrimination—and need to be addressed before any meaningful pursuit of this goal. This research serves as a starting point to address these barriers in Maldivian policies, and more broadly, it demonstrates how this method of policy analysis can identify the readiness of countries in national level implementation and monitoring of SDGs.

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Conflict of Interest

None.

Declaration of ethical clearance

None required.

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APPENDIX: List of Maldivian Policies and Legislature Consulted and Reviewed

1. The Constitution of the Republic of Maldives 2008
2. Family Act 4/2000
3. Immigration Act 1/2007
4. Domestic Violence Prevention Act 3/2012
5. Public Health Protection Bill
6. Penal Code, Law No. 6/2014
7. Sexual Offenses Act 17/2014
8. Health Care Profession Act 13/2015
9. Health Services Act 29/2015
10. Health Master Plan 2006-2015
11. Health Master Plan 2016-2025
12. National Standards for Family Planning 2005
13. National Reproductive Health Strategy 2014-2018
14. National Standards for Adolescent and Youth Friendly Health Services (AYFHS)
15. The HIV and AIDS Situation: Related Policy and Programmatic Responses of the Maldives
16. Health sector response to gender-based violence: National Guideline on providing care and prevention for Health Care Providers
17. *Nuthufaa naththailumaai hayyarun nattuvailumaai dhari vattailumaa behey* [Religious ruling on abortion] Fatwa 6 (Ref: IFA/2013/06).
18. *Maa bandu Anhenaage bandugai vaa dhariaa behey* [Religious ruling on unborn fetus] Fatwa 10 (Ref: IFA/2014/03)].
19. *Raajje gai vazeefa adhaa kurumah anna bidheyseen ge work visa aa behey qavaaidh* [Work Visa Regulation R7-2010]