**Written statement**

Joint CSO statement submitted by the **Society of Health Education (SHE)**, in collaboration with the **International Planned Parenthood Federation (IPPF)** and **Sexual Rights Initiative** **(SRI)** on the recommendations on **Maldives** UPR recommendations to the to the UPR Working Group convening in 2020.

*Presented by:*

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This joint statement is presented by the Society for Health Education, Maldives, the international Planned Parenthood Federation and Sexual Rights initiatives responding to the developments over the last reporting cycle in the Maldives on the status of Sexual reproductive health and Women’s right in the Maldives.

The overall human rights situation in the Maldives has improved significantly over the past couple of years, following several years of political and social instability which has had significant negative impacts on the gains on women’s rights and provision of health service in the country.

The existing economic and social vulnerability of women has exacerbated with the COVID-19 crisis. Even pre-COVID, the Gross National Income (GNI) per capita for women in Maldives was 48 percent lower than that of men (UNDP, 2020). This implies that, country-wide, economic inequality is one of the biggest forms of gender inequality.

Women in Maldives spend twice as much time doing unpaid domestic and care work as men. Although in Maldives women are on average equally or better educated than men, the average income of women in paid employment is twenty percent lower than that of men; indeed, women are only about half as likely as men even to be in paid employment. For many women, being in paid employment means having two jobs, as they continue to bear the domestic burden. And for women with children without a proper support system, this challenge often becomes unsustainable and professional ambitions are frequently abandoned.

In Maldives during lock down, anecdotal evidence indicates that women are spending a lot more time tending to children, making meals, cooking and cleaning. The unequal distribution of unpaid domestic and care work leaves a mark on women’s physical, mental and emotional wellbeing. It increases economic vulnerabilities as women end up with less income, savings and pensions to rely on at time of divorce, old age or during times of economic shocks.

There are also many reports about the rise in domestic violence during the crisis when people are confined to their homes for long periods of time often with perpetrators. This may also be due to frustration, anxiety over income loss and other psychological effects associated with crises. During the lockdown access to essential SRH services were completely halted or are limited due to the focus of health facilities on combating the COVID Crisis.

Concerns remain unchanged on the perennial barriers to universal access to SRHR with an estimated 52% youth practically deprived of access to SRH information and services due to a complex mix of societal taboos and policy-level inefficiencies. No progress is made to incorporate adolescent SRH (ASRH) education to schools, despite national strategy objectives to do so.

We applaud and welcome the state’s decision to withdraw the blanket reservation on article 16 of CEDAW, and for ratifying The Gender Equality Law in 2016. However, four years on, we express concerns as little or no notable implementation progress has been made since. The Domestic Violence Prevention Act 2012 too experiences small and slow progress, continuing to suffer resource constraints. DV cases are consistently observed where serious systemic failures show victims being unserved and perpetrators released. The Sexual Harassment Prevention Act 2014 too remains to be applied to be tested.

There has been a notable shift in political will and attitude towards the inclusion of women in public life over the past two year. Notably, a historic development is the appointment of two women judges to the Supreme Court of the Maldives and the recent appointment of the first women judge to the Criminal Court. The number of women in the cabinet had increased from 21% to 35%. However, women’s representation in the legislature has dropped to a record low at just 4%. A notable shift is also the 2019 landmark amendment to the Local Council Acts which mandates at least 40% reserved seats for women in the island and city councils. Notable progress has been achieved with the implementation of a 6 months maternity leave and one month paternity leave for civil service employees.

While we acknowledge the achievements made by Maldives since the last review cycle towards women’s rights and protection, we urge the government of Maldives to accept all the recommendations received during the review and take all necessary steps towards the full realisation of the concerns raised, through adoption of a plan of action in consultation with local CSOs and national and international human rights institutions.

We further reiterate the need for Maldives to:

* Revise the core school curriculum to significantly increase and improve age and developmentally appropriate, comprehensive sexuality education (CSE) to prepare and empower young people to attain good physical and mental health and well-being through adolescence and young adulthood.
* Develop and disseminate relevant SRH education materials, specifically for adolescent girls and young women, to educate and empower them to claim their SRH rights and prevent the incidence of unintended pregnancy and consequent conflict with the law.
* Incorporate SRH awareness as a public health priority within relevant policies, including the Health Master Plan and Youth Health Strategy, specifically targeted to support the adolescent and youth population.
* Implement public awareness campaigns to increase public knowledge of the SDGs, with specific emphasis on SDG-3 and SDG-5, emphasising the necessity of SRH knowledge and access to services to improve individual and family health and wellbeing.
* Expedite measures to implement the Gender Equality Law (18/2016) and formalise the Gender Equality Policy with stakeholder consultations, for immediate implementation.
* Allocate necessary budget and resources to meaningfully implement the Domestic Violence Prevention Act 2012, to improve the de-facto situation of affected women and families.
* Ensure non-replication and harmonisation of laws addressing street harassment, workplace harassment and sexual harassment in public places in their diversity of forms, to prevent dilution of outcomes favouring perpetrators, and achieve efficient and effective prevention and legal remedy for those victimised.
* Strengthen inter-sectoral collaboration across relevant State institutions such as the FPA, the Ministry of Gender, Family and Social Services, the Maldives Police Service and the Ministry of Health to develop credible and reliable tools to obtain data consistently on VAW/GBV/DV to inform policy and programme interventions.
* Issue timely public-health protection messages by the Ministry of Health and/or the Health Protection Agency to counter endorsements promoting harmful practices such as FGM and other VAW/GBV/DV in all circumstances and adopt a zero-tolerance approach to such promotion of harmful practices, especially against vulnerable groups in society.
* Strengthen social protection services and mechanisms for survivors of VAW/GBV/DV, including the establishment of shelters and mechanisms to prevent survivors from having to live with perpetrators.
* Establish a baseline on the prevalence of unsafe abortion practices in the country and formulate relevant public health legislation to address identified issues.
* Substantively revise and improve the National Standards for Family Planning Services (2017) by removing the mandatory requirement for women to obtain written or any form of spousal consent for surgical sterilisation and facilitate informed decision-making and choice on all forms of family planning methods.
* Strengthen the NRHS and other such guiding documents and ensure the development of best practice protocols to prevent individual service providers from making arbitrary decisions based on personal beliefs that result in denial of SRH services to young people.