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Society for Health Education (SHE) is a non-government organization that is proactive in identifying and addressing the crucial health and social concerns of the Maldives. It was founded in 1988 by four women with the mission to enhance the quality life of Maldivian families.

and

International Planned Parenthood Federation

Sexual Rights Initiative

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Executive Summary

1) The **Society for Health Education (SHE) in collaboration with the International Planned Parenthood Federation (IPPF) and Sexual Rights Initiative (SRI)** submits this report to the Working Group of the Universal Periodic Review (UPR) convening in 2020, to respond to developments over the last reporting cycle in the Maldives. This report is primarily an update on the status of issues reported in the first UPR Cycle from 2010-2015.[1] However, certain other observations and concerns over the last five years are included.

2) The overall human rights situation in the Maldives has improved significantly over the past year, following several years of political and social instability which has had significant negative impacts on the gains on health service provision in the country. The Maldives is still recovering from a challenging democratic transition where significant socio-political, socio-economic and socio-religious dynamics influence the country's development indicators and its human rights record.

3) Concerns remain unchanged on the perennial barriers to **universal access to SRH and rights with an estimated 52% youth demographic practically deprived of access to SRH information** and services due to a complex mix of societal taboos and policy-level inefficiencies. Duty bearers' reluctance to accept lived realities, which are by-passed with an evidence base that does not capture the situation of young people continue to prevent progress to equip young people to protect their own SR health and wellbeing. **No progress is made to incorporate adolescent SRH (ASRH) education to schools, despite national strategy objectives to do so.** NGO stakeholders continue to fill the gaps left by policy, with the successful introduction of an ASRH mobile application to reach the ill-served youth population.

4) The **inclusion of two new components in the DHS 2016-2017, one on VAW and the other on FGM are important and welcome developments**. However, the efficacy of these instruments are questioned due to the limitations and data that appear significantly misaligned with other data on the same issues. A concern then is the extent of useability of such data to inform policy. Data quality must be prioritised over data quantity. Recognition of the need to gather FGM data is progress. This baseline evidence and the known drivers and religious narratives endorsing this harmful practice require immediate State attention to protect vulnerable children. Lack of attention to such developments may be the possible cause of the unprecedented introduction of extreme radical ideologies as evidenced in the two court ruling over the past 4 years to stone women to death. This regression of the judicial system requires immediate and effective interventions to prevent non-repetition and the damaging effects of such developments on the whole society.

5) In terms of the legal framework on women's rights, **no practical progress has been made to withdraw the Maldives' blanket reservation on Article 16 of CEDAW**. The Gender Equality Law ratified in 2016 has made no notable implementation progress. **The Domestic Violence Prevention Act 2012 (DVPA 2012) 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. However, civil society actors inject life to sustain momentum to make the DVPA2012 a source of remedy and redress for violence survivors in a less than favourable environment. The Sexual Harassment Prevention Act 2014 remains to be applied to be tested.

6) There has been a notable shift in political will and attitude towards the inclusion of women in public life over the past year. Notably, a historic development is the appointment of two women judges to the Supreme Court of the Maldives. The **number of women in the executive cabinet had increased from 21% to 35%. However, women's representation in the legislature has dropped to a record low at just 4%.** At local councils, women's representation remains at a poor 4%, although the most populous urban centre in the country, Malé City, elected three women to its City Council, one of whom is the city's Mayor. The situation of Women's Development Committees (WDCs) and the prospect of decentralization remains uncertain. Women's representation in the uniformed services remain unchanged. However, **notable progress has been achieved with the implementation of 6 months maternity leave and one month paternity leave for civil service employees**.

7) This report provides a series of recommendations on two thematic areas on a variety of issues impeding the realisation of fundamental human rights for women and young people in the Maldives.

Theme 1 : Access to sexual and reproductive (SRH) rights, knowledge and services and the situation on DV/VAW/GBV

8) A perennial and serious concern in the Maldives is the **significant challenge of access to SRH rights, knowledge and services by all age groups, particularly adolescents and youth in a population where an estimated 52% are below 25 years**.[2,3] Maldives did not achieve universal access to SRH as aspired to in the Millennium Development Goal 5 (Target 5-B). If a significant shift in the current situation does not happen soon, Maldives will not be on track to achieve universal access to SRH objectives of the Sustainable Development Goal (SDG) 3 on good health and wellbeing (Target 3.7) or SDG 5 (Target 5.6). According to the Maldives Demographic and Health Survey (**DHS) 2016-2017, contraceptive use "by currently married women has declined sharply since 2009, dropping from 35% of women using any contraceptive method in 2009 to 19% in 2016-17. Use of modern methods has also decreased, from 27% of married women in 2009 to 15% in 2016-17."[4]** Notably, contraceptive commodities are provided through formal health service provider channels to married couples only, which exclude a significant demographic from this basic healthcare service. Recent studies show the outcome of such policy-based practices leading young people to believe that SRH related services are "not for them" and the mistaken "perception that SRH are only for pregnant women and married couples and a belief that the youth don't need SRH services."[5] The DHS 2016-2017 also found that the need for family planning was satisfied for 37% respondents while the unmet need for family planning stood at 31%.[6] A significant rate of contraceptive discontinuation within 12 months of uptake, in the 5 year period prior to the survey was also observed, at 34%.[7] Nevertheless, the DHS also reports that knowledge of contraception "is almost universal in the Maldives, with 98% of currently married women and 99% of currently married men age 15-49 knowing at least one method of contraception."[8] What the DHS does not account for or capture is the significant unmarried population without access to SRH knowledge and services that are nevertheless sexually active and experiencing the negative health impacts of that reality.[9]

9) Concerns reported in the last UPR cycle by SHE/SRI regarding the situation on SRH remains unchanged to date.[10] In Section 5(e) of this 2015 report, it stated that "the MDHS 2009 found that 95% of women between the ages of 15-19 "are not sexually active", stating that "pregnancy among teenagers in Maldives are rare"."[11] Consistent with this, the subsequent DHS of 2016-2017 found that "teenage pregnancy (15-19 cohort) has remained at a constant 2% in both the 2009 and 2016-2017 health surveys.[12] The latter also reported that the "median age at first sexual intercourse is 20.7 years for women and 23.1 years for men" in the Maldives.[13] However, data provided in the National

Reproductive Health Strategy (NRHS) 2014-2018 informs that "premarital sexual activity was found among 11.6% of youths" in the 18-24 cohort.[14] It is **notable that the DHS in both 2009 and 2016-2017 has yielded information on the situation of teenage pregnancy and age of sexual initiation that are quite removed from the findings of qualitative inquiries that have documented lived experiences of young people.** This is an alarming trend considering the fact that the evidence base provided by national surveys such as the DHS will inform government policy in these critical areas. Several policy barriers have been identified to access SRH, one of which is described as the "extremely slow progress on acknowledging and addressing sexual health needs of adolescent and youth who make up nearly half of the Maldivian population".[15] It is imperative that policy level understanding and a rights-based approach is used to address the persistent gaps and facilitate access to SRH to safeguard the health and wellbeing of the youth population of the country.

10) In addition to the slow policy level recognition of the lived realities of young people deprived of their SRH rights, the ambiguity of language used in national strategies provide gaps that result in arbitrary decision-making by health-service providers based on personal beliefs. As an SRH information and service provider, the experience of SHE over the past 3 years indicate the prevalence of this issue which needs to be urgently addressed. One of the objectives of the NRHS 2014-2018 was for stakeholders to collaborate to implement "family-life/life-skills education or sexuality education in at least 75% of schools and in provision of adolescent-friendly health services."[16] It would not be possible to achieve this goal without significantly strengthening the professional conduct of service providers to deliver such goals by removing existing gaps and ambiguities that allow arbitrary practices.

11) The Marital Awareness Programme run by the Family Court is a mandatory certified programme primarily targeted at first-time marriages, and mainly conducted in Malé City. A concern about this programme is the **lack of appropriate information on SRH knowledge and family planning. Considering the dearth of SRH information and education within the school education system**, it is imperative that credible and meaningful SRH information is provided to young people through this programme.

12) A disturbing development is the mandatory requirement in the National Standards for Family Planning Services (2017) for spousal written consent for surgical sterilisation, for both women and men in the Maldives.[17] While this may appear gender-equitable or neutral on paper, the prevalence of surgical sterilisation as a family planning method is disproportionately high among women. **According to the DHS 2016-2017, use of sterilisation as a contraceptive method among women was 10.1% in 2009 and 4.4% in 2016-2017.[18] For male sterilisation, the figures stood at 0.5% in 2009 and 0.1% in 2016-2017**.[19] Considering this evidence and the socio-cultural patriarchal context of the Maldives, the mandatory requirement for women to obtain spousal consent to access sterilisation as a family planning method can be construed as an indirect barrier to women's bodily autonomy and right to make decisions about her body and her SRH.

13) SHE in collaboration with UNFPA Maldives had developed an interactive mobile application to facilitate access to adolescent SRH (ASRH) information to young people in the Maldives. The application named *Siththaa* was launched in 2017, providing an information resource enabling users to send in questions on ASRH for clarification. *Siththaa* has been described as "the most successful tool in reaching out to the youth with a download number of 2484 within one year" although knowledge of the application is still limited to Malé.[20] Access to mobile technology is high in the Maldives among young people, as is internet reach and usage. Therefore, the **feasibility of upscaling *Siththaa* is a policy decision that could transform the ability of young people to access ASRH information without the challenge of approaching SRH service facilities that are not youth-friendly.**

14) SHE worked in collaboration with UNFPA to introduce and contextualize the minimum initial service package (MISP) for SRH services during emergencies. This includes measures to reduce the risks to pregnant women and young girls and reduce GBV during emergencies. MISP has been agreed to be integrated into the Health Emergency Operation Plan. SHE is engaged in programmes to train healthcare providers on MISP.[21]

15) Since the initial baseline study published in 2007, there has been no thorough national level scrutiny of the prevalence of VAW/GBV in the Maldives.[22,23] However, the DHS 2016-2017 for the first time included a component to obtain quantitative data on the prevalence of VAW which is a new development in terms of the State's recognition of the issue.[24] Key findings from the **DHS 2016-2017 report that 17% of women in the age group 15-49 had experienced physical violence while 11% had experienced sexual violence, with 4% reporting physical violence during pregnancy.[25]** Further, 41% of those who experience spousal physical/sexual violence reported sustaining injuries and 42% of violence survivors had sought help, while "36% have never sought help nor told anyone about the violence".[26] A dubiously interesting figure provided by the DHS 2016-2017 is that only 6% of ever-married women had experienced "at least three types of marital control behaviours by their husbands or partners" while 62% has never experienced the same.[27] The findings of the DHS 2016-2017 are not comparable to that of the 2007 baseline, but *prima facie*, the DHS data indicates an unconvincing improvement on the situation of VAW. Questions must be raised about the reach and method of the VAW/GBV data in the DHS, particularly in light of the conservative and increasingly radicalised religious context of the Maldives, where women are compelled to accept the notion that spousal violence is justified by religion.[28] The DHS notes that 22% of eligible respondents were not interviewed for the VAW component due to challenges such as unavailability, refusal or lack of privacy to conduct the interview.[29] These limitations are also worthy of note when considering the reliability of the data.

16) Since the adoption of the DVPA2012, significant efforts have been made by various stakeholders, specifically civil society actors, to raise the issues of VAW/GBV/DV despite slow progress on the actual implementation of the law.[30] The FPA, mandated to oversee the implementation of the DVPA2012 produces data of DV cases reported across the country. The issue of VAW/GBV/DV remain as pertinent as ever, disproportionately affecting women regardless of perceived or actual developments in this area. In 2018, the FPA initiated the first National Conference on Research in Domestic Violence, a welcome step forward to establish and strengthen knowledge and dialogue on DV in the Maldives.[31] Data available from the FPA shows consistent gender disparity in numbers of reported cases with DV affecting women disproportionately. In 2015, the number of DV cases reported to the authority by women was 74% and men, 26%. In 2016, it was 82% women and 18% men while in 2017, these numbers were the same for 2015. In 2018, the number of DV cases reported to the FPA was 75% and 24% men, showing the need to effectively implement the DVPA2012 to prevent, protect and provide social protection and judicial remedies to survivors and facilitate rehabilitation for perpetrators as required by law.[32] The absence of shelters for DV survivors and the absence of facilities and mechanisms to provide rehabilitation services to perpetrators are pending issues that require urgent action.

17) Female genital mutilation (FGM), circumcision or cutting in the Maldives came to public attention as a cause for concern nearly a decade ago in 2011.[33] Subsequently, the narrative around the hitherto well-hidden 'traditional practice' was given momentum by publicly prominent conservative clerics that advocated the practice. A *fatwa* endorsing FGM was issued in 2014 by a senior member of the Fiqh Academy, a non-legal body attached to the Ministry of Islamic Affairs which makes religious rulings. The fatwa claimed that "FGM is one of the five things that are part of fitrah, or nature."[34] Local civil society organisation Maldivian Democracy Network (MDN) has produced a study documenting

religious radicalisation in the Maldives, and identifies detailed developments including the endorsement of FGM and marital rape in these narratives which specifically undermine the human rights of women.[35] The same cleric was reported to have condemned the conditional criminalisation of marital rape in the Sexual Offences Act which was passed in 2014.[36] In this context of the regressive influences of religious radicalisation on women's fundamental human rights, it is an important development that a component was introduced in the DHS 20016-2017 for the first time in the Maldives to understand the prevalence of FGM. The DHS has established the baseline that 13% of women aged 15-49 are circumcised in the Maldives, 83% of whom reported enduring the practice prior to the age of 5 while the rest of the respondents could not recall their age of circumcision.[37] However, the DHS 2016-2017 did not collect data on "the type or severity of the procedure" citing anecdotal evidence that in the Maldives, female circumcision involves mainly "small cuts to the genitals" which fall under the WHO FGM classification Type 4.[38]

18) In October 2015, the island magistrates court of Gaaf Alif Gemanafushi issued the unprecedented sentence to stone a woman to death for alleged adultery.[39,40] According to reports, the woman was "charged after giving birth out of wedlock" having confessed to "committing adultery".[41] In January 2019, the island magistrates court of Lhaviyani Atoll Naifaru issued the same sentence against a woman similarly accused. In both cases, the Supreme Court intervened swiftly to quash these rulings.[42,43] The unprecedented introduction of the sentence of stoning to death as a punishment is deeply disturbing ushering a level of regression the country has not seen in its judicial system. It is also particularly concerning in the current context, where radical narratives justify grave human rights violations, particularly against women. These narratives have led to significant levels of harassment, fear and threats to individuals and human rights defenders who attempt to counter them.[44] It is well documented that the Maldives has experienced unprecedented regression in the country's human rights indicators in the past six years. The issues surrounding the judiciary are manifold.[45] The introduction of the idea of stoning as a punishment, while contested as an Islamic practice by scholars, is neither culturally nor judicially an accepted form of punishment in the country's history.[46] The fact that such a ruling has been issued twice in the last four years indicates a level of regression that require urgent measures to stop further deterioration.

Theme 2 : Legal and policy framework and women's representation in public life

19) The Maldives continues to retain a blanket reservation on Article 16 of CEDAW. This is despite having accepted the recommendation to lift the reservation during the first UPR cycle and having expressed agreement to a partial withdrawal in 2011[47] and 2015[48]. The situation remains unchanged to date, with no clear information available on progress.
20) Maldives ratified the Gender Equality Law 18/2016 (GEL) in August 2016, which is a landmark law to address the inherent patriarchal, societal and structural discriminatory attitudes and practices which undermine equitable access to opportunities and services for women on a par with men.[49] Three years later, practical measures to implement the GEL are yet to be realised and functional. The draft Gender Equality Policy produced in 2018 and aligned with the provisions of the GEL is currently awaiting formalisation and action. The current administration's Strategic Action Plan (SAP) 2019-2023 is due to be launched on 02 October 2019.
21) The DVPA2012 is another landmark law that criminalised domestic violence (DV) in the Maldives for the first time. However, the situation is that this important law has yet to be effectively implemented. Although some improvements in the establishment of the oversight authority for the act, the Family Protection Authority (FPA) has been achieved, the purpose of the law is yet to be served to improve access to justice and the de-facto situation of women. Consistent reports show

that perpetrators of DV are not held to account and laws are not upheld to address this crime. News reports inform of perpetrators of grievous injuries towards women being ordered to pay token fines of MVR 200/- (USD13) by courts and released without repercussion or rehabilitation.[50,51] In December 2015, the community of Gaaf Dhaal Atoll Thinadhoo unusually, came out to protest, condemning the horrific attack on a woman from that island by her estranged husband.[52] The victim, Ziyadha Naeem subsequently died of her injuries, and her husband, Ibrahim Shah was charged with her murder eight months later.[53] Despite the strong evidence against him, Shah was acquitted by the Criminal Court in a "closed-door trial" in March 2019.[54] The Prosecutor General accused the court of "disregarding strong evidence" and announced its decision to appeal the case.[55] The case of Ziyadha Naeem highlights the systemic failures to protect and provide essential services to women subjected to DV, especially in island communities where access to justice is remote.

22) The Sexual Harassment Prevention Act, 16/2014 has been in place for the past 5 years. However, its implementation is not visible while the issues of both street harassment and workplace harassment of women is evident from the efforts made by civic groups and individuals to raise these issues.[56,57] In June 2019, a man was arrested and charged under the Penal Code for street harassment, following social media disclosure of the incident, which will be a test case in the Maldives.[58] There is a need to harmonise laws to ensure effective reporting, investigation and prosecution of these assaults against women in public places. The existence of over-laps in laws has the effect of undermining the gravity of these crimes thereby weakening the legal framework to ensure women's right to enjoy public spaces without experiencing real insecurity and fear of assault.

OVERALL RECOMMENDATIONS:

I. Recognise specific Sexual and Reproductive health information need of young people by following actions:

a) 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.
b) 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.
c) 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.
d) Strengthen the Marital Awareness Programme conducted by the Family Court with non-judgmental SRH information to ensure young people are provided appropriate, scientific health information on SRH that will equip them to make sound decisions to maintain individual and family health and well-being.
e) Support the upscaling of *Siththaa* ASRH application across the country and facilitate its availability to schoolteachers and students, with the active endorsement of the Ministry of Education.
f) 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.
g) Priority actions to integrate SRH into emergency risk management systems, programmes and plans.

II. Take action to remove barriers to implementation of existing GBV specific laws and policies in the country

a) Remove the blanket reservation on Article 16 of CEDAW.
b) Expedite measures to implement the Gender Equality Law (18/2016) and formalise the Gender Equality Policy with stakeholder consultations, for immediate implementation.
c) 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.
d) Conduct an inquiry into the systemic failures that led to the death of Ziyadha Naeem to identify gaps and address these issues to ensure non-repetition and to ensure victims of DV/GBV/VAW are provided effective legal protections and redress.
e) 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.
f) 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.
g) 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.
h) The Judicial Services Commission (as mandated in Article 159 of the Constitution), and relevant stakeholders to take urgent steps to monitor the performance of judges; build knowledge and capacity of judges at all levels, particularly magistrates courts at island level, to perform their judicial duties within the laws and judicial practices of the Maldives that seek to deliver justice without gender-based discrimination, in accordance with inherent values of humanity in Islam and in Maldivian society.
i) 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.
j) Develop robust and timely policy interventions to address the issue of conservative and radical narratives that undermine the messages of equality and equity between men and women in Islam; to ensure unity, stability, health and wellbeing of the family unit and society at large by upholding the fundamental rights of all people as enshrined in the Maldives Constitution and international human rights obligations.

III. Improve availability of quality and segregated data specially to capture the needs of young people

a) Establish a baseline on the prevalence of unsafe abortion practices in the country and formulate relevant public health legislation to address identified issues.
b) 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.

c) Strengthen the existing data gathering instruments such as the MDHS to assess the situation of VAW/GBV/DV and initiate credible qualitative research to capture the lived realities of women experiencing violence in order to reliably inform policy and programme interventions. Data quality and credible methodologies must be prioritised over data quantity in all areas. Strengthen the components of the Maldives DHS to fully assess the nature and extent of the prevalence of FGM in the Maldives to obtain substantive data to facilitate effective and evidence-based policy and programme interventions.

d) 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.

e) Health policymakers, health professionals, law-makers in health and other sectors and donors to consider priority actions to integrate SRH into emergency risk management systems, programmes and plans.

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