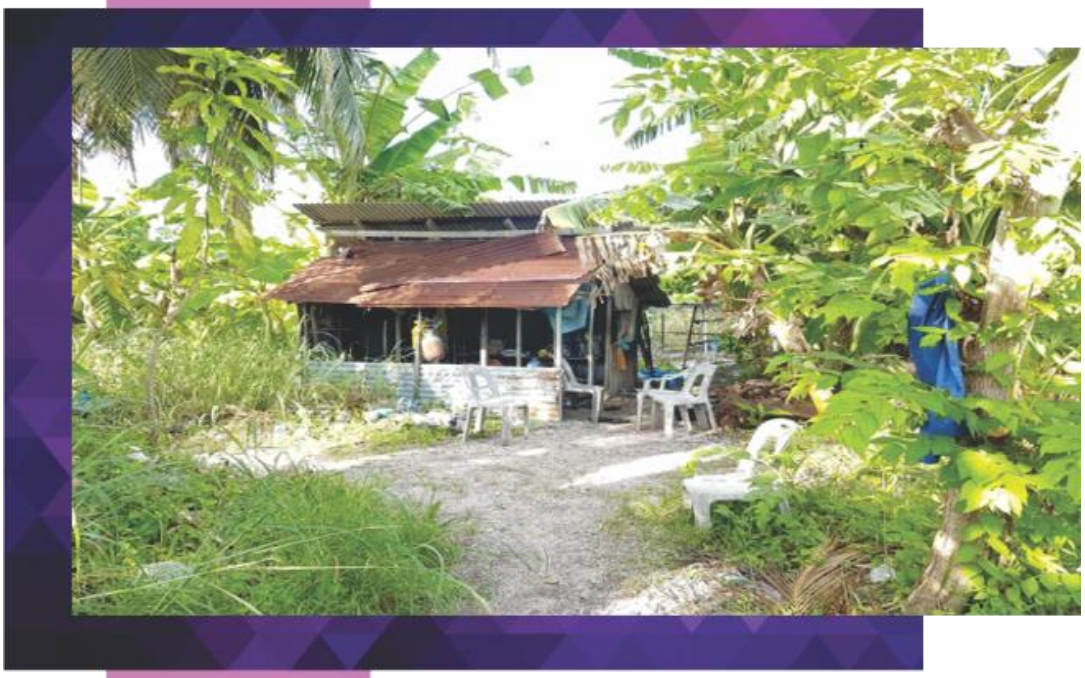
Sexual Reproductive Health Services seeking behavior among Maldivian youth between the ages of 18 - 25 years



NATIONAL REPORT

Research title: Sexual Reproductive Health services seeking behavior among Maldivian youth between the ages of 18- 25 years.

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LIST OF ACRONYMS

ARROW	Asian-Pacific Resource and Research Centre for Women
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive sexuality education
DHS	Demographic and Health survey
FSW	Female sex workers
FGD	Focus Group Discussion
FP	Family Planning
HRCM	Human Rights Commission of the Maldives
IPPF	International Planned Parenthood Federation
IDU	Injecting drug user
IDI	In-depth interview
MSM	Men who have sex with men
MMR	Maternal Mortality Rate
SAARC	South Asian Association for Regional Cooperation
STD	Sexually transmitted diseases
STI	Sexually transmitted infections
SHE	Society for Health Education
SRHR	Sexual Reproductive Health and rights
SRH	Sexual and reproductive health
UN	United Nations
TFR	Total Fertility Rate
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
WHO	World Health Organization

EXECUTIVE SUMMARY

Addressing the Sexual and Reproductive Health Rights (SRHR) needs of young people remains a big challenge in the Maldives. This study explored experiences and perceptions of Maldivian youth aged 18-24 with regard to their SRHR needs and their health seeking behavior. Health care providers from the different health facilities such as hospitals, community centers, youth health cafes and non-government organization such as SHE were consulted. These different sources were explored to study the reasons why youth are not seeking the services offered by these center and what can be done to make these services more youth friendly.

Five focus group discussions and eighteen in-depth interviews were conducted at health care facilities and youth centers in selected islands and cities across the Maldives. All interviews were audio-recorded and transcribed. Data were analyzed using the thematic framework approach.

Young people's perceptions and understanding of SRHR is limited to the information received in the school system through the biology lessons and to the life skills program conducted in the schools by the Ministry of Education. There is a communication gap among the parents of the youth regarding SRHR issues and as a result the youth seek information from friends and other family members plus electronic and print media. The school system needs to incorporate comprehensive sexuality education topics as prescribed in the UNESCO guidelines to equip the youth with the correct information regarding SRHR. The health facilities designed for the youth needs to be made more youth friendly with flexible opening hours, and younger people to provide the services and more youth friendly atmosphere to be created in these facilities.

Providing young people with SRHR information and services through the existing healthcare system, and facilities needs to be explored and services targeted at the youth made more approachable by utilizing the electronic and print media. There is need for more research to evaluate how these services can be strengthened by involving the youth in the planning implementation, monitoring and evaluation stages.

1. INTRODUCTION AND BACKGROUND

The Maldives is a chain of 1,190 small low-lying coral islands grouped into 20 administrative atolls in the Indian Ocean: Unique geography and vulnerability pose key development challenges for the country. The dispersion of the population across the Archipelago raises the cost of delivering social services, as economies of scale are difficult to achieve in service provision. The total local population of Maldives is 344,023[1]. Maldives has a migrant worker population of 144,607 out of which a large population is youth and are men and the majority are from Bangladesh and India[2]. Maldives with its small population size has a large proportion of young people. In Maldives, an estimated 52% of its population is younger than 25 years (WHO 2014). Youth unemployment is at 25.3 percent, with even much higher levels in the capital Male'. The combination of high unemployment and limited job opportunities for youths have made some of them vulnerable to negative social influences such as drug abuse and gang-related activities[3]. A youth is defined in the Maldives as young men and women aged 18 to 34 years of age while the international definitions of youth vary. For example, UNESCO uses different definitions depending on the context. For statistical consistency, the UN considers 15-24, but Organization for Economic Cooperation and Development (OECD) considers 18-29 and the South Asian Association for Regional Cooperation (SAARC) considers youth as 18-35. For the purpose of this paper youth is defined as men and women between the ages 18 to 25 years of age.

According to National Reproductive Health Strategy 2014-2018, youths go through a challenging period of puberty and become sexually active while their perception and understanding about sexuality may not be adequate. This makes them the most vulnerable group for risky sexual behaviors. Biological and behavioral survey 2008 showed an alarming set of risk behaviors in the 18-25 age category among the men who have sex with men (MSM), Injecting drug users (IDU), clients of female sex workers (FSW) and these potential channels for HIV transmission are accelerated by the non-condom-use in multiple sexual partnerships and widespread sharing of unsterile needles and syringes. Other findings include injecting drug use in prisons and rehabilitation centers and the risk behaviors

[1] National bureau of statistics Census 2014

[2] Controller of Immigration Mohamed Ahmed Hussain 'Hanafy' told the press Thursday January 17th 2019. Retrieved on 20th Jan 2019 https://maldivesindependent.com/society/number-of-illegal-migrants-estimated-at-63000-143502

[3] The world Bank (2018) Retrieved https://www.worldbank.org/en/country/maldives/overview

found among this age cohort include selling of sex, buying of sex, MSM partnership, injecting drug use, multiple partnerships through group sex, sex with non-regular partners[4]. The Maldives Demographic and Health Survey (DHS) conducted in 2009, for example, showed that 25 percent of young women and 22 percent of young men had never talked to anyone regarding SRHR issues. A recent study conducted by Human Rights Commission of the Maldives (HRCM) also showed that among the 128 youths who participated in the study, 49 percent of the youth did not know what SRH is (HRCM 2016). Currently in Maldives, there is inadequate and ill-informed knowledge on reorganization of services and sensitization of health care professionals in place with changes to the demographic profile of the country. Such misinformation leads to inadequate and inaccessible services for young people, as well as specific services for other society members, such as people with different ability[5]. The government expenditure on the health sector was 9 percent of the GDP in 2011[6].

The Contraceptive Prevalence Rate (CPR) was 35% for any method or 27% for modern method, while the unmet need for family planning (FP) was 29%. The use of any method by currently married women has decreased from 42% in the 1999 to 35% in the 2009 Demographic and health survey (DHS). Trends in contraceptive use in 1999, 2004 and 2009 shows the use of oral pills decreased from 13% (1999 and 2004) to only 5%. The use of condoms increased from 6% (1999) to 9% (2004 and 2009). The proportion of married women who were sterilized declined from 10% (1999) to 7% (2004) but reverted back to 10% (2009). Thus, female sterilization had become the most commonly used modern form of contraceptive method in the Maldives. In 2009, among the reasons for discontinuation of all methods were; wanting to become pregnant (28.3%), getting pregnant while using contraceptives (13.8%) and experiencing FP side effects (10.4%). (National Reproductive Health Strategy, 2014-2018)[7].

Maternal Mortality Ratio (MMR) of the Maldives has been reduced significantly over the years to reach 56 per 100000 live births in 2011 from its baseline figure of 500 per 100000 live births in 1990[8]. In the Maldives unsafe abortion is also a cause for maternal deaths there were 3 abortion-related deaths of the 8 maternal deaths in 2010; two were septic abortions and one

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[4] 2008 Biological and Behavioral Survey on HIV/AIDS (UNDP, 2008)

[5] ICPD Beyond 2014. Maldives: Country Implementation Profile. 2010

[6] Ministry of Health (2014) Health Master plan 206-2025

[7] The statistics for youth cohort on CPR is not available.

[8] Ministry of Health, (2012) The Maldives Health Statistics. Male,

was a post- abortion uterine rupture[9]. The total fertility rate (TFR) of the Maldives, according to the 2014 census, is 2.5. The TFR is higher among rural women than urban women. Sterilization is only permitted under the following circumstances: The client is 30 years of age or older and has at least two living children or the client is under the age of 30 and also: (a) Has had three lower segment caesarean sections, (b) Has a medical condition, or a spouse with such a condition, that would lead to high-risk pregnancy or serious health complications. For any female sterilization procedure, the spouse must provide his written consent in addition to the informed consent of the female. The same spousal consent requirement applies to both voluntary female and male sterilization[10] [11].

The total number of live births was 7182 in 2011, 3988 of which occurred in Male' and 3156 in atolls[12] . The majority of births (95%) occurred in a health facility, 85% in a public facility and 10% in a private health facility. Male' and the south central region have the highest proportion of institutional deliveries (98%), while the north central region has the lowest (90%). The proportion of births assisted by a skilled attendant was 95%, with 71% assisted by a gynecologist; 9% by a doctor and 14% by a nurse or midwife. Across the regions, it ranged from 89% in north central and central regions to 99% in Male'[13]. The coverage of postpartum/postnatal visit was 94%, with 67% received a postnatal checkup within two days of delivery with no significant discrepancy in postnatal care among region, socio- economic status or residence and about 92% of women received a postnatal checkup from a gynecologist, doctor or nurse/midwife. In 2009, the DHS estimated that the neonatal mortality rate (nmr) was 20 per thousand live births in the urban compared with 15 per 1000 live births in the rural areas[14] .

1.1 Gender based violence status and gender identities:

Maldives ranks 106 out of the 144 countries assessed by the World Economic Forum on its 2017 Global Gender Gap Index[15]. The status of the women in the Maldives was traditionally

[9] UNFPA (2016) Efficiency of SRHR spending in the Maldives

[10] Department of Public Health (2005) *National Standards for Family Planning Services*, pp 137-155, 2005.

[11] The statistics for the youth cohort is not available.

[12] Ministry of health (2012) The Maldives Health Statistics 2012.

[13] Ministry of health (2010) Maldives Demographic Health Survey 2009.

[14] Ibid

[15] The global gender gap Report, 2017, Retrieved 30th December 2018

high and can be evidenced by the Sultanas; queens. According to (Marcus 2012), Maldivian culture shares many aspects of a strong matrilineal tradition. There is no gender gap in the schooling of boys and girls in the primary and secondary and higher education levels[16]. However, when looking at the labor force participation, women's labor force participation is high but limited to the lower tiers of the whole system. Within the home, women face challenges that men do not, such as high risk of domestic violence and little control over household assets. Finally, women contribution in the political sphere is limited in local and national politics and governance[17]. The Maldives study on women's health and life experiences (WHLE Study) conducted in 2004 showed that 1 in 3 women aged 15-49 have experienced some form of physical or sexual violence during their lifetime. This includes intimate partner violence, sexual violence by family members, colleagues at work, as well as childhood sexual abuse. According to this study the following were identified *"Reports of intimate partner violence were highest in central and southern regions and lower in Male' and the North. Women were more likely to experience severe forms of physical partner violence such as punching, kicking, choking or burning rather than just moderate partner violence. The experience of physical and/or sexual partner violence tends to be accompanied by highly controlling behavior by intimate partners. There was a significant overlap between physical and sexual partner violence with most women who reported sexual violence also reporting physical partner violence. Women who are younger (aged 25-29), have lower levels of education and have been separated or divorced appear to be at increased risk of partner violence"[18].*

1.2 STI &HIV status:

HIV in the Maldives have been characterized as low prevalence. However it has to be noted that there are cohorts in the population who are vulnerable and considered as high risk groups[19]. As of 2015, 23 HIV positive cases had been reported among Maldivians, among which 12 have deceased. In the year 2015, 356 HIV positive cases were found among expatriates during pre-employment screening, and thus were not granted work permits. 9 Maldivians and 1 expatriate (until his contract concluded in 2014) continue to receive

http://www3.weforum.org/docs/WEF_GGGR_2017.pdf

[16] Information on enrolment figures from the Department of higher education and from the ministry of education.

[17] The world bank (2016) Understanding gender in the Maldives

[18] Ministry of gender and family (2004) Women's health and life experiences.

[19] Ministry of Health (2011) The HIV and AIDS Situation: Related Policy and Programmatic Responses of the Maldives

antiretroviral treatment provided by the Maldivian government[20]. In 2013 the health protection agency (HPA) reported a total of 524 STI's through the national STI/HIV surveillance system. Of the 18 HIV positive cases reported among Maldivians in 2012, only two were females. Although HIV prevalence is still below 1%, sexually transmitted infections (STIs), particularly, syphilis and Hepatitis B , was detected among the people who work in the resort sector, MSM, seafarers, construction workers and IDU[21].

1.3 Sexual Orientation

According to the Sexual Offence Act 2014 (Maldives) same-sex sexual activities even between consenting adults are illegal and are subjected to a punishment of 7 – 10 years' imprisonment. Sexual offence Act, article 24, (a) It shall be an offence to commit a sexual act with another person of the same sex. If the sexual act is committed with the consent of both persons, then both persons are guilty of such an offence. (b) It shall be an offence for a person to commit a sexual act with another person of the same sex, without the consent of the other person. (c) A person guilty of an offence under subsection (a) is liable to imprisonment for a period of (5 five to 7 seven years). (d) A person guilty of an offence under subsection (b) is liable. However, it has to be noted that there is no legal discrimination in employment on the basis of sexual orientation.

The Health Master Plan (2016-2025) includes the following objectives related to sexual and reproductive health education: "- *Provide health and life skills education through the school system and in higher education institutes. - Provide access to gender appropriate youth health services together with access to productive or leisure activities to assist young people to make and maintain healthy choices. - Develop health service capacity and mechanisms to support national efforts to address gender-based violence. - Empower young people to make healthy choices with age and gender appropriate education, skills and access to reproductive technologies. - Provide targeted health education to young migrant populations on safe sexual and reproductive health practices and prevention of sexually transmitted infections."*[22]

The age range (18 -25years) considered for this study is when important life events take place in the adolescence's life. This includes events such as the first sexual experience and the first marriage. Although Maldivian girls and boys are free to decide whom to get married and when to start having families, the lack of sexual health information and knowledge ill-equips them for crucial life challenges ahead. Maldivians generally marry in their early to mid-twenties

[20] Health protection Agency-Ministry of Health (2016) Country progress report

[21] UNDP (2008) Biological and Behavioral Survey on HIV/AIDS

[22] Ministry of Health, Maldives Health Master Plan 2016-2025,pp 39, Dec. 2014.

(men at age 25.4 and women at age 22.2). The average age difference at marriage between both men and women is about three years (UNFPA 2014). By the time they are 24 years, a large percentage of married young people would endure a divorce. In addition, several young people fall pregnant outside of wedlock leading to an increasing number of stillbirths and miscarriages. According to research these young people have been entering this period of their life unprepared and unarmed with the necessary skills and knowledge regarding their reproductive health behaviors. Youth has been sexually active resulting in pregnancies at a young age. (UNFPA annual report 2015 OIVARU)

The Family Law in Maldives restricts child marriage; however, reports indicate 35 marriages were registered to children in 2012 alone[23]. (UNFPA 2014). When a person who has not completed 18 years of age in accordance with the Gregorian calendar lodges an application to marry to the family court, the registrar of marriages has the discretion "upon having considered the person's physical well-being, competence to maintain a livelihood, and reasons for contracting the marriage," according to the Family Act. In accordance with Islamic sharia, the Maldives' family law allows children under the age of 18 who have reached puberty to get married with a special permission from the family court. The Supreme Court has amended the rules on 21st September 2016 to require the Family Court to seek its approval in writing. The Family Court must also submit an assessment report from the Ministry of Gender and Family.

There are many factors that influence youth's SRHR seeking behaviors. Although Maldives have achieved gender equality and accessibility for education and health services, it lacks comprehensive SRHR education and services. A new national curriculum is being implemented commencing from 2015. In 2015, institute for research and development undertook a mapping exercise of the resource materials of Key stages 1, 2 and 3 against the internationally recognized UNESCO standards (International technical guidance on sexuality education) to ensure highest quality life skills education is provided through the school. This exercise shows that some topics such as long-term commitment, marriage and parenting, and HIV aids stigma care, and support under the theme sexual reproductive health and the theme on sexual behavior is yet to be incorporated. Comprehensive sexuality education (CSE) needs to be introduced into the school system and has been defined as "rights-based and gender-focused approach to sexuality education, whether in school or out of school[24]". Table one has listed the acts policies and guidelines that has implications and guides the SRHR programs in the Maldives.

[23] UNFPA Press Release: Releasing of the State of the World Population Report 2014) Date: 26/11/2014.

[24] Petrova D, Garcia-Retamero R. Effective evidence-based programs for preventing sexually-transmitted infections: a meta-analysis. *Curr HIV Res* 2015; **13:** 432–38.

Table 1- Acts, Policies and Guidelines that relate to SRHR of the youth aged 18-25

Name	Institution	Year
The Behavior Communication Strategy	Ministry of Health	2000
The family Act	Ministry of Women's Affairs and Social Services	2000
Population Policy of the Maldives	Ministry of Planning and National Development	2005
Special Provisions Act to Deal with Child Sex Abuse Offenders	Ministry of Health and Family	2009
National Gender Equality Policy and Framework for Operationalization	Ministry of Health and Family	2009
The Public Health Protection Act	Ministry of Health	2012
The Disability Act	Ministry of Gender, Family and Human Rights	2012
The Domestic Violence Act	Ministry of Gender, Family and Human Rights	2012
The Anti-Torture Act		2013
National Reproductive Health Strategy	Ministry of Health	2014-2018
Maldives domestic violence prevention National strategy	Family Protection Authority/Ministry of law and Gender	2014-2016
The Sexual Harassment Act	Ministry of Law and Gender	2014
The Sexual Offence Act 2014	Ministry of Law and Gender	2014
Health sector responses to GBV- National guidelines on providing care and prevention for health care providers.	Ministry of Health	2014
The Health Services Act	Ministry of Health	2015
The Health Professionals Act	Ministry of Health	2015.
National Youth Health Strategy	Ministry of Health	2011-2015
National Strategic Plan for the Prevention and Control of HIV/AIDS, Republic of Maldives	Health protection Agency - Ministry of Health	2012-2016.
Gender Equality Act	Ministry of Law and Gender	2016
Maldives Health Master Plan	Ministry of Health	2016- 2025
Maldivian national standard statements for adolescent and youth friendly health services to be provided to all young people	Ministry of Health	Undated

1.4 Availability and range of youth Sexual and reproductive health services

Youth friendly services have not been established yet, even at the national level, despite the Youth Health Strategy and the National Standards for Adolescent and Youth Friendly Health Services stating that a comprehensive strategy to address youth SRH by will be provided through multiple agencies. There have been initiatives from *Dhamanaveshi* in 2014 and the reproductive health center in IGMH from 2010 to 2013. However, these institutions have not provided the services on an ongoing basis. The services initiated from two regional hospitals have been discontinued due to change in the management and other factors. The Youth Health Café was initiated in year 2003 in Male' at the Youth Center, to identify a model for delivery of youth friendly health services to the youth living in Male'. However, this service is limited to health education and use referrals to health facilities for counselling and accessing reproductive health services from NGOs.

Society for Health education (SHE) has been implementing programs related to sexuality education. In 2016, SHE conducted awareness sessions for over 324 parent, 884 students and 87 school staffs. As a leading service provider in the area of SRH in the Maldives a robust research on SRH services and youth behaviors can improve its services informed by empirical evidence. And while it is known that the information and knowledge is a major issue what is less known and understood in the context of Maldives are the behavioral reasons for youth to not seek available services. In this context, with the aim of reaching more youth SHE in partnership with UNFPA launched a mobile application "Siththaa". The app is an interactive app where youth can send and receive any queries regarding sexual health. Further with the help of UNFPA, SHE also launched a program called "Safe Space" where technical resource persons interact with youth in a space they feel comfortable and free to speak.

It has been observed by SHE and reported in studies and by other service providers that many young people are not comfortable approaching for services even when they know about the service. As per the study conducted by (HRCM 2016), many young people reported they are not comfortable approaching for SRH related services as many believed that services are not for them. Some reasons identified include the social, cultural and religious stigma associated with it, perception that SRH are only for pregnant women and married couples and a belief that the youth don't need SRH services. According to (UNFPA 2011), access to SRHR services by unmarried adolescents and other key population groups are hindered due to factors such as fear of being penalized for an illegal sexual offence and also distress of being stigmatized and having to face some level of discrimination by the health care service providers. Considering that an estimated 52% of Maldives population is younger than 25 years (Census 2014), there is a significant need for SRHR information and services to be directed to this age group and for research to gain empirical data directly from youth of this age group. This study seeks to examine SRH services seeking behavior among the 18-25 age groups. Understandings

of what the youth population consider important services and how they would like those services to be communicated to them is also lacking. The youth of Maldives have good education and are technology friendly. There are significant opportunities for innovative means to be used in SRHR education, information dissemination and service provision. A study that goes beyond traditional concerns and directly explore from the youth about their preferences has significant potential to improve service delivery.

1.5 Purpose of the study

This Consultancy is for the project, "The State of Region Report on Sexual and Reproductive Health and Rights (SRHR): International Conference on Population and Development (ICPD+25)", being implemented by Society for Health Education (SHE) in collaboration with Asian-Pacific Resource and Research Centre for Woman (ARROW). One modality of the project is for the National Partner Organization to choose a specific SRHR issue of important to the respective country context, and develop ICPD+25 country monitoring report applicable for national level advocacy, mid-term review of the 6th Asia Pacific Population Conference (APPC), and ICPD+25 review. The purpose of this consultancy is to look at SRHR from the perspective of how youth seeking services are and what challenges they face by researching Maldivian youth between the ages of 18-25. The study will broadly focus on the following objectives:

1.6 Objectives of the study:

- To assess the behavior among youth in seeking SRH services
- To examine the challenges faced in accessing the services
- To contribute to advance in SRH education and services for youths

2. RESEARCH METHODOLOGY

This study will aim to answer the following questions.

- What are the factors that influence behavior among youth in seeking SRH services?
- What are the existing challenges and impediments in accessing the available services?
- How to improve and advance SRH services for youths?

The study will focus on evidence, current events bringing as much as possible best practices from other countries in similar socio-cultural situations.

Given the objectives of this study a qualitative research framework is appropriate as we are seeking understanding of this issue through the participants' experiences of their seeking the SRHR services. In particular, in-depth interviews and Focus Group Discussions (FGDs) are chosen as the methods of data collection. In-depth interviews with service providers and practitioners in the field will complement the FGDs data. FGDs provide insights into how people think and provide deeper understandings of the phenomena being studied. Therefore, FGDs has significant potential to generate rich and valuable data relevant to the objectives of the study. Furthermore, considering the costs associated with doing research in the Maldives due to the geographical dispersion of population into many islands, FGDs are more feasible than surveys and individual interviews. Because the target group of this study is 18-25 years the first step of the research is to identify the youth population. Table 1 shows populations of 18-25 age group for Male' and Atolls as per the 2014 Census.

Although qualitative research and FGDs in particular do not demand representative samples of the population, considering the various differences in different parts of the Maldives in terms of health and SRHR services available the research will seek to capture data from youth from different parts of the Maldives. An approach of bringing in more diversity and different range of experiences in order to get a better understating of this issue a purposive sampling technique was used. Considering the time and resources constraints for the study the participants were recruited from islands/atolls with the largest population. Thus two cities are selected out of the three ie: Male' which includes (Hulhumale, VilliMale' and Male') and Fuvahmulaku to conduct the FGD due to time constraints and from two different atolls (one from the north and one from the south) two island (B.Eydhafushi, and Dh Kudahuvadhoo) is selected based on convenience to travel.

Table 2- Age distribution of Male' and atolls for age cohort between 18-25

Single Age	Republic			Male'			Atolls		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
Total	52,255	24,321	27,934	25,859	12,510	13,349	26,396	11,811	14,585
18	6,375	3,148	3,227	3,136	1,501	1,635	3,239	1,647	1,592
19	6,107	2,890	3,217	3,227	1,523	1,704	2,880	1,367	1,513
20	6,231	2,923	3,308	3,363	1,592	1,771	2,868	1,331	1,537
21	6,404	3,038	3,366	3,310	1,619	1,691	3,094	1,419	1,675
22	6,391	2,920	3,471	3,181	1,516	1,665	3,210	1,404	1,806
23	6,805	3,133	3,672	3,254	1,618	1,636	3,551	1,515	2,036
24	7,025	3,205	3,820	3,244	1,627	1,617	3,781	1,578	2,203
25	6,917	3,064	3,853	3,144	1,514	1,630	3,773	1,550	2,223

Source: Census data 2014

Table 3 – Number of participants of FGD and in-depth interviews

Names of Sites	Focus group discussion (FGD)	In-depth interview(IDI)
Male'	1	8
Villi Male'	1	2
Hulhumale	-	5
Gn. Fuamulaku	1	1
Dh.Kudahuvadhoo	1	1
B.Eydhafushi	1	1
Total	**5**	**18**

Considering the nature of the topic and the age group each FGD was maintained between 7 - 10. In most cases FGDs were conducted for males and females separately as participants may feel uncomfortable talking about SRH issues. However, some FGDs are mixed in capital Male' and in the islands. Otherwise it will be men only or women only focus groups.

2.1 Data Collection

An in-depth interview (IDI, FGD) (annex 1) guideline was used to conduct the interviews for the health personnel and a more detailed in-depth interview guideline was designed and administered for the focus group discussions (FGD). The guideline was first prepared in English and then translated to Dhivehi. A professional translator translated the guidelines from English to Dhivehi. The translated Dhivehi version of the questionnaire was used to seek the information from the interviews with the health personnel and the FGD. All the interviews and FGD were conducted in Dhivehi and notes were taken by a research assistant. The guidelines were pretested with a health personnel and a youth prior to implementation. The guidelines were focused on demographic aspects of the interviewees in the first part and the second part was focused on-perceptions on sources of sexual and reproductive health service utilization. Young people were briefed about the purpose of the study and data were collected after a verbal informed consent. During the data collection process the interviews and FGD were recorded with the consent of the people involved. After the interviews the health personnel were given forms to be filled in about the number of people who visited the services during the last year and the reason for seeking the services. With the FGD each individual was given a form to fill in regarding the health outlets they have visited during the last year and the reasons for visiting the services. The interviews took about 30 minutes and the FGD about 45 minutes for each FGD. Data quality was assured through careful design of the questionnaire. The research assistant was trained in one day about the purpose of the study, the questionnaire in detail, the data collection procedure, the data collection setting and the rights of study participants. The collected data were checked for completeness and consistency after each day of data collection by entering the data and listening to the recorded versions of the interviews and double checking with the researcher.

2.2 Data Analysis

Transcription of the data collected in this study was done by the research assistants under the guidance of the researcher. The verbatim transcription was done directly into English from Dhivehi. All the interviews and FGD were recorded and detailed notes were taken by the research assistant. The notes were translated into English and compiled onto the forms. While conducting the FGD both English and Dhivehi were used according to the preference of the respective groups. The transcripts saved as an individual word document with clear labelling showing the study site, type of interview and respondents demographic information. The researcher cross-checked the transcripts for accuracy and language translation consistency. Trustworthiness of the data was met through triangulation of three aspects of data collection: i) having a wide range of respondents,

ii) by using more than one method of data collection such as IDIs and FGDs,

iii) by using different geographical locations (cities and islands in the north and the south to conduct IDI and FGD. Data analysis was conducted using the thematic framework approach.

2.3 Ethical considerations

In the IDIs, informed consent was obtained from each health personnel, verbally, after a detailed explanation about the purpose of the study had been given. With the FGDs, verbal consent was obtained from all group members from the FGD moderator to signify the group's acceptance to participate in the study. All the participants were informed that the discussion was being recorded and that this information will only be used for the purpose of this research. Respondents were assured of anonymity of the data collected and that their personal data would only be accessible to the research team. Participants were informed of their right to refuse to participate in the study or withdraw from the discussion at any time during the interview. Ethical approvals for this study was sought by SHE prior to undertaking this study from the relevant authorities.

With regards to FGDs, verbal consent was obtained from all group members from the FGD moderator to signify the group's acceptance to participate in the study. All the participants were informed that the discussion was being recorded and that this information will only be used for the purpose of this research. Respondents were assured of privacy and confidentially and that the data collected would only be accessible to the research team. Participants were informed of their right to refuse to participate in the study or withdraw from the discussion at any time.

2.4 Limitations of the study

This study is a qualitative study across limited sites in Maldives hence the results presented cannot be generalized to the whole population of the Maldives. Due to the time constraints (4 weeks to undertake the study) the sites were limited only to the accessible sites. Data on actual service utilization trends were collected from the specific sites to corroborate the findings. Focus Group Discussions with young people were not disaggregated by marital status categories. There is some evidence that younger youth do not have the same perceptions and needs as older youth who are married. According to the policies and guidelines in the Maldives contraceptives can only be administered to married couples thus the youth seeking contraceptive services in a formal health facility would only be married youth.

2.5 Results

A total of 5 FGDs, were held with young people aged between 18–24 years, 1 with girls and 1 with boys and 3 mixed group. The questions were posed to find out if the youth were working or not working. Furthermore, the participants were asked if they were married or not married. Two FGDs were held with young people from cities and the other three from the islands across the country. A total of 18 IDIs were conducted with health personnel out of whom 5 were men and 13 were women. The health personnel were from health facilities while 3 were from youth centers and only IDIs were held with health personnel. More health personnel were interviewed from health facilities/hospitals which were from the government and private sector. The health personnel involved doctor's nurses and health workers. More health personnel were from health facilities than youth centers because it is the most common service delivery model available. There are other hospitals and health facilities plus youth centers in other areas of the country however these were not visited due to logistical and financial limitations.

Table 4–Details of people who participated in the IDI

Study site	Sex of the respondents		Total
	Female	**Male**	
Male (SHE)	1	1	2
Youth /health Café (Male')	3		3
Eydafushi	1		1
FuahMulah	1		1
Dhamana Veshi (Male')	5	3	8
Kudahuvadhoo	1		1
Vilingili	1	1	2
Total	**13**	**5**	**18**

Source: Study findings

Table 5–Details of people who participated in the FGD

Study site	Sex of the respondent		Youth who are working	Youth who are married	Total
	Female	Male			
Male'(SHE)	8	5	5	1	13
Eydhafushi	2	8	4	-	10
Fuvahmulak	0	6	-	-	6
Male'	6	0	-	-	6
Kudahuvadhoo	6	1	4	-	7
TOTAL	**22**	**20**	**9**	**1**	**42**

Source: Study findings

3. FINDINGS

The study findings are reported according to the themes that emerged from the data. These themes are: a) SRHR problems faced by young people b) Health seeking behaviors of youth c) Perceptions of existing SRHR services d) Suggestions on how to improve SRHR services

3.1- SRHR problems faced by young people

The youth who participated in the focus groups (FGD) were initially asked to identify the sexual and reproductive health problems they face, and what SRHR means to them. The answers were very vague. This reflects the social and cultural barriers to discussing these issues openly in a group. All the youth responded by stating that they have heard about reproduction, and fertilization in their biology lessons in the school and in the life skills lessons conducted in some schools. None of the youth discussed about any reproductive health issues they have experienced or faced in the focus groups and pointed out that they were not comfortable discussing these issues with their peers as well. Other concerns included limited information and knowledge on the reproductive health generally, problems related to physical body change during the period of adolescence and relationship problems and lack of parental guidance on puberty and changes in the body during puberty.

Table 6- Demographic characteristics

Characteristics	Responses
Mean age of respondents FGD youth group 22 (n=42) range	18 years -24 years
Mean age of health personal 35 (n=16)range	25years – 59 years
Educational background of parents/spouse	
1.Basic Education	11
2.Primary Education	5
3.Secondary Education	9
4.University/college	17

Source: Study findings

Then mean age of the respondents who participated in the focus group discussion are 22 which is the target audience for this study. The mean age of the health professional who were working in the health facilities as service providers were 35. The age of the service provider was taken as a negative factor contributing to youth not being comfortable in seeking the health services which was pointed out in the focus group discussions. Table 3 shows that the parents who have university or college education is 40 percent and yet all the youth in the focus groups except for very few cases stated that the parents were open about discussing sexuality issues specially contraceptives and experiential sexual topics. This issue is discussed in detail later in the paper.

Table 7 – Knowledge about SRHR among the youth (FGD)

Emergent theme	Definitions	Sample quotes
Knowledge about general SRHR	Statements mentioning the source of SRHR information by the participants. (n= 25)	*"We do know what SRH is because we learned it in school /college. We learned it in school as a subject called life skills, which is a must for all the students to attend in our school. However, this life skills program was not conducted in the school where all of us attended. This subject is outside the main curriculum and we attend these sessions as an extra curricular activity. We learned about contraceptive methods such as condoms, copper T and pills. We even learned about sexually transmitted diseases like HIV/Aids syphilis through these session"*
Knowledge about pregnancy and abortion	Statements mentioning the source of information by the participants. (n= 15)	*"We did get the information about pregnancy and abortion from school Biology lessons apart from that we learned from the internet sources"*
Knowledge about Puberty (menstruation and ejaculation).	Statements mentioning their own experience by the participants (n= 17)	*"We never ask parents, all of our parents discussed about body changes at puberty, when it happens only they come to discuss about it with us when we asked and not before even then our parents do not tell us the details. Most of us are not very comfortable talking about it with our parents because it is not a subject we discuss at home".*
Knowledge about STI, HIV/AIDS	Statements mentioning the source of STI, HIV/AIDS information by the participants. (n= 19)	*"we talk about it with friends mostly about STI/STD , how to prevent pregnancy"*

Youth who participated in the FGD reported the lack of communication with mothers and fathers. All the youth (100 percent) preferred to discuss and also discussed SRHR issues with elder brother sisters and cousins with in the family circle. On the issue of communication with parents (90 percent) of the participants stated that the communication was restricted only to girls communicating with the mothers rather than boys. Only 10 percent of the participants (boys) reported communicating with fathers on SRHR issues. The youth also highlighted that the parents who communicate with them generally talk about sexual risk prevention and developmental topics compared with experiential sex topics. Frequently discussed topics include: HIV/AIDS, STDs, substance use, menstruation (girls), physical development and puberty. For instance, both health worker's/ service providers in health facilities and young people reported puberty as the most widely discussed topic. However, health workers reported that one of the most common topics they discuss with youth was STI's. Youth also stated that 90 percent of mothers and 10 percent of fathers had talked to them about growing up. This study has found out that higher proportions of mothers communicate more with daughters than sons on almost all topics. Finally, both parents hardly discuss contraceptive and experiential sex topics with their children and this was observed when the youth did not know the meaning of the term contraceptive when they came across the term while filling in the forms provided to the youth after the FGD. The youth has reported they had never discussed topics such as condom use, contraception and pregnancy with their parents. Table 5 shows that knowledge of SRHR services was sought from different sources and 20 percent being the schools followed by 15 percent from internet and friends. Knowledge about places of STI treatments was sought from different sources of print and electronic the media and hospitals have been mentioned by 45 percent of the respondents.

Table 8 - Knowledge of SRHR (FGD)

Knowledge of SRHR	Information about SRHR	Comments/source
Knowledge of services	Knowledge of supply sources for specific contraceptive methods	**Hospital** N=7, **Pharmacy** N=8, **School** N=12, **Friends** N= 9, **Internet** N= 9, **sister** N=1, **Family members** N= 1 **elders** N=2, **Face book** N= 2 **YouTube** N=1, **Biology text book** N=3, **SHE** N=1, **Family clinic** N=1, **Google** N= 2, **Leaflet** N= 1 **Encyclopaedia** N=1.
	Knowledge of places of STI treatment	**Hospital** N=18, **Clinics** N=1,**Fb** N=1, **SHE** N=4, **leaflets** N= 2, **Safe space** N=1, **Health clinic** N=1, **Public poster** N=3, **Internet** N=2, **Friends** N=2, **Parents** N=1, **Books** N= 1 **advertisements** N=1, **Family** N=1, **HPA** N=1

Source: Study findings

3.2 Health seeking behaviors of the youth (FGD and IDI)

In this study 90 percent of the youth respondents have stated that the first and preferred place of treatment for females and males both if they encounter any sexual and reproductive problems relating to STIs, is the internet, and the pharmacies. This was followed by friends and relatives (older sisters/brothers, cousins). Some of the respondents (specially girls) stated that they will seek professional help from doctors by telling their parents. Other respondents (girls in FGD) voiced out their opinions that seeking help from a health professional is not attractive because their parents might come to know of the visit. In many Asian countries, young women are likely to face family and community censure, are shyer or more embarrassed about accessing services and are more likely to face negative attitudes from providers[25].

"Youth are afraid to talk about sexuality related issues because they feel they are being judged or that they might be reported or their parents might be notified. There is a lot of confidentiality issues but those who come to get the services regularly are very comfortable with the services" (IDI009 youth health café personnel Male').

"Mostly the girls have the problems but they don't come to the hospital, sometimes they will come and see the gynecologist and we don't get to talk to them, sometimes when they see

[25] WHO (2007) Adolescents, social support and help-seeking behavior -An international literature review and program consultation with recommendations for action.

me on the road they might approach me and ask questions for the last two years we have a center called adolescent youth friendly center the number of youth coming to seek the service is very less. We have around 9 staff trained who is working in that center" (IDI 0010 Eydhafushi Hospital)

3.2.1-The Youth Health café: The youth health café was opened in 2003 and this facility is hosted in the social center in Male'. The staff in the youth health café stated that most of the youth who come to seek the services are boys and the area of SRHR that they seek information most about is sexual dysfunction. Only two youth (table 9) has been documented to have sought the services of the youth health café within a one-year period of when youth health café was providing SRHR services.

"*We recently started providing individual health counselling but the youth are not aware of it so the number of youth seeking the service is less and since it is not properly advertised youth are not aware of the health café services but we have conducted a number of successful awareness programs, we do have outreach programs, individual health education, health screening, but it is not functioning very well due to many factors. All the programs are organized on a yearly basis to be undertaken throughout the year. Outreach programs are planned for the atolls 2 atolls to be reached per year, and once a month we organize awareness programs for youth in Villigili, Hulhumale, and Male'. And since youth is involved in we planned to educate them through sports". (IDI 009 Youth Health Café Male').*

Table 9 - Youth Health Café/ Clinic

Number of visits by youth 18-25 with in the last 12 months	Reasons for the visit	Type of facility	Consulted Doctor/nurse/health care professional
2	Information regarding contraceptives &SRHR	Youth health café/ clinic	Health care professional

Source: Youth Health Café

3.2.2-Dhamanaveshi (Urban Health Care Center)

The Dhamanaveshi youth center was opened on the 4th of September 2013 in Male' to provide youth a facility to visit and receive SRHR services. Dhamanaveshi provide services for youth from 0800- 1400 hours on weekdays and Tuesdays from 1400-1700 hours. The timings of the services are not very convenient for the youth so the amount of youth coming to

receive the service are very few. Only one youth have been reported to seek SRHR services within a one-year period.

"The environment also plays a big role when it comes to youth they prefer more space and entertainment which we don't have and since this place is more advertised as the vaccine unit we don't get a lot of youth coming to get out services. This year we are planning to have a lot of awareness programs in different schools including the parents. We are planning to have awareness programs in our facilities and the services we provide so that the number of youth seeking our services will increase". (IDI 001-008 Dhamanaveshi Male')

The discussions from the officials in Dhamanaveshi showed that Dhamanaveshi was known to the people as an institution that provides vaccine services. This is also a formal institution which provides vaccines to the children and the adults as one of its functions. The timing of the services was also pointed out by the officials from Dhamanaveshi as a factor for the low turnout because it coincided with the school and working hours.

Table 10- Dhamanaveshi SRHR services

Number of visits by youth 18-25 with in the last 12 months	Reasons for the visit	Type of facility	Consulted Doctor/nurse/health care professional
1	Consultation	consultation	Doctor

Source: Dhamanaveshi SRHR services

3.2.3- B.Eydhafushi Adolescent youth friendly health services: The services were inaugurated in January 2018 inside the Eydhafushi Regional Hospital. This unit is staffed by nine personnel who have community health backgrounds and are equipped with the skills and knowledge to provide the needed services for the youth. The health personnel who was interviewed stated the following.

"We were trained in adolescent and youth behavior their attitudes and other characteristics of adolescents --- but not on how to approach or communicate with youth on SRHR issues. So I feel that I am not equipped with the skills on communicating this to the youth since it is a very sensitive subject" (IDI 0010 Eydhafushi Hospital).

The turnout by the end of 2018 was not very effective and the youth who come seeking the services were very few. The community health unit has embraced another strategy in this community to raise community awareness on health issues that the community encounter, by visiting the households on a monthly basis and finding opportunities to discuss relevant health issues that concerns the community such as dengue, antenatal and prenatal

information and services which includes SRHR issues as well. This door to door visits have been reported to be successful and some of the youth have come forward with SRHR problems such as STI and requested for information informally from the community health personnel.

Table 11- Eydhafushi Adolescent youth friendly health services

Number of visits by youth 18-25 within the last 12 months	Reason of the visit	Type of facilities	Consulted Doctor/nurse/health Care professional
15	Family planning	Mobile teams visits (Door to door)	Health care professional

Source: Eydhafushi Hospital

3.2.4-SRHR programs of SHE:

SHE has been implementing programs related to sexuality education. In 2016, SHE conducted awareness sessions for over 324 parent, 884 students and 87 school staffs. As a leading service provider in the area of SRH in the Maldives a robust research on SRH services and youth behaviors can improve its services informed by empirical evidence. And while it is known that the information and knowledge is a major issue what is less known and understood in the context of Maldives are the behavioral reasons for **youth to not seek available services.** In this context, with the aim of reaching more youth SHE in partnership with UNFPA launched a mobile application "Siththaa". The app is an interactive app where youth can send and receive any queries regarding sexual health. Further with the help of UNFPA, SHE also launched a program called "Safe Space" where technical resource persons interact with youth in a space they feel comfortable and free to speak. A family planning Centre and well women center is operated in the Society for health education where the services are provided by trained health professionals[26].

The safe space program launched by the society for Health education and UNFPA in 2018 is an innovative program which was aimed at promoting a youth friendly atmosphere to discuss SRHR issues. This project was undertaken with the aim of strengthening the accessibility of adolescent friendly health information in out of the school setting for youth. By the end of this program, the aim was to establish and provide SRHR information in an out of the school setting for youth in a more relaxed atmosphere such as the cafes. These sessions were conducted in open cafes to reach out to the marginalized youth. The safe space program has been able to reach a total of 707 youth members this year. This program has worked well and since SRHR is a taboo topic there were no responses initially but gradually the youth opened

[26] Information provided from the Society for Health education

up and some of the challenges faced by this respective program was the need to register the youth prior to the sessions. The cafe's also do not have private rooms where sessions can be taken privately and that became a barrier for them to open up as well. This is a pilot program and needs to be scaled up at the regional and national levels[27].

Table 12 SRHR Clinic and Well women center of SHE

Number of visits by youth 18-25 within the last 12 months	Reason of the visit	Type of facilities	Consulted Doctor/nurse/health Care professional
165 females 34 males	Family planning Clinical Assessment	Well woman centre SRHR clinic	Gynaecological doctor/health professionals

Source: SHE

Table 13 -Villimale' Hospital (Community center)

Number of visits by youth 18-25 within the last 12 months	Reason of the visit	Type of facilities	Consulted Doctor/nurse/health Care professional
19 maternity clinic 07 reproductive health	Antenatal check-up/birth control	Hospital	Health professional /community health workers

Source: Villimale' hospital

Table 14- Kudahuvadhoo Hospital (Community Health Unit)

Number of visits by youth 18-25 within the last 12 months	Reason of the visit	Type of facilities	Consulted Doctor/nurse/health Care professional
63	Family Planning	Community Health Unit	Health professionals
06	Health Education		
02	Seeking information		

Source: Kudahuvadhoo Hospital

Out of all the health facilities which provides SRHR services to youth the numbers show that more youth seek services from the programs undertaken by the Society for Health education with in the last one year in Male' and the greater Male' region. More youth friendly programs

[27] Information provided by the Society for Health Education

have been offered from the facilities in the Society for health education such as the safe space program and the Siththaa app.

"The only barrier is that parents are not very supportive and since we are a very close community and due to cultural factors parents are not very comfortable talking about SRHR, if they initiate only we talk about SRHR however we will talk to our children because we feel that this is very important information and every person needs to know the correct information". (FGD 004 Mixed group)

3.3- Perceptions of existing SRHR services:

Perceptions of services were both positive and negative and differed for different institutions such as hospitals and other facilities which provides services for the youth. In Male' and greater Male area the girls visiting hospitals and consulting a gynecological doctor reported that the services as good, affordable and helpful with positive interaction with Health Service Providers. Boys said that services available at the hospitals and health facilities were good but the health personnel's age did matter because they feel awkward to talk to a person who are older, however a 100 percent of the respondents agreed that they will seek help from a doctor if they encounter any SRHR problems which they cannot deal with by seeking help from relatives who are older than them or the internet sources.

"We really don't know about the youth friendly services in the hospital. Maybe they have not promoted the service in our community and we are hesitant to ask these kinds of questions to health personnel who are older than us. If we come across any problem, we go and seek help from the doctor in the hospital". (FGD 002 mixed group Eydhafushi)

"Conducting awareness programs in café's to reach out to youth is a good strategy, safe spaces have been able to reach a rough total of 600 youth members this year rather than bringing them to us we go and meet them in café's ,it works well when we first start it's like since it's a taboo topic but gradually they open up and the difficulty we face is that we need to register them and when it comes to space the cafe's do not have private rooms where we can take sessions privately and that becomes a barrier for them to open up" (IDI 0011 She personnel)

"This is something we struggle as well that's why we try to organize session in a youth friendly atmosphere and social media would be a good place to talk about it but it's hard to write. Even chat rooms are not very popular among the youth because they don't have the trust and confidence because comfort level is like a big hurdle among them" (IDI 0012 She personnel).

Table 15 shows that only 20 percent of the respondents go to a health facility to seek services when they encounter a problem. Other respondents (80 percent) have stated that they get

information via the internet and treat themselves using home remedies and if it is not treated only then they seek the services of the doctor in a hospital.

Table 15- Use of SRHR services

Use of SRHR services	Facility/number of visits/reasons	Comments/source
Use of services	Have you ever visited a health facility or doctor of any kind to receive services or information on contraception, pregnancy, abortion or sexually transmitted diseases?	**(No)** N= 32 **(yes)** N=8
	Thinking about your last visit, did you go to a government clinic, health centre or hospital or a private doctor or clinic?	**Government Hospitals** N= 11 **Private Hospitals** N= 4
	Number of visits in last 12 months	**3 visits** N=3, **2 visits** N= 2, **1 visit** N= 1, **10 visits** N=1

Source: Study findings

From table 16 it can be seen that out of the 42 respondents in the FGD only one respondents have asked for contraceptive services because contraceptives are available only to married couples for the health facilities. This shows that youth will only seek the services if they are married. In the services provided 80 percent of the respondents have agreed that there was sufficient privacy however 79 percent of the respondents felt that they were not able to ask the required questions. None of the respondents have sought treatment for any sexually transmitted infections in a facility.

Table 16- Details of visits to a facility within the last 12 months

Visits with in the last 12 months	Facility/SRHR method/treatment	Comments/source
Characteristics of most recent visit	Type of facility (Government , Private, Other)	Government N= 10, Private N=4
	When you last saw a doctor or a nurse, what was your reason for going? Contraception, STD, Gynaecological exam, Pregnancy test, Pregnancy termination, MCH, Other	Vaginal discharge N=1 STI screening N=1 To seek information re STD N=1
	Exposure to information about contraception	No exposure N=29 Yes N=12 Somewhat N=1
	Whether contraceptive services were requested	Yes N=1
	Whether staff spoke about contraception, STIs, pregnancy	Yes N= 4 No N=7
	Whether respondent felt able to ask questions	Yes N=6, No n= 24
	Whether questions were answered adequately	More or less N=1 No N= 7, Yes N=26
	Whether there was sufficient privacy	Yes N= 10, No N=2
Source of contraceptive methods	Source of method used with first partner	Condoms / IUD N= 3
	Source of method used with current boy/girl friend/spouse	No girlfriend but still use condoms N=1.
Source of STI treatment	Source of treatment for most recent STI episode	NA

Source: Study findings

3.4-Suggestions on how to improve SRH services

In one of the sites the youth had no idea of the services being offered from the hospital and that the hospital had a specialized unit which provides services for the youth. The youth suggested to have more awareness programs and give more information like make posters or even publish it on the website where it is accessible to the youth and the larger community.

*"Youth don't come seeking our service they **find all the information on the internet**. A lot of people coming to seek family planning services even before they visit, they already know the information through the internet and what they prefer". (IDI 0013 Villigili hospital)*

*"**Eliminating the topics** and regarding it as a taboo is not the answer. The teachers have to become aware of the reality that kids in school in this country are sexually active and need to be informed at an early age, mostly they are misinformed and sometimes they don't want to believe that it is happening and that in Maldives children are getting sexually active at a young age. Even the research shows that when they get the correct information they will not go for experimentation because experiment is already happening and with the correct information they know a bit better and they have the choice on how to protect themselves" (IDI 0011 SHE personnel).*

*"Guidance by medical officers to improve primary urban health which includes youth is one thing we can do and we can **train school health personnel** working in schools to be more aware of these cases to strengthen the services provided in the school system" (IDI 001-008 Dhamanaveshi Male').*

*"People who know that I am an employee at SHE are more comfortable in opening up and **age is a factor**, youth find it more comfortable to open up to someone who is around their age and in the SRHR service section there are young people providing the services. There are cases where they come asking for help with abortion or pregnancy" (IDI 0012 SHE personnel).*

*"We provide a Youth kiosk, available on request, SRH services available in the morning urgent cases are attended to and even condoms are available, but since the services are available **only at working hours it is not so convenient** for the youth there have been cases where we have opened the services at odd hours on request, and we do have an app (Siththaa App) which helps youth to get a lot of answers within 24 hours" (IDI 0012 SHE personnel).*

On the topic of linking and strengthening the services in the school the respondents provided the following:

"In school it is important that all students know about the menstruation, puberty and hormone changes that happen. It should not only be the science students but all should know the bodily changes and that consent is really important in a relationship since the children are sexually active at a young age it is a very important to provide information about consent and safe sex mostly religion comes when we talk about sex but we need to acknowledge that it is happening. ***CSE session for students*** *in the higher grades should be provided, consent in a relationship and safe sex, they should know the real meaning of relationships and consent so if we can include these in the curriculum that would be really good" (IDI 009 youth Health Café Male').*

4. SUMMARY AND DISCUSSION

4.1 Knowledge about SRHR among the youth:

One factor that was highlighted in all the discussions from both girls and boys in all the focus groups in Male' and the islands showed that there was a lack of communication between the parents and their sons and daughters which was the basis of the misinformation. The consequences were that all the participants lacked proper parental guidance on issues related to SRHR. Parents who were university graduates also hesitated talking to the children on issues such as menstruation, body changes at puberty, consequences of unprotected sex. Because, either they did not have time, or were afraid and uncomfortable having such discussions or due to cultural limitations. One key personnel in a health facility stated that there is distance between the children and their parents when they reach puberty. On the topic of puberty, the facilitator posed the question of "*hinaigathun*"[28] (bathing/washing the body) at the end of menstruation and whenever ejaculation has happened which has to be performed according to Islam. Most participants responded that they have learned it from the Islam books in school. Lack of proper understanding or open communication channels between parents and their children was stressed by boys and girls from all study sites. Various studies find that adult attitudes about youth sexuality is a major barrier to adolescents feeling comfortable in seeking information and services from either service providers or parents. In spite of many research findings to the contrary, adults believe that helping adolescents deal with sexual and reproductive health matters will encourage sexual activity (Newton, 2000).

"There is lack of communication between the parents and the children, especially when it's about SRHR, us young people learn about sexual health from our relatives who are older than us such as cousins and brother and sister of the same sex ...we have lost contact with our parents—" (FGD 002 mixed group Male').

[28] hinaigathun can be explained as Ghusl (Arabic: الغُسل) is a term in fiqh that refers to the Islamic ritual bath of the whole body.

4.2 Health seeking behaviors:

In Bangladesh, young girls report that they are frequently put off using available health services because they feel shy and specially fear of the parents knowing about the visit, (Mitra et al., 1997). In India research has shown that with adolescent girls in the case of SRH needs, young women consult their parents first, then doctors, with the most common treatment for SRH-related issues being over-the-counter medication (Devi et al., 1999). These trends are common across many developing country settings for youth. This study has shown that the reasons why most boys have stated they will not go to their parents is they feel shy and hesitant to discuss these issues with parents rather they would search the internet and buy medicine over the counter from pharmacies. Research from Bangladesh has found that in the case of STIs, the preferred place of treatment for female adolescents (both married and unmarried) was pharmacies, followed by local healers (Barkat et al., 2000).

Many youth clinics offering services to the youth are designed by service providers, policy makers and other adults without any involvement from the youth and thus create a mismatch between the needs of the youth and the services provided by both formal and informal institutions. For example, the topics decided by the youth health café to conduct monthly awareness programs are decided by the staff themselves without any input from the youth who are seeking the services and thus end up by having a low turnout. WHO (2007) states that to to understand why young people seek help, and what help they seek, requires understanding of how the youth define their needs, in addition to understanding the perceptions of parents, service providers, policy-makers and other adults.

4.3 Perceptions of existing services:

All the youth who participated in the focus groups and the health personnel interviewed discussed the importance of introducing comprehensive sexuality education in the schools. Except for the youth in Male' none of the youth outside Male' and the greater Male' area have heard about the Siththaa app introduced by SHE. Social norms strongly forbid premarital sex; unmarried youth are hesitant about seeking care even if they have a painful genital ulcer or a possible unwanted pregnancy. In one of the sites the community health personnel noted that there was a case of 14-year-old unmarried pregnant girl but have not sought help from the health facility as yet. Barker (2005) states that they are likely to try to deal with the problem themselves, or with the help of friends or siblings whom they can trust to keep their secrets. To ensure that no one around them comes to learn about their problem, they tend to turn to service delivery points such as pharmacies and clinics at a safe distance from their homes, as well as to service providers who are as keen as they are to maintain secrecy (such

as those who carry out abortions illegally)[29]. In the case of the Maldives literature has shown that abortions are performed outside the country or through illegal means inside the country.

5. CONCLUSION AND RECCOMENDATION

This study has found out that youth are attracted to services when they are offered in a youth friendly manner, there is ample evidence to say that because 90 percent of the respondents who have participated in this study from Male' and the greater Male' area has received SRHR related services from SHE. Some of the characteristic of the services offered were flexible hours, flexible places such as café and the information being provided by young people themselves. A report published by UNFPA in 2018 called the efficiency in SRHR spending in the Maldives discussed the importance of establishing youth friendly services as the most cost effective strategy. The strategies identified are to target the youth who are in this age cohort of 18 to 24 years and deliver efficient SRHR services. Another strategy was to strengthen the services in the school system by training the school councilors to provide efficient and effective counselling to the youth who are in the school system.

Another major finding is strengthening of the CSE in schools so that the students have the correct information regarding SRHR. The new National Curriculum has yet to incorporate some of the key themes under the UNESCO guidelines. The teachers need to be well equipped in teaching these themes and topics. UNFPA (2018) in collaboration with NIE has developed a module for teacher with the aim of assisting teachers to effectively deliver the topics in the national curriculum and further research needs to be undertaken to see the effectiveness of this module by all the stakeholders including the Ministry of Education and the higher education institutions who are training teachers.

Another finding is that awareness programs designed for the youth need to involve the youth in the planning, implementation, monitoring and evaluation stages and peer educators trained during the implementation of these awareness components to gain the confidence of the youth seeking the services. These can be addressed by the UN agencies and the government and non-government institutions implementing these programs.

One important finding highlighted in this study is the breakdown of the communication between parent and child especially fathers and son communication regarding sexual knowledge needs to be strengthened. The Maldivian society is still very conservative with

[29] Barker G, Olukoya A and Aggleton P. Young people, social support and help-seeking. *International Journal of Adolescent Medical Health*, 2005, 17, 4:315–336

regards to discussion around sex and sexual health because of existing religious, social and cultural norms and values. Future research should involve the design, implementation and evaluation of structural interventions addressing the social, cultural and economic drivers of sexual health of both boys and girls. These issues can be addressed by all the stakeholders including UN agencies and government and nongovernment institutions addressing these programs.

This study has found out that the Siththaa app has been the most successful tool in reaching out to the youth with a download number of 2484 within one year. Therefore, this study recommends the Siththaa app to be used by all the health service providers and SHE to play a part in partnering with the Ministry of Health to introduce this App to all the health service providers across the country.

This study also recommends the exploration and further studies to include the immigrant population in this age cohort to see their SRHR seeking behaviors in this country since a total of 144,607 out of which a large population is youth and are men. This statistic was released by the Immigration department on the 17th of January and was beyond the scope of this study.

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ANNEX 1

In-depth interview guideline

Oral Informed Consent

My name is _____ I am a researcher collecting data for a study. Our research topic is "Sexual and Reproductive Health services seeking behavior among youth in the Maldives". I will be very appreciative if you could provide answers for this questionnaire. It will enable me have a reliable data for analysis. Please be assured the answers you provide will be treated with confidence.

If you agree to take part in this interview/FGD, I will be asking you questions about your personal information (such as phone number), expenses, personal views on SRHR. You are free to not answer any question that you don't feel comfortable with and can end the interview at any time.

The expected duration of the interview is 30 minutes. However, this time may be adjusted accordingly during the interview. You may opt not to answer any question. The questions are only intended to generate information for research and policy purposes. Although there are no direct benefits to you by participating in this assessment, the knowledge you share with us will contribute to strengthening future policies related to SRHR service delivery at the national and community levels.

If you have any questions, you can contact the researcher on the following.
Would you like to participate in this research?

RESPONDENT HAS BEEN READ THE CONSENT SCRIPT AND AGREES TO PARTICIPATE IN ASSESSMENT:	YES _____ NO _____

I (enumerator) have read the above information to the interviewee, acknowledged comprehension, and received verbal consent to administer the interview.

_____ _____

Enumerator signature Date

(MM/DD/YYYY)

FGD Guideline

Questionnaire number .....Name of the island: .....Atoll.....,

SECTION A Demographic information

1. Gender of the respondents .....

2. Age .....

3. Occupation .....

4. Education level: a) Adult education, b) Primary, c) Secondary, d) College, e) University

5-Mariatl status

5- Are you employed:

6- What is your salary scale: Below 5000, 5000 to 10,000, above 10,000

7- What is the education level of your parents/spouse: a) Adult education, b) Primary, c) Secondary, d) College, e) University

Section B FGD guideline

1. Do you know what Sexual and Reproductive Health (SRH) is? a. Yes b. No

2. How do you learn about Sexual and Reproductive Health? Through: a. Friends b. Parents c. Sibling d. Spouse e. Media (please specify) f. Other (please specify)

3.How often do you seek information about Sexual and Reproductive Health? a. Very Often b. Often c. Once a while d. When the need arises f. Never d. Other (please specify).

3.On what topic(s) do you seek Sexual and Reproductive Health information? a. HIV/ AIDS b. Pregnancy/abortions c. Protection/ safe sex d. Other (please specify).

5. Which of these sources adequately provide you with your needed SRH information? a. Friends b. Parents c. Sibling d. Spouse e. Media (please specify) f. Other (please specify)

6. Which of the following sources of Sexual and Reproductive Health information do you regard as credible/ reliable? a. Mother b. Father c. Sibling d. spouse e. Newspaper/Magazines f. Radio g. TV h. Internet i. Friends j. Other (please specify) why?

7.Which of these sources do you feel most comfortable seeking SRH information? a. Mother b. Father c. Sibling d. spouse e. Newspaper/Magazines f. Radio g. TV h. Internet i. Friends j. Other (please specify) Provide reason(s) for your answer in this question a. Accessibility b. Comprehensive c. informative d. Privacy e. support my own beliefs/values f. Other (please specify)

8. Which of the following is your preferred source of Sexual and Reproductive Health information? a. Mother b. Father c. Sibling d. Spouse e. Newspaper/Magazines e. Radio f. TV g. Internet h. Friends i. Other (please specify)

9. What informs your choice of a particular source of SRH information? a. accessibility b. comprehensive c. informative d. privacy e. supports my own beliefs/values f. other (please specify).

10. Have you ever discussed SRH matters in your family? If yes, how often? a. often b. very often c. once a while

11.If no, why?

12.Which of your family members do you discuss sexual and reproductive health issues with? a. Mother b. Father c. Sibling d. Spouse e. Other (please specify).

13. Do you feel comfortable discussing SRH issues with your parents/spouse? a. Yes b. No

14. If no, why?

15. Do your parents/spouse feel comfortable discussing SRH with you? a. Yes b. No

16. How would you rate your parents'/spouse knowledge on sexual and reproductive health? a. very low b. low c. average d. High e. very high

17. How does communication on SRH with your parent's/spouse start?

1. They initiate the discussion
2. I ask them questions/ tell them what i am going through
3. When there is discussion or advertisement about sexual and reproductive health on TV/radio
4. Other (please specify) .....

18.Which area(s) of SRH do you usually discuss with your family? a. Pregnancy/abortion b. Condom use/safe sex c. HIV/aids d. Other (please specify)

19-How will you rate the credibility of your family as a source of sexual and reproductive health information? a. Very credible b. Credible c. Not credible d. Other (please specify).

20. Do you discuss SRH with your friends? If yes which of the following are reasons for seeking SRH information from your friends? a. Age group/shared beliefs b. Confidentiality c. informative/knowledgeable d. Availability e. Reliability f. specify

21. How often do you discuss SRH with your friend(s)? a. Often b. Very often c. Not often d. Not at all f. Other

22. What topic(s) of SRH do you discuss with your friend(s)?
a. Pregnancy/abortion b. HIV/AIDS c. Safe sex/condom use d. Other (please specify)

23. From which of these media outlet do you search SRH? a. Radio b. TV c. Print d. Internet

24.Why do you access SRH information from this outlet? a. Confidentiality b. informative/knowledgeable c. Availability d. Reliability e. Other (please specify)

25.On what topic do you seek SRH information from the media? a. Pregnancy/abortion b. HIV/AIDS c. Safe sex/condom use d. Other (please specify)

26- What is your perception of the services offered in your island/community/health center/hospital.

27- Do you know about the Siththa App introduced by SHE?

28- Do you know about the safe space introduced by SHE? (question is specifically for youth living in Male, Hulhumale' and Vilimale').

29- How do you think these services can be made more youth friendly?

The below table on SRHR health services needs to be filled in by the interviewees in the FGD (individually by referring to the last 12 months)[30].

Knowledge of SRHR	Information about SRHR	Comments/source
Knowledge of services	Knowledge of supply sources for specific contraceptive methods	
	Knowledge of places of STI treatment	
Use of services	Have you ever visited a health facility or doctor of any kind to receive services or information on contraception, pregnancy, abortion or sexually transmitted diseases?	
	Thinking about your last visit, did you go to a government clinic, health centre or hospital or a private doctor or clinic?	
	Number of visits in last 12 months	
Characteristics of most recent visit	Type of facility (Government , Private, Other)	
	When you last saw a doctor or a nurse, what was your reason for going? Contraception, STD, Gynecological exam, Pregnancy test, Pregnancy termination, MCH, Other	
	Exposure to information about contraception	
	Whether contraceptive services were requested	

[30] Adapted from Asking young people about sexual and reproductive behaviors: Introduction to Illustrative Core Instruments (2001) UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction

	Whether staff spoke about contraception, STIs, pregnancy	
	Whether respondent felt able to ask questions	
	Whether questions were answered adequately	
	Whether there was sufficient privacy	
Source of contraceptive methods	Source of method used with first partner	
	Source of method used with current boy/girl friend/spouse	
Source of STI treatment	Source of treatment for most recent STI episode	

Section 3: In depth Interview guide with health personnel

We would like you thank you for participating in this interview.

The reason for interviewing you and other health workers is to have your opinion on these issues as they related to young people. In particular, we would like to know whether you think the services offered for the youth is adequate.

The interview will take about 45 minutes. If you feel that there are related issues that are relevant and important, you are welcome to raise these issues during the interview. In any use of the material at a later stage, confidentiality will be ensured.

SECTION A Demographic information

1. Gender of the respondent .....

2. Age .....

3. Occupation .....

4. Education level: a) Adult education, b) Primary, c) Secondary, d) College, e) University

SECTION B In depth interview guideline

- What is your profession and how long have you been working in it?
- How much of your job involves working with young people?
- Have you had any specific training concerning working with young people?

Young people and sexuality:

- What do you think are the main problems young people today are facing when it comes to sexuality?
- What is your experience in discussing sexuality and related issues with young people?
- In your experience, are young people comfortable in accessing sexual and reproductive health services?
- Do you provide services for young people?
- Do you think the school is a good place for young people to learn about sexuality and sex-related issues?
- What should they teach in the school curriculum before they leave school?
- Are you aware of the topics regarding SRH in the school curriculum?
- Show the topics which have not been incorporated yet from the UNESCO guidelines.
- Do you think the school curriculum is enough?
- What do you think can be done to strengthen the comprehensive sexuality education in schools?
- What are the barriers to setting up links between schools and health care services?
- How do you think these services can be made youth friendly?

The below table on SRHR health services needs to be filled in by the health personnel interviewed (individually by referring to the last 12 months).

Use and perceptions of health services

Number of visits by youth 18-25 with in the last 12 months	Reasons for the visit	Type of facility	Consulted Doctor/nurse/health care professional

This research is part of State of the Region Report on Sexual and Reproductive Health and Rights: International Conference on Population and Development (ICPD+25) monitoring initiative by ARROW. This initiative includes 13 partners and generates monitoring evidence around twenty-five years of implementation of the ICPD Programme of Action (ICPD POA) in the respective countries for advocacy. The evidence from the report is expected to inform the Mid-term Review of the 6th Asia Pacific Population Conference (APPC) in 2018 at the regional level, the national policy dialogues in 2019 at the national level, and the ICPD+25 review in 2019 at the international level.

ARROW is a regional and non-profit women's NGO based in Kuala Lumpur, Malaysia, and has consultative status with the Economic and Social Council of the United Nations. Since it was established in 1993, it has been working to advance women's health, affirmative sexuality and rights, and to empower women through information and knowledge, evidence generation, advocacy, capacity building, partnership building and organizational development.

Partner Background

Society for Health Education (SHE) is a non-governmental 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 of life of Maldivian families. Keeping in line with the society's mission, it embraces the following mandate:- Strive to improve the quality of life of the Maldivian people. Harness the expertise of national professionals, on a voluntary basis for development programs. Endeavour to raise awareness on health and social issues. SHE's programs and activities encompass campaigns, events, training, research and advocacy efforts towards the empowerment of women, advancement of women's rights and building resistance against violence, discrimination and injustice. SHE brings the collective expertise, experience and engagement of its members, volunteers and staff, in partnership with government organizations, UN agencies, civil society and private sector, in order to fulfil gender and rights issues in Maldives

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