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Maldives

Reproductive health survey: follow up

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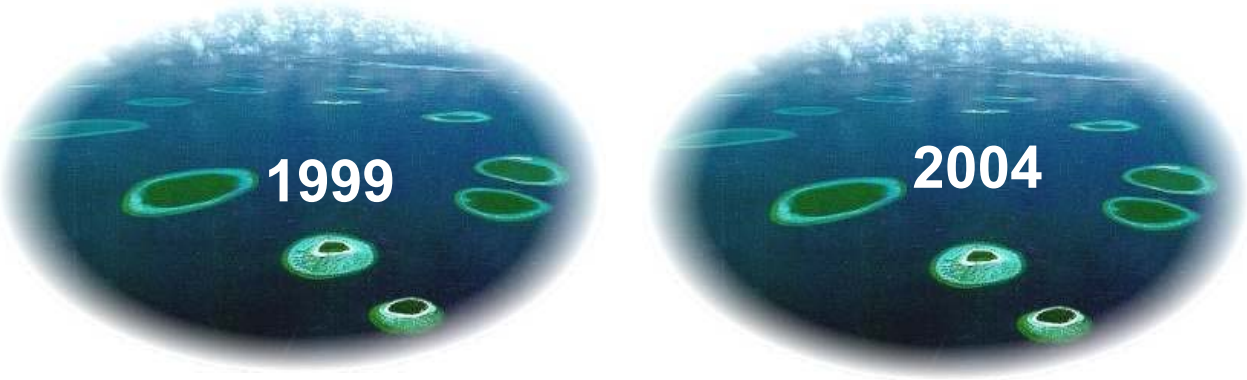
REPUBLIC OF MALDIVES
REPRODUCTIVE HEALTH SURVEY
2004



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We are particularly grateful to all the community members who took the time to answer questionnaires and participate in focus group discussions. The information they contributed will be used to develop and improve the reproductive health services.

Abbreviations:

AIDS	Acquired Immune Deficiency Syndrome
FHW	Family Health Workers
HIRU	Health Information and research Unit
HIV	Human Immunodeficiency Virus
IGMH	Indira Ghandi Memorial Hospital
MOH	Ministry of Health
RHS	Reproductive Health Service
STIs	Sexually Transmitted Infections
UNFPA	United Nations Population Fund

Summary

The survey is a follow up to the baseline reproductive health survey of 1999. It provides information for evaluating the five-year Reproductive Health Programme of the Ministry of Health and the Department of Public Health as well as new information about adolescent sexual and reproductive health to guide future programmes aimed at youth. The survey was commissioned by the Ministry of Health and was carried out by the Health Information and Research Unit (HIRU) of the Ministry of Health with technical support from CIETinternational and funding and support from UNFPA Maldives.

Methods

The multistage cluster sample from the baseline survey was again used in the follow-up survey. Stratification was by region and by presence of different types of health facility. Islands within each group were randomly selected. Usually the sample site included all the households on the island. For larger islands, an area sample of approximately 100 households was randomly selected as the sample site. In Male' five sites were selected randomly from among enumeration blocks in the 1995 census. A total of 24 sites were selected. Weights were calculated to take into account the uneven sampling fraction between strata.

Indicators and instruments for the survey were agreed in consultation with HIRU, the Ministry of Health, the Department of Public Health, UNFPA, NGOs and other concerned agencies. The instruments included: a household questionnaire, an adult questionnaire, a youth questionnaire, key informant interview schedules, schedules for institutional reviews of health facilities, and guides for focus group discussions.

Trained field teams undertook the field data collection. In each site, all households were included, with an interview with every married woman aged 15-49 and married man aged 15-64. All unmarried youth from the same households aged 15-24 were asked to attend a central place in the community to complete a self-administered questionnaire.

Focus group discussions with adult males and females were carried out in one randomly selected site from each of the 6 regions. Focus group discussions with adolescent boys and girls were carried out in all islands (19 sites). In Male', focus group discussions were carried out in 3 of the 5 sites.

Key informant interviews in each sample island, except Male', collected information from the island chief, the president of the women's committee and the head teacher/supervisor. An institutional review of the local health facility was carried out in all the sample islands.

Data entry for the household, adult and youth questionnaires was by scanning the completed questionnaires using Remark 5.5 software. Data entry for the key informant interviews and institutional reviews was undertaken using Epi Info. Data analysis used Epi Info and CIETmap software packages.

Findings

The survey sample

	1999	2004
Households	2254	2279
People	15,646	16,078
Female respondents	3199 aged 15-49	2693 married aged 15-49
Male respondents	514 aged 15-64	1409 married aged 15-64
Female youth	-	663 unmarried aged 15-24
Male youth	-	469 unmarried aged 15-24

Over 2000 households were included in 1999 and 2004. In 1999, we interviewed females aged 15-49 years in the households (whether married or not) and male household heads aged 15-64 years. In 2004 we interviewed ever married female household members aged 15-49 years and ever married male household members aged 15-64 years. In addition in 2004, we also included unmarried youth in the households aged 15-24 years, who completed a self-administered questionnaire: 663 females and 469 males.

Adult married household members

Knowledge about STIs and HIV/AIDS

In 2004, the majority (68%) of health workers interviewed said STIs were "very rare" in the communities they served. And more than a third thought there was 'no problem with reproductive health' in the communities they served.

The proportion who knew at least one sign of STIs rose from 35% in 1999 to 48% in 2004. The proportion who would go to a health facility with an STI symptom rose from 86% in 1999 to 96% in 2004. Knowledge of how to catch STIs also rose: 57% knew at least one way of catching an STI in 1999 and 79% in 2004. In 2004, 90% of respondents could mention a way to

protect themselves against STIs. Most respondents on islands with an atoll (66%) or regional (72%) hospital were aware that their local health facility could treat STIs, while some 39% on islands with a health centre thought this, and 15% on islands with a health post or health section.

The proportion who had heard of HIV/AIDS was very high: 99% in both 1999 and 2004. And most (92% in 1999 and 91% in 2004) knew of at least one way of catching HIV/AIDS.

Antenatal, delivery and postnatal care

In 2004, all except one woman aged 15-49 years who delivered within the last year reported at least one antenatal care visit during the pregnancy, while in 1999 88% of women had a least one antenatal care visit during their last pregnancy (in 1999 the reported pregnancies were not limited to those in the last one year). Two thirds (62%) of women in 1999 reported four or more antenatal care visits, and this proportion had risen to 91% in 2004. In 2004, 70% of women said they were seen by a gynaecologist in their last ANC visits, while 25% were seen by another doctor and 4% by a TBA.

Iron supplementation in pregnancy also rose: in 1999 50% of women took iron during their last pregnancy, while in 2004 87% of women who delivered in the last year took iron during the pregnancy. In 2004, 80% of pregnant women took iron for more than two months and 43% took iron for seven months or more.

In 2004, most (85%) women delivered with skilled attendance (50% gynaecologist, 18% other doctor, and 16% nurse, 1% community health worker). The proportion attended by a gynaecologist was even higher in Male' (69%). It is likely that the gynaecologist was available but not actually present at the birth in many cases.

In 2004, 60% of women reported having contact with a health care professional within six weeks of giving birth, and 49% of these said they were given family planning advice when they had this contact.

Knowledge and practice of contraception

The mean number of children of women aged 15-49 years was 4.2 in 1999 3.5 in 2004. The mean 'ideal number' of children mentioned by these women was 3.0 in both 1999 and 2004. In 2004, almost two thirds of married women (62%) did not want more children.

Most household respondents (91% in 2004, compared with 86% in 1999) knew of at least one modern method of contraception. Some 12% of household respondents in 2004 knew the correct time during the menstrual cycle when a woman is most likely to conceive; women are twice as likely to know as men. This was about the same as in 1999 when 10% had correct knowledge about the most fertile period of the menstrual cycle.

Some 23% of respondents knew any side effects of contraceptives. The most common side effects cited were irregular periods and spotting (9%), back or stomach pain (5%) and dizziness or headache (4%).

Contraceptive prevalence rate (%)

	1999	2004
All methods	42	39
Modern methods	33	34
Modern temporary methods	23	27

The 2004 CPR among married women aged 15-49 years was:

- 39% for all methods of contraception (including traditional, 'natural' methods)
- 34% for modern methods of contraception
- 27% for modern, temporary methods of contraception (excluding sterilisation).

Between 1999 and 2004, the CPR for all methods has remained stable, but there has been some increase in modern methods and a corresponding decrease in traditional methods. In 2004 condoms have become the second most common method after the pill, rising from 6% in 1999 to 9% in 2004. In 2004, among married women aged 15-49 years, 37% did not want more children yet were not using a modern method of contraception. This unmet need for modern contraception was less than in 1999 (42%).

In 2004, 70% of women reported that the decision about whether or not to use contraception was taken in discussion with the spouse, 8% reported taking the decision by themselves, and 11% said the spouse made the decision. Some 11% said it was not discussed at all. Women who were involved in the decision were more likely to use contraceptives than those who had no say in the decision.

The most common reasons given for choosing a particular method of contraception were “don’t want more children” (42%) and “convenience of use” (20%). There was some difference between methods in reasons for choice. The most common reason given by those who had never used contraception was that they perceived there to be no need (40%).

Reproductive health services

In 2004, 72% of household respondents rated the reproductive health services in their area as ‘good’. This is less than the proportion rating the services as ‘good’ in 1999 (77%).

Whereas in 1999 77% of household respondents did not cite any problems with reproductive health services, in 2004 48% did not cite any problems. The most commonly mentioned problems concerned lack of specialists and doctors as well as lack of medicines and services. The distance and transport to the facilities was also a concern. Commonly suggested improvements were more information and more doctors,

In 2004, 10% of women aged 15-49 years visited a health facility in the last three months specifically for reproductive health care. The equivalent figure in 1999 was 8%, although a number of other visits to health facilities for other purposes were also reported in 1999.

In 2004, all the required medicines, contraceptives and materials were available in 96% of reported visits of women aged 15-49 to health facilities for reproductive health services, with little variation by type of facility. The equivalent figure in 1999 was 93%. Some 40% of the female service users paid something for overall costs in 2004.

Some 87% of women aged 15-49 who used services for reproductive health care in 2004 were satisfied with the service they received on their last visit, compared with 96% satisfied in 1999. In 2004, 96% of the women reproductive health service users were satisfied with privacy of the service, compared with 97% in 1999. In 2004, male service users were less satisfied than women with both the overall service and with privacy.

In 2004, 69% of households outside Male' reported they had been visited by an FHW, compared with 46% of households outside Male' in 1999.

Adolescent sexual and reproductive health

The overall response rate for youth identified in the households was 42%, ranging from 100% in some islands to only 12% in Male'. More than half (59%) the 1141 unmarried youth aged 15-49 years who completed an interview were female. Some 57% of the females and 50% of the males were under 18 years old. Over half (59%) were in school, mostly up to grade 10. There was little gender gap in school attendance.

Among the youth who participated, 70% were living with both parents, 10% were living alone and 8% were living with another family. Most of the youth (78%) did not have a job. Among youth not in school, 25% had a full time job and 12% had a part-time job. Half of the youth (51%) said they did not spend any money on themselves, excluding what their parents might spend on them. On the other hand, 14% had more than Rf 500 to spend on themselves each month. More males were in the higher spending categories.

Some 20% of the youth respondents said they participated in a social, school or volunteer group, with this being more popular among the males (26%) than among the females (16%). Some 77% reported watching television daily or almost daily, while 57% listened to the radio daily or almost daily, and 24% read newspapers or magazines daily or almost daily. Only 4% said they used internet daily or almost daily and 83% said they never or almost never used internet.

Nearly half the youth (46%) said they did not talk to anyone about sex, while a friend was the commonest choice (32% of males and 24% or females). Few mentioned parents or teachers. Many reported their parents talked to them about their future and about relationships, but few said their parents talked to them about sex (28% of females and 12% of males).

Knowledge and perceptions about HIV/AIDS and STIs

Almost all the youth had heard of HIV/AIDS and knew of at least one way to avoid catching the infection. The commonest suggestion (69%) to avoid HIV/AIDS was

to respect religious tradition. Many mentioned "get more information" as a way to avoid the infection. Knowledge of how to avoid STIs was also quite good, although again many said the way to avoid was to get more information. However, 26% said they did not know about any signs of STIs, while two thirds thought avoiding people with infection was the best way to avoid catching an STI.

There was a lack of knowledge about some important matters related to HIV. About a third of respondents (34%) did not know if people with HIV can look healthy. Some 13% believed that one can get HIV from eating with someone who has AIDS. Half (50%) agreed that condoms can protect against HIV/AIDS, but (35%) did not know if condoms can protect.

Perceptions and knowledge about gender and sex

Responses to some questions revealed some misconceptions. Some 20% of youth agreed that a girl can get pregnant anytime once she has had her first period. And most respondents did not know correctly the most fertile period in the menstrual cycle, although over a third thought only having sex at certain times of the menstrual cycle was a good way to avoid pregnancy. Over half (56%) said always using a condom was the best way to avoid pregnancy, while around 40% thought withdrawal before ejaculation was effective.

About half (48%) said they presently got information about sex from school, and 29% from a health facility. But 67% said they would prefer to get information from a health facility.

Youth sexual activity

Some 9% of the young people said they had had sexual intercourse; 14% or males and 5% of females. Of those over 18 years old, 13% said they had had sex. Almost two thirds (62%) of those who had had sex said their first sexual intercourse was before the age of 18 years.

About 45% of those who were sexually active said they never use a condom. The most common reason for not using condoms was not liking to use them (23/59). Of those using condoms, 21/48 said they get them from a pharmacy, and 14/48 from friends.

Some 4% said someone around their age (within 5 years) had involved them in unwanted sexual activity, and 4% said that this had happened to them with someone older than them.

Some 26 respondents (about 2% of the total) said they had been pregnant or fathered a child. Of these pregnancies, 16 led to a live birth and 6 were aborted.

Introduction

Background

The Republic of Maldives has 199 inhabited islands and about 1000 other islands including resorts stretching across 500 miles of Indian Ocean. These islands form 26 natural atolls, which for purposes of administration are grouped into 20 units, also called atolls. Most of the islands are small, few with a land area in excess of one square kilometer, and are low lying, with an average elevation of 1.6 m above sea level. The geography of the country, with the costs of transport and diseconomies of scales, makes delivery of services of any kind very expensive and difficult. Nevertheless, the country has made great efforts to establish and expand its service delivery network.

The population of the Maldives was 270,101 in 2000 (1). In addition to this there are 19,000 resident foreign workers and their dependents. About 27% of the population live in the capital island of Male'. In addition to Male's permanent population, it also has a floating population of several thousands who arrive from other islands for commercial purposes, education and medical treatment. The population is growing at an annual rate of 1.96%

Rationale for the Survey

The Reproductive Health survey of 2004 is a follow up to the Reproductive Health baseline survey was which conducted in 1999 by the Ministry of Health (2). As a follow-up survey it aims to measure the changes in areas highlighted in the 1999 baseline survey. This survey also provides baseline data for the reproductive health sub-programme under the UNFPA Third Country Programme (3). Hence it also covers new areas such as reproductive health needs of adolescents as well as touching on issues such as management of the RH programme and quality of services.

Using evidence from the 1999 survey, a number of interventions have been carried out to improve the reproductive health situation, availability and access to services and the reproductive health knowledge of men and women. Studies conducted since 1999 have indicated improvements in some areas such as antenatal care and skilled attendance at birth. However, there still

remain large gaps in knowledge, particularly about sexual and reproductive health behaviour. Information on knowledge, attitudes and behaviour of adolescents and young people is particularly limited.

Survey Objectives

The aim of the survey was to collect data on the availability and quality of RH services, reproductive and sexual health knowledge, attitudes and behaviour among men, women and adolescents. A particular focus was to collect information on knowledge, attitudes and behaviour of adolescents regarding sexual and reproductive health. The specific objectives of the survey were:

- To measure knowledge, attitudes and behaviour about reproductive health among married men aged 15 to 64 and married women aged 15 to 49.
- To measure knowledge, attitudes and behaviour about sexual and reproductive health in unmarried young men and women aged 15-24 years.
- To assess the availability, access, utilization and quality of reproductive health services for the target population.
- To assess the level of participation of men in reproductive health care and men and women's role in decision making in relation to reproductive health and family planning.
- To measure and estimate contraceptive prevalence, unmet need and features of contraceptive use including method mix, method failures, and reasons for discontinuation.
- To identify the needs and priorities for future action in the above areas.

Methods

Methodological approach

The CIET methodology used in the 1999 and 2004 reproductive health surveys has the underlying aim of 'building the community voice into planning'.

The CIET Methodology (Annex 1) uses a cross-design of quantitative and qualitative methods for reiterative, cyclical data gathering and analysis. The methods provide a substrate for ongoing interaction between programme managers and intended service users. The idea is to contribute to a culture of quality service delivery based on evidence of results.

In 1999, the baseline reproductive health (RH) survey(2) employed the CIET methodology to provide both baseline indicators for measuring programme impact and information to assist planning of aspects of the programme as it evolved. This follow-up survey provides information about the change in target indicators during the programme period, as well as information useful for future programme planning, especially in the sector of adolescent sexual and reproductive health.

The survey sample

In 1999, the target population for the RH sub-program was “people in need of reproductive health care” the providers of that care and the community stakeholders. This also defines the target population for this follow-up survey. The estimated programme target population size was over 132,000 people living on 199 inhabited islands (Male’ and the atolls).

Household Sample
Since this is in part a follow-up survey, the sample used is the same as the one used for the 1999 survey. It is a multistage cluster sample, designed to give representative results at national level. The sampling process is described in detail in the report of the 1999 reproductive health survey (2). The first stage was stratification into six regions. In the next stage, the islands in each region were divided into three groups: those with a regional hospital (there is only one of these per region); those with a health centre; and those

Table 1. Islands in the sample
HC= Health Centre RH=Regional Hospital
AH= Atoll Hospital HP= Health Post

Island	Region	Type of island	
		1999	2004
Hoarafushi	N	HC	HC
Hanimaadhoo	N	Neither	HC
Hirimaradhoo	N	Neither	Neither
Kulhudhuffushi	N	RH	RH
Maalhendhoo	NC	Neither	Neither
Ungoofaaru	NC	RH	RH
Kihaadhoo	NC	Neither	Neither
Eydhafushi	NC	HC	AH
Kurendhoo	NC	Neither	Neither
Rasdhoo	MER	HC	HC
Hangnameedhoo	MER	Neither	Neither
Muli	SC	RH	RH
Mulah	SC	Neither	Neither
Maabaidhoo	SC	Neither	HC
Hirilandhoo	SC	Neither	HC
Hithadhoo	SC	HC	HC
Hoadedhdhoo	S	Neither	Neither
Fuvahmulah	S	HC	AH
Hithadhoo	S	RH	RH
Male' (5 clusters)	NA	NA	NA

without either. Islands within each group were randomly selected, the sampling fraction chosen to give a sample size in each stratum proportional to the relative population in each stratum.

For most of the selected islands, the number of households was under around 150 and the sample site included all the households on the island. For larger islands, an area sample of approximately 100 households was randomly selected as the sample site. In Male' five sites consisting of three contiguous enumeration blocks were selected randomly from among enumeration blocks in the 1995 census.

The selected islands in the sample of 1999 and 2004, by region and type of health facility, are shown in Table 1.

Weighting of the household sample

The sample is not fully proportional to the population, since some strata were relatively over sampled in order to collect sufficient information. For example, all islands with a regional hospital are included in the sample. In order to take this into account and avoid bias in the national figures calculated from the sample, weighting factors were calculated. In each case the weight is the proportion of the actual population in the stratum divided by the proportion of the sample population in the stratum.

Sample for qualitative data collection

Focus group discussions with unmarried young men and women were conducted in each site (island). Focus group discussions with adult males and females were carried out at a regional level, randomly choosing one site in every region. In Male', focus group discussions with adult males and females and with unmarried young men and women were carried out in 1 of the 5 sites.

Key informant interviews were carried out in each sample island to collect information from the island chief, the head teacher/supervisor and the president of the women's committee. In Male', only school supervisors were interviewed.

An institutional review of the local health facility was carried out in all the sample islands. In Male' an institutional review was conducted in IGMH, Male'

Health Centre, Villingili Health Centre and SHE (an NGO).

Survey instruments

Indicators to be included in the survey were agreed in consultation with the Health Information and Research Unit (HIRU) of the Ministry of Health, the Department of Public Health, UNFPA, NGOs and other concerned agencies. Indicators were included based on programme priorities and review of recent information from other data sources.

The survey instruments were developed in collaboration with the Ministry of Health and the Department of Public Health, UNFPA colleagues and a number of other stakeholders. They include: the household questionnaire, the adult questionnaire, the youth questionnaire, the key informant interview schedules, the schedules for institutional reviews of health facilities, and the guides for the focus group discussions. A stakeholder workshop to get input from relevant people in government, NGOs and donor agencies was held in Male' on 3 March 2004.

In the household questionnaire closed questions (with a limited choice of responses, such as yes/no or a range of three possible opinions) were employed where appropriate. For issues about opinions and knowledge (of signs of STI, for example), multiple answers were allowed. The closed questions in 2004 were possible based on the experience of the 1999 survey findings and the options used were those chosen when the questions were asked in an open-ended format in 1999.

The instruments were initially produced in English, then translated into Dhivehi and back-translated into English to check the preservation of the intended meaning. Before finalisation, the instruments were pre-tested in non-sample field sites and minor changes were made as a result. The final instruments were produced in a scannable format to allow the subsequent data entry by scanning of the completed questionnaires.

Training and fieldwork

Training workshop in Male'

Six teams, each containing a team leader, a supervisor and 7-8 interviewers, were recruited. The six field supervisors and six team leaders were staff from DPH, MOH, UNFPA and Youth Centre in Male'. Interviewers were all female school leavers (O'Level standard) from Male'. The task of the interviewers was to administer the household questionnaire to all households in the site, while the focus group discussions and other interviews were conducted by the team leaders and supervisors.

When they visited households, interviewers asked all eligible youth if they would participate in the survey. Those who were eligible for the youth category were given a slip with their household ID number and asked to come to a central point in the community later in the day. When they attended later they were asked to complete a self-administered questionnaire under supervision. The household ID was used *only* to link the youth interviews to the household information.

A household interview

Field staff were recruited in the middle of April 2004 and trained in Male'. The training for interviewers lasted 3 days and included a field practice of administering the household questionnaire in a non-sample site. The training for supervisors lasted a day and included training in facilitating focus group discussions as well as in how to administer and check the household questionnaire.

The fieldwork for the different areas took place more or less simultaneously. The teams traveled to their regions and stayed there until they had completed data collection from that region. The fieldwork was completed by the end of May 2004.

Scanning the questionnaires

Data management and analysis

Survey supervisors and staff from MOH prepared the questionnaires for scanning. This process is the first stage of cleaning prior to scanning.

Questionnaires were then scanned using the Remark 5.5 software. Data from all three instruments were then cleaned using Epi Info software (4). Logical checks were applied to the data set and corrections made as

necessary. Data scanning and cleaning were completed by early June 2004.

Data from the key informant interviews and institutional reviews was coded and then entered using Epi Info. The focus group reports were translated into English and then the themes expressed were coded and entered, again using Epi Info. The focus group themes identified are shown in Annex 2.

Basic analysis of the key quantitative data was undertaken by the CIET team. The Epi-Info programme CSAMPLE (4) was used to calculate weighted proportions of key indicators. In practice, the weighted proportions are very close to the unweighted proportions for the key indicators. Unless stated otherwise, values of indicators quoted in the report for the whole of the Maldives are weighted.


Workshop in Male' to discuss key findings – July 2004

The key findings were discussed in a stakeholder workshop in Male' on 1 July 2004. Participants included those in the design workshop and others from government, NGOs and donor agencies. The feedback from the workshop participants helped to give further context to the findings and guided the further analysis of some aspects of the findings.

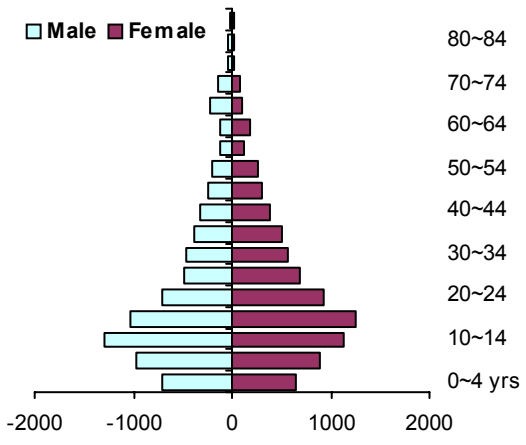
Table 2 Survey population by island (2004)

Island	No. HHs	No. of Resp.	No. of people
Hoarafushi	100	176	654
Hanimaadhoo	100	144	549
Hirimaradhoo	61	97	294
Kulhudhuffushi	100	185	710
Maalhendhoo	100	137	451
Ugoofaaru	100	162	745
Kihaadhoo	48	78	258
Eydhafushi	100	164	712
Kurendhoo	100	120	542
Rasdhoo	99	152	731
Hangnameedhoo	75	109	542
Muli	96	172	649
Mulah	100	207	704
Maaeboodhoo	100	196	714
Hirilandhoo	100	215	631
Hithadhoo	100	208	595
Hoadedhdhoo	100	107	495
Fuvahmulah	99	117	557
Hithadhoo	100	136	792
Male'	501	1220	4753
Total	**2279**	**4102**	**16078**

Table 3 Age distribution of sample population

Age group	No. (%) of population 1999	2004
Under 5	2344 (15%)	1362 (9%)
5-9	2439 (16%)	1853 (12%)
10-19	4434 (28%)	4682 (30%)
20-29	2377 (15%)	2814 (18%)
30-39	1841 (12%)	1933 (12%)
40-49	972 (6%)	1245 (8%)
50-59	704 (5%)	714 (4%)
60 +	523 (3%)	1021 (7%)
All	**15634**	**15624**

Figure 1 Age and sex distribution of the sample population



Findings: adult men and women

The population

The 2004 survey included some 16,078 people living in 2279 households from 20 islands included in the survey. A total of 4102 respondents from 2279 households were interviewed. In addition, 1141 young men and women ages 15 to 24 also participated. Table 2 shows the number of households, respondents and people in each of the sample islands. Each island had one sample site, except Male' where there were five separate sites.

Table 3 shows the age distribution of the sample population. Just over half (52%) of the sample population were under 20 years old.

In 39% (887/2272) of households, the respondent was the household head, while in a third (32%, 716/2272) the spouse of the household head responded on behalf of the household, and in 13% (300/2272) it was one of the children (over 15 years old) of the household. In most households (86%, 1958/2279), the respondent for the general household information was female.

Among the overall sample population in the households, information on sex was available for 15816 people. Among them, 7596 (48%) were male. The age and sex structure of the sample population is shown in Figure 1.

The mean household size nationally in 2004 was 7.1, median 6. One out of three (33%, 3137/9631) household members over 14 years old were reported to have never been married, while 59% (5682) were currently married, 4% (419) were divorced and 4% (393) were widowed.

Economic status of the households

In the 2004 survey, the household questionnaire also collected information related to the perceived general economic status of the household.

Half of the households (50%, 1138/2272) said they were able to save within the last year after all household expenditures.

While the income of 61% (1385/2266) of households was reported to have stayed the same during the last 3 years, more than a quarter of households (27%, 604) reported an increase in their income in the same period, and 12% (277) reported a decrease in income.

Household respondents

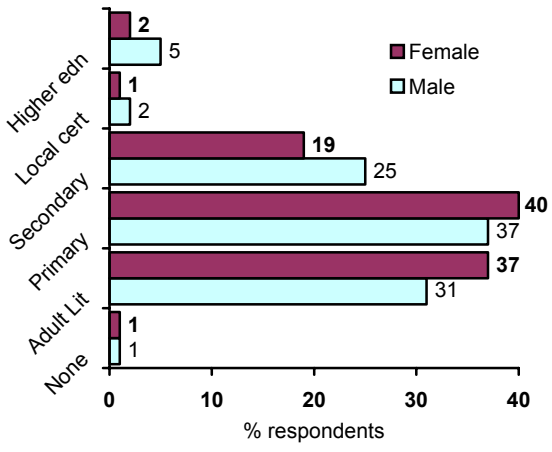
Table 4. The survey sample

	1999	2004
Households	2254	2279
People	15,646	16,078
Female respondents	3199 aged 15-49	2693 married aged 15-49
Male respondents	514 aged 15-64	1409 married aged 15-64
Female youth	-	663 unmarried aged 15-24
Male youth	-	469 unmarried aged 15-24

The survey was designed to obtain information on knowledge and practice about contraception, knowledge about STIs and HIV/AIDS, and opinions and experience of reproductive health services from all ever-married women between 15 and 49 years of age and all ever-married men between 15 and 64 years of age in each household, present at the time of this survey. Information on antenatal, delivery and postnatal care was collected from ever-married women between 15-49 years of age. In total, 4102 respondents answered the household questionnaire. Among them, one third (1409, 34%) were male while the rest (2693, 66%) were female. Table 4 shows the people interviewed in each household in 1999 and 2004. Note that in 2004 we also collected information from unmarried youth identified in the households (see later section for the findings on unmarried youth).

The mean age of married respondents was 35 years, median 34 years. Among the men, 17% (243) were older than 49 years. Whenever a comparison between male and female respondents is made in the following analysis, only respondents less than 50 years of age have been included in order to draw a fair comparison between males and females. Inclusion of the few men over 50 years old made little difference to the findings.

Figure 2 Education of respondents by sex (2004)



Education

When asked about their highest education level, less than 1% of male respondents (7/1166) said they had received no education. This proportion was just over 1% (35/2691) for female respondents. Some 31% of males (358/1166) and 37% (999/2691) of females had a basic literacy education level. Another 37% (435/1166) of males and 40% (1072/2691) of females had achieved the primary level of education. Some 25% (286/1166) of males and 19% (503/2691) of females had reached secondary level, while much smaller proportions had achieved higher levels of education. (Figure 2).

Occupation

Table 5 Occupation of respondents aged 15-49 years

Occupation	Number (%) respondents	
	Male	Female
None	103 (9%)	1959 (73%)
Fishing	203 (17%)	39 (2%)
Tourism	33 (3%)	4 (-)
Government	365 (31%)	453 (17%)
Private job	285 (24%)	134 (5%)
Agriculture	4(-)	3 (-)
Self employed	173(15%)	98 (4%)
Total	**1166**	**2690**

Table 6 Age of first marriage and education of women (2004)

Education	No of women	Age of 1st marriage	
		Mean	Median
Primary and above	1657	19.1	19
None or non-formal	1034	17.2	17

Table 7 Age of 1st marriage and age (women)

Age	No.	Age of first marriage	
		Mean	Median
Up to 30	1216	19.1	19
> 30	1477	17.8	17

Age of 1st marriage and age (men)

Age	No.	Age of first marriage	
		Mean	Median
Up to 30	377	22.3	22
>30	789	22.3	21

The occupations of respondents under 50 years old are shown in Table 5. Some 9% (103/1166) of men reported they were unemployed compared with 73% (1959/2690) of women. Among men, the main source of employment was the government (31%, 365/1166). Government was also the main employer for women.

Age of first marriage

The mean age of first marriage for male and female respondents was 22.3 years and 18.4 years respectively, and the median age of first marriage for male and female respondents was 22 years and 18 years respectively.

As in 1999, the age of first marriage among female respondents who had received education through formal schooling was higher than the age of first marriage among women who had received no education or only non-formal education (Table 6).

Women below 30 years of age at the time of the survey had married two years later than respondents over 30 years of age (Table 7). The difference in age of marriage by age at the time of the survey was not significant among men. This suggests that the age of first marriage has increased especially among women belonging to the younger generation.

Knowledge about STIs and HIV/AIDS

Health workers' knowledge about STIs

Some 22 health staff from health facilities visited on the islands answered questions related to general and reproductive health topics. When asked about the main problems in the communities, seven of them mentioned STIs or related symptoms. When asked if STIs were a problem in the community, 8 out of 22 said they were frequent and 4 said they happened sometimes, while 8 said they were very rare.

During the institutional review, the health worker in charge of each health facility was also asked what features would make them suspect that someone was suffering from a reproductive tract infection/STI. The

most commonly mentioned symptom was pain or irritation when urinating (13 mentions), discharge (12 times) and back or stomach pain (10 times). Two health care providers said they did not know of any symptom of an STI.

When asked about the consequences of untreated STIs, the most common answer from health staff was infertility or problems in conceiving (20 times), cancer (5 times) and weak child or miscarriage (4 times each).

It is important that health workers have good knowledge of the likely signs and symptoms of STIs. They need to pass on this information to the communities they serve, in order to improve the levels of public knowledge of the signs of STIs. The findings indicate that there is a need to improve the knowledge of health care workers about the symptoms and signs of STIs.

Respondents' knowledge about STIs

Household respondents were asked what signs of STIs they knew of, about ways of catching STIs, about ways of protecting themselves from STIs and about what action would they take if they developed any of the signs of STIs they had mentioned. These were all open questions, in order to explore the knowledge of the respondents.

The signs of STIs mentioned by respondents are shown in Table 8. In 1999, a third of respondents (36%; 1282/3551) were able to mention any sign of STIs, but almost half (48%, 1899/3987) were able to do so in 2004. A respondent in 2004 was one a half times more likely to be able to mention a sign of an STI compared with a respondent in 1999[1]. The increase in knowledge between 1999 and 2004 occurred to the same extent in both men and women. In 2004, 50% of women could mention any sign of an STI compared with 45% of men under 50 years old[2]. The increase in knowledge of signs of an STI was not explained by the higher proportion of respondents in 2004 with at least primary education: there was a similar increase in knowledge among both educated and non-educated respondents.

Table 8. Signs of STIs reported by respondents

Signs of STI	No (%) of respondents	
	1999	2004
Don't know	2272(65%)	2088(51%)
Itching and soreness	297 (8%)	1057(26%)
Urination problem	291 (8%)	759 (19%)
Discharge	285 (7%)	759 (19%)
Fever	241 (7%)	274 (7%)
Poor immunity/prone to infection	217 (6%)	104 (3%)
Rashes	173 (5%)	439 (11%)
Weakness/tiredness	148 (4%)	137 (3%)
Loss of appetite/weight	139 (4%)	82 (2%)
Back/ stomach pain	129 (4%)	369 (9%)
Bleeding	101 (3%)	232 (6%)
Swollen glands	30 (2%)	85 (2%)
Miscellaneous	259 (7%)	78 (2%)

[1] 1899/3987 (48%) respondents in 2004 could mention a sign of an STI compared with 1282/3551) respondents in 1999. OR 1.61, 95% CI 1.46-1.77

[2] 508/1132 (45%) men could mention a sign of an STI compared with 1297/2616 (50%) of women. OR 0.83, 95% CI 0.72-0.96

The regional breakdown of knowledge about any sign of STIs is shown in Annex 5.

Table 9. Actions that would be taken if signs of STI developed

Actions	No (%) respondents	
	1999	2004
Go to HC or hospital	1112 (86%)	1775 (96%)
Go to traditional healer	43 (3%)	11 (1%)
Go to pharmacy	40 (3%)	31 (2%)
Avoid sexual contact	34 (3%)	14 (1%)
Report it	6 (1%)	1 (-)
Nothing	4 (-)	4 (-)
Ask friends	3 (-)	4 (-)
Don't know	58 (5%)	-

Respondents who were aware of any signs of STIs were asked what actions they would take if they developed any of these signs. The majority (96%, 1775/1840) of respondents said they would go to a health center or hospital to seek health care (Table 9). This is an improvement from 1999 when 86% of respondents said they would go to a health centre or hospital.

Table 10 shows the knowledge of respondents about ways of catching STIs. They could mention up to three ways. While in 1999 nearly half (43%, 1475/3496) of respondents did not know any ways of catching STIs, 21% (849/4102) did not know any ways of catching STIs in 2004. The most common answers given were: from multiple partners, or from an infected spouse or partner. The proportions mentioning different ways have changed somewhat between 1999 and 2004, with 'multiple partners' being more commonly mentioned in 2004.

Table 10. Awareness of respondents of ways of catching STIs

Ways of catching STIs	No (%) of respondents	
	1999	2004
Don't know	1489 (43%)	849 (21%)
Infected spouse/partner	1118 (32%)	365 (9%)
Needles/blood	591 (17%)	142 (4%)
Multiple partners	484 (14%)	1107 (27%)
Interpersonal contact	*98 (3%)*	*131 (3%)*
Freq. sexual intercourse	62 (2%)	260 (6%)
Poor hygiene/cleanliness	*15 (-)*	*333 (8%)*
Unprotected sex	9 (-)	323 (8%)
Sex during menstruation	*5 (-)*	*84 (2%)*
Sharing condoms/sex toys	2 (-)	63 (2%)

Some of the answers given were probably not valid ways of catching STIs (those shown in *italics* in Table 10). If only the valid answers are included, 67% (2738/4102) respondents in 2004 knew a valid way of catching STIs.

In 2004, household respondents were additionally asked how they could protect themselves against catching STIs. Nine out of ten (90%, 3697/4102) mentioned at least one way of protection. The single most mentioned way of protection was to be faithful (26%, 1081/4102), followed by using condoms (26%, 1062/4102) and abstinence (24%, 962/4102). In addition, some 20% (836/4102) said one must avoid sex with infected people and 9% (375/4102) said that respecting religious tradition is a way of protection. Finally, 2% (78/4102) said one must avoid sharing needles or sharp objects.

The proportion knowing at least one way to protect themselves against catching an STI in the different regions is shown in Annex 5.

Table 11. Awareness of availability of treatment for STIs in local health facility

Type of health facility on island	n (%)
Atoll hospital	187 (66)
Regional hospital	468 (72)
Health centre	405 (39)
Family HP or HS	123 (15)
Male'	984 (81)
Total	*2167 (54)*

Respondents were asked whether they know if STIs (apart from HIV/AIDS) could be treated at the local health facility: 54% (2167/4028) thought that their local health facility could treat STIs. Respondents living on islands with a regional hospital or atoll hospital were more likely to think treatment for STIs was available locally, compared with those respondents on islands with a health centre (Table 11). Few respondents living on an island with a family health post or family health section thought these facilities could provide treatment for STIs. The awareness of households about availability of treatment corresponds quite well with actual availability, which is mainly confined to health centres and above. But there is an apparent lack of awareness of treatment availability in health centres.

Respondents' knowledge about HIV/AIDS

Table 12. Awareness of household respondents of ways of catching HIV/AIDS

Suggested ways	No (%) of respondents 1999	2004
Sexual contact	3002(84%)	3772(92%)
Blood transfusion	1613(45%)	2571(63%)
Infected needles	976(27%)	1409(34%)
Interpersonal contact	*182 (5%)*	*50 (1%)*
Infected mother to child	51 (1%)	188 (5%)
Razors, *toothbrushes…*	52 (1%)	40 (1%)
Homosexuality	41 (1%)	140 (3%)
Breast feeding	15 (-)	19 (1%)
Kissing	*6 (-)*	*15 (-)*
Mosquitoes	*4 (-)*	*16 (-)*
Don't know	228 (6%)	104 (3%)

Public awareness of HIV/AIDS remains high. As in the previous survey in 1999, in 2004 nearly all (99%, 4043/4087) household respondents had heard of HIV/AIDS.

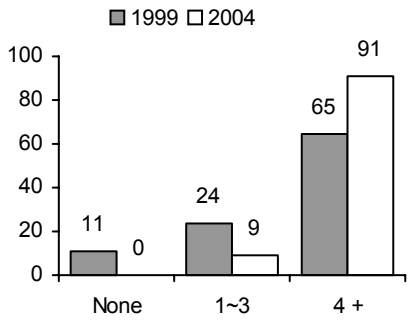
When asked how HIV/AIDS is transmitted, 98% (3998/4102) gave some answer. This proportion was even higher than in 1999 when 94% (3340/3568) of respondents gave some answer (Table 12). The most commonly cited ways of catching HIV/AIDS in 2004 were: through sexual contact, through blood transfusions and through infected needles.

The proportion knowing at least one way of catching HIV/AIDS was high in all regions (Annex 5).

Despite this apparent high awareness of the population about HIV/AIDS and ways in which this infection can be caught, one in four of the 23 health staff interviewed in the island health facilities, when asked about the main reproductive health problems in the community, said lack of awareness about HIV/AIDS was a problem (see Annex 3). Their reasons for saying this are not clear. It could be that their involvement in campaigns to raise awareness about HIV/AIDS still left them with an impression that more awareness raising was needed in this area.

Antenatal Care

Figure 3. Number of antenatal visits in the last pregnancy



Ever-married women aged 15-49 years were asked if they had ever been pregnant: 91% (2332/2566) said they had been pregnant at least once. One in ten said they were currently pregnant (260/2651). One quarter (24%, 650/2662) said they had actively been trying to get pregnant in the last two years.

Some 274 women reported on antenatal, delivery and postnatal care for deliveries during the last one year.

The policy of the Government in the Maldives is to encourage women to have four or more antenatal visits in each pregnancy. In 2004, all except one woman (273/274) who delivered in the last year reported at least one antenatal care visit. Nine out of ten (91%, 249/274) reported at least four visits for antenatal care. Both figures are higher than those reported in1999 (Figure 3). Note that in 1999 reported pregnancies were not limited to those in the last one year, so some of them could have been some years previously.

The proportion of women in 2004 who reported at least the recommended four visits in their last pregnancy is shown by region in Annex 5. The lowest coverage was in the northern atolls and the highest in the southern atolls.

Table 13. Attendant at last antenatal care visit (2004). Number (%)

Who attended	Male' (n=79)	Atolls (n=196)	Total (n=275)
Gynaecologist	71 (90)	120 (62)	191 (70)
Doctor	7 (9)	61 (31)	68 (25)
CHW	0	4 (2)	4(2)
FHW	1 (1)	0	1 (-)
TBA	0	11 (6)	11 (4)

Women were also asked who attended them during their last antenatal check up. They were mostly seen by specialists. Some 70% (191/275) said they saw a gynaecologist and 25% (68/275) saw another doctor. Some 4% (11/275) saw a TBA and 2% (4/275) saw a community health worker. The proportion of pregnant women seen by a gynaecologist was higher in Male' than elsewhere; outside Male' more of them were seen by a non-specialist doctor and 6% by a TBA(Table 13).

Table 14. Advice at last antenatal care visit (2004). Number (%)

Advice	Male' (n=70)	Atolls (n=175)	Total (n=245)
No advice	10 (14)	36 (21)	46 (19)
Nutrition	22 (31)	69 (39)	91 (37)
Delivery	8 (11)	21 (12)	29 (12)
High risks	8 (11)	19 (10)	27 (11)
Immunisation	0	1 (1)	1 (-)
Fam planning	18 (26)	18 (10)	36 (15)
Newborn care	3 (4)	9 (5)	12 (5)
STI prevent	1 (1)	2 (1)	3 (1)

When asked about the advice received on their last antenatal visit, one out of five (19%, 46/245) women said they received no advice. The advice they most commonly recalled was about nutrition (37%, 91/245), family planning (15%, 36/245) and preparation for delivery (12%, 29/245). Some also mentioned advice about high risks (11%, 27/245) and 5% (12/245) mentioned advice about newborn care. There was little difference in advice between Male' and the atolls (Table 14).

Iron supplementation in pregnancy

Iron supplementation during pregnancy is important. Anaemia is a common problem in Maldivian women. According to the 1993/94 National Nutrition Survey (5), nearly 62% of non-pregnant and 68% of pregnant Maldivian women are anaemic. Figures from the more recent MICS survey (6) still indicate that 56% of pregnant women and 50% of non-pregnant Maldivian women are anaemic. These figures are affected by the high rate (about 20%) of thalassaemia carriage in the population.

Among women who delivered in the last year, 87% (222/256) reported taking any iron supplements during the pregnancy. This is an important increase compared with the 1999 reproductive health survey, when 50% of women reported taking any iron supplements during their last pregnancy. Note, however, that in the 1999 survey the information about pregnancy was not limited to deliveries in the last year, so some of the reported pregnancies could have been some years previously.

Table 15. Iron taken in pregnancy in last year (2004). Number (%)

Iron taken	Male' (n=71)	Atolls (n=185)	Total (n=256)
None taken	8 (11)	26 (14)	34 (13)
One month	6 (9)	12 (7)	18 (7)
2-3 months	10 (14)	31 (17)	41 (16)
4-6 months	12 (17)	40 (22)	52 (20)
7-9 months	35 (49)	76 (41)	111 (43)
Any iron	63 (89)	159 (86)	222 (87)
Iron for 2 months plus	57 (80)	147 (80)	204 (80)

Four out of five women pregnant in the last year (80%, 204/256) took iron supplements for at least two months during their pregnancy, and nearly half (43%, 111/256) took iron for at least seven months (Table 15). There was not much difference between Male' and the atolls in iron supplementation in pregnancy (Table 15), even though in the smaller islands the iron is supplied free while in Male' and some of the larger islands it is prescribed and has to be bought from the pharmacy.

The proportion of women taking iron during their last pregnancy by region is shown in Annex 5.

Among the few women who did not take any iron during their pregnancy, the most common reason they gave for not taking iron supplements was that they were not given any (7/27) while about half (14/27) could not give any specific reason. Only one woman said the iron was too expensive.

Delivery and postnatal Care

Among deliveries in the last year, half (50%, 140/278) were reported to be attended by a gynaecologist and one in five (18%, 49/278) were attended by a doctor. Nurses attended 16% (44/278) of deliveries. Trained TBAs delivered 8% (23/278) of babies while untrained TBAs delivered 6% (17/278) of babies. Four deliveries were attended by a Community Health Worker. Thus, 85% of deliveries were attended by skilled personnel.

Table 16. Attendance at delivery in last year (2004). Number (%)

Who attended	Male' (n=80)	Atolls (n=198)	Total (n=278)
Gynaecologist	55 (69)	85 (43)	140 (50)
Doctor	9 (11)	40 (20)	49 (18)
Nurse	16 (20)	28 (14)	44 (16)
CHW	0	4 (2)	4 (1)
FHW	0	1 (1)	1 (-)
T-TBA	0	23 (12)	23 (8)
UT-TBA	0	17 (9)	17 (6)

T-TBA=trained TBA; UT-TBA=untrained TBA

Table 16 shows the attendance at delivery in Male'and the atolls. In Male' two thirds of deliveries in the last year (69%, 55/80) were reported to be attended by a gynaecologist. This does not necessarily mean that in this proportion of deliveries the gynaecologist was actually physically present, but rather that women were under the care of a gynaecologist who was available if needed, while the actual delivery was probably attended by a nurse.

More than half of women who delivered in the last year (60%, 142/236) said they had contact with a health care provider in the six weeks following the delivery. These post-natal health care provider contacts were more frequent in Male' (Table17). Among those women who had contact with a health care provider after delivery, half (49%, 67/136) reported they were given family planning advice (Table 17).

Table 17. Contact with health care provider within 6 weeks of delivery and advice given (2004). Number (%)

	Male' (n=77)	Atolls (n=159)	Total (n=236)
Contact with health care provider	64 (83)	78 (49)	142 (60)
	(n=63)	(n=73)	(n=136)
Given FP advice	34 (54)	33 (45)	67 (49)

The proportion of women having postnatal contact with a health care provider by region is shown in Annex 5.

Contraception practice and knowledge

Some 71% (2722/3859) of ever-married men and women aged 15-49 years reported they had been married to only one person. Some 17% (672) had been married to two different people, 7% (260) had been married to three different people and the remaining 5% had had more than three spouses. There was no difference between men and women in number of spouses. Among the small group of men aged 50 years and above, 37% (91/243) reported only one spouse, 29% (71) had had two spouses, 16% (38) three spouses, and the remaining 18% more than three spouses.

Actual and desired family size

The ideal number of children mentioned by ever-married women aged 15-49 years was 3.0 in 2004, having been 3.1 in 1999. The mean number of *living* children of these women in 2004 was 3.5, while in 1999 the mean number of children *borne* to these women was 4.2. Note that the two figures are not exactly comparable, although they do suggest a fall in the number of children borne to women between the two surveys. This is in line with other studies reporting a fall in fertility rates in the Maldives.

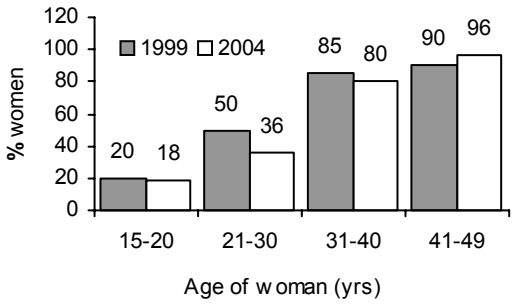
Table 18. Number of children by age of mother (2004)

Age group	Number of women	Number of children	
		Mean	Median
15-20	48	1.3	1
21-30	903	2.0	2
31-40	914	4.0	4
41-49	482	5.5	6

The mean and median numbers of living children of ever-married women of different age groups in 2004 is shown in Table 18.

In 2004, among ever-married men aged 15-49 years, the mean ideal number of children mentioned was 3.1 and their mean number of living children was 3.2. Among the small number of ever-married men aged 50-64 years (243), their ideal number of children was 3.5 and their actual number of living children was 6.2. This again illustrates the falling fertility rates in recent times.

Figure 4. % of married women not wanting more children, by age



Some 62% (1523/2472) of currently married women aged 15-49 years said they did not want more children in 2004. The equivalent figure in 1999 was 68% (1473/2166). Not surprisingly, a higher proportion of older women reported that they do not want any more children (Figure 4). The higher proportion not wanting more children in 1999 compared with 2004 is mainly in the age group 21-30 years. This age group had a mean

Figure 5. % of women wanting more children and number of existing children

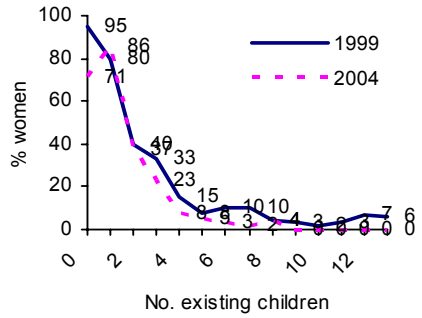


Figure 6. % ever-married women who have ever used contraception, by age

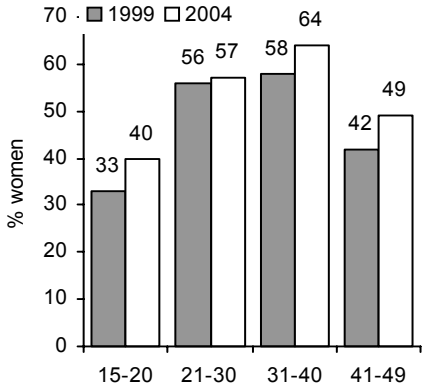


Table 19. Ever-married women who have ever used contraception (2004). Number (%)

Age group	Male' (n=711)	Atolls (n=1922)	Total (n=2693)
15-20 (n=97)	13 (42)	26(39)	39 (40)
21-30 (n=636)	156 (48)	480 (61)	636 (57)
31-40 (n=972)	155 (62)	464 (64)	619 (64)
41-49 (n=505)	81 (50)	167 (49)	248 (49)
All (n=2693)	405 (53)	1137 (59)	1542 (57)

Table 20. Ever-married men who have ever used contraception (2004). Number (%)

Age group	Male' (n=377)	Atolls (n=789)	Total (n=1166)
15-20 (n=10)	1 (50)	2 (25)	3 (30)
21-30 (n=367)	57 (50)	115 (50)	172 (47)
31-40 (n=496)	83 (55)	204 (59)	287 (58)
41-49 (n=293)	50 (56)	99 (49)	149 (51)
All (n=1166)	191 (51)	420 (53)	611 (52)

of 2.00 living children in 2004 and a mean of 2.70 children borne to them in 1999.

The proportion of women wanting to have more children declined with the number of children that they had already (Figure 5). In 2004, the range wanting more children was from 71% in those with no children to 3% in those with 8 or more children. This range was from 95% to 5% in 1999.

Contraceptive use

Ever used any contraception

In 2004, 57% (1542/2693) of ever-married women aged 15-49 years and 52% (611/1166) of ever-married men aged 15-49 years said they had ever used a method of contraception, including traditional methods. The equivalent figures in 1999 were 54% (1284/2396) for ever-married women and 58% (163/280) for ever-married men.

The proportion of ever-married women who have ever used any method of contraception was higher in 2004 than in 1999 in all age groups. The highest proportion who have ever used any contraceptive method was among women aged 31-40 years in both 2004 and 1999 (Figure 6).

Table 19 shows the proportion of ever-married women who have ever used contraception in Male' and the atolls in 2004. The proportion who have ever used contraception was somewhat lower in Male', especially among women aged 21-30 years.

Table 20 shows the proportion of ever-married men in 2004 who reported they had ever used any method of contraception, in Male' and the atolls. The proportions of men who have ever used contraception were not different between Male' and the atolls.

Current use of contraception

Table 21. CPR in 1999 and 2004. Number (%)

CPR	1999 n=2181	2004 n=2479
All methods	923 (42)	972 (39)
Modern methods	723(33)	842 (34)
Modern temp methods	506 (23)	658 (27)

The Contraceptive Prevalence Rate (CPR) among married women aged 15-49 years has been estimated based on the reported current use of contraception among married women aged 15-49 years. The CPR for all methods of contraception (including traditional methods) was 39% (972/2479) in 2004, having been 42% (923/2181) in 1999 (Table 21). There was virtually no change in the CPR for modern methods of contraception: it was 34% (842/2479) in 2004, having been 33% (723/2181) in 1999. The CPR for modern temporary methods was 27% (658/2479) in 2004, having been 23% (506/2181) in 1999.

Thus, between 1999 and 2004, there has been little change in the overall use of contraception, but a shift towards modern temporary methods and away from traditional methods.

Table 22. CPR in Male' and the atolls in 2004. Number (%)

CPR	Male' n=712	Atolls n=1767	Total n=2479
All methods	264 (37)	708 (40)	972 (39)
Modern methods	225(32)	617 (35)	842 (34)
Modern temp methods	167 (24)	491 (28)	658 (27)

The CPR in Male' and the atolls is shown in Table 22. The CPR is in fact higher in the atolls than Male', including the CPR for modern temporary methods.

Table 23. Mix of contraceptive methods in 1999 and 2004 in married women. Number (%)

Methods used	No (%) of respondents 1999	2004
None	1258 (58%)	1507 (61%)
Pill	273 (13%)	325 (13%)
Injectables	60 (3%)	61 (3%)
Condom	140 (6%)	227 (9%)
Female sterilisation	207 (10%)	170 (7%)
Male sterilization	10 (1%)	14 (1%)
IUCD	24 (1%)	41 (2%)
Diaphragm	1 (-)	0 (-)
Norplant	8 (-)	4 (-)
Traditional methods	200 (9%)	130 (5%)

The mix of contraceptive methods reported in 1999 and 2004 is shown in Table 23. Among married women aged 15-49, pills and condoms were the most popular methods of contraception in 2004. Condom use increased from 6% in 1999 to 9% in 2004, over taking female sterilisation as the second most popular method of contraception. Pill use remained constant at 13%. The reported use of traditional methods fell from 9% in 1999 to 5% in 2004.

Table 24. Contraceptive method mix in Male' and the atolls in 2004 (married women 15-49 years)

Methods used	Male' (n=712)	Atolls (n=1767)
None	448 (63)	1059 (60)
Pills	51 (7)	274 (16)
Injectables	11 (2)	50 (3)
Condom	80 (11)	147 (8)
Female sterilisation	55 (8)	115 (7)
Male sterilization	3 (-)	11 (1)
IUCD	21 (3)	20 (1)
Diaphragm	0	0
Norplant	4 (1)	0
Traditional methods	39 (6)	91 (5)

Table 24 shows the contraceptive method mix in Male' and the atolls in 2004. The use of the pill is more popular outside Male', while the use of condoms is more popular in Male'. The CPR for all methods, modern methods, and modern temporary methods by region is shown in Annex 5.

In 2004, the CPR for modern methods was similar among women under and over the age of 30 years[3] and among women with and without at least primary education[4].

[3] 380/1205 (32%) of married women aged 15-30 years were using a modern method of contraception, compared with 484/1457 (33%) of married women aged 31-49 years. OR 0.93, 95% CI 0.78-1.10

[4] 529/1640 (32%) of married women aged 15-49 with at least primary education were using a modern method of contraception, compared with 335/1020 (33%) of those with basic or no education. OR 0.97, 95% CI 0.82-1.16

Figure 7. CPR modern methods in 1999 and 2004 in married women, by age

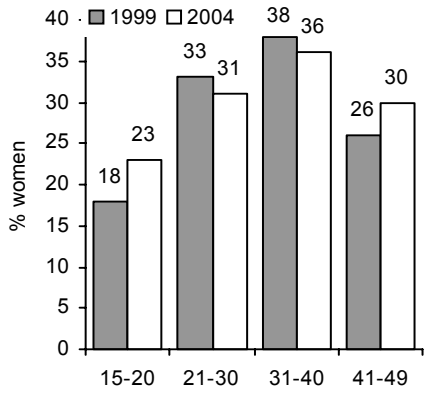


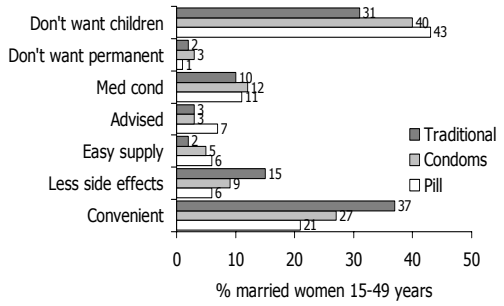
Table 25. Mix of contraceptive methods in married men and women aged 15-49 in 2004 Number (%)

Methods used	No (%) of respondents	
	Men	Women
None	708 (63%)	1507 (61%)
Pill	94 (8%)	325 (13%)
Injectables	15 (1%)	61 (3%)
Condom	147 (13%)	227 (9%)
Female sterilisation	38 (3%)	170 (7%)
Male sterilization	14 (1%)	14 (1%)
IUCD	16 (1%)	41 (2%)
Diaphragm	0 (-)	0 (-)
Norplant	3 (-)	4 (-)
Traditional methods	85 (8%)	130 (5%)

Table 26. Reasons of married women aged 15-49 for choice of contraceptive method (2004)

Reasons	No. (%) resp.
Don't want children	412 (42%)
Convenient to use	194 (20%)
Less side effects	72 (7%)
Easy to get supply	34 (4%)
Advised to use	55 (6%)
Due to medical condition	157 (16%)
Don't want permanent method	23 (2%)
Don't know	71 (7%)

Figure 8. Reasons for choosing different contraceptive methods



In both 1999 and 2004 the highest CPR for modern methods was among women aged 31-40 years, as shown in Figure 7. There has been an increase in the use of modern methods of contraception between 1999 and 2004 among the youngest age group (age 15-20 years) and among women aged 41-49 years, while the rates have stayed the same or fallen slightly among women in the middle age groups.

Among married men aged 15-49 years interviewed in 2004, the CPR for all methods was 37% (412/1120), for modern methods 29% (327) and for modern temporary methods 25% (275).

The method mix among married men and women aged 15-49 years in 2004 is shown in Table 25. Compared with women, men reported more use of condoms and less reliance on the pill.

Reasons for choice of contraceptive method

Women currently using contraceptives were asked the reason for choosing their current method over other contraceptive methods. They were allowed to give more than one answer. Among respondents who provided a relevant answer to this question, the two most common reasons for choosing a particular method of contraception were not wanting any (more) children (42%, 412/977) and convenience of use (20%; 194/977). Reasons for contraceptive method choice are shown in table 26, for women using any method. There was little difference in the reasons for method choice between Male' and the atolls.

The reasons for choosing the method varied with the method being used. Figure 8 shows the reasons women gave for choosing the pill, condoms or traditional methods. Convenience and lack of side effects are common reasons for choosing traditional methods, and not wanting more children is of relatively less importance. For the pill and condoms, the desire not to have more children is the key reason given, with convenience of relatively less importance.

In the adult focus groups, participants discussed the reason why condom use is relatively low among married couples in the Maldives, although condom use has increased since 1999. The group participants

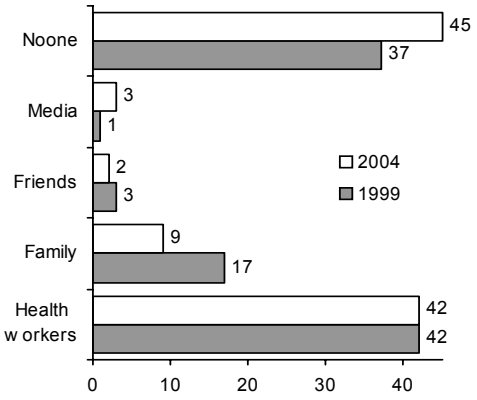
Table 27. Source of advice about contraception for current contraception users by gender and region (married,15-49 years) (2004) Number (%)

Source	Gender		Region		Total
	Male (n=403)	Female (n=938)	Male' (n=389)	Atolls (n=952)	(n=1341)
No one	294 (62)	417 (45)	239 (61)	437 (45)	666 (50)
Friends	4 (1)	15 (2)	8 (2)	11 (1)	19 (1)
Family	17 (4)	86 (9)	23 (6)	79 (8)	102 (8)
Health workers	113 (28)	394 (42)	104 (27)	403 (42)	507 (38)
Media	20 (5)	27 (3)	15 (4)	32 (3)	47 (4)

considered condoms were not much used because they reduce satisfaction during sexual intercourse. There was also a belief expressed that condoms are not effective. There are misconceptions about condoms, perhaps due to lack of information. For example, some group participants believed that a condom might get stuck in the woman after sex.

Source of advice about contraceptive methods

Figure 9. Source of advice about contraception



Married female respondents who were currently using contraceptives were asked who advised them about choice of contraceptive method. Figure 9 shows their reported sources of advice in 2004 and 1999. In 2004, as in 1999, health workers (42%; 394/938) were still the most popular advisors, followed by family members (9%; 85/938). Health workers are clearly a trusted source of advice about contraception and it is important that their own knowledge is accurate and up to date.

There were some differences in sources of advice about contraception methods between Male' and the atolls and between male and female contraceptive users aged 15-49 years. These are shown in Table 27. Less male users said they got their advice from health workers, and more of them said they got advice from 'no one' compared with female users. Similarly, less contraceptive users in Male' got advice about contraceptive methods from health workers compared with users in the atolls.

Source of contraceptives

Table 28. Source of contraceptives in married users aged 15-49 years in 2004. Number (%)

Source	Male' n=376	Atolls n=969	Total n=1345
Local health facility	42 (11)	643 (66)	685 (51)
Local pharmacy	21 (6)	73 (8)	94 (7)
Pharmacy, other island	2 (1)	21 (2)	23 (2)
Pharmacy, Male'	83 (22)	22 (2)	105 (8)
IGMH	57 (15	53 (6)	110 (8)
SHE	50 (13)	1 (-)	51 (4)
Friend/family	4 (1)	5 (1)	9 (1)
Abroad	74 (20)	17 (2)	91 (7)
No need	43 (11)	134 (14)	177 (13)

In 2004, respondents were asked where they were getting the contraceptives they were currently using. About half (51%, 685/1345) of contraceptive users aged 15-49 years said they get their contraceptives in the local health facility. Some 7% (94) said they bought contraceptives from the local pharmacy, while 8% (105) went to a pharmacy in Male. The IGMH was the source of contraceptives for 8% (110). About 7% (100) said they got their contraceptives from abroad.

Users in the atolls were more likely to get their contraceptives from the local health facility. Some 2%

got their contraceptives from a pharmacy in Male' (Table 28).

Decision maker about contraception

Contraceptive users and non-users were all asked who made the decision about the use of contraception. The responses are shown in Table 29. Among married female respondents aged 15-49 years, 70% said they made the decision about using contraception together with their spouse, 8% said they made the decision themselves, and 11% said their spouse made the decision. A further 11% said the subject had never been discussed. Among married male respondents in the same age group, the responses were quite similar (Table 29), with again 70% saying the decision was made jointly with the spouse.

Table 29. Decision maker about use of contraception reported by married men and women age 15-49 years in 2004. Number (%)

Decision maker	Male (n=1131)	Female (n=2503)
Self	87 (7)	202 (8)
Spouse	160 (14)	273 (11)
Both	790 (70)	1753 (70)
Never discussed it	98 (9)	275 (11)

There was little difference between Male' and the atolls in the reported decision maker about contraception.

"Both [men and women] should be responsible [for contraception]"
Focus group of married men

In the adult focus groups, most participants considered that the decision about use of contraception should be made jointly between male and female partners. In some groups it was noted that women may fail to initiate the discussion about contraception, implying that it is considered primarily a female responsibility to think about contraception.

There was a relationship between the decision maker and the use of contraception, as shown in Table 30 for married women aged 15-49 years. The highest proportion using a modern method of contraception (39%) was among those where the decision was taken jointly; the proportion using a modern method was 31% if the spouse made the decision and only 3% if the issue was never discussed at all.

Table 30. Decision maker and use of contraception in married women 15-49 yrs

Decision maker	Number (%) using modern contraception
Self	75/198 (38%)
Spouse	82/269 (31%)
Both	676/1733 (39%)
Never discussed it	9/273 (3%)

Reasons for discontinuing contraception

Among the 1542 women in 2004 who had ever used any contraception, 466 (30%) of them had discontinued contraceptive use at the time of the survey. The reasons they gave for stopping use of contraception are shown in Table 31. As in 1999, the most common reason women gave in 2004 for discontinuing contraception was side effects. Women also commonly stopped because of wanting more children. In 2004,

Table 31. Reasons for discontinuing contraception

Reasons	No (%) of respondents 1999	2004
Side effects	102 (34%)	113 (24%)
Spouse absent	62 (21%)	39 (8%)
Want more children	34 (11%)	81 (17%)
No reason	30 (10%)	101 (22%)
Pregnant/failure	19 (6%)	31 (7%)
Inconvenient	18 (6%)	29 (6%)
Supply stopped	11 (4%)	1 (-)
Spouse disagrees	9 (3%)	19 (4%)
Taking too long	6 (2%)	1 (-)
Doctors advised	6 (2%)	46 (10%)
Too old to use	2 (1%)	5 (1%)
Total	299 (100%)	466 (100%)

about a fifth of women said they stopped for no specific reason.

The reasons given by women for discontinuing contraception were similar between Male' and the atolls.

Among the 611 men under 50 years in 2004 who had ever used any contraception, 162 (27%) of them had discontinued contraceptive use at the time of the survey. The most common reason for men gave for discontinuing the use of contraception was that they wanted more children (28%, 46/162). Some 17% (28/162) mentioned side effects, and 7% (12/162) said contraception was inconvenient.

Reasons for never using contraception

Table 32. Reasons for never using contraception i ever-married women and men aged 15-49 years

Reason	1999 Women n=1061	2004 Women n=1121	Men n=545
No need	497 (47)	448(40)	257 (47)
Religion/tradition	16 (2)	7 (1)	7 (1)
Don't want to use	294 (28)	125 (11)	80 (15)
Spouse disagrees	67 (6)	53 (5)	5 (1)
Service not available	78 (7)	43 (4)	15 (3)
Inconvenient	52 (5)	54 (5)	27 (5)
Side effects	57 (5)	42 (4)	17 (3)
Spouse away	-	36 (3)	6 (1)
No particular reason	-	313 (28)	131 (24)

In 2004, the most common reason given by the 1151 women who had *never* used contraception was that there was no need (40%, 448/1121) (Table 32). . In 1999, this proportion giving this reason was slightly higher (47%; 498/1063). In 2004, fewer women than in 1999 said they had never used contraceptives simply because they did not want to, but in 2004 28% could give no specific reason for never using contraceptives. Few women in 2004 said a contraception service was not available to them. For the older respondents the decision not to use contraception may have been taken some years ago, when the use of contraception was rare.

In 2004, the men under the age of fifty who had never used contraceptives gave similar reasons (Table 32).

The reasons given for never using contraception were broadly similar between Male' and the atolls.

Unmet need for contraception

Among married women aged 15-49 years, 37% (913/2471) do not want more children and yet, at the time of the survey, they are not using any modern method of contraception. In 1999, this proportion was 42% (876/2140). For married men under 50 years, this proportion is 36% (402/1119).

Figure 10. Unmet need for modern contraception, by age group

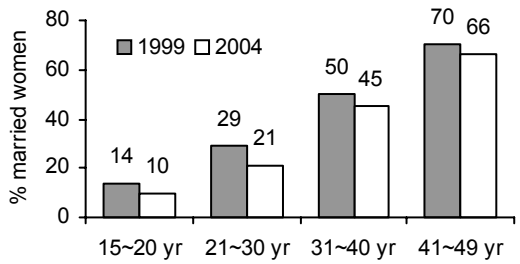


Table 33. Unmet need for modern contraception among married women aged 15-49 years in 2004. Number (%)

Age	Male'	Atolls	Total
15-20	2 (7)	7 (11)	9 (10)
21-30	72 (23)	147 (20)	219 (21)
31-40	80 (36)	315 (47)	395 (45)
41-49	9 (65)	196 (67)	290 (66)
All	248 (35)	665 (38)	913 (37)

Table 34. Contraceptive methods known to household respondents

Methods	No. (%) of respondents	
	1999	2004
Pill	2787 (76%)	3192 (78%)
Condom	2293 (63%)	3144 (77%)
Injectables	1873 (51%)	2117 (52%)
Operation	833 (23%)	953 (23%)
IUCD	826 (23%)	1264 (31%)
Trad. methods	454 (12%)	697 (17%)
Others	43 (1%)	-
Diaphragm	19 (1%)	191 (5%)
Norplant	5 (-)	304 (7%)
Don't know	489 (13%)	360 (9%)

Table 35. Awareness of different methods of contraception in 2004. Number (%)

Methods	Male'	Atolls	Total
Pill	770 (67)	2292 (85)	3062 (79)
Condom	897 (78)	2122 (78)	3019 (78)
Injectables	450 (39)	1609 (59)	2059 (53)
Operation	263 (23)	640 (24)	903 (23)
IUCD	419 (37)	821 (30)	1240 (32)
Trad methods	193 (17)	472 (17)	655 (17)
Diaphragm	100 (9)	86 (3)	186 (5)
Norplant	181 (16)	119 (4)	300 (8)
Don't know	80 (7)	214 (8)	294 (8)

Table 36. Side effects of contraceptives known to contraceptive users (2004)

Side Effects	No (%) of respondents
Irregular periods or spotting	125 (9%)
Nausea/vomiting	19 (1%)
Dizziness /headache	62 (4%)
Weight changes/swelling	56 (4%)
Back, stomach or genital pain	72 (5%)
Discomfort on intercourse	37 (3%)
Not reliable/can fail	36 (2%)

The proportion of married women with unmet need for modern contraception increases with age as shown in Figure 10. Older women are less likely to want to have more children (see above) and also (among those over 40 years old) less likely to be using contraception. Thus the proportion not wanting more children but not using contraception increases.

The unmet need for modern contraception was not very different between Male' and the atolls (Table 33).

Knowledge about contraception

Ever married men and women in 2004 were asked what contraceptive methods they knew of, in an open-ended question. Most respondents (91%, 3742/4102), both male and female, knew of at least one modern method of contraception. In 1999, the proportion of respondents knowing at least one contraception method was slightly lower at 87% (3162/3649). Pill, condoms and injectables were the three most common methods known, followed by "operation" and IUCD. Table 34 shows the proportion of respondents who were aware of different methods. For all methods, awareness was higher in 2004.

Awareness of different methods of contraception in Male' and the atolls is shown in Table 35. Awareness of injectables was apparently higher in the atolls, while awareness of norplant was higher in Male'.

Knowledge of side effects of contraceptives

In 2004, 23% (332/1473) of respondents currently using any method of contraception were able to name at least one side-effect of contraceptives. The most common side effects mentioned by respondents in an open question were irregular periods or spotting (9%, 15/1473), dizziness and headaches (4%, 62/1473) and weight changes (4%, 56/1473) (Table 36).

The relatively low knowledge about side-effects of contraceptives was similar among male and female contraceptive users and in Male' and the atolls.

Knowledge of side-effects is important. If people do not understand what are the likely side-effects they might stop contraception for symptoms that are actually

Table 37. Awareness of availability of different methods of contraception in local health facility

Method	Male' n=1220	Atolls n=2882	Total n=4102
None	1 (-)	26 (1)	27 (1)
Pills	881 (72)	2347 (81)	3228 (79)
Injectables	571 (47)	1501 (52)	2072 (51)
Condoms	928 (76)	2083 (72)	3011 (73)
F sterilization	347 (28)	397 (14)	744 (18)
M sterilization	194 (16)	162 (6)	356 (9)
IUD	424 (35)	425 (15)	849 (21)
Diaphragm	108 (9)	26 (1)	134 (3)
Norplant	192 (16)	33 (1)	225 (6)
Don't know	146 (12)	350 (12)	496 (12)

Table 38. Awareness of methods of CP available locally by type of health facility on island; n(%)

Method	AH	RH	HC	HP
None	0	3 (1)	5 (1)	18 (2)
Pills	244(87)	561(86)	876(80)	666(78)
Injectables	205(73)	487(74)	518(48)	291(34)
Condoms	233(83)	519(79)	797(73)	534(63)
F steril	119(42)	272(42)	4 (0)	2 (0)
M steril	17 (6)	144(22)	0	1 (0)
IUD	106(38)	256(39)	55 (5)	8 (1)
Diaphrgm	5 (2)	17 (3)	3 (0)	1 (0)
Norplant	3 (1)	26 (4)	3 (0)	1 (0)
DK	22 (8)	48 (7)	153(14)	127(15)

HP=Family health post or family health section

Table 39. Knowledge about when during the menstrual cycle a woman is most likely to conceive

Time most likely to conceive	No (%) of respondents	
	1999	2004
A few days after purity bath	1899(53%)	2677(66%)
Just before the next period	128 (4%)	200 (5%)
In the middle between 2 periods	349 (10%)	468 (12%)
All the time	20 (1%)	21 (1%)
Don't know	1215 (34%)	720 (18%)

unrelated to the contraception. Or they may fail to seek help when they have a side-effect that could be dealt with by a simple change in the method.

Knowledge of contraceptives availability

Ever-married men and women were asked about their knowledge of methods of contraception available in their local health facility. One in ten respondents (12%, 496/4102) said they did not know what contraceptives were available in the local health facility and 1% (27/4102) said that no contraceptives at all were available. Some 79% (3228/4102) mentioned that the contraceptive pill was available from the local health facility, while 73% (3011/4102) mentioned condoms and 51% (2072/4102) mentioned injectables. The awareness of availability of different contraceptives in the local health facility in Male' and the atolls is shown in Table 37.

The awareness of types of contraception available from the local health facility varied according to the type of health facility available on the island (Table 38). To some extent this reflects actual availability of types of contraception from different levels of health facilities.

Knowledge about most fertile period during the menstrual cycle

Respondents were asked when during the menstrual cycle a woman is most likely to conceive, in an open question. In 2004, 66% (2677/4086) thought a woman was most likely to conceive a few days after the purity bath. Some 12% (468) gave the correct answer: in the middle between two periods (Table 39). The proportion knowing the correct answer was similar in 1999 and 2004. The proportion with correct knowledge was also similar between men and women and between Male' and the atolls.

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This lack of accurate knowledge about when a woman is most fertile is a concern given that a number of couples are relying on the rhythm method of contraception.

Reproductive health services

Review of facilities

As part of the survey, the health facilities serving the sample communities were visited and reviewed. The main findings are summarised in the following section. The full findings are tabulated in Annex 3.

In total, 23 health facilities of different types were reviewed: 5 regional hospitals (including IGMH), 10 health centres (including Male'and Villingili), 2 atoll hospitals, 3 family health posts and 2 family health sections. One NGO run facility was reviewed in Male'.

Table 40. Allocated and filled posts in health facilities
A=Allocated P= Present

Post	RH (5)		HC/AH (12)		HP/NGO (6)	
	A	P	A	P	A	P
Doctors	34	33	20	18	4	4
Nurses	121	114	59	59	4	4
Gynaecologists	5	5	3	3	1	1
TBA (trained)	30	30	30	30	9	9
TBA (untrained)	3	3	2	2	-	-
FHW	14	14	18	16	8	8
CHW	1	1	4	3	3	3
RHO	3	3	1	1	-	-
CHS	8	8	9	9	-	-

Table 40 lists the numbers of allocated posts in each type of facility and the number of staff present at the time of the survey. In most cases, all allocated posts were reported to be filled.

Most facilities had the appropriate medicines and equipment available. However, there were some gaps. For example, antibiotics were in stock in 6 of the 12 health centres. Urine testing kits (uristicks) were found in 1 of the 6 health posts. A height scale was found in 3 health posts, although the health worker in 5 health posts claimed to measure the height of women during pregnancy.

The facilities provided a range of services related to reproductive health. All facilities reported providing family planning and health education and all provided counselling. Twenty one of the 23 facilities provided antenatal and postnatal care; 20/23 provided iron supplementation; 17/23 had STI treatment and delivery facilities. Some 7/23 provided surgery. About half the facilities (12/23) had laboratory diagnostic facilities. These facilities are not made available in Family Health Posts and Family Health Sections.

When asked about services they did not provide but they considered to be needed by the community, the respondents most commonly mentioned the need for more qualified staff and more staff in general. Some also mentioned laboratory services.

Most (19/23) of the facilities said they received complaints about their service from the local community. The most common complaints they

mentioned were: bad behaviour of health staff, lack of medicines and inexperience of staff. When asked what could be done to improve their services, most respondents asked for more qualified staff, new medical equipment and upgrading of the facility. These requests are quite similar to the suggestions from the households about what improvements they would like to services (see below).

Opinions of reproductive health services

The majority (72%, 2923/4074) of household respondents rated the reproductive health services in their area as 'good'. This is slightly less than in 1999 when 77% of respondents said that services were good. The proportions of respondents giving different ratings for reproductive health services are shown in Figure 11. Note that this includes male respondents over the age of 49 years in both 1999 and 2004. The ratings were much the same if respondents over 49 years old were excluded. The lower proportion rating the services as 'good' in 2004 compared with 1999[5] was present among both men and women, among those with and without education and in both Male' and the atolls. The *fall* in household rating of services was also not explained by any of the service factors noted in the institutional reviews of the facilities, including such things as the presence of posters, the provision of IEC sessions, whether the height of pregnant women was measured, whether the facility felt they had community support and whether they heard complaints from the public about their service, even though some of these factors were related to the rating in 2004 (see below).

Figure 11 Household respondents' ratings of reproductive health services

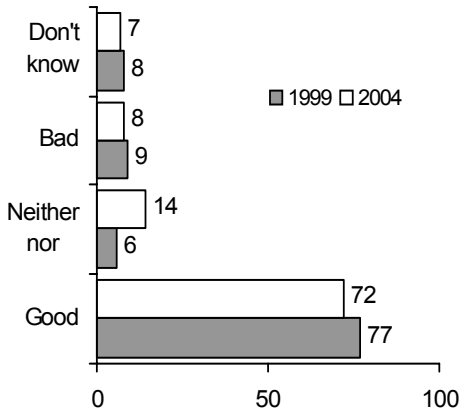


Table 41. Ratings of reproductive health services by respondents (15-49 years), by gender and region (2004). Number (%)

	Gender		Region		Total
Rating	Male (n=1157)	Female (n=2676)	Male' (n=1143)	Other regions (n=2690)	(n=3833)
Good	730 (63)	2033 (76)	873 (76)	1890 (70)	2763 (72)
Average	182 (16)	336(13)	116 (10)	402 (15)	518 (14)
Bad	142 (12	149 (6)	59 (5)	232 (9)	291 (8)
Don't know	103 (9)	158 (6)	95 (8)	166 (6)	261 (7)
	(n=1054)	(n=2518)	(n=1048)	(n=2524)	(n=3572)
Good	730 (69)	2033 (81)	873 (83)	1890 (75)	2763 (77)
Average or bad	324 (31)	485 (19)	175 (17)	634 (25)	809 (23)

The ratings of reproductive health services in 2004 by males and females aged 15-49 years and by household respondents in Male' and the atolls are

[5] 2923/3784 (77%) rated the services as good in 2004, compared with 2835/3324 (85%) in 1999. OR 0.59, 95% CI 0.52-0.66. This excludes the "don't know" responses to the question.

shown in Table 41. Women tended to rate the services more positively than men[6] and people in Male' rated services more positively than did people in the atolls[7].

The regional variation in the rating of reproductive health services in 2004 is shown in Annex 5.

In 2004, people on an island where the health facility was noted to have educational posters on display were more likely to rate reproductive health services as good[8]. People whose local facility reported hearing complaints about their service were also more likely to rates the services as good, compared with the few whose local facility said they did not hear complaints[9]. Hearing complaints shows some concern and responsiveness to public opinion.

Household respondents were asked what problems they perceived with reproductive health services, in an open question. The willingness of respondents to cite problems with the services has apparently increased between 1999 and 2004. Although the overall rating of the services was not much less positive in 2004 than in 1999, in 2004 less than half the respondents (48%, 1956/4102) said there was "no problem" with the services, while in 1999 most (77%, 2303/2921) respondents said there was "no problem".

Table 42. Perceived problems with reproductive health services, from household respondents

Problems	No (%) of respondents	
	1999	2004
Bad attitude of staff	149 (13%)	216 (5%)
Staff absent/lack of staff	54 (5%)	187 (5%)
Lack of specialist/doctors	22 (2%)	506 (12%)
No female doctor	51 (4%)	469 (11%)
Long waiting time	7 (1%)	176 (4%)
Opening hrs/holiday service	5 (-)	43 (1%)
Problem with token system	7 (1%)	68 (2%)
Lack medicine/equipment	106 (9%)	479 (12%)
Lack of counsel/health ed	109 (9%)	319 (8%)
Poor quality care	30 (3%)	470 (12%)
Poor physical condition	16 (1%)	78 (2%)
No facility on the island	94 (8%)	152 (4%)
Health centre too far away	90 (8%)	597 (15%)

The problems with reproductive health services mentioned by household respondents (both male and female) in 1999 and 2004 are summarised in Table 41. The proportions mentioning problems of lack of staff, lack of equipment, and distance of the health facility have increased somewhat between 1999 and 2004. Note that the figures in Table 42 include the few male respondents over the age of 49 years. Excluding them makes little difference to the figures.

In 2004, there was not much difference between men and women aged 15-49 years in the problems they cited with reproductive health services.

[6] 890/1266 (70%) of men rated services as good, compared with 2033/2518 (81%) women.)R 0.56, 95% CI 0.48-0.66. This excludes the "don't know" responses to the question.

[7] 926/1109 (84%) of respondents in Male' rated services as good, compared with 1997/2675 (75%) of those in the atolls. OR 1.72, 95% CI 1.43-2.07. This excludes the "don't know" responses to the question.

[8] 2722/3436 (79%) of people served by a health facility displaying posters rated the RH services as good, compared with 201/348 (58%) served by a health facility not displaying posters. OR 2.79, 95% CI 2.20-3.53

[9] 2607/3344 (78%) of people whose facility reported hearing complaints rated services as good, compared with 316/440 (72%) of those whose facility did not hear complaints. OR 1.39, 95% CI 1.10-1.75

Table 43. Problems with RH services cited by respondents (15-49 years) in 2004. Number (%)

Problems	Male' n=1148	Atolls n=2711
No problem	659 (57)	1189 (64)
Health center too far away	23 (2)	539 (20)
Lack of female doctors	21 (2)	434 (16)
Bad attitude of staff	40 (4)	165 (6)
Lack of medicine/ equipment	32 (3)	416 (15)
Staff absent/lack of staff	34 (3)	138 (5)
No facility on the island	6 (1)	138 (5)
Lack of counselling/ health ed	53 (5)	249 (9)
Lack of specialists/doctors	56 (5)	424 (16)
Long waiting time	77 (7)	88 (3)
Problems with token system	36 (3)	28 (1)
Opening hours/holiday service	13 (1)	25 (1)
Poor quality care	130 (11)	318 (12)
Poor physical facilities	18 (2)	55 (2)
Lack of privacy	23 (2)	61 (2)

Table 44. Household respondents' suggestions for improving reproductive health services

Suggestions	No (%) of respondents 1999	2004
Staff		
More doctors/ specialists	392 (13%)	1201 (29%)
Better attitude of HW	68 (2%)	272 (7%)
More training of HW	56 (2%)	486 (12%)
Time		
More time with patients	7 (-)	183 (5%)
Service, quality		
Provide more information	600 (20%)	1487 (36%)
Improve quality of care	228 (8%)	1061 (26%)
Provide medicine & equip.	99 (3%)	465 (11%)
Improve facility condition	278 (10%)	273 (7%)
Access		
Near by health center	202 (7%)	318 (8%)
More community support	93 (3%)	378 (9%)
No suggestion	483 (14%)	676 (17%)
Don't know	1305(44%)	476 (12%)

There was some difference in the problems cited in 2004 by respondents (aged 15-49 years) in Male' and respondents in the atolls (Table 43). Not surprisingly, lack of staff, equipment and facilities and distance to the health facility were more often cited by respondents outside Male'.

Household respondents were asked for suggestions for improvements to reproductive health services, in an open question. Again, the proportion of respondents willing and able to make a suggestion for improvement was higher in 2004 than in 1999. In 1999, more than half the respondents either specifically had no suggestion or were unable to formulate a suggestion, but in 2004 28% (1152/4102) had no suggestion to make.

The suggestions of the household respondents are summarised in Table 44. The figures in Table 43 include the small number of men aged over 49 years who were interviewed. Excluding them makes little difference to the figures. In 2004 there was little difference in the pattern of suggestions between men and women and between respondents in Male' and the atolls.

The suggestions shown in Table 44 mostly reflect the problems cited in Table 42. In 2004, the single most requested improvement for reproductive health services was provide more information (36%, 1487/4102). Other popular requests were for more doctors and specialists (29%, 1201) and a generally improved quality of care (26%, 1061).

The increased public willingness to cite problems with health services and suggest solutions may relate to their overall increased awareness of health services and, paradoxically, to the wider range of services now available in the atolls. It also suggests they are becoming more demanding of services.

Experience of reproductive health services

Household respondents were asked if they had visited any health facility (government, NGO or private) in the last 3 months. In 2004, only visits for reproductive health care were asked about, while in 1999, visits for general health care were also included. In 2004, both

Figure 12. % of visits to different health facilities

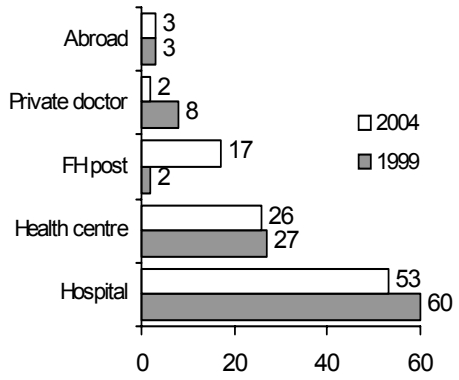


Table 45. Purpose of visiting health facilities (women aged 15-49 visiting for RH care)

Purpose	No (%) respondent	
	1999 n=240	2004 n=273
Get contraceptives	12 (5)	145 (53)
Side effects CPs	6 (3)	0
Antenatal care	73 (30)	66 (24)
Delivery	34 (14)	21 (8)
Postnatal care	8 (3)	8 (3)
Immunisations	4 (2)	14 (5)
Period problems	41 (17)	0
Infertility	4 (2)	10 (4)
Other RH issues	13 (5)	0
Abdo pain/ miscarriage	33 (14)	6 (2)
Urinary tract infection	12 (5)	3 (1)

men and women were asked about their use of reproductive health services, while in 1999 only women were asked about their use of services. In order to compare use and experience of services between 1999 and 2004, we have therefore included only visits related to reproductive health care (excluding the general visits in 1999) and only visits by women (excluding those visits made by men in 2004). The use and experience of services by men in 2004 is described separately.

In 2004, 10% (274/2678) of women aged 15-49 years visited a health facility for reproductive health care in the last three months. The equivalent figure in 1999 was 8% (244/3089). Further details were sought about the most recent visit.

Figure 12 shows the type of facility visited in 2004 and 1999 (among women aged 15-49 years visiting for reproductive health care). There was a higher proportion of visits to family health posts in 2004. In 2004, rather more women in Male' said they visited a hospital compared with women in the atolls. The types of facilities visited by men in 2004 were similar to those visited by women.

Table 45 shows the purposes of visiting the health facilities, among women aged 15-49 who visited for reproductive health care. The main difference between 1999 and 2004 is the higher proportion of women visiting to get contraceptives in 2004. This might reflect the different wording of the question about visits to health facilities between the two surveys.

Availability of required medicines

Nearly all women aged 15-49 years who reported on a visit to a health facility for reproductive health care in 2004 (96%, 262/273) said that all the required medicines, contraceptives or materials were available in the facility. The equivalent figure in 1999 was 93% (222/238). There was little difference between types of facility in the high availability of medicines. In the few cases where the medicines were not available in the facility, private or community pharmacies are present in most islands with a health centre or higher level of health facility.

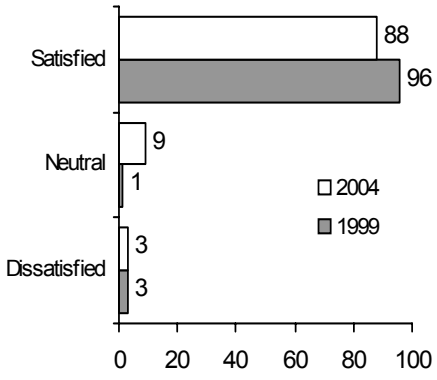
Costs of visits to health facilities

Respondents were asked about the costs of their last visit to a health facility for reproductive health care in the last three months. In many cases respondents could only recall the total cost and could not give details of the individual elements of transport, medicines and other costs. The data on the actual costs of the relatively small number of visits reported is not easy to interpret and is therefore not reported here.

In 2004, some 40% (110/273) of women aged 15-49 visiting a health facility for reproductive health care reported paying something for transport, medicines or other costs. In 1999 nearly all (95%, 204/215) the women aged 15-49 years visiting a facility for reproductive health care reported paying something. It is possible that payments reported in 1999 were more inclusive than in 2004.

Among those women in 2004 who said they paid something for their visit, 90% (94/104) said they were able to afford the costs on their own or their family income.

Figure 13. Satisfaction with reproductive health service on last visit (women 15-49 yrs)



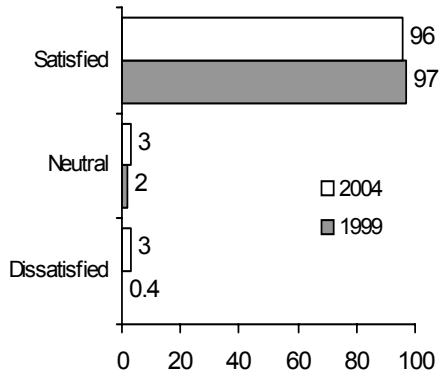
Satisfaction with service received

Respondents were asked how satisfied they were with the service they received on their last visit to a health facility for reproductive health during the last three months. In 2004, 88% (233/265) of women aged 15-49 said they were satisfied, 9% (25) were neutral and 3% (7) were dissatisfied. In 1999, also among women aged 15-49 attending for reproductive health care, 96% (227/236) were satisfied, 1% (3) were neutral and 3% (6) were dissatisfied. The levels of satisfaction in 2004 and 1999 are illustrated in Figure 13.

A woman who visited a health facility for reproductive health care in 2004 was significantly less likely to be satisfied with the service compared with a woman who visited for reproductive health care in 1999[10]. The fall in proportion of women service users satisfied between 1999 and 2004 occurred as much in Male' as in the atolls.

[10] 234/266 (88%) of women who visited for RH care in 2004 were satisfied with the service compared with 230/240 (96%) in 1999. OR 0.32, 95% CI 0.14-0.70

Figure 14. Satisfaction with privacy of RH service on last visit (women 15-49 yrs)



In 2004, the few men aged 15-49 years who visited health services for reproductive health care were less likely to be satisfied with the service compared with women visiting the services[11].

Satisfaction with privacy of service

Adequate privacy is generally considered to be an important aspect of good reproductive health services. Women who attended health services were asked about their satisfaction with the privacy of the service on their last visit.

In 2004, among women aged 15-49 who attended a health service for reproductive health care in the last three months, nearly all (96%, 253/264) expressed satisfaction with the privacy of the service. The equivalent figure in 1999 was 97% (228/234). Figure 14 shows the ratings for satisfaction with privacy of reproductive health service visits in 1999 and 2004.

In 2004 satisfaction with privacy was high in both Male' and the atolls irrespective of the type of health facility visited. The few men who visited services for reproductive health care were less likely to be satisfied with privacy compared with the women who visited[12].

Concepts of privacy might change in the future and service users might be more critical of lack of privacy in health services and reproductive health services in particular. There is little evidence of a change in perceptions of privacy between 1999 and 2004. The high satisfaction with privacy among service users might mask concerns about privacy among people who do not use the services. Indeed, concerns about privacy and confidentiality might be reasons for some people not making use of reproductive health services. This was not assessed in the survey.

[11] 66/86 (77%) of men who visited services for RH care were satisfied with the service, compared with 234/266 (88%) of women. OR 0.45, 95% CI 0.23-0.89

[12] 76/86 (88%) of men who visited services for RH care were satisfied with privacy, compared with 253/264 (96%) of women. OR 0.33, 95% CI 0.12-0.88

Visits of Family Health Workers (FHWs)

It is currently official policy that FHWs should visit all households in their area regularly, once a month. However, this policy does not include Male'as there are no FHWs in Male'.

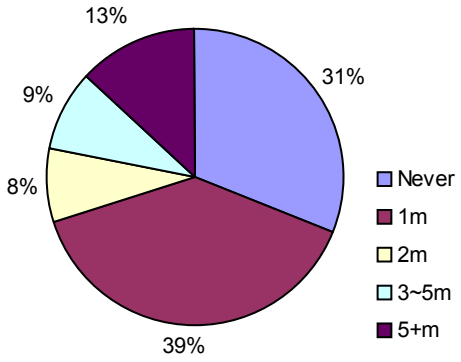
Household respondents outside Male' were asked when the household last had a visit from the FHW.

In 2004, 69% (859/1252) of households outside Male' reported having had a visit from the FHW at some time. This was an increase from the 46% (740/1617) of households outside Male' in 1999 who reported being visited by the FHW.

The proportions of households outside Male' in 1999 and 2004 reporting a visit from the FHW at some time are shown by region in Annex 5.

Some 39% (482/1252) of households in 2004 reported a visit of the FHW one month ago or less, 7% (95) reported a visit two months ago, 9% (124) 3 to 5 months ago, and 13% (158) more than 5 months ago (Figure 15).

Figure 15. Time since last visit of FHW to households outside Male' (2004)



Households in 2004 that reported a visit from the FHW were asked about the purpose of the last visit. The most common reported purpose of the FHW visit was to provide information (77%, 648/842). Other visits were to provide antenatal care (9%, 73) or because someone was ill (as an emergency) (69, 8%).

Findings: unmarried youth

The youth population

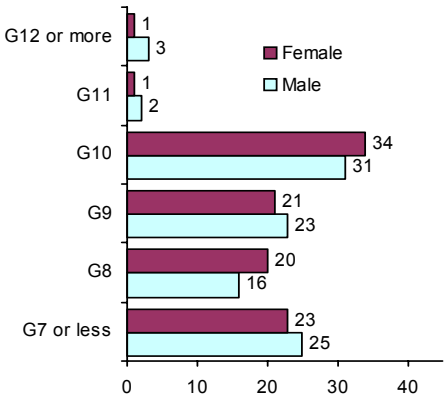
Table 46. Youth respondents by island (2004)

Island	No. HHs	No. Male	No. Fem.
Hoarafushi	100	14	45
Hanimaadhoo	100	12	39
Hirimaradhoo	61	9	13
Kulhudhuffushi	100	9	22
Maalhendhoo	100	9	12
Ugoofaaru	100	41	49
Kihaadhoo	48	4	16
Eydhafushi	100	41	61
Kurendhoo	100	16	29
Rasdhoo	99	13	30
Hangnameedhoo	75	31	32
Muli	96	47	48
Mulah	100	48	39
Maaeboodhoo	100	42	51
Hirilandhoo	100	30	20
Hithadhoo	100	11	18
Hoadedhdhoo	100	11	25
Fuvahmulah	99	12	25
Hithadhoo	100	10	16
Male'	501	59	73
Total	**2279**	**469**	**663**

Some 1141 youth participated in the survey. Table 46 shows the number of young men and women who participated in the survey. The overall response rate of youth (the proportion of those identified in the households who attended to complete a questionnaire) was 42% and varied from 100% in some of the islands to 12% in Male'. The youth who participated in the survey may be more compliant and better behaved than average and the findings might therefore be an underestimate of youth sexual risk behaviour. Also, the findings do not reflect fully the situation of unmarried young people in Male', many of whom might be living away from their families and who may well be at higher risk than other unmarried young people. Therefore the findings of the survey of unmarried youth should be interpreted with caution. They provide useful pointers for action but they may not be representative of the situation of all unmarried youth, especially unmarried youth in Male'.

Of those who participated, 41% (469/1132) were male and more than half (54%, 612/1132) were under the age of 18.

Figure 16. Education level in males and females



Almost two thirds (59%, 674/1134) were in school at the time of the survey. Very few respondents were in the higher levels of education: 3% (33/1098) were in grade 11 or more. One in four was in grade 7 or less (24%, 254/1098). The proportion of males and females by level of education is shown in Figure 16.

In the focus group discussions, many young people expressed their concerns about the limited opportunities for further education on their islands.

Living arrangements and economic status

Some 70% (779/1117) of the young people said they were living with both parents. There was no significant difference in this between males and females. One in ten youth said they lived alone (10%, 112/1117) and about 8% (86/1117) said they lived with another family.

Figure 17. Work status of males and females not in school

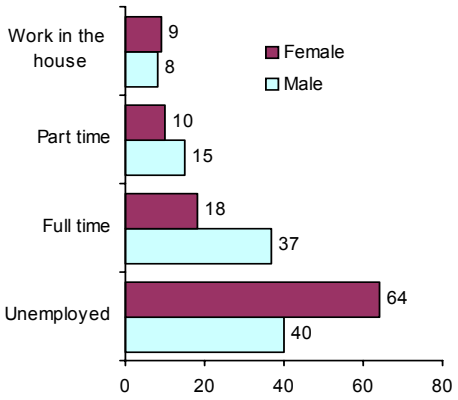
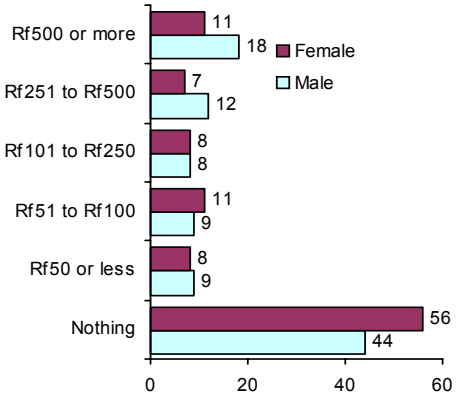


Figure 18. Amount of money youth spent on themselves each month



"Everyone feels that the youth discipline is very low on the island, especially among males. Parents' attention is low and use of drugs is high"
Focus group of unmarried young women

Of those youth who did not live with their family, 33% (76/229) said they paid rent and half (51%, 117/229) stayed free where they were living. Some 16% (36/229) said they work around the house to pay for their stay.

More than three quarters of all the youth respondents (78%, 862/1101) said they did not have a job. Among those who were *not* attending school, 55% (243/446) said they did not have a job, 25% (112) had a full time job, 12% (53) had part time work and 9% (38) were paid to work around the house. Unemployment was a major concern raised by the participants in the youth focus groups.

Among youth not in school, more females than males were unemployed and more males had a full time job. The breakdown of work status by gender among youth not in school is shown in Figure 17.

Half the youth (51%, 544/1065) said they did not spend any money on themselves each month, excluding what their parents might spend on them. On the other hand, 14% (149/1065) had more than Rf 500 to spend on themselves each month. One in ten (10%, 107/1065) said they spent between Rf50 and Rf100 per month. More females than males (44%, 194/438 for males and 56%, 344/618 for females) said they spent nothing on themselves. More males than females were in the higher spending category. The amount youth had to spend on themselves each month is shown in Figure 18.

One in five (20%, 227/1109) young people said they actively participated in volunteer groups, school groups, sports or social groups. This was more popular among the males (26%, 119/460) than among the females (16%, 104/640).

Who youth listen to and talk to

Media use

More than three quarters of young people (77%, 863/1128) said they watched television everyday or almost everyday, and another 13% (152/1128) said they watched at least once a week. About one in ten (9%, 107/1128) said they watched television occasionally or never. More than half (55%, 595/1081) of those who watched television said they watched TV Maldives and 45% (486/1081) watched cable or satellite television.

Table 47. Youth and the media: what do the young people watch, listen to and read?

Media	Male	Female	All
Television			
English movies	77(18%)	23(4%)	100(10%)
Dhivehi dramas	80(19%)	184(30%)	264(25%)
Hindi dramas	39(9%)	213(34%)	252(24%)
Music	65(15%)	133(21%)	198(19%)
Sports	94(22%)	5(1%)	99(9%)
News/documentaries	75(17%)	61(10%)	136(13%)
Radio			
English songs	31(8%)	11(2%)	42(4%)
Hindi songs	23(6%)	59(11%)	82(9%)
Dhivehi songs	92(23%)	148(27%)	240(26%)
Drama/story	31(8%)	86(16%)	117(12%)
Info./awareness prog	71(18%)	140(26%)	211(23%)
News	148(37%)	96(18%)	244(26%)
Magazines			
Daily newspapers	84(22%)	51(9%)	135(14%)
Dhivehi magazines	294(75%)	538(90%)	832(84%)
Hindi magazines	1(-)	5(1%)	6(1%)
English magazines	12(3%)	9(1%)	21 (2%)

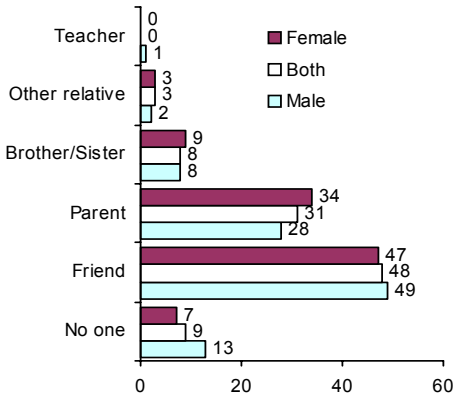
Some 57% (648/1134) said they listened to the radio everyday or almost everyday and 14% (156/1134) said they listened at least once a week. More than a quarter (28%, 314/1134) said they occasionally or never listened to the radio.

One in four (24%, 276/1130) young Maldivians said they read newspapers and magazines everyday or almost everyday and 40% (456/1130) said they read them at least once a week. Some 13% (148/1130) said they read magazines about once a month and 22% (250/1130) said they occasionally or never read them.

Table 47 shows the television and radio programmes and magazines that are most popular with youth in the Maldives.

Young people were also asked about their internet usage. Four in five (83%, 925/1111) young people said they occasionally or never used the internet. Only 4% (47/1111) said they used it everyday or almost everyday and 8% (94/1111) said they used internet at least once a week, while 4% (45/1111) used it about once a month.

Figure 19. Who youth talk to about their problems



Who youth talk to

When asked about whom they talked to most when they had a problem, almost half the respondents (48%, 533/1118) said they talked to a friend and about a third (31%, 350/1118) talked to a parent. Some 8% (95/1118) talked to brothers and sisters. About one in ten (9%, 105/1118) said they did not talk to anyone about their problems. Figure 19 shows the people male and female youth choose to talk to about problems.

Table 48. Who young people talk to about sex

	No (%)
No one	508 (46%)
Parent	83 (7%)
Brother/sister	15 (1%)
Boyfriend/girlfriend	121 (11%)
Friend	300 (27%)
Teacher	41 (4%)
Other relative	24 (2%)
Other adult	11 (1%)
Total	1103 (100%)

When asked who they talk to about sex, almost half (46%, 508/1103) the youth said they did not talk about sex to anyone (Table 48). Over a quarter said they talked to a friend (27%, 300/1103). One in ten (11%, 121) said they talked to their boyfriend or girlfriend about sex. Some 7% (83) said they discussed sex with their parents.

Figure 20. What parents talk to unmarried youth about

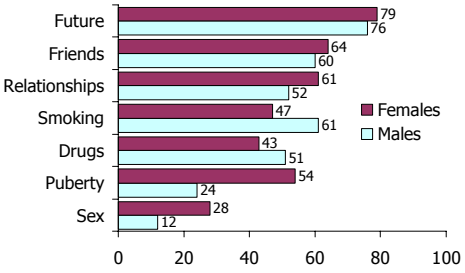


Table 49. Ways of avoiding catching HIV/AIDS reported by 1141 youth

	No (%)
Respect religious tradition	783 (69)
Avoid sharing sharp objects	759 (67)
Get info about it	740 (65)
No premarital sex	522 (46)
Always use condoms	503 (44)
Have one partner	495 (43)
Don't have sex	443 (39)
Avoid people with AIDS	379 (33)
Cannot avoid it	111 (10)
Don't know	50 (4)

Table 50. Ways of avoiding catching HIV/AIDS reported by young men and women. No. (%)

	Males n=468	Females n=663
Respect religious tradition	315 (67)	464 (70)
Avoid sharing sharp objects	281 (60)	472 (71)
Get info about it	277 (59)	459 (69)
No premarital sex	192 (41)	328 (50)
Always use condoms	215 (46)	282 (43)
Have one partner	192 (41)	300 (45)
Don't have sex	181 (39)	258 (39)
Avoid people with AIDS	141 (30)	235 (35)
Cannot avoid it	53 (11)	56 (8)
Don't know	27 (6)	23 (4)

"There is no risk: people know who is infected with AIDS and they stay away from them"
Focus group of unmarried young men

Table 51. Youth perceptions about catching HIV/AIDS. Number (%)

Statement	True	False	DK
People with HIV can look healthy (1099)	501(46)	225(21)	373(34)
You can get HIV from eating with someone with AIDS (1094)	140(13)	692(63)	262(24)
Condoms can protect against HIV/AIDS (1090)	544(50)	161(15)	385(35)

We asked the young people about the topics that their parents or guardians talked to them about. Some topics were more commonly talked about than others: three quarters (78%, 877/1131) of youth said that their parents talked to them about their future, about two thirds (62%, 684/1098) said they talked to them about their friends, and 58% (628/1092) said they talk to them about relationships. About half (53%, 579/1099) said their parents talked to them about smoking and 46% (506/1095) said they talked to them about drugs. Some 42% (455/1095) said their parents talked to them about topics related to puberty, and 21% (231/1094) said their parents talked to them about sex. There was a difference between males and females in the topics parents discussed with their children (Figure 20).

Knowledge about HIV/AIDS and STIs

Knowledge and perceptions about HIV/AIDS

Almost all (97%, 1097/1133) the unmarried youth had heard of HIV/AIDS.

The young men and women were asked how they could best avoid catching HIV/AIDS. They could indicate their agreement or disagreement with a range of potential ways of avoiding the infection. Some 10% (111/1141) said that HIV/AIDS cannot be avoided. Only 4% (50/1141) said they did not know how they could best avoid catching HIV/AIDS. Almost half (44%, 503/1141) said the best way to avoid infection was by using condoms. One in three (33%, 379/1141) said the best way of avoiding HIV/AIDS was by avoiding people with AIDS. It is not entirely clear if they meant avoiding sexual contact with people with AIDS or avoiding social contact with them as well. Other choices are shown in Table 49. The responses in young men and women separately are shown in Table 50.

To explore perceptions about HIV/AIDS and related issues, the young people were given a list of statements and were asked to indicate if they thought each statement was true or false. Their responses are shown in Table 51.

About one third (34%, 373/1099) did not know if people with HIV could look healthy. However, almost

half (46%, 501/1099) said that people with HIV could look healthy. Some 13% (140/1094) thought they could get HIV from eating with someone who had AIDS, but 24% (262/1094) did not know if HIV could be caught in this way. Half the respondents (50%, 544/1090) said that condoms could protect against HIV/AIDS, but one in three (35%, 385/1090) did not know if condoms could protect them from HIV/AIDS.

"You have to get it from a person far away, for example in a resort"
Focus group of unmarried young men

All the opinion leaders interviewed in the islands were in favour of providing information to youth about HIV/AIDS (60/60).

In the separate focus group discussions of unmarried young men and women, many participants were of the view that the risk of catching HIV/AIDS was very low in the Maldives. In general, HIV/AIDS was associated with foreigners, Maldivians working abroad, and those people who work on resorts. Many thought it was not an issue in the Maldives.

Table 52. Ways of avoiding catching STIs reported by 1141 youth

	No (%)
Avoid people with STIs	766 (67%)
Get info about it	742 (65%)
Respect religious tradition	720 (63%)
Always use condoms	534 (47%)
No premarital sex	504 (44%)
Have one partner	496 (44%)
Avoid sharing sharp objects	470 (41)
Don't have sex	409 (36%)
Cannot avoid it	40 (3%)
Don't know	45 (4%)

Table 53. Ways of avoiding catching STIs reported by young men and women. No. (%)

	Males n=469	Females n=663
Avoid people with STIs	287 (61)	474 (72)
Get info about it	280 (60)	455 (69)
Respect religious tradition	290 (62)	426 (64)
Always use condoms	237 (51)	290 (44)
No premarital sex	165 (35)	336 (51)
Have one partner	178 (38)	315 (48)
Avoid sharing sharp objects	172 (37)	294 (44)
Don't have sex	182 (39)	223 (34)
Cannot avoid it	19 (4)	20 (3)
Don't know	18 (4)	27 (4)

Table 54. Signs or symptoms of STIs identified by 1141 youth

	No (%)
Urination problems	576 (51%)
Itching and soreness	565 (50%)
Discharge	510 (45%)
Bleeding	387 (34%)
Poor immunity	328 (29%)
Back/stomach pain	259 (23%)
Rashes	240 (21%)
Weakness/tiredness	218 (19%)
Swollen glands	205 (18%)
Loss of appetite/weight	191 (17%)
Fever	156 (14%)
Miscellaneous	156 (14%)
Don't know	293 (26%)

Knowledge about STIs

Young people were asked how they could protect themselves from STIs. They could choose as many options as they wanted from a list of potential methods of protection. Their responses are shown in Table 52. Very few (3%, 40/1141) of them said that one cannot avoid these infections, and 4% (45/1141) said they did not know how to protect themselves from STIs. The most popular method mentioned was to avoid people with STIs. It was not clear if this meant avoiding sex with these people (assuming one could reliably identify them) or avoiding social contact with them. Two out of three (65%, 742/1141) said they needed more information in order to avoid catching STIs. The responses in young men and women separately are shown in Table 53.

When asked to identify signs or symptoms of STIs from a list, one in four (26%, 293/1141) responded that they did not know any signs or symptoms of STIs. The most frequently mentioned symptoms were urination problems (51%, 576/1141), being itchy and sore (50%, 565/1141) and discharge (45%, 510/1141). The frequency of different responses is shown in Table 54.

Young respondents were asked what they would do if they developed any of the STIs symptoms. Four out of five (80%, 816/1020) said they would consult a health worker or a doctor, one in ten (12%, 124/1020) said they did not know what they would do, and 1% (12/1020) said they would do nothing about it.

More than half of the respondents (54%, 589/1098) agreed that the statement "condoms can protect against STIs" was true, but a third (34%, 379/1098) did not know if this was true or not.

All the opinion leaders interviewed were in favour of providing information to youth about STIs.

Perceptions about gender and sex

"The girls have no use in society"
Focus group of unmarried young men

"Girls do not have the same rights as boys. Sometimes when girls want to play "Bashi" the boys come and tear the net"
Focus group of unmarried young women

Young people were given a number of statements and asked to indicate if they agreed or disagreed. Almost half (48%, 518/1088) agreed that "boys and girls are equal", while (42%, 459/1088) disagreed. One in ten (10%, 111/1088) said they did not know.

One in five (20%, 206/1051) agreed that "once a girl starts her periods, she can fall pregnant anytime she has sex". About half (48%, 504/1051) said they did not know, and a third (32%, 341/1051) disagreed.

Some 68% (724/1068) disagreed with the statement that "a boy needs to have sex to show he is a man", while 9% (96/1068) agreed with the statement. Some 23% (248/1068) said they did not know.

"Some girls won't say No cause they love the boy"
Focus group of unmarried young women

"Most of the time it is the girl who initiates sex"
Focus group of unmarried young men

Some four out of five (77%, 844/1091) of youth agreed that "you don't need to have sex with your boyfriend/girlfriend to show that you love them". One in ten (9%, 101/1091) did not know and 13% (146/1091) disagreed with the statement. Similarly, 76% (809/1064) did not agree that "most of my friends think that you should have sex with your boyfriend or girlfriend to show that you love them". Some 11% (120/1064) agreed with the statement and 13% (135/1064) did not know.

There was generally little difference between young men and young women in their level of agreement with the statements.

Knowledge about sex and contraception

Table 55. View of youth about when during the menstrual cycle a woman is most likely to conceive

Time most likely to conceive	Number (%) responses	
	Male	Female
A few days after purity bath	69 (15%)	220 (34%)
Just before the next cycle	51 (11%)	59 (9%)
In the middle of 2 cycles	75 (16%)	101 (15%)
All the time	4 (1%)	3 (-)
Don't know	260 (57%)	270 (41%)

Table 56. Ways of avoiding pregnancy reported by young men and women. No. (%)

	Males n=469	Females n=663
Always use a condom	261 (56)	372 (56)
Only have sex at certain times of the menstrual cycle	164 (34)	315 (48)
Don't have sex	189 (40)	259 (39)
Withdraw before ejaculation	200 (43)	229 (35)
Cannot avoid it	24 (5)	12 (2)
Don't know	94 (20)	120 (18)

When asked on which days of the menstrual cycle a woman is most likely to conceive, almost half (48%, 536/1121) the young people did not know the answer. One in four (26%, 291/1121) said a few days after purity bath and one in ten (10%, 110/1121) say just before the next cycle. Some 16% (177/1121) knew the correct answer: in the middle, between two periods. In Table 55 the responses of young men and women are shown separately.

Young people were asked how they could best avoid getting pregnant or getting their partner pregnant. The responses for males and females are shown in Table 56. Some 3% (36/1132) thought pregnancy could not be avoided and one in five (19%, 214/1132) said they did not know how to avoid pregnancy. About 40% (448/1132) thought avoiding sex was the best way to avoid pregnancy. Some 42% (479/1132) thought having sex at certain times of the menstrual cycle was the best method to avoid pregnancy. This is of concern given the low level of knowledge about when in the menstrual cycle a woman is most likely to conceive. Over a third (38%, 429/1132) thought that withdrawing before ejaculation was an effective way to avoid pregnancy. Over half (56%, 633/1132) said that using condoms all the time was an effective way to avoid getting pregnant.

In addition, some 61% (665/1085) of youth thought the statement that "condoms can protect against unwanted pregnancy" was true.

One in four (24%, 261/1091) young people thought the statement that "talking about condoms makes young people more promiscuous" was true. Almost half (48%, 524/1091) did not know if it was true or not. Some 17% (183/1091) thought it was true that "people who live here think that talking about condoms makes young people more promiscuous" and more than half (58%, 634/1091) did not know if it was true or not.

"It is an encouragement because they are sure not to get negative results"
Focus group of unmarried young men

This view that talking about condoms makes young people more promiscuous was confirmed in the separate focus groups of unmarried young men and women. The majority of participants in both male and female groups thought that talking about condoms would indeed make young people like them more

"Because many want to experience sex. When they learn a condom prevents pregnancy, it is an encouragement to use it"
Focus group of unmarried young women

promiscuous. The general feeling was that talking about condoms would give a certain confidence that there will be no pregnancy or STIs, and would encourage youth to engage in sexual activities.

Most opinion leaders interviewed in the islands (56/60) were in favour of giving information to youth about contraception. But many (37/60) also believed that talking to unmarried youth about sexual health condoms would promote promiscuity. Some (22/60) disagreed with this view.

"It happens. That's why we see people pregnant before they get married"
Focus group of unmarried young women

In almost all focus group discussions, young people say they think that the Maldivian youth is generally sexually active before marriage.

"One percent might not do it and all the others do"
Focus group of unmarried young women

The issue of unwanted pregnancies and abortion was discussed in the focus groups of youth. The majority seemed to accept that unwanted pregnancies did occur and some groups even said they happened frequently. In a small number of the groups the participants said that unwanted pregnancies never happened there. They mostly suggested that more information and awareness programmes about how to avoid pregnancy would be the best solution for the problem.

"Some people have an abortion and when they come back, they say they had tuberculosis"
Focus group of unmarried young women

Concerning abortions, the focus groups also agreed these were happening among unmarried youth in the Maldives. In some groups the participants suggested that usually when an unmarried pregnancy happens, the boy takes responsibility and there is be no need for an abortion.

"They have all the equipment necessary for abortion under the seats of motorbikes. It is also available from pharmacies. Half of the youth do this act"
Focus group of unmarried young men

Preferred sources of information about sex

The most common current sources of information about sex reported by youth were from school (48%, 545/1141), from television and radio (41%, 472/1141) and from friends (41%, 466/1141) (Table 57).

However, when asked where they would prefer to get information about sex, health facilities were the most popular choice (67%; 767/1141), while 34% (391/1141) mentioned school and 34% (386/1141) television or radio (Table 57).

There was some uncertainty among opinion leaders interviewed in the islands about the provision of information on reproductive and sexual health in

Table 57. Actual and preferred sources of information about sex

Source	Number (%) responses	
	Actual	Preferred
School	545 (48%)	391 (34%)
Parents	168 (15%)	283 (25%)
Friends	466 (41%)	269 (24%)
TV/Radio	472 (41%)	386 (34%)
Newspapers/mag.	343 (30%)	288 (25%)
Internet	81 (7%)	149 (13%)
Health Facility	328 (29%)	767 (67%)
Nowhere	146 (13%)	37 (3%)

schools. Half the opinion leaders (30/60) said that schools on their island provided information sessions on reproductive health. Some (9/60) did not know if such sessions were provided or not and 21/60 did not think that schools on their island provided reproductive health information sessions.

"Health workers are educated in the matter, so the best thing is to go to a health worker"
Focus group of unmarried young women

In the focus groups of unmarried youth, the issue about sources of information about sexual health was also discussed. In most focus groups, both male and female, participants said their main source of information about sexual health was from doctors or health staff. Most of them also said they would prefer to get such information from the hospital or health centre and health staff. Many expressed the need to get the information in a more confidential setting. It was clear from the discussion in many of the groups that unmarried young men and women did not feel comfortable discussing sexual health matters with their parents.

"Teachers kick you out of the class as soon as you ask something like that: the best thing is to go to a health worker"
Focus group of unmarried young men

Youth relationships and sexual activity

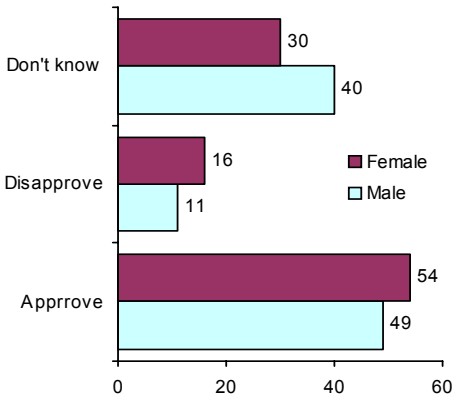
Youth relationships

"I cannot sleep without flirting with a boy, at least once a day"
Focus group of unmarried young women

Almost half (49%, 553/1138) the youth said they had a boyfriend or a girlfriend.

Of those who answered a question about their parents' attitude to their having a girlfriend or boyfriend, more than half (52%, 391/758) said their parents approved of them having a girlfriend or boyfriend. About 14% (105/758) said their parents disapproved and a third (35%, 262/758) did not know the attitude of their parents or guardians towards their relationship. The responses for young men and women are shown in Figure 21.

Figure 21. Attitude of parents/guardians towards relationships



Of those who had a boyfriend or girlfriend, almost two thirds (63%, 390/620) said they met their boyfriend or girlfriend in a private house, which could be their own house, friends' house or at a relative's place. One in five (18%, 113/620) said they met in public places such as parks, restaurants or on the street. About 15% (95/620) said they met at more quiet public spaces like beaches or islands.

Youth sexual activity

One in ten 9% (99/1121) of young people said they had had sexual intercourse: 14% (63/459) young men and 5% (34/653) young women. Almost two thirds (62%, 58/94) of those who had had sex said their first sexual intercourse was before the age of 18 years.

When asked how often they used condoms in the last year when having sex, 4% (4/94) of those who said they had had sex said they do not know what a condom was. Some 45% (42/94) said they never used a condom, while one in ten (12%, 11/94) said they always used condoms during sexual intercourse.

Of those who were sexually active and used condoms, nearly half (20/49) said they used them to avoid pregnancy and a few (9/49) used them to avoid STIs and HIV/AIDS. One in four (12/49) said they used condoms because they wanted to and some (8/49) said they used them because their partner wanted them to.

Young people were asked why they did not use condoms. Of those who were sexually active, one in ten (5/59) said they did not know what a condom was. The most common answer was dislike of using condoms (23/59). A smaller number (10/59) said their partner did not like to use condoms. Some (8/59) said it was difficult to get condoms.

Of those who were sexually active and used condoms, nearly half (21/48) said they got them from a pharmacy. Some (14/48) got their condoms from friends, and a few (10/48) said their partner got the condoms. A few (3/48) unmarried young people said they got condoms from health service providers.

Of young respondents who were sexually active and used condoms, nearly half (24/57) said it was easy to get condoms, a quarter (15/57) said it was somewhat difficult and some (8/57) said it was very difficult. Others (10/57) said their partner got the condoms.

"We can get 3 condoms for Rf20: isn't it expensive? On the other hand we also have to buy cigarettes. How can we get money to do all that stuff?"
Focus group of unmarried young men

In the focus groups of unmarried youth, some participants raised the issue about the price of condoms and the difficulty of getting them.

Over half the opinion leaders interviewed in the islands (35/60) agreed that unmarried youth were sexually active on their islands.

Youth unwanted sexual activity

Some 4% (43/1123) of young men and women said that someone around their age (within 5 years) had involved them in unwanted sexual activity. The proportion was the same in males (4%, 17/458) and females (4%, 26/656). Some 4% (48/1118) of youth said that someone older than them had involved them in unwanted sexual activity; 3% (15/455) of males and 5% (33/654) of females.

Youth pregnancy

When asked if they had ever been pregnant or knew that they have fathered a child, 26 respondents said yes (about 2% of the total). Of the 26 who had been pregnant or fathered a child, 17 were female and 8 male (one did not reveal his/her sex). Of those who revealed they had been pregnant or fathered a child, 25 gave the outcome of the pregnancy: 16 live births, 6 abortions, 2 stillbirths, and 1 spontaneous miscarriage.

Half the opinion leaders interviewed in the islands (31/60) said they were aware of teen pregnancies on their islands. But half of them (32/60) said such unwanted pregnancies were infrequent or rare, and some (9/60) denied they ever happened. On the other hand, about a third of the opinion leaders (17/60) agreed that unwanted pregnancies were a big issue for their communities. Most opinion leaders thought that abortions took place infrequently (30/60) or never (19/60) on their islands.

Conclusions

The main purpose of this report is to set out the facts about reproductive health in the Maldives in 2004, including a comparison with the situation in 1999. The report also includes an attempt to set out a baseline about adolescent sexual and reproductive health in the Maldives. The main work of drawing conclusions from the findings and using them to develop action plans and policy recommendations is beyond the remit of this report. Hopefully, the report will be used as the starting point for wide discussion among stakeholders in the Maldives and development of action plans and policy recommendations based on the findings. Some key issues arising from the findings are teased out here as a contribution to the debate that needs to take place.

Sexually transmitted infections (STIs)

Knowledge about sexually transmitted infections among the population has improved since 1999, so that now half the adult married population knows of at least one symptom of an STI, and nearly all would go to a health facility with such a symptom. Most (79%) know of a way to catch an STI and 90% can mention a way to protect themselves against STIs: most commonly by being faithful, using condoms, or avoiding sex either altogether or with infected persons. Among unmarried young people, two thirds thought the best way to avoid STIs was to avoid (sex with) people with STIs and two thirds said they needed more information about how to avoid STIs. The increase in knowledge about STIs among married adults is encouraging but there are still important gaps and the population, including young people, needs to be better informed about how to protect themselves against contracting STIs. Health care workers are an important source of information for the public but their own knowledge about STIs first needs to be improved.

HIV/AIDS

Awareness about HIV/AIDS remains almost universal among married adults and is also universal among unmarried youth. Knowledge about ways to contract HIV is also good among adults and youth. However, there are concerns. The youth survey revealed that many think a good way to avoid HIV is to avoid sex with someone infected, implying a belief that one can

reliably identify infected persons. Also, there is a perception, shown in the survey of unmarried young people, that within the Maldives the risk of contracting HIV is very low or non-existent and one can only catch the infection from someone outside. For a number of reasons, complacency about the low risk of HIV in the Maldives is dangerous. The Maldives is close to India where there is an exploding HIV epidemic, it has an important tourism industry which can import HIV infection into the population, and it has increasing problems of drug use and prostitution which can lead to repaid spread. The HIV campaign needs to change from one of awareness to one alerting people to the real risks of contracting HIV and informing them about how to protect themselves from infection, with a key message of "make no assumptions, anyone could be infected". Waiting until HIV infection is established in the Maldivian population will be too late to avoid a serious epidemic.

Contraception

There has been little change in the overall rate of use of contraception between 1999 and 2004 but there has been a shift in the method mix, away from traditional methods and towards modern temporary methods. The shift towards more effective methods is reflected in the falling fertility rate reported by other studies. There has been an increase in the use of condoms, which is encouraging as condoms have a dual role of protection against pregnancy and STIs (including HIV). There is room for more increase in use of condoms as a means of contraception. For example, women whose husbands are away for periods may not want to use a method such as the contraceptive pill continuously, but they need contraception when the husband comes home. It is clear that the knowledge about fertility during the menstrual cycle is very poor among both married adults and unmarried young people, so their reliance on rhythm methods for contraception is likely to be ineffective.

Antenatal, delivery care and postnatal care

The Maldives has achieved a very good level of antenatal and delivery care, despite the challenges of its geography. Nine out of ten pregnant women now have at least the recommended four antenatal care visits, most are seen by a gynaecologist, and eight out of ten

take iron for two months or more of the pregnancy. Antenatal care is a little lower in the northern atolls and iron supplements are a little lower there and in the southern atolls. Some 85% of women have skilled attendance at delivery and 60% have a postnatal care contact within six weeks of the delivery. The next challenge is to ensure health care contacts in the immediate two weeks postnatal period.

Reproductive health services

Between 1999 and 2004 health services to the islands have been expanded, with new health centres and atoll hospitals being opened. Despite this, the public rating of the reproductive health services available to them has fallen. This may reflect increased awareness of the possible services available and a more informed, demanding population. There are real difficulties in providing a high quality health service in the Maldives, with its population spread over many small islands. An important challenge is a shortage of health care workers to staff health care facilities. It is difficult to recruit enough trained and skilled health care workers, especially for postings in the atolls. Opening new facilities is of little use unless they can be adequately staffed. Both the public and service workers agree that lack of skilled staff is an important problem with the health services at present.

Adolescent sexual and reproductive health

This is the first survey in the Maldives to include an attempt to collect information about sexual and reproductive health from unmarried young people. The low response rate, especially in Male', means that the extrapolation of the findings to the whole of the youth population of the Maldives has to be cautious, but nevertheless the findings provide some useful indicators about the present situation and the gaps in services for youth.

The survey highlights some issues about condoms and their availability to unmarried youth. There is a widespread perception, including among youth themselves, that talking to unmarried young people about condoms, let alone making them easily available, will make them more promiscuous. The consequences of unprotected youth sexual activity are already being seen in unplanned pregnancies among unmarried young

women. The sexually active youth of the Maldives also need to protect themselves against HIV infection. Youth sexual activity is a sensitive issue and the debate about appropriate sexual and reproductive health services for youth will need to be handled carefully, with respect for religious beliefs.

The factual knowledge of unmarried young people about STIs and HIV is quite good, and comparable with that of the married adults surveyed. Like the adults, they have some misconceptions about risks of HIV infection and how to protect themselves from STIs and HIV infection, which need to be corrected. In response to several questions many youth said they needed more information. There are important gaps in their knowledge about matters such as how to prevent pregnancy. Many youth do not talk to anyone about sex. At present half of them get their information about sex from lessons in school but two thirds would prefer to get information from health facilities. This is a challenge for the health services. Health care workers need training both in the relevant facts and in communication skills to allow them to communicate effectively with youth. Services need to be accessible and user-friendly for youth. There are some good examples of this taking place in Male' but services are needed throughout the Maldives. Youth are a crucial target group and adolescent sexual and reproductive health is a focus of the current reproductive health programme in the Maldives. The findings in this report provide a baseline for assessing the effects of this programme.

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Annex 1

CIET social audit methods

Over nearly two decades the CIET group has developed and refined its social audit methodology, working in some 48 countries across the world. Rooted in modern epidemiology and participatory research techniques, CIET methods have been applied in health[13], education[14], water and sanitation[15], land mines[16], economic sanctions[17], prevention of sexual violence[18] and the impact of structural adjustment measures on the vulnerable. The methods have been used to measure impact, coverage and cost in the fields of environment[19], urban transport[20], agricultural extension[21] and judiciary[22]. It has proved useful for community-designed strategies to combat corruption in the public services in several countries[2324]. Many of these initiatives have involved reiterative cycles of evidence gathering, analysis and socialization, leading to planning, interventions and impact assessment at the local, regional, and national levels.

The CIET social audit cycle

The dynamic behind the social audit process is simple: collect information about public services from people supposed to be served, and from service providers, and use this as a basis for involving them in making changes to improve the services.

Key steps in the social audit process include:

- Collect information from households in representative communities about use, experience and perceptions of public services;
- link this with information from the services themselves;
- analyse the findings in a way that points to what actions might improve matters;
- take the findings back to the communities for their views about what could improve the situation;
- bring the findings and suggestions to discussions between service providers, planners and community representatives and provide support to help them plan and to implement changes;
- close the loop with a repeat fact-finding exercise to assess the changes and their effects.

Figure 1 represents the social audit cycle.

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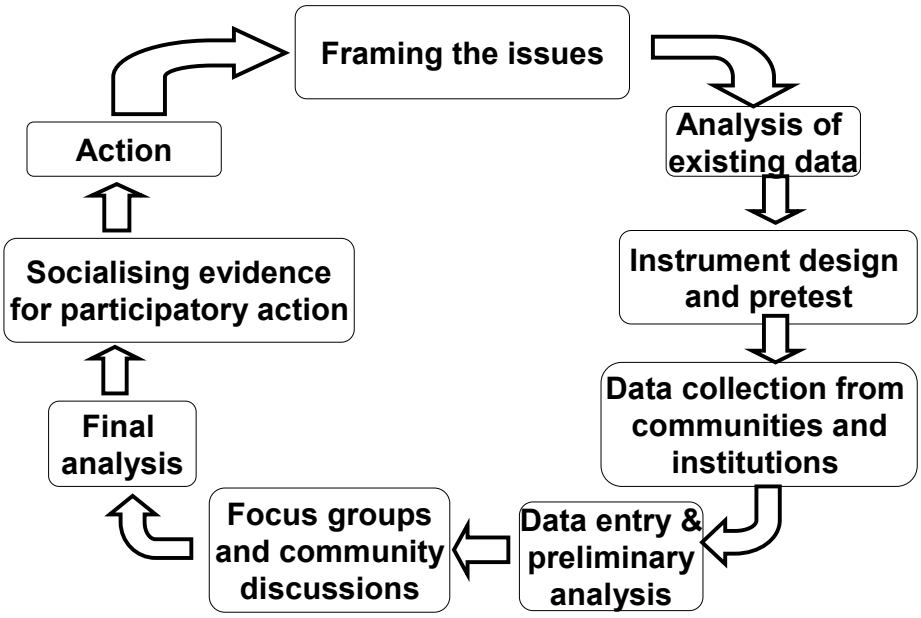
Figure 1. The CIET social audit cycle



Several specific design features of the social audit strengthen the community voice in governance:

- the sample is carefully chosen to cover all types of community; information they provide includes their access to and experience with services, their satisfaction and their suggestions for service improvement;
- in-depth interviews with clients establish the terms of the social audit instruments;
- community members and service providers participate in the fact finding;
- community members and service providers participate in analysis of the evidence, adding their experience and ideas to formulate local solutions;
- the workshopping process allows both one-to-one interaction and group discussion of the evidence and the ways forward;
- with repeated surveys, the reiterative nature of the process helps to build community capacities and confidence to participate in governance.

Annex 2

Summary of themes from focus group discussions

The following tabulation summarises the themes that arose in the 20 focus groups with unmarried young men (aged 15-24 years) and the 19 focus group discussions with unmarried young women (aged 15-24 years).

1. What is the general situation of adolescents in this island?

- Youth are capable, well behaved. Good situation in general	4 male groups	2 female groups
- Youth are misbehaved/ the situation is bad	5 male groups	3 female groups
- Most are employed	1 male group	1 female group
- Most are unemployed	5 male groups	2 female groups

a. What kind of work do they do?

- Government job	6 male groups	5 female groups
- Most are in tourism industry	9 male groups	6 female groups
- Unemployed	2 male groups	3 female groups
- Agriculture	2 male groups	
- Fishing	3 male groups	4 female groups
- House work		5 female groups
-Construction	2 male groups	1 female group

b. How do they spend their leisure time?

- Sports/games/TV/read books/listen to music/films	14 male groups	12 female groups
- Spend it with their partners	5 male groups	1 female group
- Smoking/loitering/fighting	4 male groups	3 female groups
- Walking on the beach/street with friends	7 male groups	3 female groups

2. What are the main problems for young people your age in this island?

- No jobs	15 male groups	15 female groups
- Alcohol/drugs/smoking	6 male groups	6 female groups
- Pregnancies	1 male group	
- No activities. Too much loitering and wasting time	6 male groups	5 female groups
- No further opportunities for education	9 male groups	4 female groups
- Bad/limited health services	1 male group	2 female groups
- Inequalities between girls and boys (sports)		1 female group
- Teen pregnancies		1 female group

3. Do you think young people in the Maldives are sexually active before marriage?

a. How common is this?

Yes, they are	20 male groups	18 female groups
No, haven't heard of it		1 female group

4. Young people tell us that they do not always use a condom when they have sexual intercourse:

a. Why do you think that is?

b. What do you think are the chances of a sexual partner you might have in the Maldives being infected with an STI or with HIV?

c. Why do you think that?

Use condoms to be protected from pregnancies/STIs	8 male groups	7 female groups
Probability of catching STIs/AIDS high	6 male groups	11 female groups
Probability of catching AIDS low but STIs high	5 male groups	
Sex with foreigners or people who travel abroad might give you AIDS/STIs	3 male groups	
Because lots of people work abroad		2 female groups
AIDS is not a major concern in Maldives. Only in other countries	3 male groups	
People don't engage in safe sex/ low awareness	4 male groups	4 female groups

From having sex with foreigners in resorts	4 male groups	1 female group
From blood transfusion	2 male groups	3 female groups
Not easy to find condoms/ Condoms are expensive	6 male groups	6 female groups

5. Who do you think should take responsibility for using contraception - the boy or the girl?
a. Why do you think that?
b. What happens about that in practice?

Boys	2 male groups	1 female group
Girls	2 male groups	1 female groups
Both	19 male groups	17 female groups

6. Do you think girls in this part of the Maldives feel able to say "no" if their boyfriend wants to have sex with them? Do you think they feel able to insist their partner wears a condom when they have sex?
a. Why do you think that girls find it hard to express their views about these things?
b. What would you say to a girl you knew to help her deal with these situations?

Girl should be able to say no	14 male groups	12 female groups
Girls don't say no because they are weaker/timid	13 male groups	12 female groups
At least they should ask to use a condom	1 male group	2 female groups
Girls don't say No when in love	1 male group	1 female group
Don't know		1 female group

7. Do you think that young people will become promiscuous if we talk to then about sexual health, including condom use?
a. Why do you think that?
b. Do adults who live here believe that young people will become promiscuous if we talk to them about condoms?

Yes	16 male groups	13 female groups
No	4 male groups	5 female groups
Some	2 male groups	2 female groups

8. Where do young people like you get information about sexual health from?
a. What about their parents?
b. What about teachers or health workers?
c. Who would young people trust to give them information about sexual health?
d. Where would be a good place for young people to get information and advice about sexual health?

- Get it from doctors/health staff	16 male groups	13 female groups
- Get it from teachers/counsellors	3 male groups	2 female groups
- Get it from friends	5 male groups	
- Parents don't have the right info/ cannot ask parents about things if we are in trouble/ not comfortable with parents	11 male groups	5 female groups
- Parents are good if they have the right info		5 female groups
- Would like to get it from books/media	1 male group	
- Would like to get it from teachers/school	4 male groups	6 female groups
- Would like to get it from hospitals/HC/health workers	16 male groups	13 female groups
- Would like to get it on the Internet	1 male group	1 female group
- Would like to get it at a free/private place	5 male groups	7 female groups
- Toll free line	1 male group	1 female group

9. Do you think young people in this island have unwanted pregnancies?
a. How much of an issue is it?
b. Why do you say so?
c. How can we address the issue?

- It happens more or less rarely	13 male groups	7 female groups
- It happens a lot	5 male groups	9 female groups
- It doesn't happen	1 male group	2 female groups
- We should get the info about it from	1 male group	

parents/school

- Have awareness programmes	7 male groups	6 female groups
- Provide information about it	4 male groups	6 female groups
- Not a problem on this island: no need to discuss it	1 male group	

10. Do you think young people in this island have induced abortions?
a. How much of an issue is it?
b. Why?

- Yes, very rare/sometimes	10 male groups	7 female groups
- Never happens	5 male groups	2 female groups
- Happens often	4 male groups	5 female groups
- Some say rare, some say very often	2 male groups	1 female groups
- Don't know		3 female groups

Annex 3

Review of health facilities and interviews with health care providers

Table 1. Type of facility (n=23)

Regional hospital	5
Atoll hospital	2
Health centre	10
Family health post	3
Family Health Section	2
NGO	1

Table 2. List of staff responsible for reproductive health

	Number of allocated posts			Number of staff present		
	RH	HC/AH	FHP/NGO	RH	HC/AH	FHP/NGO
Gynaecologist	5	3	1	5	3	1
Doctor	34	20	4	33	18	4
Regional health officer	3	1	0	3	1	0
Nurse	121	59	4	114	59	4
Community health supervisor	8	9	0	8	9	0
Community health worker	1	4	3	1	3	3
Family health worker	14	18	8	14	16	8
Trained birth attendant	30	30	9	30	30	9
Untrained birth attendant	3	2	0	3	2	0

Table 3. Services related to reproductive health provided by facilities

	RH (5)	HC/AH (12)	FHP/NGO(6)	All (23)
Antenatal and postnatal care	5	12	4	21
TT immunization	5	10	3	18
Iron supplements for women	4	10	6	20
Vitamin A supplements for women	3	2	1	6
Delivery	5	9	3	17
Family planning	5	12	6	23
Health education	5	12	6	23
Counseling	5	9	6	20
Treatment of STDs	5	10	2	17
Surgical interventions	5	2	0	7
Laboratory diagnostic facilities	5	6	0	11

Table 4. Type of diagnostic facilities for institutions with laboratories

	Number of laboratories where diagnostic facilities are available n=11
Hepatitis B	11
VDRL test	11
HIV antibodies	9

Table 5. Availability of stocks and equipment in facilities

	RH (5)	HC/AH (12)	FHP/NGO(6)	All (23)
Condoms	4	11	6	21
Oral contraceptive pills	5	11	6	22
IUCD	5	3	1	9
Injectables	5	11	4	20
TT vaccine	5	7	1	13
Antibiotics (two types)	4	6	4	14
Iron tablets	3	10	5	18
Vitamin A capsules	4	6	2	12
Delivery kit	3	10	4	17
Sphygmomanometer	5	10	6	21
Urine testing sticks	5	9	1	15
Adult weighing scales	5	10	5	20
Height measuring board	5	7	3	15
Photometer (working)	5	9	2	16

Table 6. In the last 6 months have you had a stock-out of:

	RH (5)	HC/AH (12)	FHP/NGO(6)	All (23)
Condoms	2	7	3	12
Oral contraceptive pills	2	7	3	12
IUCD	2	5	1	8
Injectables	2	8	4	14

Table 7. Are there any posters on display?

	RH (5)	HC/AH (12)	FHP/NGO(6)	All (23)
Yes	4	10	5	19
No	1	2	1	4

Table 8. Type of posters on display

	RH (4)	HC/AH (10)	FHP/NGO(5)	All (19)
High risk during pregnancy	0	3	1	4
AIDS	4	4	1	9
Reproductive health and family planning	0	2	2	4
General health	0	0	1	1

Table 9. What do you think are the main reproductive health problems in the communities you serve?

Problems mentioned	More than one answer possible			
	RH (5)	HC/AH (12)	FHP/NGO(6)	All (23)
No problem	0	3	1	4
Lack of awareness of AIDS	1	2	2	5
Anaemia	2	1	1	4
Self medication and transport problems	0	2	0	2
STDs	1	4	1	6
Infertility	1	1	0	2
Side effects of available CP methods	1	1	0	2
Pregnancies	1	0	1	2
Using contraception	0	1	1	2

Table 10. How much of a problem is there with STDs in the communities you serve?

	RH (4)	HC/AH (11)	FHP/NGO(6)	All (21)
Frequent	1	5	2	8
Sometimes	2	1	1	4
Very rare	1	4	3	8
Don't know	0	1	0	1

Table 11. What features would make you suspect that someone is suffering from a reproductive tract infection?

Signs and symptoms	More than one answer possible			
	RH	HC/AH	FHP/NGO	All
Pain or irritation while urinating	6	6	1	13
Discharge	3	5	4	12
Back, stomach or hip pain	1	6	3	10
Fever	3	2	2	7
Itching	1	4	1	6
Genital ulcer or pain	1	2	0	3
Bad smell	0	1	1	2
Menstrual disorder	0	0	1	1
Frequent urination	0	1	0	1
Don't know	0	1	1	2

Table 12. What do you think are the possible consequences of an untreated STD?

Consequences mentioned	More than one answer possible			
	RH	HC/AH	FHP/NGO	All
Infertility	4	9	3	16
Damage to the reproductive system	2	2	2	6
Cancer	1	2	2	5
Miscarriage	1	3	0	4
Weak child	1	3	0	4
Problems conceiving	1	1	2	4
Eyesight of newborn	0	2	1	3
Spreading the disease	0	3	0	3
Kidney problems	1	1	0	2
HIV/AIDS	0	0	1	1
Low birth weight	0	0	1	1
Pain during intercourse	0	0	1	1
Abdominal pain	1	0	0	1

Table 13. Number of IEC sessions provided to the community in the last 3 months

	RH (5)	HC/AH (12)	FHP/NGO(6)	All (23)
None	0	3	0	3
Some(mean=11 median=6 – All facilities)	4	9	6	19
Don't know	1	0	0	1

Table 14. Number of IEC sessions provided to the young people of the community in the last 3 months

	RH (5)	HC/AH (12)	FHP/NGO(6)	All (23)
None	0	7	3	10
Some (mean=6 median=4 – All facilities)	4	5	3	12
Don't know	1	0	0	1

Table 15. Do you measure the weight of women during pregnancy when she comes for her visit?

	RH (5)	HC/AH (12)	FHP/NGO(6)	All (23)
Yes	5	11	5	21
No	0	1	1	2

Table 16. Do you measure the height of women during pregnancy when she comes for her visit?

	RH (5)	HC/AH (12)	FHP/NGO(6)	All (23)
Yes	4	7	4	15
No	1	5	2	8

Table 17. How do you do follow-ups of home based mother card?

	RH (5)	HC/AH (12)	FHP/NGO(6)	All (22)
Ask the mother to come with the card	0	3	0	3
We don't use it	2	4	2	8
During the visit	2	5	4	11

Table 18 What counselling services do you provide?

	More than one answer possible			
Services provided	RH (5)	HC/AH(12)	FHP/NGO(6)	All (23)
Family planning	3	7	5	15
STDs	3	4	0	7
Nutrition	1	2	1	4
Postnatal care	1	2	0	3
Antenatal care	0	2	0	2
Relaxation for pregnant women	0	2	0	2
Personal hygiene	1	0	1	2
Counseling	0	1	1	2
Immunisation	1	0	0	1
Thalassemia	0	1	0	1
Environmental sanitation	0	1	0	1
Reproductive health	0	1	0	1
Smoking	0	0	1	1
Diabetes	1	0	0	1
Heart disease	1	0	0	1
Children rights	0	0	1	1
Other	0	1	1	2

Table 19. How much support do you get from the community?

	RH (5)	HC/AH (12)	FHP/NGO(6)	All (23)
Lots of support	4	8	6	18
Some support	1	3	0	4
No support	0	1	0	1

Table 20. What services do you think are needed by the communities you serve but which you are not able to provide?

	More than one answer possible			
Services	RH (5)	HC/AH (12)	FHP/NGO(6)	All (23)
None	1	1	0	2
Service of qualified staff	2	4	2	8
More staff	0	5	2	7
Laboratory	0	4	2	6
Bigger and better facilities	0	2	2	4
Pharmacy/medical shop	0	1	1	2
Child health services	0	2	0	2
24 hours service	0	2	0	2
Postnatal care	1	0	0	1
Family planning motivation by health staff	0	1	0	1
Provide more information to men	1	0	0	1

Table 21. Do you hear complaints from the local communities about your services?

	RH (5)	HC/AH (12)	FHP/NGO(6)	All (23)
Yes	4	11	4	19
No	1	1	2	4

Table 22. Type of complaints received

	More than one answer possible			
Complaints	RH (5)	HC/AH (12)	FHP/NGO (6)	All (23)
Bad behaviour of health staff	2	5	0	7
Lack of medicine / no pharmacy	0	2	2	4
Lodging problems in health facilities	0	2	1	3
Inexperienced staff	0	3	0	3
Need more staff/ gynaecologists	1	1	0	2
More working hours	0	2	0	2
Low number of beds	0	1	0	1
No laboratory	0	1	0	1
Bad quality drugs	1	0	0	1
Midwives missing home visits	0	0	1	1

Table 23. What could be done to improve your services?

	More than one answer possible			
Suggestions	RH (5)	HC/AH (12)	FHP/NGO (6)	All (23)
More qualified health staff	3	5	3	11
New medical equipment	2	6	3	11
Upgrading the institution	2	2	2	6
Assignment of doctors	0	4	1	5
Laboratory	0	1	1	2
Regular delivery of commodities	0	2	0	2
Emergency transport	0	1	0	1
More nurses	1	0	0	1
Awareness programmes	0	1	0	1
24 hours service	0	1	0	1

Table 24. Receipt and circulation of National standard guidelines for family planning (NSGFP), Reproductive Health Guidelines 1997(RHG) and IEC guidelines 2003

n=5

Regional hospitals	Received		Circulated	
	Yes	No	Yes	No
NSGFP	5	-	5	-
RHG	5	-	5	-
IEC	4	1	4	1

Table 25. Receipt and circulation of National standard guidelines for family planning (NSGFP), Reproductive Health Guidelines 1997(RHG) and IEC guidelines 2003

n=12

Health Centres and Atoll hospitals	Received		Circulated	
	Yes	No	Yes	No
NSGFP	9	3	9	3
RHG	11	1	9	3
IEC	11	1	10	2

Table 26. Receipt and circulation of National standard guidelines for family planning (NSGFP), Reproductive Health Guidelines 1997(RHG) and IEC guidelines 2003

n=6

Family Health Posts / NGO	Received		Circulated	
	Yes	No	Yes	No
NSGFP	4	2	4	2
RHG	5	1	5	1
IEC	5	1	5	1

Annex 4

Interviews with key informants

Table 1. Designation of key informants

	n=60
Island chief	19
Head teacher/supervisor	22
President of Women's development committee	19

Table 2. Are there any NGO's in the Reproductive Health sector working on this island?

	n=60
Yes	5
No	55

Table 3. Do the schools on this island provide information sessions on reproductive health?

	n=60
Yes	30
No	21
Don't know	9

Table 4. Do you think unmarried adolescents on this island are sexually active?

	n=60
Yes	35
No	15
Don't know	10

Table 5. Have there been any pregnancies among unmarried teenage girls on this island in the last year?

	n=60
Yes	31
No	19
Don't know	10

Table 6. Are you in favour of providing information to unmarried adolescents about puberty?

	n=60
Yes	58
No	1
Don't know	1

Table 7. Are you in favour of providing information to unmarried adolescents about STDs and HIV/AIDS?

	n=60
Yes	60
No	0

Table 8. Are you in favour of providing information to unmarried adolescents about family planning?

	n=60
Yes	56
No	4

Table 9. How much of an issue is unwanted pregnancies among the young people on this island?

	n=60
Big issue	17
Not frequent	22
Very rare	10
Never happens	9
Don't know	2

Table 10. Do you have any suggestions for developing youth friendly services for adolescents' health problems?

	n=60
Provide information at women's committees, hospitals and clubs	40
To educate parents as well as kids	13
Raising awareness about disease before they get them	5
Don't know	2

Table 11. Do you have any suggestions for improving reproductive health services on the island?

	n=60
Yes	57
No	3

Table 12. Suggestions for improving reproductive health services on the island

	More than one answer allowed
Nothing	3
More information and programmes	19
Raise awareness	16
More staff/services	10
Counseling services for all ages	1
Coordination fro more programmes	1
More family planning	1
Workshops fro youth	1
TV programmes	1
Better facilities	1
Teach reproductive health at schools	1
Make condoms available	1
Have family planning in all offices	1
Special offices for family planning and reproductive health	1

Table 13. Do you think that young people will become promiscuous if we talk to them about sexual health, including condom use?

	n=59
Yes	37
No	22

Table 14. How much of an issue is induced abortions on this island?

	n=59
Big issue	9
Not frequent	12
Very rare	18
Never happens	19
Don't know	1

Annex 5

Key indicators by region

Indicator	North	NC	Male'	MER	SC	South	National
No. houses	361	448	501	174	496	299	2279
No. of respondents	602	661	1220	261	998	360	4102
Contraceptive prevalence rate (CPR): married women aged 15 to 49 years							
CPR (all methods)	31%(114)	36%(153)	37%(264)	44%(77)	48%(261)	39%(103)	39%(972)
CPR (modern methods)	27%(99)	31%(132)	32%(225)	43%(75)	39%(212)	37%(99)	34%(842)
CPR (modern temporary methods)	24%(87)	25%(106)	24%(167)	32%(57)	30%(160)	31%(81)	27%(658)
Knowledge of STIs and AIDS: all household respondents							
% know any signs of STIs	38%(222)	46%(300)	47%(568)	59%(151)	50%(474)	52%(184)	48%(1899)
% know ways of catching STI	76%(456)	73%(479)	81%(984)	76%(198)	83%(832)	84%(304)	79%(3253)
% know a valid way of catching STIs	65%(389)	68%(448)	64%(781)	67%(174)	68%(683)	73%(263)	67%(2738)
% know a way of protection from STIs	92%(556)	86%(571)	91%(1115)	90%(236)	90%(896)	90%(323)	90%(3697)
% know ways of catching AIDS	97%(583)	96%(633)	99%(1207)	99%(258)	97%(964)	98%(353)	98%(3998)
Antenatal visits, iron intake and post-natal contacts with HC providers for married women aged 15-49 who delivered in the last 12 months							
% had at least 4 antenatal visits	77%(26)	89%(42)	90%(71)	88%(7)	96%(67)	100%(36)	91%(249)
% had any iron in last pregnancy	80%(24)	87%(40)	89%(63)	100%(8)	90%(62)	78%(25)	87%(222)
% had contact with HC provider within 6 weeks of delivery	54%(14)	34%(13)	83%(64)	38%(3)	56%(31)	53%(17)	60%(142)
Percentage of households that received a FHW visit (excluding Male')							
% houses ever visited by FHWs in 1999	37%(123)	41%(159)	-	44%(48)	48%(220)	58%(190)	46%(740)
% houses ever visited by FHWs in 2004	84%(231)	53%(160)	-	76%(100)	75%(258)	55%(110)	69%(859)
Household rating of RH services: all households							
% who rate RH services as 'good'	74%(443)	63%(415)	76%(926)	66%(168)	73%(727)	68%(244)	72%(2923)