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Shaffa Hameed

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To be young, unmarried, rural, and female: intersections of sexual and reproductive health and rights in the Maldives

Shaffa Hameed 

Research Fellow, London School of Hygiene and Tropical Medicine, London, UK. Correspondence: shaffa.hameed@lshtm.ac.uk

Abstract: *This paper explores sexual and reproductive health and rights (SRHR) among young people, identifying intersecting factors that create inequities in access to services, health-seeking behaviour, and ultimately health outcomes. Based on qualitative interviews with young people in the Maldives, it demonstrates how these intersectional experiences are contrary to what is often assumed in official data, policies, and services. Three factors were found to shape young people's experiences: marital status, gender, and urban/rural differences. Non-marital sexual activity is illegal in the Maldives, but it is somewhat expected of unmarried men, while unmarried women are stigmatised for being sexually active. Although access to SRH services is restricted for all unmarried people, young women face additional difficulties, as the risk of being exposed is much greater in small island communities. Maldivian island communities are extremely small and characterised by an inward-looking culture that exerts considerable social pressure, particularly on unmarried women. For an unmarried woman, being known to be sexually active, or worse, pregnant outside of marriage, has severe social consequences including stigma and isolation from the community, and their own family. This concern is more prevalent among rural young women, as they live in smaller communities where stigma is inescapable. The need to avoid public scrutiny and humiliation contributes to making unsafe abortion a common solution for many unintended pregnancies. Failure to acknowledge these intersecting factors in SRHR experience and access has led to inequities among an already overlooked population, shaping their experiences, knowledge, health-seeking behaviour, and health outcomes. DOI: 10.1080/09688080.2018.1542910*

Keywords: sexual and reproductive health and rights, intersection, young people, gender, inequities, access to services, vulnerable population, contraception, abortion, Maldives

Introduction

Sexuality is a moral issue in most contexts, making sexual health an uncomfortable topic for many. Sexual health, which comprises the non-procreative health aspects of sexuality, can be difficult for politicians and policymakers to address. Sexual health outside of formal and socially sanctioned unions can be even more problematic.^{1–3} When considering the sexual health of young people (defined here as under 25 years), the difficulties in developing adequate responses are magnified, as morality, tradition, and gender norms come into play.^{2,4–6}

When the 1994 International Conference on Population and Development (ICPD) declaration called for universal access to sexual and reproductive health (SRH) services, most of the Muslim-majority countries in attendance endorsed the

declaration, but reserved the right to implement it within their legal framework.⁷ Such reservations contribute to making SRH services legally inaccessible for unmarried people, a situation compounded by policy silence within most Islamic countries.⁸ Reluctance to acknowledge “illicit” (e.g. non-marital or same-sex) sexual activity has led to inadequate responses to pertinent SRH issues such as HIV/AIDS in many Islamic countries in Asia and the Middle East.⁹ Policy and service environments created and sustained by conservative policies can discourage people from seeking services, which can lead governments to underestimate prevalence and engender programmatic complacency.⁹

Women are more likely to be married at a young age, compared to men, in all countries in Asia, and there is persistent sociocultural pressure favouring

early marriage and fertility for women.¹⁰ However, the regional median age at first marriage has been rising, and youth who live in urban areas and have secondary education seem more likely to delay marriage.¹⁰ The widening gap between age of sexual initiation and age at marriage translates to a longer window in which premarital sexual activity may take place, though national-level statistics for this still prove elusive in Asia.¹⁰ A review of SRH studies on unmarried youth in Asia and the Pacific indicates that while traditional attitudes and expectations about preserving virginity until marriage were still prevalent among young people, premarital sexual activity did occur.¹¹ Many report that these attitudes were more permissive towards young men, who were somewhat expected to engage in premarital sexual activity. Young women, however, were expected to be chaste and naïve, and had to manage sociocultural concerns about stigma and unintended pregnancies.¹¹

Despite being committed to international mechanisms and global platforms, failing to acknowledge sexual and reproductive health and rights (SRHR) inequities created by tradition, gender norms, and sociocultural pressure can cause vulnerable groups to be left behind to face potentially severe health outcomes. Using the Maldives as a case study, this paper explores SRHR inequities among young people, demonstrating the contrast between assumptions in policies, services, and the intersectional experiences of youth, particularly young unmarried women.

Youth SRHR in the Maldives: official data, policies and services

The Maldives is an island nation with a population of about 400,000 and a young age structure. Nearly half the population are aged under 25 and 20% are aged between 15 and 24 years.¹² There are 188 inhabited islands, of which 123 islands have a population of less than 1000 people. Only one island, besides the one where the capital is situated, has more than 10,000 people.¹² This geographical dispersion makes equitable service provision difficult. The Maldives is a wholly Muslim country and follows the *Sharia* or Islamic law. Although Islam had been practised in moderation in the past, there is a growing Islamic fundamentalist influence.^{13–15} This rise in Islamic fundamentalism, as well as global cultural flows, have contributed to dramatic changes in Maldivian society in terms of reformulating masculinity and

gender relations that had previously kept intimate partner violence against women relatively low (20%).^{15,16} The historic fluidity in marriage and divorce practices was replaced with a heightened expectation that marriage must last forever, along with legal restrictions and social stigma related to divorce.¹⁵ The census reports a mean age at marriage for women as 22.5, and 25.8 years for men.¹²

Non-marital sexual activity is illegal in the Maldives, government data on the SRHR needs of youth are limited, and there are policy silence and severe SRH service restrictions for unmarried youth.¹⁷ Youth SRHR were not acknowledged in Maldivian policies until the early 2000s^{18,19}; this is nearly 20 years after family planning was initiated for married couples,²⁰ and at least 10 years after unsafe abortion was mentioned (briefly) in official reports.²¹ Official reports still cite religious sensitivity as an obstacle to researching and providing services for unmarried sexually active youth.^{22–24} In the policy arena, these issues are vetoed on the grounds of being too culturally sensitive or unacceptable; and the need for data on non-marital sexual activity continues to be dismissed. The resulting lack of data then forms the basis for programmes and policies that ignore the prevalence of non-marital sexual activity, locking data and policies in a vicious cycle.¹⁷ This results in a situation where official SRHR data are often in short supply, are censored, and often have low validity.

Nationally representative data on the prevalence of non-marital sexual activity were collected for the first time in 2009 when the Maldives DHS data showed only 11.6% of youth aged 18–24 years (9% female, 20% male) had engaged in premarital sex.²⁵ Policymakers, service providers, and youth interviewed in 2009 found this figure a gross underestimation.¹⁷ Pre-2009, the only state-approved data on premarital sexual activity were derived from a self-administered component in the 2004 Reproductive Health Survey that had an extremely low response rate (12%) in urban areas, potentially due to the sensitivity of the topic.^{26,27} The researchers acknowledged that this may have under-represented youth living away from home, and that only limited generalisations could be drawn.²⁶ It is unsurprising, then, that young people, if unmarried, maintain underserved in contemporary SRHR policies and services.

Policies and service provision guidelines remain a grey area. Service providers are instructed not to discriminate against users, naming various

characteristics including marital status. Yet a request for contraception could be linked to illicit sexual activity if a person is not married.²⁸ Since the guidelines do not explicitly allow or disallow the service provider from providing contraceptives, they are able to provide or refuse this service and may not be held accountable for either decision. Health seekers could then be denied access to contraceptive services, enhancing their vulnerability to sexually transmitted infections (STIs) or unintended pregnancy. Although both are concerns for public health authorities, they cannot compel service providers to provide contraceptive services, given the lack of clarity in policies.²⁹ A study in 2016 found that the general consensus among government and non-government stakeholders is that this grey policy area is intentionally maintained, as a change would require challenging religious authorities.²⁹ This challenge would likely be lost in a political climate where religious influence is becoming increasingly formalised as a part of policymaking¹⁷ and increasingly conservative views are prevalent.¹³

Health services that are known to accommodate youth SRHR needs without emphasising “illicit” sexual activity are mostly located in the capital city Male’, making access difficult for youth from the other 187 inhabited islands. A 2012 study found these services under-funded, under-staffed, and most significantly, under-utilised, as the need to work undetected by critics limits their reach.¹⁷ In 2013, the Ministry of Health released the National Standards for Adolescent and Youth Friendly Health Services but there is little evidence of its implementation or impact.³⁰ More recently, UNFPA Maldives supported a local NGO to introduce Safe Space information sessions for youth about SRHR concerns.³¹ Although this too is currently Male’-based, the partnership has also launched a mobile app to provide information and chat-based advice to extend reach beyond the capital.³¹

It has been argued that it is the insular nature of small islands characteristic of the Maldives that upholds and enforces compliance to traditions, not the religiosity that is cited in official narratives as a reason for policy silence and service unavailability.¹⁷ Although not the sole source of sociocultural influences, the effects of insularity – geographic and sociocultural – are amplified in small islands.³² With over half of the inhabited 188 islands sized between 1 and 39 hectares and populated by less than 1000 people,¹² Maldivian

island communities are extremely small and characterised by an inward-looking culture that exerts considerable social pressure and boundaries within which young people must exist.

Methods

This paper primarily draws on semi-structured, in-depth interviews ($n = 61$) conducted with Maldivian youth aged 18–24 years from three field sites (the capital city Male’, Raa Atoll from the north and Laamu Atoll from the south), in 2009, as part of a broader mixed-methods study on the disconnect between youth experiences and policies in the Maldives.¹⁷ The sample was purposively selected using Patton’s maximum variation sampling strategy³³ based on geographical variation, gender, marital status, age, level of education, and living arrangements. These categories were used to determine a sample of at least 20 respondents per field site. In each field site, potential interviewees were approached in youth communal areas, on the street, or by visiting randomly selected houses. They were checked for eligibility (aged 18–24 years) and fit, allowing good distribution across each category without oversampling one characteristic. Interviewees were provided with information about the study, and assured of confidentiality. Interviews were conducted at a time of their choosing in a private, quiet, and informal setting. Researcher reflexivity journals were maintained to manage, where possible, power imbalances between researcher and interviewees, including notes such as: “researcher is female and obtaining tertiary education overseas, while interviewees included men and women, and educated to diploma or undergraduate level.”

Ethical approval was obtained from the Research Ethics Committee at the London School of Economics and Political Science who concluded that appropriate ethical safeguards were in place. Ethical approval was not required from Maldivian authorities as these were required only for surveys at that time, though relevant authorities were kept informed.

The iteratively developed and piloted interview guide explored young people’s attitudes towards, and experience of, non-marital sexual activity, marriage, relationships, abstinence, abortion, access to services, and religion. All interviews were audio-recorded and conducted by the author after informed written consent was obtained. Transcripts were coded and analysed in Dhivehi (official

Maldivian language) using discourse analysis, with selected quotes translated to English to illustrate key points. The first phase of analysis involved generating initial codes, searching for thematic patterns, and checking for variability and consistency. Next, tentative hypotheses were formed and checked against the data in an iterative process.³⁴

Official narratives were captured through documentary analysis of SRHR policies and national studies in the Maldives, including the first Demographic and Health Survey 2009.²⁵

Results

Three factors were found to shape young people's SRHR experiences, sometimes counter-intuitively to what official data and policies lead us to expect. Furthermore, these factors interacted to produce a compound effect creating inequities among an already overlooked and underserved population, shaping their SRHR experiences, knowledge, health-seeking behaviour, and ultimately health outcomes.

Marital status

Since marital status remains the definitive factor in controlling access to SRH services, it was expected to play a similar role in shaping young people's SRHR experiences, given the illegal status of non-marital sexual activity. However, it appeared that this contributed more towards how careful they were, rather than whether or not they *do* engage in non-marital sex.

Yeah, I don't think it's a problem, if one person does that with another. It's actually not a problem any more." (M13, married, male, urban)

"That is, well, it's between those two people right? Different people have different attitudes about it ..." (R13, unmarried, male, rural)

Married and unmarried youth held similar attitudes towards non-marital sex, but what differed was that unmarried youth needed to consider the repercussions of diverting from social norms informed by religion. Despite the criminalisation, nearly all youth respondents identified legal repercussions (such as being reported or arrested by authorities) as far less serious than social repercussions. These include being labelled, taunted, gossiped about and consequently bringing shame on the family, being kicked out of their home, and becoming socially isolated. These forms of

informal societal punishment are of immense concern to Maldivian youth given the nature of small island life. These concerns were described in response to a series of "what if?" scenarios. One scenario was about a hypothetical unmarried friend of theirs who had been sexually active. The majority of respondents reported that the scenario was not surprising, and most went on to say it had happened to them.

Moreover, the religious sensitivity cited and assumed in policies (e.g. national Health Reports for 1999, 2001, and 2004)^{24,35,36} were not reflected in young people's narratives. Respondents rarely mentioned religious adherence in discussing reasons for having non-marital sex – their responses identified sex as opportunistic ("because their parents are not there"), accidental ("because they get carried away"), expected ("it's the next step in the relationship"), and experimental, among others.

"[...] Why do they wait? Hmm ... how do I say, they just don't have a chance ... they're not in relationships ... maybe they can't go out ... the chances increase when you're in a relationship." (R10, unmarried, male, rural)

When identifying reasons why some people do not have non-marital sex, some youth responded in relation to morality, saying it was because they were "good" and "religious" ("good" did not always mean "religious adherence", but "good" as in obeying parental rules). This could indicate a link between religiosity and abstinence but could equally be indicating social desirability where they feel they are expected to denounce non-marital sex and label it "bad". An unmarried male respondent mentioned his sexual activity as something he did even though he prayed, describing how he did not feel the two activities were contradictory. So, while religion influences young people's reported attitudes, it does not necessarily shape their sexual behaviours in the way official narratives assume. In contrast, gender stereotypes and biases were prevalent in young people's narratives about sexual behaviour, but absent in policy narratives.

Gender

A 2016 review of Maldivian SRHR policies revealed that while overtly discriminatory policies were rare, there were some that were disadvantageous to women – these include requiring spousal consent when undergoing sterilisation, and common

references to “couples” in contraceptive service guidelines. More disconcerting findings included: legislation allowing child marriages in certain conditions; inconsistent prohibition of marital rape; unsuitable interventions for gender-based violence cases; and absence of active discouragement and prohibition of female genital mutilation.²⁹ These are examples of inadequate policy and service responses that do not reflect the intersectional inequalities in young women’s and men’s experience of SRHR.

In a hypothetical scenario where a man was sexually active before marriage, both men and women said this was unsurprising and somewhat expected. Contrarily, most respondents felt it would be surprising to learn a female friend was sexually active before marriage. However, the majority clarified that the surprising aspect would be more about *knowing* she was sexually active, rather than her *being* sexually active. The following quotes are responses to being asked what would happen if people in the community found out an unmarried woman was sexually active.

“It’ll be a very big deal [...] it would be difficult for her to go out ... to face other people, it would be difficult right? What happens is... a lot of people would taunt and mock her... she’d get a lot of people’s ridicule for it.” (L19, married, male, rural)

Respondent: *[...] Her whole image would be destroyed completely. In islands ... well, one person might chatter about it and then it will be all over the whole island ... and they would talk about it constantly ... and they would talk in a very ... a degraded person ... I mean she’ll be like a very immoral person ... everyone will see her that way ... she’d be labelled.*

Interviewer: *Would they say it to her face?*

Respondent: *They might say it to her face too, like say she was on the street and they might just say it to her as she passes ... But like to walk up to her and scream about it ... they wouldn’t do that but people in this island ... well, people in this island are very nosy ... you know ... they would talk ... and if they hear something like that they might build it up as they go on. Yeah they might exaggerate ... that she got pregnant and she aborted the child ... they make up stuff like that.* (R14, married, female, rural)

Young men reported they would not – and did not – receive the same treatment if found out to be sexually active or to have fathered a child outside of marriage. Young women, though more likely to

receive public humiliation, found it more difficult to access SRH services as families tended to control daughters more than sons. They also perceived that their actions are monitored, and rumoured about, more than their male peers. The ways in which this contrast in experience and in access has shaped safe sexual practices and health-seeking behaviour is discussed later.

Urban/rural differences

Respondents were given another scenario, where an unmarried friend seeks their advice suspecting a STI. Responses were generally ambivalent, as most youth said they would just encourage their friend to go to a doctor. The Maldives DHS found that 92.4% of youth aged 18–24 reported knowing a place for treatment if they suspect a STI.²⁵ While this lends weight to the mainstream belief that young people will “just find a way” even if policies and services are restrictive, probing about where they would seek treatment revealed deeper issues of accessibility. This included their financial ability and freedom to travel to another island to avoid “leaks”, not just about their health status but also regarding their sexual activity.

A large proportion of unmarried youth respondents in the Maldives DHS, as well as in a web-based survey on youth sexual attitudes and practice, identified tertiary hospitals as places to seek SRH services; both of these are located in the crowded capital Male’.^{17,25} The interviews revealed some reasons behind this. Some respondents felt the crowds and queues in Male’ hospitals would allow a person to be anonymous, or even claim they were there accompanying another person. Others felt small private clinics in Male’ were numerous enough, so that they could sneak into one without attracting much attention.

Interviewer: *Okay so say a friend comes and says she thinks she’s got an STI but she doesn’t know what to do. What do you do?*

Respondent: *I think I would tell her to go to a doctor.*

Interviewer: *Where would you go, to show a doctor?*

Respondent: *Anywhere.*

Interviewer: *Anywhere? [Names two hospitals in Male’, one state, one private]? A clinic?*

Respondent: *Any of those. The [state hospital] or [private hospital] to see first what it is and whether it can be treated.*

Interviewer: *Yeah. Say for example she says she doesn't dare go, a sister of a friend works there, they might find out. Do you think that something that could happen?*

Respondent: *Yeah, yeah it could happen. Then let's just go somewhere where she doesn't know anyone. (M20, unmarried, female, urban)*

Young people based in islands have fewer options. Many would opt to go to regional hospitals instead of the lower level health facilities on their island where they might be recognised. However, with just six regional hospitals around the country, this necessitates travel for most people. Young women especially, would need to give their family a reason for travelling. The alternative would be to seek services closer to home, which many agreed would pose a great risk of their anonymity and privacy being compromised.

Being found out or labelled by their community can be catastrophic to some youth, often making it difficult to remain on that island. However, one key feature of islands is “isolation” which refers to the need for a dedicated journey to leave (or visit) the island³² – a feat that is difficult for average, unmarried, Maldivian youth without financial assistance. In youth narratives, family or parents were inconsistent avenues of help. Most young people interviewed expect to be disowned or kicked out of their homes if they were found to be sexually active or pregnant outside of marriage. They were very conscious of how their behaviour reflects on their family, creating added pressure for youth to conceal illicit sexual activities, even at the expense of their own health.

“[...] when she got pregnant while in school, she wrapped her [stomach] in cloth and later ... her mother and them ... well, she delivered in the bathroom and the baby ... when they found her the baby had died they say ... I don't know if the baby was killed ... There's no facility like that on this island, I mean you can't get pills like that but I guess you could drink something like bleach but ... she wrapped herself in cloth until she gave birth ...” (R14, married, female, rural)

Reflecting on another hypothetical scenario where an unmarried friend is pregnant, most youth speculated the best course of action would be to carry the pregnancy to term, and avoid *faafa egge machchah faafa* – i.e. to “commit sin upon sin”. It was clear that youth perceived abortion to

be more closely linked to their religious beliefs than non-marital sexual activity. Their stance did not seem to be reflecting pro-life arguments regarding abortion – there was almost no discussion of the foetus as a life. Instead, it seemed to be because Islamic doctrine regarded it as a sin. That Islam allowed pregnancy termination within the first trimester was mentioned by only two respondents, indicating gaps in knowledge about SRH options and rights. What follows from these difficulties in preventing unintended pregnancies, in hiding it from family and community, but also in bearing the consequences of carrying to term, is described below.

Intersectional consequences for SRHR

The concept of intersectionality is used to understand “how multiple social identities such as race, gender, [...] intersect at the micro level of individual experience to reflect interlocking systems of privilege [...] at the macro social-structural level”.³⁷ As Bowleg remarks, it is particularly applicable to public health in order to acknowledge, illustrate, and address disparities in health outcomes.³⁷ The multiple and intersecting inequities for young, unmarried women living in rural island communities compound their vulnerabilities through sociocultural pressure, limited SRHR knowledge, and lack of access to contraceptive services. This leaves them with very few options for their SRH concerns. They are stigmatised if found out to be sexually active, which also limits their access to contraceptive services. The need to avoid public scrutiny and humiliation contributes to make unsafe abortion an option for unmarried women who find themselves with an unintended pregnancy.

Interviewer: *Okay let's take one step further and say a female friend of yours comes to you and says she's pregnant and asks what she can do?*

Respondent: *Oh with that, well ... there's not much to do right ... if she's pregnant ... the thing is, it's very common isn't it ... girls getting pregnant and getting an abortion ... it's very common. If you can't get it done around here, then go to Male' ... if you can't get it done in Male' then go to India.*

Interviewer: *Do you hear that a lot ... on this island too?*

Respondent: *As far as I know ... there's a relative of mine who's arranged three abortions ... like going to India for it ... [...] he helped three different girls to get abortions. (L19, married, male, rural)*

Interviewer: *Okay, say for example a friend of yours came and told you she was pregnant. What would you do?*

Respondent: *If she says she's pregnant then ... well I'm going to say what I think about this okay ... I do actually know it's a bad thing but the way we think about it ... we think to ourselves if ... like, I get pregnant ... then I'll immediately get some pills and quickly take it ... I think I'll do something like that (laughs). So I think I'll tell my friend the same thing. (R14, married, female, rural)*

Although abortion was described as a sin, the majority of youth interviewees agreed that abortion is extremely common among unmarried youth. About a quarter of the respondents reported knowing of up to five cases of unsafe abortions among unmarried peers, four reported knowing between 5 and 10 cases, and 9 reported knowing about over 10 cases of unsafe abortion as a result of unintended pregnancies among unmarried youth.

Respondent: *[...] these days I mean ... I can say that a lot of the girls tend to do abortion and -*

Interviewer: *How many cases of abortion have you heard of?*

Respondent: *Many*

Interviewer: *[...] Okay so how many from ... people who you know ... among them, about how many would there be?*

Respondent: *Yeah it will be more than 20 seriously*

Interviewer: *That's loads eh, so it is pretty common*

Respondent: *Yeah it is common. (M17, unmarried, male, urban)*

Interviewer: *Do you hear about babies being [aborted]?*

Respondent: *Well ... recently a friend was also ... by accident ... she got pregnant ... we didn't talk to her, we didn't even want to ...*

Interviewer: *Do you think it is common?*

Respondent: *It's common now yeah ... what happens now is there are these pills to [abort] so it's become an easy thing. (L13, married, female, rural)*

The quotes demonstrate a striking aspect about abortion – that it is considered an “easy fix” to an unintended pregnancy. When asked if they knew how people got abortions, nearly all respondents were able to describe different ways of inducing abortion, the most common of which was consuming pills, usually in combination with another medication. Exactly half of the in-depth

respondents said they would be able to acquire these abortion-inducing pills.*

Interviewer: *Okay so a girl comes to you and says she's pregnant. What can she do?*

Respondent: *Get her a pill*

Interviewer: *What kind of pill?*

Respondent: *I don't know the name*

Interviewer: *What happens when you take it?*

Respondent: *Um ... like ... the baby gets ...*

Interviewer: *Aborted?*

Respondent: *Aborted*

Interviewer: *How easy do you think it is to find it?*

Respondent: *It's not so easy. I have to call many people and ... it takes some effort. (M02, unmarried, male, urban)*

“More friends in [neighbouring island], most friends there, it happened to them, to a few of my friends ... I mean, there's a lot of youth who ... when I was living there, it happened to a few friends and they took some kind of pills and aborted ... I know they did. The other, those who gave birth ... there was one girl who gave birth while in school ... she didn't go to classes after that.” (R16, unmarried, female, rural)

The easy access to abortion counters young people's fear of unintended pregnancies, and replaces the difficulties of acquiring contraception and seeking professional help during which they risk being exposed. They practice contraception by abortion. For unmarried young women living in rural island communities, the alternative has far-reaching consequences such as loss of education and employment opportunities in addition to social isolation. Another key factor contributing to unsafe sexual practices is their limited knowledge of and attitudes towards STIs.

It has been previously shown that the Maldives DHS has exaggerated the availability of SRHR knowledge among young people. High proportions of those who claim to have learnt this information in school and standalone seminars were unable to report knowledge of contraception and STIs.¹⁷ Nation-wide campaigns have led to high levels of knowledge on HIV/AIDS but very low awareness of other STIs.¹⁷ The emphasis on

*It is unclear whether or not they were referring to emergency contraceptive pills, as I did not want to introduce new information to the discussion.

AIDS awareness, including information on its low incidence in the country, also contributed to many youth identifying AIDS as a worst-case but unlikely scenario, which in turn has led them to underestimate the risk and effects of other STIs.¹⁷ Furthermore, in the absence of information about other STIs, young people's reliance on peers leads them to underestimate the incidence of other STIs as they have not heard of other related peer experiences.¹⁷ Reports of STI cases among peers were low (compared to reports of unintended pregnancies and abortion); this is believed to be a result of extremely low awareness of STIs and their often asymptomatic nature. Concerns about the risk of STIs are therefore low. This is congruent with studies that reported how youth respondents believed HIV/AIDS was more common than any other STI.³⁸ As a result of this unawareness about STIs and the impact of unsafe abortions, young people, particularly unmarried women, have been exhibiting health practices that could leave lasting impact on their health outcomes.

Discussion

This paper has demonstrated how societal practices upheld by tradition (often misidentified as religion), gender norms, and sociocultural pressure shape young people's experiences of SRHR in the Maldives, often in ways that are unacknowledged in policies and services. Marital status, gender, and urban/rural differences create SRHR inequities among an already overlooked population, shaping their access to services and health outcomes. Limitations of the study include exclusion of young people below 18 years. Although this was for ethical reasons, anecdotal reports indicate that sexual initiation occurs at younger ages. It would also strengthen the study if a wider range of field sites were sampled to provide further insight into urban–rural differences, also considering rapid development, migration, and resort-based youth.

For young men and women living throughout the Maldives, being unmarried does not necessarily preclude them from engaging in sexual activity. However, in a context that does not recognise nor accept that this occurs, their access to contraceptive services is limited. Being female adds another layer of restrictions to their access as well as their experiences. Unmarried women are stigmatised for being sexually active while it is

somewhat acceptable for, and sometimes expected of, unmarried men. This is in line with the 2006 systematic review by Marston and King that showed similar gendered double standards prevalent in many settings – sexual experience being desirable among young men but undesirable among young women, as is carrying or buying condoms, because it implies sexual experience.³⁹

Access to contraceptives and SRH services is restricted in unmarried people, with geographical, financial, and additional restrictions in rural areas, as the risk of being exposed is much greater in small island communities. With limited SRHR knowledge, young women rate the risk of STIs and unintended pregnancies to be considerably less serious than the social consequences of getting “found out” as being sexually active, which also contributes to low contraceptive use. Their attitudes towards unintended pregnancies are further shaped by their access to abortion. This is a common avenue taken by many young women worldwide in order to avoid the guilt and shame of non-marital pregnancies.⁴⁰ Although illegal in the Maldives, unsafe induced abortion is common among unmarried youth. Most youth can readily name a number of ways of inducing abortion and are confident in their ability to arrange an abortion, frequently more confident than in their ability to obtain contraceptives. Thus, an unintended pregnancy is considered easily fixed by abortion.

Severe social consequences result if a young unmarried woman is found out to be sexually active or, worse, pregnant outside of marriage. These include stigma and isolation from the wider community, and sometimes from their own family. This concern is more prevalent among rural young women as they live in smaller communities where stigma is inescapable, reputation of self and family are highly valued, and people tend to be more conservative. Young women face these consequences worldwide, with stigma, social exclusion, and forced withdrawal from education all having lasting, negative effects on their life course.^{40,41}

This perilous combination of attitudes, misinformation, and fears is what shapes SRHR for unmarried young women in the Maldives, particularly those in rural communities. Their sexual practices are considered illicit, and therefore undeserving of targeted information or service provision. The sociocultural pressures they face, disproportionately more than their male peers, are

unacknowledged, creating further vulnerabilities and narrowing their SRH options and choices. The resulting decisions, such as unsafe abortions, could ultimately affect their health outcomes. This case study of the Maldives, in a context that fails to recognise the intersecting factors that shape SRHR, shows what it means to be young, unmarried, rural, and female.[†]

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ORCID

Shaffa Hameed  <http://orcid.org/0000-0003-2723-1709>

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Résumé

Cet article se penche sur la santé et les droits sexuels et reproductifs chez les jeunes et identifie des facteurs croisés qui créent des inégalités dans l'accès aux services, les comportements de recherche de soins de santé et, en fin de compte, les résultats sanitaires. Se fondant sur des entretiens qualitatifs avec des jeunes aux Maldives, il démontre comment ces expériences intersectionnelles sont contraires aux postulats fréquemment trouvés dans les données, politiques et services officiels. Il révèle que trois facteurs façonnent les expériences des jeunes: la situation matrimoniale, le sexe et les différences entre urbains/ruraux. Les relations sexuelles extraconjugales sont illégales aux Maldives, mais elles sont en quelque sorte escomptées des hommes célibataires, alors que les femmes célibataires sont stigmatisées si elles sont sexuellement actives. Même si l'accès aux services de santé sexuelle et reproductive est limité à toutes les personnes mariées, les jeunes femmes rencontrent des difficultés supplémentaires car le risque d'exposition est beaucoup plus grand dans les petites communautés insulaires. Les communautés insulaires maldiviennes sont extrêmement petites et caractérisées par une culture repliée sur elle-même, qui exerce des pressions sociales considérables, en particulier sur les femmes célibataires. Pour une femme célibataire, avoir une vie sexuelle active ou, pire, être enceinte en dehors du mariage, a de graves conséquences sociales, notamment la

Resumen

Este artículo explora la salud y los derechos sexuales y reproductivos entre jóvenes e identifica los factores de intersección que crean inequidades en el acceso a los servicios, comportamientos de búsqueda de salud y, a la larga, en los resultados de salud. Basado en entrevistas cualitativas con jóvenes en las Maldivas, el artículo demuestra cómo estas experiencias interseccionales son contrarias a lo que a menudo se da por sentado en los datos oficiales, políticas y servicios. Se encontraron tres factores que afectan las experiencias de las personas jóvenes: estado civil, género y diferencias urbanas/rurales. La actividad sexual no matrimonial es ilegal en las Maldivas, pero es algo esperado de hombres solteros, mientras que las mujeres solteras son estigmatizadas por ser activas sexualmente. Aunque el acceso a los servicios de SSR es restringido para todas las personas solteras, las jóvenes enfrentan más dificultades, ya que el riesgo de exposición es mucho mayor en comunidades de islas pequeñas. Las comunidades de las islas maldivas son muy pequeñas y están caracterizadas por una cultura introspectiva que ejerce considerable presión social, en particular en mujeres solteras. Para una mujer soltera, ser conocida por ser activa sexualmente, o aun peor, por quedar embarazada fuera del matrimonio, tiene graves consecuencias sociales, tales como estigma y aislamiento de la comunidad y su propia familia. Esta preocupación

stigmatisation et l'isolement de la communauté, et de sa propre famille. Cette préoccupation est plus répandue parmi les jeunes femmes rurales puisqu'elles vivent dans des communautés plus restreintes où il est impossible d'échapper à la stigmatisation. La nécessité d'éviter le regard public et les humiliations contribue à faire des avortements à risque une solution fréquente pour beaucoup de grossesses non désirées. L'incapacité à prendre acte de ces facteurs croisés dans l'expérience et l'accès à la santé et aux droits sexuels et génésiques a abouti à des inégalités dans une population déjà négligée, façonnant son expérience, ses connaissances, ses comportements de recherche de soins de santé et ses résultats sanitaires.

es más predominante entre mujeres jóvenes rurales, ya que viven en comunidades más pequeñas donde el estigma es ineludible. La necesidad de evitar humillación y escrutinio públicos contribuye a que el aborto inseguro sea una solución común para muchos embarazos no intencionales. Al no reconocer estos factores de intersección en experiencia y acceso a los servicios de SSR, surgen inequidades entre una población de por sí olvidada, lo cual define sus experiencias, conocimientos, comportamiento de búsqueda de salud y resultados de salud.