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Situation Analysis of Children and Youth in the Maldives

UNICEF Maldives Country Office

October 2021

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Published by UNICEF 2021
Editing, design and layout: Green Ink, United Kingdom (www.greenink.co.uk).

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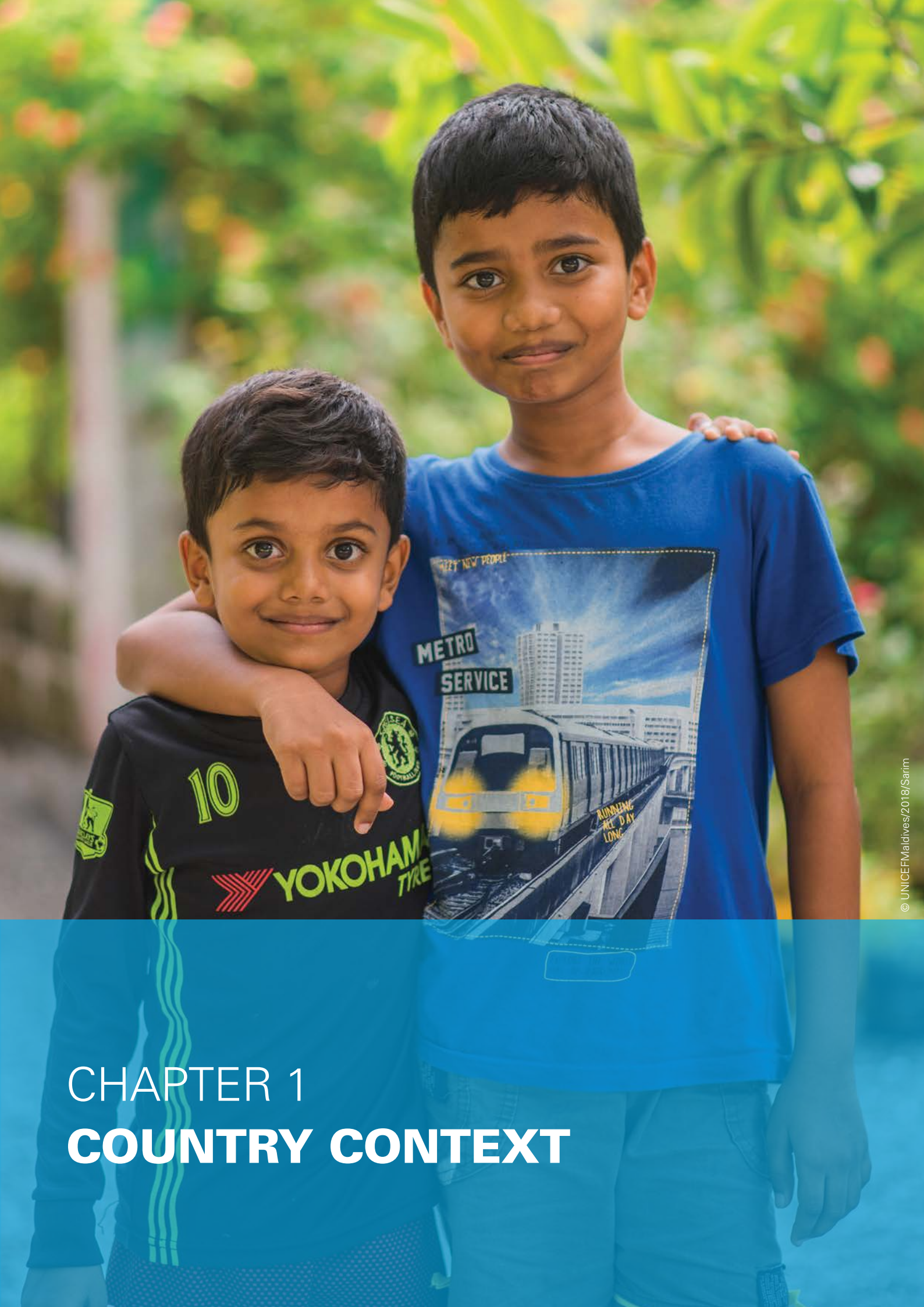

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CHAPTER 1
COUNTRY CONTEXT

Over the last four decades, the Maldives has experienced massive economic development and social transformation. Gross domestic product (GDP) per capita increased from US$3,300 in 2003 to US$10,541 in 2019, taking the Maldives from a least developed to an upper middle-income country. During this period, primary school enrolment improved from 15 per cent to 96 per cent, life expectancy increased by 30 years, and the under-5 mortality rate fell from 27 to 8[1] and the maternal mortality rate from 97 to 53.[2] With the national health insurance scheme, the Maldives is well on its way to achieving universal health coverage (UHC) and coverage of essential health (with the UHC index at 72 per cent in 2018),[3] and education services and improvement of living conditions. It has the highest total health expenditure rate and social sector budget allocation in South Asia.[4] Health expenditure has seen an annual average growth of almost 20 per cent since 2004.[5] However, socioeconomic and geographical inequalities persist: many of the remote islands have not had an equal share of socioeconomic development, while new social and health challenges have begun to emerge among children and young people.

The COVID-19 pandemic and the subsequent global recession are creating unprecedented health and socioeconomic challenges in the Maldives. As of 3 August 2021, the Maldives had confirmed 77,758 cases of COVID-19, with 222 deaths.[6] The sudden halt of international tourism in 2020 brought an unprecedented economic shock, weakening the country's fiscal and external position, threatening economic and developmental gains, and increasing food insecurity due to disruptions in the supply chain. The social and livelihood costs are immense: children's learning is being severely affected, public health indicators reflect under-utilization across the population and amongst vulnerable groups, and people have lost incomes and require urgent protection. In 2020, the Maldives' real GDP fell by 18.6 per cent, while the poverty rate increased from 2.1 to 7.2 per cent from 2019 to 2020.[7] As the crisis continues, the social and economic impacts intensify, while demand for the government's recovery efforts increases.


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As a Small Island Developing State (SIDS), the Maldives is uniquely vulnerable to certain impacts of the pandemic. For example, the country is reliant on tourism for foreign exports: in 2019, direct export revenues from international tourism represented 57 per cent of GDP.[8] As a result of the pandemic, real GDP fell by 18.6 per cent in 2020. The poverty rate increased from 2.1 per cent in 2019 to 7.2 per cent in 2020.[9]

Country features

With nearly 1,190 small coral islands dispersed across 90,000 square kilometres of ocean, the Maldives has unique economic, demographic, physical and social features.[10] Half the population lives on just one island: Malé, the capital of the Maldives and one of the most densely populated places in the world.

More than 37,000 children (33.5 per cent of all those in the country) live in Malé. The remaining 66.5 per cent (73,850) of the country's children live in the atolls. These small, geographically remote island communities, 80 per cent of which have a population of 2,000 people or fewer, present a unique challenge: many atolls lack the schools, health care, local government and police services that are needed to ensure a safe and secure environment for children, especially those who are vulnerable.

Poverty and inequality

While 8 per cent of the Maldives' total population is income-poor (with almost a third within one or two points of the national poverty line), 28 per cent are multidimensionally poor, particularly in health (nutrition and access to health-care facilities) and living standards (safe drinking-water, sanitation and overcrowding). In five of the country's six regions, almost 50 per cent of the population is poor; 87 per cent of the country's poor people – 82,761 – live outside Malé. Poverty is greater in female-headed households on the atolls, in households with children younger than 17 years of age and in households with a disabled family member.

The highly congested urban neighbourhoods of Malé, the capital, are in many ways a different world to the atolls where community life centres around extended families practising traditional livelihoods such as fishing

or small-scale agriculture. In recent years, the social and cultural boundaries of island communities have been vastly expanded by new economic opportunities emerging from the tourist industry. This has led to more migration, new residential and consumption patterns, and other shifts such as improved education, health, and other public services. At the same time, however, there have been some negative reactions to this development and progress, possibly reflected in the increasing support for religious fundamentalism among some people, alongside more reasonable demands for greater regional autonomy and improved island access to essential services. The Government's decentralization agenda, intended to devolve some decision-making to local councils, may help to address the latter concern.

In 2014, overall school attendance (ages 5–17 years) was 94 per cent; however, only 71 per cent of children aged 17 years were in school. In addition, many children are already working by this age: 13 per cent of children aged 15 to 17 years and as many as 65 per cent of 17-year-olds.

Nationwide, nearly one third of children aged 17 years are out of school, a figure that is higher in the outer atolls, where 33 per cent of boys and 35 per cent of girls are out-of-school. This includes some of the most vulnerable girls and boys such as those in state care facilities and children with disabilities. Limited opportunities for skills development, quality education and employment have resulted in many young people neither in education, employment nor training.

Labour force participation among women has declined during recent decades; currently, 41 per cent of women aged 18–35 years are not in employment. The low female labour participation shows the need to promote technical and vocational training-focused engagements or other opportunities, including through public-private partnerships.

Structural characteristics and vulnerabilities

Economically, the Maldives has the unique features of a traditional ocean and island economy overlain by a sophisticated modern tourism industry. Many formal jobs are held by expatriates, with local employment low and, in the tourism sector, fixed by law at 51 per cent of the total. The largest employers of locals are the public and informal sectors, both of which are dominated by women employees.

The Maldives is an Islamic state, with one ethnicity. The country is small, both in area (298 square kilometres) and in population (531,000). COVID-19 – and increasingly, climate change – has highlighted the underlying vulnerabilities of the tourism-led economic model. This has occurred against the backdrop of a growing migrant population and widening inequalities and vulnerabilities, both in income and in access to essential services. To address these gaps, critical national policies have been developed and implemented.

The Maldives as a Small Island Developing State

To understand the national context for children and women in the Maldives, recognizing the vulnerabilities of the country as a SIDS is critical. The Maldives faces vulnerabilities including: a lack of macro policy buffers and limited fiscal instruments to mitigate global economic shocks; risks stemming from lack of inclusion, especially of youth and women, putting pressure on the labour market; environmental risks due to climate change and natural hazards; and risks associated with water resource management, food security and waste management.[11] The Maldives has multiple macro-economic features that limit its policy options in growth and development. This includes a narrow economic base with high dependency on tourism, substantial reliance on imported food, medicine and health equipment, and oil supplies for energy, limited local food production, and stress on available natural resources.

Challenges and opportunities

There is evidence that the COVID-19 pandemic is exacerbating the already significant ongoing inequalities in the Maldives.[12] Provision of basic essential services in all islands is relatively costly and inequalities across the atolls/regions, revealed by the Multidimensional Poverty Report 2020,[13] are unlikely to be addressed amid the current economic collapse, even with the commitment of external support. The pandemic has revealed limited use

and knowledge of innovation and technology by the public sector and a relatively modest financial investment in public goods.

The Government has embraced a degree of innovation in technology and e-government to ensure delivery of essential services during lockdown periods under the Public Health Emergency (PHE). According to a 2021 study by the World Bank, A Digital Dawn,[14] while more than 60 per cent of the population has access to the internet, most of these people live in Malé. The pandemic has highlighted the potential of new technologies for improving access to services such as health, education and others. However, according to the same report, the relatively high cost of internet access, limited digital literacy outside the capital and the inconsistent quality of internet services need to be overcome before the country can take full advantage of new technologies.

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CHAPTER 2

LEARNING AND DEVELOPMENT

In the Maldives, primary and secondary education is both free and compulsory. Before the pandemic, the country had reached almost 100 per cent net enrolment at primary and secondary level[15] (Education Statistics, 2019). Opportunities for higher education, including vocational and skills training, are being expanded. While significant barriers remain, it is important to acknowledge the recent progress that has been made in children's education rights by the Maldives.

Education for all

The new Education Act 24/2020, ratified in November 2020 and due to be implemented from August 2021, is an important step towards 'education for all'. The Act consolidates education service delivery, provides reforms to teacher registration and licensing of qualifications and establishes a school inspectorate. Authorities are urged to ensure that education embraces all vulnerable children, including children with disabilities and special education needs (SEN).

Current challenges include:

- Provision of equitable access to education, especially for children with SEN and children at risk
- Reducing the learning gap, enhancing teaching and leadership qualities
- Strengthening the administration of the education system
- Facilitating a learning environment to ensure the provision of holistic education
- Strengthening education governance
- Integrating vocational education into the school system.

COVID-19 and the education sector

In a country not unfamiliar with natural disasters or catastrophes, the COVID-19 pandemic is perhaps the most significant setback to children in memory: the direct and negative impacts on their education rights – schooling and learning, as well as health and well-being – will be felt by an entire generation.[16]

When the Maldives declared a PHE in March 2020, schools were closed for the mid-term holidays. An Education Sector Response Plan (ERP) was prepared, which recognized that some children would be at particular risk. For example, underperforming students risked becoming demotivated and dropping out during the school closure and children from poor and vulnerable families who depend on the school breakfast programme were affected.

Disengagement from school had social effects, including an apparent rise in criminality and exposure to abuse and exploitation. Young children may be ill-prepared to enter formal primary schooling, whilst many adolescents in upper secondary level from vulnerable and low-income families might lack the qualifications required to enter university programmes.

Parents and caregivers were tasked with becoming full-time educators, while also facing substantial new financial and other costs (including for remote learning, TVs and radio access, reliable power supply, sanitizing materials and clean water). This burden, previously borne by the government, was now partially or substantially borne by parents. This could result in parents becoming more substantive partners of educators, as children's learning is driven through digital learning or platforms.

The first schools to reopen, from July 2020, were those on islands free of COVID-19. In Greater Malé, schools began reopening from 4 October for Grades 9–12. The situation was reviewed every two weeks. Reopened schools operated on a reduced or adapted timetable, often by combining days on-site with remote learning. The ERP also focuses on ensuring learner and community safety, which requires 'safe schools' as well as 'safe homes', resulting in unprecedented investment and promotion of better water, sanitation and hygiene (WASH) in schools and homes to prevent the spread of COVID-19.

The need for modern learning spaces, libraries, technology, science laboratories, a stable energy supply and reliable internet access, among other things, is widely acknowledged. The pandemic has highlighted the urgency of improving the infrastructure of schools and other public facilities.

The impacts of COVID-19 and the PHE in education are apparent in the irrecoverable loss of study time, the

increased anxiety and stress of learners, teachers and parents in adapting to the demands of remote learning, truncated curricula and suspension of examinations. Children in vulnerable groups are most affected; this includes: students from other islands studying in Malé; children returning to their home island from Malé; children with disabilities that cannot be provided for remotely; children of disadvantaged families in locations with limited Internet access or regular radio and TV; and children of immigrant workers.

Challenges and opportunities

There are grounds for cautious optimism for the resumption of 'normal' school-based learning. Yet, the overall goal of the ERP – minimizing loss of learning whilst preventing COVID-19 in schools and local communities – remains challenging. Many expatriate educators have returned to their home countries, leaving island schools short-staffed and limiting professional services for children.

ICT and online learning

A positive development is the country-wide adoption of ICT in learning: learners, teachers, parents, administrators and public information institutions have undergone a crash course in using and strengthening online learning and teaching. The response to the pandemic has accelerated resilience and 'creative adaptation' in schooling, which could lead to enhanced education outcomes and new employment opportunities for young people in the digital economy.

Foundation and pre-primary education

The Maldives has made rapid progress in pre-primary (ages 3 to 5 years) enrolment rates.[17] In 2021, a total of 20,718 students were enrolled in 325 schools at the pre-primary level, with the vast majority enrolled in the correct year for their age.[18]

COVID-19 has put the 'school readiness' of young children at risk. School-readiness programmes are an essential component of the country's strategy to overcome the gaps – income, geographic, and more – that impact young children moving from pre-primary to primary schooling. The programmes are particularly important for children with disabilities. Home-based learning for this age group was provided by schools through parents using online learning methods and other forms of technology such as Viber and WhatsApp. Televised lessons were provided and data suggests that these were widely accessed.

Primary schooling

Primary school participation in the Maldives is universal. However, learning performance is a concern: assessments in 2016 showed literacy and numeracy gaps on all islands, including Malé, indicating a national challenge.[19,20] 'Serious remediation' was recommended at the primary school level, requiring enhanced teacher proficiencies. Learners aged 6–9 years are at a particularly vulnerable stage of cognitive and behavioural development and have

experienced the greatest impact of the shift to online learning. The impact on younger children – including curriculum changes, interactions with teachers, changing parental roles, English-language acquisition and more – remains to be fully assessed.

Quality of teaching and support for teachers

There is a shortage of qualified teachers and an absence of new entrants into the profession. Island schools run the risk of being understaffed and underserved, as new recruits must adapt to the national system and the demands of teaching during a pandemic, including adapting to remote and blended learning. This has made teaching of subjects such as Social Studies, Health and Physical Education and Creative Arts particularly challenging in all key stages. However, these are important subject that can inculcate key competencies envisaged in the national curriculum if taught adequately. Anxiety and stress amongst teachers, the ongoing pressures on household budgets from low salaries and increased costs of teaching online contribute to the difficulties of promoting education as a profession of choice.

Nationally, qualified expatriate teachers make up 24 per cent of all teachers (although recruitment has been impacted by travel restrictions). However, studies suggest that expatriate teachers are no better trained than their Maldivian counterparts.[21]

Pupil–teacher ratios in the Maldives are low.[22] Teachers in small schools often teach classes of multiple age ranges and teach various subjects simultaneously to learners of differing levels.[23] This limits their ability to provide age-appropriate and quality education, especially when required to teach subjects in which they have not been trained.

Education infrastructure

Many schools across the country need additional buildings/classrooms.[24] Some schools are required to offer pre-primary, primary and secondary education in the same buildings, with children attending at different times of the day. Around 20 per cent of schools need refurbishment of existing toilets or lack separate toilets for girls and boys. This is even more important during the COVID-19 health emergency.

Upper secondary schooling

Despite near universal enrolment in lower secondary level, overall enrolment decreases sharply in the upper

secondary level, with more girls than boys transitioning to upper secondary level. Fewer than 50 per cent of learners remain enrolled in upper secondary school and take one or both 'A' level exams.[25]

The low net enrolment rates at this level are particularly significant for males aged 16–18 years. However, female enrolment also decreases significantly at this age.[26] There is a stark difference between Malé and the islands in upper secondary participation, which is likely to be exacerbated by the impact of COVID-19. Children on the islands disadvantaged by their limited choices for upper secondary education will be directed towards the local job market, for which they are ill-prepared.

Alternative pathways to formal education

Learners who de-enrol from secondary school can access higher education via either the Secondary School Certificate Examination for Islamic Studies and Dhivehi or the HSSC examination. However, access and participation are difficult for many learners. A further disadvantage is that children receive one year less of schooling and may struggle to meet the demands of a university course.

An alternative approach is 'high-quality remote learning', which was not widely adopted before the pandemic. The Ministry of Education is currently in the process of determining the alternative pathways.

Technical and Vocational Education Training

Technical and Vocational Education Training (TVET) is delivered in- and out-of-school, mainly through the Maldives Polytechnic, Regional Youth Vocational Training Centres (RYVTCs) and other learning institutions. However,

few schools on the islands beyond Malé and the regional capitals have the teaching staff to provide these courses.

Enrolment rates in TVET have fallen steadily since 2016. Goal 2 of the Ministry of Education's (MOE's) Education Sector Plan 2019–2023 is to increase skills for youth and adults through an equitable expansion of TVET programmes; however, the response has been poor, with 560 students enrolled in 2018 and just 76 girls.[27] A government report concluded that RYVTCs had been 'tried and did not succeed' and suggested that the experience be examined to develop a more effective strategy.[28]

Youth employment

Youth unemployment is a serious and growing problem in the Maldives. In 2019, 26.6 per cent of 15–19-year-olds and 10.9 per cent of 20–24-year-olds who fall within the labour force were unemployed.[29] In 2016 (the last estimation), 23.5 per cent of youth were not in education, employment or training, the majority females aged 20–24 years.[30] Addressing youth unemployment, which is likely to be worsened by COVID-19, is a pressing social protection issue.

Violence against children and gender-based violence in schools

The Global School-based Student Health Survey 2014 found that one in four children aged 13–15 years is bullied in school.[31] To address the problem, the MOE and UNICEF developed an Anti-Bullying Policy as part of the Government's '100 Day Plan' aiming "to tackle bullying at its roots".[32] Launched in 2019, it aims to increase awareness of the problem and train counsellors to help affected students.

There is a dearth of qualified psychosocial professionals in the country. Moreover, schools lack the resources to recruit counsellors and teachers do not receive adequate training to deal with child protection issues, including mental health issues. Maldivian children are under pressure to achieve academically, negatively affecting their mental health. This stress comes from parents and teachers and is compounded by the minimal time allocated to extra-curricular activities and physical exercise programmes in schools.

CHAPTER 3

HEALTH AND WELL-BEING

Many infectious diseases have been eliminated in the Maldives. The country has the highest total health expenditure rate and social sector budget allocation in South Asia.[33] Since 2004, health expenditure has seen an annual average growth of almost 20 per cent.[34] Data show a rapid expansion of medical services since 2005. While there are both national and expatriate health-care professionals, the dependency on expatriates remains high, including over 70 per cent of doctors. This leads to high turnover of staff and continuous recruitment. Medical staff, from specialist doctors to nurses and health-care workers, are part of the Government health-care system, possess the necessary qualifications and are an integral part of the provision of primary health-care services on every island.

Health for all

The health system has four levels of service delivery: central, regional, atoll and island. The Malé hospital has a department for child growth monitoring. All regional/atoll level hospitals have obstetrics and gynaecology specialists and services, and a network of primary health centres is established in the islands. The government has a 'Health Master Plan 2016–2025', focusing on newborn health, congenital disability prevention and nutrition.[35]

The National Reproductive Maternal, New-born, Child and Adolescent Health Strategy and Action Plan 2020–2025 provides practical guidance for delivering child health and development interventions and addresses social, economic and geographical inequalities. Other policies are in place for sexual and reproductive health, mental health, immunization and non-communicable diseases. Vaccination of children is also included in the recently passed Child Right's Act (2019), giving it a legal standing. The Integrated National Nutrition Strategic Plan (2013–2017) has now ended, but the national nutrition programme and interventions are being implemented, focusing on malnutrition among children: 'the most critical public health concern' in the 2015 UNICEF Situation Analysis. Overweight and obesity as well as anaemia in children are emerging areas of concern, with nearly half of boys and girls having anaemia (according to the Demographic Health Survey [DHS], 2016–2017). Exclusive breastfeeding rates increased from 48 per cent in 2009 to 64 per cent in 2017 (DHS, 2016–2017).


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The Maldives has made limited progress towards achieving the diet-related non-communicable disease (NCD) targets and no progress towards achieving the obesity target. Around 51 per cent of children under 2 years of age receive the minimal accepted diet (DHS, 2016–2017), meaning that nearly half of all children do not receive an adequate diet for optimal growth. Qualitative assessments such as the Rapid Assessment on Infant Young Child Feeding (2018) have identified that a major contributing factor is poor responsive feeding skills among parents and caregivers. An estimated 11.4 per cent of adult women and 5.8 per cent of adult men live with obesity. The Maldives faces a 'double burden' for nutrition: high child malnutrition and high adult obesity. Diabetes is estimated to affect 10.7 per cent of women and 11.1 per cent of men, correlated with a high-sugar and saturated-fat diet, physical inactivity and smoking. These are lifestyle risk factors for NCDs, targeted in public health campaigns.

Early childhood development

The Maldives has made significant progress in early childhood development (ECD), including in early learning and vaccination. However, the country does not currently have an ECD policy. Interventions are provided separately by various sectors. There is no comprehensive parenting programme or mechanism to reach parents of young children. As the only sector routinely in contact with children under 3 years of age and their parents, the health sector could be instrumental in promoting ECD, positive parenting and nurturing care.[36]

All births take place in a health-care facility with a skilled birth attendant present. The Maldives has met its Global Nutrition Target for exclusive breastfeeding (64 per cent); data shows progress on under-age 5 stunting, underweight and wasting, though there is still a gap to reach the Sustainable Development Goal (SDG) targets.

Although there are gaps in the Maldives ECD programme for access to safe water and hand washing in homes, this is not highly correlated with infant or child mortality. There is evidence of unmet needs in ensuring that families are offered more effective maternal services, planning

for pregnancy and spacing and education about early stimulation, nurturing care, growth and development.

Integrated public health care

All citizens of the Maldives, irrespective of socioeconomic level, have access to public health care. While 8.2 per cent of the population is poor, the effects on children are mitigated by free health care and social protection grants for single mothers and children.[37] However, many households led by women home-based workers are vulnerable to broader socioeconomic health determinants.

There is an increasing focus on poverty within a broader spectrum of issues, such as urbanization, and on how children are impacted. While urban poverty is not fully documented in the Maldives, for those living in Malé and greater Malé – one of the world's most concentrated and unique urban communities – the norm is overcrowded and inadequate accommodation in low-cost and poorly planned flats, with multiple deprivations that increase the vulnerability of children. Children and youths in atoll cities, regional centres and small islands also experience day-to-day challenges.

Beyond medical services, children can be highly vulnerable in various dimensions of health and well-being. Accommodation, adequate space, power supply, TV or internet access, food and clean water for food preparation, drinking or hand washing can all create challenges in the physical and social environment of children.

COVID-19 and the health sector

COVID-19 exposed the health system to a new and unexpected threat, requiring significant redirection and repurposing of health and human resources[38] and resulting in massive unbudgeted expenses during a global economic recession and the collapse of international tourism. Non-essential health programmes were suspended during the lockdown, and their human and health resources reassigned to the PHE. From 15 April 2020, when the first community COVID-19 infection in the Maldives was confirmed, those with symptoms were required to quarantine, sites were identified for the isolation of infected patients, and regional hospitals were prepared for critically ill patients. All in- and outpatient childcare services were halted for the period, as were routine health care and antenatal care, newborn and child health services, and reproductive services. Health-care staff and clinics became 'frontline first responders' for COVID-19. Combined, this

led to disruption of routine child health services in the capital, including vaccination and growth monitoring and promotion services.

By mid-June 2020, it was evident that a longer-term strategy to respond to COVID-19 was required. The urgency of creating an inclusive, equitable and sustainable response in line with the country's public health approach became apparent. The crisis exposed weaknesses in the public health system and gaps in current policies and programmes that were evident pre-COVID-19. A fuller account of the health emergency in all its dimensions, the lessons learned, and its specific effects on children, mothers, and families, youth and disabled people should inform actions to remedy the setbacks of the past year.

Challenges and opportunities

Communicable diseases

Through public health campaigns, the Maldives has successfully eliminated malaria, leprosy, filariasis and rubella and reduced tuberculosis cases. However, Dengue fever, Zika virus and other illnesses that have likely become more common in the Maldives due to climate change, have not yet been targeted by public health campaigns. Further, influenza and new emerging diseases such as COVID-19 require ongoing efforts to ensure pandemic preparedness is in built into the health system.

The prevalence of HIV/AIDS in the Maldives is very low (since 2015, 23 HIV-positive cases have been reported). There have been no cases of mother-to-child HIV transmission since 2019.[39] However, the Maldives is still considered highly vulnerable to an HIV epidemic due to high-risk behaviours, such as drug use, among small numbers of vulnerable young people.[40] It is concerning that young people who have attended AIDS-awareness programmes at schools have a low level of comprehensive and accurate HIV/AIDS knowledge.[41]

Childhood immunization

The Maldives has implemented sustained public health programmes against epidemics and infectious diseases. The lessons learned have been vital in responding to COVID-19, and include the need for a clear national policy, sustained public awareness of the challenges through coordinated Risk Communication and Community Engagement (RCCE) planning, public participation regarding interventions and strategies, including vaccines, and a comprehensive advocacy and awareness programme.

Despite these successes, there has been a recent decline in vaccination coverage. Vaccine coverage reached a high of 93 per cent for all vaccines in 2009 but declined to 77 per cent in 2017 (DHS, 2016–2017). This is concerning because the rates may fall below the herd immunity threshold (the minimum percentage of people in the population who need to be vaccinated to ensure that a disease does not persist).[42] In 2016–2017, the DHS found, for example, that only 75 per cent of children received the second dose of a measles-containing vaccine, well below the herd immunity threshold of 92–94 per cent.[43] Subsequently, there was an outbreak of measles in early 2020, dispelling the optimism of 2017, when the Maldives was measles free. In 2016–2017, coverage of the DPT vaccine (diphtheria, polio and tetanus) was 85 per cent; if coverage declines further, herd immunity against diphtheria could also be lost.[44]

The decline in vaccine coverage could be due to multiple factors: concerns around the MMR vaccine and the supposed link with autism (based on a debunked study widely circulated on social media), and a rise in vaccine hesitancy in general. Social media propaganda by anti-vaxxers, both local and international, has been identified as a key threat. Efforts are being made to curtail misinformation/disinformation and strengthen and increase demand for vaccination. There have been a few cases where religious views have been cited as a reason for vaccine refusal – in these case, individuals are misinformed, or have their own interpretations where vaccination is occasionally viewed as counter to fundamental tenets of Islam. However, mainstream religious scholars have clarified that this is a misinterpretation.[45]

The review of the Expanded Immunization Programme (2019) identified several systems-related issues that could contribute to the decline in immunization rates, including cold chain and supply issues, and the lack of a functional health data system to monitor and track coverage. Limited human resources, capacity gaps including strong technical staff, and complacency were also noted as contributing

factors.[46] Vaccination rates vary according to location, with children in Malé more likely to be fully vaccinated than those elsewhere (83 per cent compared with 74 per cent).[47] As vaccines are free and accessible in every community, this could be due to lower demand and low compliance by parents. In 2019, with support from UNICEF, the Health Protection Agency finalised a public communication plan to strengthen confidence in immunization and immunization services.[48]

Non-communicable diseases

Child malnutrition

According to the WHO Global Nutrition Targets, by 2025 the Maldives should achieve:

- a 40 per cent reduction in the number of children under-5 who are stunted
- a 50 per cent reduction in anaemia in women of reproductive age
- a 30 per cent reduction in low birthweight
- no increase in childhood overweight
- an increased rate of exclusive breastfeeding in the first six months, to at least 50 per cent
- a reduction in childhood wasting to less than 5 per cent.[49]

For stunting, underweight and wasting, the indicative data of the DHS, 2016–2017 appears to show a recent overall improvement.

Birthweight

Low birthweight is an indicator of multifaceted health problems, including long-term maternal malnutrition and poor health care during pregnancy. The prevalence of low birthweight was 11 per cent in 2009, rising to 13 per cent in 2016–2017.

Childhood mortality

In 2019, infant mortality in the Maldives was estimated at 6.5 per 1,000 live births.[50] The improvement in infant

mortality rates is the most rapid in South Asia.[51] The under-five mortality rate decreased to 7.6 per 1,000 live births from 12 per 1000 in 2009.[52] Childhood mortality rates are consistently higher for boys than girls (1.22 male deaths for every female death in the under-fives in 2018).[53] The majority of under-five deaths are due to neonatal causes (70 per cent), followed by acute lower respiratory infections (11 per cent). Most neonatal deaths are caused by congenital anomalies (29 per cent), preterm birth (28 per cent), or birth asphyxia and birth trauma (25 per cent).[54] A low rate of diarrheal infections suggests that WASH and infant nutrition programmes are effective.

Neonatal mortality has not declined at the same rate as infant or child mortality and remains an area of concern. In 2014, neonatal deaths accounted for 63 per cent of infant deaths (under 1 year of age); 89 per cent of neonatal deaths occurred within the first week of life. The risk is higher for babies born to first-time mothers, very young or older mothers, babies born to mothers with more than three children, and babies born after a short birth interval (less than 24 months after the preceding birth).

Maternal nutrition and health

Mothers' nutritional and health status during pregnancy is a crucial factor in neonatal mortality, but also affects health well into childhood. For example, children may inherit anaemia from their mothers. In the DHS, 2016–2017, haemoglobin data for children aged 6 months to 5 years showed that half of the children were suffering from some degree of anaemia. Surprisingly, anaemia was associated with increasing household wealth. The reasons for this are unclear.

While there are many opportunities to provide information on nutrition during pregnancy and for infants and children – during antenatal care, routine growth monitoring, child health visits, and immunization sessions – information is often not given due to a lack of staff, insufficient staff training, time constraints, and a lack of privacy. Health Officers and Community Health Workers have low confidence and knowledge in providing counselling.

Healthy diet and lifestyle

Overweight and obesity are increasing, and there is a risk that past progress could be reversed. Adults are facing a double burden of underweight and over-nutrition. Children could soon face the same challenge: compounded with micronutrient deficiency, this could become a triple burden. The DHS, 2016–2017, found that 5 per cent of children under the age of 5 years were overweight. Amongst youth, the subjects of the WHO School-based Health Survey 2014, 15 per cent of students aged 13–17 years were overweight and 5 per cent were obese. Students in Malé were significantly more likely to be overweight than those in the atolls (19 per cent compared to 13 per cent).

One third of students (34 per cent) interviewed during the 2014 School-based Health Survey drank carbonated soft drinks at least once per day, and 14 per cent ate at a fast-food restaurant at least three days per week. Fast food consumption was higher in Malé than in the atolls. The Maldivian diet is high in saturated fats, salt and sugar, and low in vegetables and fruits. This increases the likelihood of developing hypertension, cancer, diabetes and obesity in adulthood. There is a need for public health policies that promote a healthy diet, instilling healthy eating habits in children.

Assessments indicate that there is little functional knowledge of food,[55] and a preference for convenience food alongside a reluctance to expend time, money and effort on healthy food. Health is often considered the responsibility of health-care facilities, with more demand for curative services than for public health. Some unhealthy foods are perceived as high-status (such as packaged food) and served on special occasions, and junk food is widely consumed. In addition, increasing urbanization and conflicting demands for public space in Malé are barriers to physical activity.

Tobacco, alcohol and drugs

Compared with other countries in South Asia, smoking rates in the Maldives are higher than average.[56] The Government has strengthened tobacco control measures, including a 40 per cent increase in taxes on tobacco products and a ban on the sale of tobacco in schools and health-care facilities.[57] New products such as e-cigarettes create new challenges for legislation, policy and regulation.[58]

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Despite being prohibited in the Maldives, there is evidence that alcohol consumption is an emerging problem.[59] Addressing and supporting behaviour change amongst adolescents and young people concerning alcohol or any other prohibited substances requires broad engagement, consensus-building among duty-bearers and rights-holders, and sensitive, cross-cultural, age-appropriate interventions.

Young people make up a high proportion of drug users in the Maldives. While low among those under 16 years of age, in 2018, young people aged 16–24 accounted for around a third (35 per cent, or 277 cases) of the total narcotic abuse cases reported.[60] The Ministry of Health acknowledges the problem of adolescent drug use, including that there are no specific services for those under 18 years of age,[61] and is exploring alternatives to drug treatment programmes.

Drug awareness programmes and life skills education are available in schools. However, in an attempt to limit the risk of indirect negative effects due to exposure to possible inappropriate content (as perceived by some parents), and the Ministry not having control over content and delivery, there are restrictions on external parties such as non-governmental organizations (NGOs) accessing schools to conduct these programmes. Parental and community disapproval of life skills education (linked to sexual and reproductive health) is reported, which may be a barrier to its delivery due to perceptions that awareness programmes contribute to a rise in drug use among children and encourage sexual behaviour at early age.

Mental health

There is limited research on mental health in the Maldives.[62] The mental health of children and young people is regarded as an area of emerging concern, and one that is linked with issues of substance abuse. In the Global School-based Health Survey undertaken in 2014, 19 per cent of students had made a plan for how they would attempt suicide and 13 per cent had seriously considered attempting suicide.[63] Sixteen per cent of students had felt lonely and 15 per cent were so worried that they could not sleep at night, most or all of the time during the previous 12 months. Girls were significantly more likely to report both of these issues than boys.[64] Another concern related to children's well-being in school is the very high level of pressure placed on Maldivian children to achieve academically, which negatively affects their mental health. Qualitative interviews revealed the source of the pressure comes from parents and teachers alike. It was reported that bullying is another issue that causes distress. Children are also affected by parental conflict and dysfunctional family environments.

The National Mental Health Strategic Plan 2016–2021 sets out the plan to attain an optimal mental health system. Three of the strategies relate directly to children and young people, namely promoting the mental well-being of vulnerable children, promoting mental well-being in schools, and promoting adolescent mental health.[65] The strategic plan has informed the National Mental Health Policy 2015–2025, the objectives of which are to provide adequate finance for mental health services; develop community-based mental health services integrated with general health services; prevent mental disorders and promote mental health; and prevent discrimination against people with mental disorders.[66]

Access to public health services, including mental health, is via medical diagnosis, which constitutes a significant barrier for marginalized and poor people. The Centre for Mental Health in Malé, established in 2019, is the referral centre for the country, while other counselling services are offered in the community, schools and NGOs.[67] The COVID-19 pandemic is generally acknowledged as exacerbating mental health concerns and issues for children and young people.

There is limited availability of mental health services. Overall, there is a dearth of mental health professionals in the country, with few registered professionals and few professional university programmes. There are no psychological or mental health services on most islands. While there is some mental health training at local institutions for counsellors, nurses and primary health-care workers who work with children, this is limited, with little practical emphasis. The State provides some financial assistance for chronic mental health problems in childhood, but there is currently little financial assistance for disability associated with chronic psychiatric disorders.

An urgent need for action is expressed by young people and there are calls from parents and young people for more mental health support. Young people have experienced unprecedented lockdown conditions, heightened poverty and deprivation, fear, anguish and feelings of hopelessness and helplessness. Children and youths in marginalized, vulnerable and poor households have experienced mental strain and feelings of loss, isolation and despair. Children with special needs and disability are at particular risk.

Sexual and reproductive health

The fertility rate in the Maldives has fallen in recent years.[68] The median age at first marriage has increased since 2009, from 19.0 years to 20.9 years. Age at first sexual intercourse increased from 19.6 in 2009 to 20.7 in 2016–2017. These trends are greater in Malé than more rural areas.

Pre-marital sexual activity is illegal and there are severe restrictions on access to contraception for unmarried youth.[69] Interviews with young men and women found a high level of social stigma attached to non-marital sex.[70] These social consequences were more concerning to young people than religious values or the risk of pregnancy or sexually transmitted infections. Young women face harsher criticism than young men.

Young people reported low levels of comprehensive knowledge about sexually transmitted infections, including HIV/AIDS (DHS, 2016–2017). Young women reported that male partners were reluctant to use condoms. While high in terms of the social consequences of being 'found out', the risk of unintended pregnancy was considered to be resolved through illegal abortions or 'the morning-after pill'.[71] Data and research on abortion are not readily available due to the sensitive nature of the topic.

Adolescent sexual and reproductive health is a component of the extra-curricular Life Skills Education programme for secondary schools. Policymakers, teachers, some parents and students recognise the value of Life Skills Education.[72] However, the programme is not implemented consistently across schools. A 2016 study by the Maldivian Human Rights Commission found that sexual and reproductive health are taboo within Maldivian society, leading to unwillingness or reluctance amongst children to discuss these topics with their parents or even health-care professionals.[73] A common concern was that teaching sexual and reproductive health would lead to a rise in non-marital sex.

CHAPTER 4

CHILDREN'S RIGHTS TO PROTECTION AND JUVENILE JUSTICE

Child protection policies in the Maldives are framed within a human rights approach and oriented to the guidelines of the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child. Fully realising rights for children, broadening a local constituency supportive of children's rights, and developing a sustainable, robust framework for the realisation of these rights across the child protection sector – and beyond – is an urgent challenge as the country recovers from the effects of the COVID-19 pandemic.

Violence against children

Child abuse, sexual abuse and trafficking, online exploitation, bullying in schools and neglect are critical protection issues for children. Unfortunately, the necessary data are often unavailable or out-of-date. The Maldives Child Protection Database, for example, is reported not to be 'fully operational'. In January 2021, the Ministry of Gender, Family and Social Services (MoGFSS) reported 124 cases (involving 80 girls and 44 boys) of violence against children (VAC), including 42 cases of sexual abuse, 15 cases of physical abuse, 4 of emotional abuse, and 46 cases of negligence.[74]

Children are also exposed to gender-based violence (GBV) and domestic violence (DV) in the home. In January 2021, the MoGFSS recorded 47 GBV/DV cases (involving 42 girls and 5 boys). The average monthly number of GBV/DV cases is 40. There is a correlation between VAC, GBV and poverty rates, which implies violence in the home is increasing as the country experiences the most severe economic depression of modern times due to the COVID-19 pandemic.

Maltreatment of children, whether through physical, sexual or emotional abuse or neglect, is detrimental to the physical, psychological and social aspects of a child's growth.[75] Exposure to violence or abuse in childhood increases the risk for delinquency, substance abuse and criminal behaviour in adulthood.[76] The Convention on the Rights of the Child strongly recommends that physical violence against children be prohibited in all settings, including the child's home.[77]

Growing awareness of the negative consequences of violence and abuse and national attention on social media may bring about an attitudinal shift towards the physical punishment of children. Sexual abuse of children, particularly by those in a position of authority, has been the subject of a recent Parliamentary Inquiry, which found multiple failures in how reported cases of sexual abuse of children were handled.[78]

As in other countries, online sexual abuse, particularly of girls, is a growing concern.[79] Online abuse of children has reportedly increased during the COVID-19 lockdown: the MoGFSS reported 16 cases of online cyberbullying between July 2020 and January 2021.

The MoGFSS did not receive any reports of child trafficking in 2017 or 2018, and only one case in 2019. Despite this, the US Department of State ranks the Maldives as a 'Tier 2 Watch List' country, as it does not fully meet the minimum standards for the elimination of trafficking.[80] Human Rights Watch reported that the Maldives was 'both a destination and a source country for women and children subjected to forced labour and sex trafficking.' Interviewees for the 2019 UNICEF Situation Analysis described an organised sex trade, with girls regularly being ferried to tourist islands.

According to the US State Department, the Maldives Government has made significant efforts to establish a 'working-level anti-trafficking unit within the Ministry of Economic Development'.[81] The Maldives Police Service trained 25 police and immigration officials during the reporting period on protecting children from 'child sex offenders, including child sex tourists.' It also undertook a 'child safe tourism' campaign directed at guesthouse and resort operators in two atolls during the reporting period.[82] An anti-trafficking hotline has been established in the Maldives.

One in four children aged 13–15 years are bullied in school.[83] To address this, the MOE and UNICEF developed an Anti-Bullying Policy as part of the Government's '100 Day Plan' which "aims to tackle bullying at its roots."[84] The policy, launched in February 2019, proposes initiatives to increase awareness of the problem and to train counsellors to help affected students.


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Children in conflict with the law

In the first six months of 2019, 155 children were apprehended for criminal behaviour; 95 per cent were boys. Most were aged 16–17 years when apprehended and 45 were aged 13 –15, including 2 girls. It was not possible to obtain data on how many of the children apprehended were charged with a criminal offence, how many cases proceeded to trial, or how many children were convicted.

Most criminal charges brought against children relate to drug offences, including possession and the sale/supply of drugs. It was estimated in 2016 that there were 7,500 drug users in Malé, most of whom were aged 15–24 years.[85] Youth involved in gangs are engaged in the sale and supply of drugs.

Criminal offending by boys is likely exacerbated by gang membership. A 2012 report noted the spread of gang culture in Malé, with 20–30 different gangs with 50–400 members in each,[86] many of whom were male youth. A widespread breakdown in family structures and the search for new ways of belonging was one reason given.[87] There is little reason to presume gang membership is any lower today.

Children in alternative care

There are two State alternative care institutions for children in the Maldives. As of March 2021, in line with the Government's new policy of placing children in smaller institutions, children have been relocated from these two central institutions to new state-run facilities on nine smaller islands. This introduces a new dynamic into small island communities, creating challenges that will need to be addressed. In January 2021, MoGFSS reported that there were 110 girls and 112 boys in State care.

Children in state care are often subjected to discrimination by community members. The limited human resource capacity at the homes also means that children do not receive the much-needed individual care and support. In addition, children face a number of challenges during and after they are reintegrated back into their families or communities, as neither the children nor the families and communities are well prepared for it, which often results in the child returning to the state care institution.

The existing foster care system is functional but slow – further assessments are needed to understand the bottlenecks and barriers that hinder efficiency. The new Child Rights Protection Act paves the way for establishing broader options for alternative care.

Other child protection issues

Growing religious conservatism

There is concern regarding increased religious conservatism and its implications for some of the cultural and human rights of women and children. Many young men (up to 200) have joined Islamic State and other extremist groups overseas. Young women have been widowed or separated from their husbands following years of conflict and are raising young children in dangerous situations. The Government has announced its intention to relocate Maldivian citizens back to their home country, within a transitional justice and community-based rehabilitation programme.[88] There are reported to be 64 mothers and children held in special camps overseas, many requiring documentation and birth registration as well access to other essential services.

Age of marriage

The legal minimum age of marriage is 18. Marriage is nearly universal in the Maldives, although women marry about four years earlier than men. The median age at first marriage is 20.9 years among women and 24.7 years among men. Twenty-one per cent of women and only 3 per cent of men aged 25–49 years married before their 18th birthday.

Child marriage

Under SDG 5.3, the Maldives has committed to eliminating child, early and forced marriage by 2030. Recent data suggests that child marriage is rare in the Maldives – there were no recorded marriages among 15–17-year-old children in 2017,[89] 16 in 2015 and 10 in 2016[90] – but anecdotal reports indicate that child marriages are carried out abroad or in private Islamic ceremonies.[91]

A recent report found general disapproval towards the practice of child marriage in the Maldives.[92] Most respondents were aware of the negative consequences of child marriage, such as difficult pregnancy, labour and delivery, increased school dropouts and decreased income.[93] Respondents also indicated they would likely report child marriage cases to the authorities.

Female genital mutilation

It is difficult to determine the extent of the practice of female genital mutilation (FGM) in the Maldives. According to the DHS 2016–2017, 13 per cent of Maldivian women aged 15–49 years have undergone the procedure.[94] The DHS revealed regional variation in prevalence, with a smaller proportion of women in the North Central region (10 per cent) than in the Southern region (15 per cent) having undergone FGM. The ratio of women who believed that their religion requires FGM and want the practice to continue was highest amongst women with no education (23 per cent and 13 per cent respectively) and lowest amongst those with secondary education (7 per cent and 6 per cent respectively). Promisingly, the prevalence differs significantly with age, with only 1 per cent of girls aged 0–14 and 15–19 years having undergone FGM, compared with 38 per cent of women aged 45–49.[95]

Birth registration

A child needs to have a birth certificate in the Maldives to access health care, education and social benefits.[96] Later, a birth certificate is needed to obtain a national identity card, which is required when applying for a passport, a bank account, a driving licence, or getting married.[97]

According to the Civil Registration and Vital Statistics in Asia and the Pacific,[98] the Maldives is on track to achieve its targets for 2024: 100 per cent of births are registered and 100 per cent of children under 5 years old have had their birth registered.[99] The DHS 2016–2017 showed that the percentage of children under 5 years of age whose births had been registered with civil authorities was 98.8 per cent in 2016–2017, though it was slightly lower for boys (98.5 per cent) than girls (99.1 per cent).[100] This has increased significantly from 93 per cent in 2009.[101]

The DHS 2016–2017 found that, in Malé, just 1.8 per cent of children did not have a birth certificate, compared with 10.2 per cent of children in the atolls.[102] This is likely related to the fact that some islands do not have registration points.

Concern has also been expressed about registering the births of non-citizen children in the Maldives. The Committee of the Rights of the Child has made clear that States must ensure universal birth registration for all children, irrespective of migration status or that of their parents and that any legal or practical barriers must be removed.[103]

Legislative reforms and access to a comprehensive child protection system

The passing of two landmark Acts signals a period of transformation for child protection in the Maldives to improve and coordinate a fragmented system.[104]

Child Rights Protection Act

The Child Rights Protection Act[105] lays the legal groundwork for the care and protection of children, including determining the responsibilities of duty-bearers, establishing intersectoral collaboration in child protection cases and stipulating the measures to be taken against those who fail to care for children. The Act also requires the government to establish a national-level Child Rights Council and independent Office of Child Ombudsperson.

The Act further provides for the establishment of a centrally located Child and Family Protection Service (CFPS). The duties of the CFPS include: safeguarding and promoting the interests of children in need of assistance and care; investigation; making arrangements for the provision of services; coordinating the treatment of children who are substance abusers; responsibility for foster care.

The 2019 Act establishes a National Framework for Providing Care and Protection to Children, which covers reporting, investigation, removal and alternative care options for

children in need of care and protection, social assistance and coordination of activities conducted by families, society, the State and private parties to protect children. Sanctions are established for those who neglect, harm or harass children. A social assistance system is established for guardians who are unable to provide reasonable protection or require assistance to raise their children.

A key component of the broader child protection system is the Community Social Groups (CSGs): multi-agency committees that include government and NGOs. CSGs play a vital role in protecting vulnerable groups, including children, as a first-line response mechanism to support child victims of violence, abuse, neglect and exploitation, critical in remote islands without the presence of social workers. Their role includes supporting vulnerable children and families, assisting in offering services to meet the needs of vulnerable children, including emergency protection support for child victims of violence, if necessary.[106] The government aims for at least 90 per cent of islands to have CSGs by 2023.[107]

The Act requires the CFPS to establish and run a free 24-hour child helpline to enable children in need of care and protection to seek information about their rights and file their case.[108] In 2017 UNICEF supported the MoGFSS and Maldives Police Service to establish a call centre for the helpline and develop a mobile application called 'Ahan', through which child abuse can be reported.[109] The Ahan app and call centre are both linked to the Maldives Child Protection Database to enable better information sharing.[110]

Juvenile Justice Act

The Juvenile Justice Act came into effect in November 2020. The Act establishes a new juvenile justice system, primarily, in line with the provisions of the Convention on the Rights of the Child. The principal aims of the new law are to safeguard children from the negative impact of being subjected to a punitive criminal justice system. Law enforcement personnel who work with children must receive special training. Children's procedural rights and human rights are guaranteed. The law promotes pre-trial diversion and only permits the detention of a child as a last resort. The Juvenile Justice Act also raised the minimum age of criminal responsibility to 15 years.

A Juvenile Court was established in Malé in 1997, with jurisdiction to adjudicate criminal offences committed by children. Outside Malé, jurisdiction over the less severe juvenile cases lies with the magistrates' courts. The Juvenile Justice Act requires that Juvenile Courts be established in all regions and run in a child-friendly manner.[111] Children who are above the minimum age of criminal responsibility and confess to the abuse of drugs will have their cases transferred to the Drug Court, which will evaluate the level of addiction and to determine the most appropriate treatment plan for the child. [112]

Under the Act, a risk assessment must be carried out to determine whether the child should be diverted or whether there should be an investigation and prosecution of the child.[113]

If the matter proceeds to trial, the Juvenile Justice Act 2019 contains procedural safeguards and assures the child legal representation. The Act requires that the judge consider the child's psychological, cognitive, physical, familial and social circumstances, needs of the community, and the victim's rights.[114] The Juvenile Justice Act explicitly prohibits the passing of a death sentence on minors.

The Act also addresses the criticisms of the conditions to which children are subjected in both police detention and prisons, including a lack of separation from adults, overcrowding, inadequate facilities and violence from both prison staff and other detainees, as well as sexual abuse.[115]

Challenges and opportunities

The Juvenile Justice Act is an opportunity to overhaul a much-criticised juvenile justice system and, if implemented, could stand as a model for other countries in the region. This requires physical infrastructure changes, training at all levels of the justice system and the implementation of a wide range of Regulations to be followed by the various actors within the juvenile justice system.[116]

The Child Rights Protection Act 19/2019 came into force on 20 February 2020. The Act's provisions address many of the criticisms of the child protection system, most of which relate to the lack of intersectoral coordination between actors in the system. The Act provides a comprehensive framework for child protection. The procedures to be followed, the standards to be applied, and the mechanisms for cross-agency and sector working have yet to be published. Once the new instruments have been published, there will need to be extensive training for all professionals, practitioners, NGOs and community groups working on child protection if the implementation is to be effective.

The political will to improve the child protection system is evidenced by the Child Rights Protection Act. However, key stakeholders note the need for the government to make child protection an explicit government priority. It will be a significant challenge for the government to implement the child protection provisions of the Child Rights Protection Act, not least because it will require a substantial financial commitment.

Another challenge for the MoGFSS has been recruiting and retaining an appropriately qualified workforce. The MoGFSS relies on caseworkers to undertake social work. There are no qualified or willing residents to take a job as a caseworker in some atolls and enticing caseworkers to remote atolls is difficult. Caseworkers frequently have to travel from the central atoll island to the outlying islands to assess and monitor cases, as the Ministry currently has a presence in only 20 out of 189 islands.[117] The civil service treats the posts as administrative posts rather than technical posts and, as a result, pays a lower salary, with no travel or living bonus.[118]

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Although the Ministry envisages a caseload for a caseworker of between 25–30 cases, the true caseload tends to be higher, up to 70–80, leading to frustration and burn out amongst caseworkers. With the low salary, this leads to a high turnover of caseworkers.

These challenges are compounded by the lack of data on violence against children and child protection. This is a barrier to the development of policy on child protection and the effective implementation of a functioning child protection system.

Under-reporting remains a challenge. There are several reasons for non-reporting, including fear of the consequences and a belief that service providers are unlikely to be sympathetic to their claims.[119] A commonly held perception is that it would be a 'betrayal' to file a report against a member of one's own family[120] and a view that what happens within a family is 'private'. Other reasons given by young victims include fear, a sense of shame, self-blame, and possibly breaking up the family.[121]

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CHAPTER 5
SOCIAL PROTECTION

A comprehensive social protection system is essential for reducing the vulnerability of the most deprived persons, including children, to social risks. Social protection systems can strengthen the capacity of families and carers to care for their children and overcome barriers to accessing essential services, such as health care and education, contributing to the reduction of inequality gaps. Social protection measures can also help cushion families from livelihood shocks, including unemployment, loss of a family member or a disaster. They can build resilience and productivity among the population.

Social protection systems are essential to ensuring children's rights to social security[122] and an adequate standard of living for their physical, mental, spiritual, moral and social development.[123]

Social protection includes a range of systems and programmes, which fall into three main categories:

1. Social insurance programmes: contributory schemes to provide security against risk, such as unemployment, illness, disability, etc.;
2. Social assistance programmes: non-contributory measures such as regular cash transfers targeting vulnerable groups, including persons living in poverty, persons with disabilities, the elderly or children;
3. Social care services, including child protection prevention and response services.

Legislation and social protection programmes

While the Maldives has eradicated extreme poverty, there are significant disparities in gender, region and age. Multidimensional poverty and income disparities are increasing.[124] Citizens look to the government to ensure that social services are equitably available and provided irrespective of their income level or social-economic status; however, these services alone cannot easily overcome these disparities. An adequate social protection system draws on the country's major social programmes to deliver equitable, quality, and affordable health, education, and financial services.

Two universal social insurance programmes apply to Maldivian citizens. First, the 2009 Maldives Pension Act introduced universal pensions for all citizens.[125] Although not directly relevant to children, pension payments relieve family members of supporting their elderly parents.

The second programme (Aasandha Programme) was created by the 2011 National Social Health Insurance Act, which provided a legal framework for universal health insurance coverage. Aasandha covers the cost of medicines and inpatient services in public health institutions. In 2017, health insurance expenditure was 9.03 per cent of GDP.[126]

Social protection and COVID-19

With the onset of COVID-19, social protection emerged as a vital component of public health emergencies. In 2020, the Maldives implemented three social protection measures in response to COVID-19: additional benefits for unemployed workers and dependents; subsidies to wages; and housing and essential service waivers/subsidies.[127]

In emergencies, social protection can widen access to essential services such as health, job and income security, combatting poverty, unemployment, and bringing stability to homes through measures covering costs of food, fuel and utilities, building community resilience and social cohesion. Social protection can stabilize household incomes and address the needs of vulnerable populations, including older persons, people with disabilities and chronic diseases, and informal workers not covered by statutory social protection. Income support through social assistance payments, cash transfers and other benefits is a critical component of the emergency response.

Challenges and opportunities

Large socioeconomic and welfare disparities persist, with over 90 per cent of poor Maldivians living in the atolls. Although the government has introduced universal health coverage and social assistance programmes to relieve poverty, there are weak links between the different programmes, with different ministries taking responsibility for various benefits and little communication between them.[128] Difficulties with compiling a single comprehensive register of people at risk have made it difficult to ensure effective coordination across the many government agencies and departments responsible for payment of various grants. There is an urgent need to develop more robust online data management systems to support a national system and allow local access to critical information on those most at risk.

The process of applying for social assistance is administratively difficult, expensive to run and only benefits certain groups. For instance, while a single parent is eligible

for the single parent allowance, a two-parent family, even if they live in poverty, is only eligible for a food subsidy.

To be effective, the social protection system needs a high degree of coordination between institutions, as well as effective decentralisation of services and staff to regional atoll centres. The COVID-19 pandemic has demonstrated the difficulties of managing by distance. Over the last year, it is these aspects – improved opportunities for remote working by officials, remote online access to key databases, and improved communications and networking to ensure rapid identification of extreme need or gaps in access to existing grants or services – that have emerged as critical constraints in the sector.

There is a growing consensus amongst policymakers and development practitioners that social assistance, in the form of regular cash transfers to families living in and vulnerable to poverty, should be a key component of a social protection system, as this would enable families to invest in children's well-being[129] without discrimination as to parentage or who the child is living with. Cash transfers can also protect children in vulnerable households from the devastating impacts of disease epidemics, natural disasters and economic shocks.

In mid-2020, the United Nations in the Maldives concluded: "The COVID-19 crisis has likely further exacerbated and exposed underlying systemic inequities, new inequities particular to vulnerable groups, and potentially undermining social cohesion." The same report noted that the county is witnessing the coming together of pre-existing vulnerable groups – women, children, youth, elderly, migrants and people with disabilities – into a more visible social category of 'the permanent poor'. If this is so, it calls into question the current approaches, the recent performance by key duty-bearers, and the adequacy of the available measures. There is an urgent need to better define appropriate social protection packages for the most vulnerable groups impacted by COVID-19.

UNICEF is currently exploring universal child benefit as a foundation for establishing universal social protection systems and as a step-change in promoting child outcomes and achieving the SDGs.[130] The Maldives does not include a universal child benefit in its social insurance scheme at present, though it does have some social assistance benefits that are directly related to children.

CHAPTER 6
CLIMATE CHANGE

Few countries are confronted so directly and with such urgency as the Maldives with the immediate and long-term challenges of climate change. The country's unique geography and physical features place it at high risk of natural hazards exacerbated by climate change.[131] The World Bank Climate Knowledge Portal reports that the average annual natural hazard occurrence is: floods (33 per cent); epidemics (33 per cent); earthquakes (and tsunamis) (16.7 per cent); and storms (16.7 per cent). Four-fifths of these events are directly related to climate.[132]

Global warming is expected to have an accelerated impact on local water and air temperatures. This will negatively impact people's health and mental well-being, as well as the country's biodiversity, rainfall, and water security. Climate vulnerability, including potable water insecurity, is an immediate health risk in the atolls, which depend on emergency water supplies to the affected islands at certain times of the year; island communities currently do not have the Integrated Water Resource Management (IWRM) system in place, in which harvested rainwater and desalinated water is stored and piped to households.

Extreme climate events impact the health and mental health of children and adults, and impact children's learning as schools close during severe weather events. During the hot season children report having skin rashes and being unable to concentrate on their studies due to the intense heat. Coastal erosion is exacerbated by climate change and children have noted that losing their beaches to the sea is a huge, irreplaceable loss.[133]

Extreme climate events, such as heat waves, storms, floods and drought, are significant threats. Eighty per cent of Maldivians live on a narrow strip of land within 100 metres of the sea and one metre above sea level on average. Island homes and public infrastructure are vulnerable to climate-linked change associated with higher tidal surges, flooding and more intense and frequent tropical storms. Critical infrastructure, including schools, is not designed to accommodate the effects of a changing climate, hindering children from fully enjoying their full rights.

Climate change is likely to exacerbate some of the systemic inequalities across regions in the Maldives.[134] Small size and geographical dispersion increase exposure to natural hazards, as seen during the 2004 tsunami. In addition, the speed of biodiversity and marine nature loss due to rising water temperatures and the loss of coral reefs has implications for food security and threaten both sustainable livelihoods of islanders and tourism.

Policy and legislation

The seriousness of climate change in the Maldives was highlighted by the 12 February 2020 declaration by the People's Majlis of the national climate emergency and

the Climate Emergency Act that followed (May 2021). The impact of environmental and climate change in the Maldives has immensely complicated the primary health care (PHC) aspects of children's health and well-being. Since the 1980s, the Maldives has actively encouraged the international community to rally around the climate change agenda, notably through its membership of SIDS, Alliance of Small Island States (AOSIS), and Forum of Small States (FOSS).

The current administration has set several goals and targets, including the decision to engage young people in the national and global climate change agenda, and pledges to reach net zero emissions by 2030 and to go zero-single-use-plastic-waste by 2023. The Maldives is a member of the International Renewable Energy Agency, an intergovernmental organization that supports countries in their transition to a sustainable energy future.

A significant component of the Climate Emergency Act stresses the positive engagement of communities, especially young people, to adopt low-carbon lifestyles to help strengthen overall national climate resilience. Together with key climate-proofing and adaptation infrastructure, behaviour and social change would ensure that the country builds its adaptive capacity to address exacerbated climate risks. However, the latter has not been adequately addressed by community engagement programmes, largely leaving the future of climate resilience currently relying on infrastructure alone. The Nationally Determined Contributions (NDCs)[135] of the Maldives, as the national plans for climate action under the Paris Declaration focus more on infrastructure and less on changing lifestyles to achieve climate resilience.

Climate change and COVID-19

The country is currently in the grip of two natural crises – COVID-19 and climate change – that are putting new and unprecedented pressures on the national system and the natural environment. Since the 2004 Indian Ocean tsunami disaster, emergency preparedness and planning in the Maldives has been rigorous. However, during the uncertainty of the pandemic, the government is poised between emergency and recovery, with lockdowns to contain the spread of COVID-19 interspersed with periods of limited opening to support social and economic activity.

While many experts predict that the impact from COVID-19 will be temporary – with global growth anticipated to recover by 2023 – the impact from climate change on people and natural resources is permanent. Unless an alternative development model that incorporates climate, change adaptation is pursued, the lost development associated with the COVID-19 pandemic may be irreversible.

ANNEX 1

INPUTS FROM STAKEHOLDER CONSULTATIONS

Education, learning and employability

- Education Act, 2020: a singular moment to ensure every child's right to education.
- Skills development, including vocational skills for school children and out-of-school children, needs to be strengthened with additional capacities and financial resources. Increased support needs to be provided to successfully implement the competency-based curriculum to equip students with 21st century skills for life and work.
- Quality of education across all levels and across the country needs to be improved for better learning outcomes.
- Transition from Grades 10 to 11 is the most critical challenge, mainly due to limited access to upper secondary education in the atolls.
- Teacher training and learning resources need to be updated to enhance the quality of teaching and inclusion.
- Inclusion in schools needs to be strengthened through provision of disability-inclusive facilities and teaching and learning materials, and promotion of inclusive attitudes and behaviours.
- Many of the country's schools need additional resources for climate resilient infrastructure, including appropriate WASH facilities.
- Youth employability (16–25 years) was a critical challenge, a 'serious and growing problem', even before COVID-19. This problem is likely to be exacerbated by the economic impact of COVID-19.

Health and well-being

- Access to basic health care is available throughout the country, though quality of services differs.
- There is high demand for curative services. Inclusive public health (delivered through PHC platforms) is a key driver to increase health equity and ensure outcomes for all.
- COVID-19 has revealed gaps in the current PHC delivery model, especially at the island level, in monitoring and the referral system. There is significant potential for integrated digital health within the health system service delivery.
- Immunization and maintaining high vaccination rates require heightened efforts, backed by stronger data and information systems, monitoring and supportive supervision. There is a significant need to strengthen the immunization programme capacity and cold chain system.
- There are emerging issues related to health care in urban settings. These challenges to child health need to be co-prioritized. At the same time, quality of health services in island settings needs to be considered
- ECD requires support through improved family/maternal services, including mental health.
- The neonatal mortality rate is a concern and may require a unique initiative.
- Nutrition and healthy lifestyles may require a broader, systems level approach beyond health. Coordination and implementation of health promotion programmes is currently limited, with no systematic approach, and is therefore inadequate.
- Sexual and reproductive health requires professional attention – the focus should be expanded to include families and parenting.
- Youth and adolescent health services – in and out of school – are a key gap. There is limited engagement with adolescents or young people on their health needs by the health sector. The services are general, and young people are not accessing them frequently. The coordination between different sectors is also weak, and programmes are fragmented.

Child Protection and Juvenile Justice

Violence against children:

- The Child Rights Protection Act (CRPA) was enacted in 2019, paving the way to safeguard the rights of all children across the country.
- Regulations and policies need to be developed and strengthened to implement the vision of the CRPA.
- Cross-sectoral collaboration is necessary to implement the key policies that are already in place and improve results for children.
- Capacity and coordination across all social service actors need to be strengthened to ensure quality of service provision.
- Understanding the scope and scale of the issue of sexual violence in the country is difficult due to geographical, human and financial resource challenges in conducting research.
- Different manifestations of violence: new and emerging forms of violence against (and amongst) children, such as grooming for sexual abuse and online bullying, need to be identified and addressed.
- Tracking patterns throughout the course of the pandemic is crucial to analyse whether existing mechanisms and channels for reporting and response are adequate.

Children and drugs:

- Primary prevention and early intervention for drug abuse need to be strengthened to prevent children from coming into contact with the law.
- Drug-related crimes, including use, possession, peddling and trafficking, are amongst the most commonly committed type of crimes amongst children in conflict with the law.
- Involvement of children in drugs with gangs is a particular area of concern that needs to be addressed.
- Strengthening the Life Skills programme in schools is an important intervention for prevention of drug abuse and risky behaviours.
- Counselling and mental health support services for children need to be strengthened.
- Drug treatment and rehabilitation for adolescents is not available.

Children in conflict with the law:

- The Juvenile Justice Act was enacted in 2019 with a vision to deter children from the criminal justice system. Supporting regulations and policies need to be developed and strengthened to ensure implementation of the Act.
- Cross-sectoral collaboration is a major challenge, with many agencies having a role to play in ensuring that the new legislation is effectively implemented.
- Diversion, rehabilitation and reintegration programmes need to be developed.
- Alternative sentencing options need to be developed.
- Capacity-building and training of juvenile justice officers, police officers, probation officers and correctional officers are necessary for the delivery of programmes.
- New facilities are not available.

Children in alternative care:

- Government has developed a new approach to children and adolescents in institutional care, including decentralization and de-institutionalization.
- The test of the new policy is improvement in the quality of care in government institutions, with a single oversight mechanism and uniform standards.
- The approach needs to be translated into a policy level strategy for standardized procedures in ensuring the protection of children who are under State care.
- Girls and boys in alternative care in the Maldives are among the most vulnerable; addressing their needs and ensuring their rights are key components of any strategy.
- This area requires specific skills and expertise and a dedicated approach that is multisectoral and coordinated.
- Children under State care often face discrimination and stigmatization from staff and the general public and have limited contact with siblings and family.
- The lack of individual care plans or no long-term solutions/plans for the children is a major challenge in ensuring the well-being of children under State care.
- Standard operating procedures exist but are not used and often considered not user-friendly and appropriate.
- Monitoring of shelters is a challenge, which is expected to be exacerbated with decentralization.
- Children are very often moved between facilities without prior notice or preparation and their views are often not heard at the decision-making level.
- Limited capacity of staff at the institutions is a challenge.
- Decentralization policy and practice will need to be assessed for impact on children and host communities.

The Child Protection sector is 'under construction' and there are key gaps:

1. Limited human resources/technical capacity.
2. Weak engagement with youth and adolescents.
3. Limited and weak services for victims/survivors of VAC, GBV and DV.
4. Lack of coordination mechanisms and collaboration between sectors.
5. Lack of a long-term vision and plan for the sector, particularly for key areas of protection.
6. Limited and lack of systematic data collection, analysis and use.
7. Commissioned studies in key areas are required.

There are four key areas for systems strengthening in the sector:

1. Capacity-building of the social service workforce, including social workers, health workers, teachers, police officers, etc.
2. Engaging communities (through community social groups for parenting programmes, awareness programmes for violence prevention, prevention of juvenile crimes, diversion programmes and child rights awareness, drug abuse prevention/treatment/rehabilitation/reintegration programmes).
3. Strengthening the legal frameworks and their roll-out for reporting, referral and monitoring, including drafting legislation, regulations, policies and SOPs, strengthening Maldives Child Protection Database, call

centres/child helplines, coordination, and monitoring and evaluation.

4. Expanding and strengthening partnerships with civil society organizations and the private sector.

Social protection

- Increasing the role of local councils to better identify vulnerable populations and those who are eligible for social protection.
- Establish a mechanism for data integration: an integrated, comprehensive single registry that can be grouped by different schemes such as People with Disabilities and other vulnerable groups, to assist in verifying eligibility.
- Establish a graduation mechanism: empower vulnerable groups and decrease their dependency on schemes.
- Targeted mechanisms to ensure reach and increase accessibility.
- To ease the application process involves a collective effort.

Climate change

- Work with adolescents and young people from across the country on climate change education to build their capacity to promote and engage in climate action in their communities.
- Continue advocating with the Government, civil society and the private sector to position adolescents as agents of change who can be pivotal in achieving national climate change-related goals, including adopting green-lifestyles.
- Build strategic partnerships with the private sector to work with island communities, especially adolescents and young people to implement climate action projects at the island-level.
- Engage with the Government to revise the NDCs to incorporate behaviour and social change to achieve national goals to build climate resilience.
- Continue to support the incorporation of climate change and disaster risk reduction into key sectors such as education, health, social protection and child protection.

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