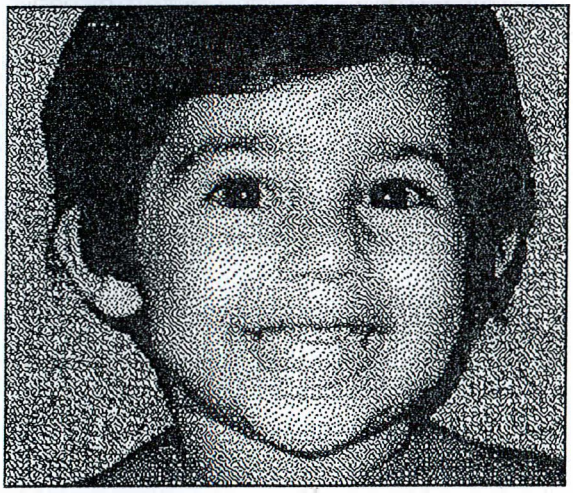
THE CHILD IN MALDIVES
- A DECADAL REVIEW



GOVERNMENT OF MALDIVES

1989

The Child In Maldives
- A Decadal Review

The Maldivian child is born into a natural environment that is at once supportive and fragile. Situated between the latitude 7° 6' 30" N to 0° 41' 48"S and longitude 72° 31' 30" E to 73° 45' 54" E, the 200 islands that are presently inhabited, are, like the other 1200 or so, sparsely endowed, yet surrounded by one of the finest marine eco-systems anywhere. Male' is the capital city and supports nearly 25 percent of the 200,000 (1988 mid year estimate) population of the Maldives. The rest of the 199 islands are grouped under 19 administrative atolls and 4 regions.

Over the past decade, the country has achieved a steady rate of economic and social development. The GDP has increased at an average annual rate of 10 percent. Inspite of the global economic debt crisis, and the pressures of internal financial adjustments to support the rapid pace of infrastructure development, the Maldives has been successful in maintaining a steady increase in the financial allocations for the social sector.

"Children First", has always been the fundamental developmental principle in the Maldives. The present report, is a review of the status of children, specially in the field of education and health, in the Maldives.

NATIONAL INITIATIVE

In response to the proclamation of 1979 as the Year of the Child, as a lead in from the 1978 Alma Ata Conference on Primary Health care leading to Health For All By The Year 2000 and the global understanding that the next decade should focus on the survival, growth and development of the child and that children should form the central point of the overall development process, the Maldives embarked upon an ambitious development plan.

The concern of the status and the well being of the child had the endorsement and political commitment at the highest levels in the Government. His Excellency, President Maumoon Abdul Gayoom, in many National and International fora, including the UN and SAARC, has given a strong support to the philosophy of "Children First".

To implement the government commitment, a special commission was setup in 1979. The commission, was based in the Ministry Of Education.

The success of the commission is reflected by the fact that within a year of its formation, the recommendations were incorporated in the sectoral plans, as a part of the overall development plan. Children, thus became priority for each and every sector of the government.

Two critical areas were identified as the priority areas for action - Health and Nutrition of children and children's Education.

DECADAL PROGRESS REVIEW

1. Health and Nutrition:

Emphasis during the decade was on ensuring and enhancing child survival, growth and development. Targets set up for the decade were achieved ahead of time and had to be revised during the first five years of implementation. These revised targets were in line with those established for the Health For All By The Year 2000. Some of the achievements of the decade in the field of Health and Nutrition are listed below.

1.1 Universal Child Immunization

Maldives was successful in achieving universal child immunization in 1989- a full year ahead of schedule. As a result of sustained coverage, the Maldives has been Polio free since 1981. No cases of other EPI diseases also, have been reported from the country in the last three years. With over 80 percent coverage with tetanus toxoid immunization in women 15 - 44 years of age, the stage is now set for the elimination of neo-natal tetanus by the year 1995. Due to the geographical layout of the country, EPI diseases are not endemic in the Maldives, but occur as epidemics due to importation of an active case from the neighboring countries. It is therefore difficult to estimate the annual reduction of cases and deaths due to EPI diseases.

1.2 Infant and Child Mortality Rates

The Alma Ata Conference laid out the goals of reducing the infant mortality rate to less than 60 per thousand live births and the under five year mortality rate to less than 90 per thousand live births by the year 2000. Later, a new challenge was placed before the nations of the world, to reduce by half the IMR and U5MR of 1980, or achieve the Alma Ata levels, which ever were less. The Maldives responded to both the challenges and has succeeded in bring down its IMR from 110 in 1980 to less than 50/1000 live births in

1988 and its U5MR from over 166/1000 live births to less than 70/1000 live births in 1988 - a full 12 years ahead of schedule. The decline in these two rates is further continuing.

1.3 Management and Control of Diarrhoea

The successful implementation of diarrhoea management programme through the use of Oral Rehydration Therapy (ORT) has led to the reduction of diarrhoea case fatality rate from 9 percent in 1984 to 3 percent in 1987 - an annual average reduction rate of 27.9 percent. It is important to note that during the period of review, the Maldives faced an epidemic of diarrhoea and still the case fatality rate continued to decline. This reflects on the success of the oral rehydration therapy in the Maldives. A recent international review assessed that access to ORS in the country was 100 percent. Over 80 percent mothers knew how to prepare the solution, and of these, over 40 percent actually prepared the solution correctly under observation. These rates, to the best of our knowledge, are one of the highest in South Asia.

The coral structure of our islands and the small ground water aquifer, which is an easy prey to ground pollution, is one of the major causes of diarrhoea in the country. To reduce the incidence of diarrhoea, safe water supply and sanitation schemes were given high priority in the development plan. By 1988, over 90 percent of the households in Male' had access to safe drinking water and facilities for the safe disposal of human waste. In the atolls, over 40 percent of the population now has access to safe drinking water through rain water catchment tanks and nearly 15 percent to facilities for safe disposal of human wastes. The long distances between the islands and the lack of suitable/acceptable designs for the safe disposal of human waste, have been the main limiting factors. However, efforts to overcome these have already been initiated.

1.4 Breast Feeding

Breast feeding is universal in the Maldives, breast milk being introduced to the child within the first two to three hours. The effectiveness of this is reflected in the growth pattern of the Maldivian children discussed later in the text.

1.5 Child Nutrition and Growth

The staple diet in the Maldives is fish and rice. Fish is abundantly available to the population from the rich seas and rice is imported by the government and made available at a controlled price. Except during the Second World War period in the 1940's, the Maldives has not faced any period of famine, starvation or hunger. The analysis of the height of over 1000 maldivian women between the age of 20 years and above confirms this impression. Basic food availability has therefore not been a critical determinant of the nutrition and growth of the Maldivian children.

An analysis of growth chart data of over 4000 Maldivian children (equal number of boys and girls) shows that on an average, a Maldivian child is born at about 80 percent of the International standard for weight (Harvard 50th percentile). As a result of universal breast feeding, discussed earlier, the child rapidly gains weight and reaches almost international weight for age standards by three months. Weaning is usually introduced at about 4 months of age and this coincides with growth faltering of children. The still limited availability of safe water to some island population, the unhygienic preparation of weaning foods and the low level of awareness regarding frequency, duration and quality of weaning foods could be the causes of this faltering. The growth continues to falter till about 18 months of age after which it stabilizes, although at a lower level. This analysis has now given us the direction for our future programme implementation in the field of growth promotion. This computerized analysis is, we believe, first of it's kind taken at such a scale in the developing world. (See Fig. 1).

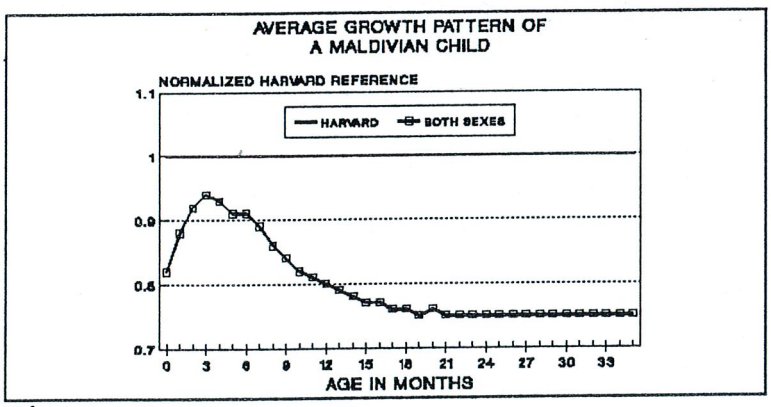


Figure 1

The same analysis also indicates that family size has no effect on the growth of the child, confirming the observation made earlier, that basic food availability (ensured by the government) is not determinant of growth in the Maldives.

1.6 Creating a Sustainable Health Infrastructure

The need to enhance survival, growth and development, to eliminate disparity between various parts of the country and the need to immunize all children in the country, led to the development of a sustainable infrastructure in the country. What seemed to some as monofocal approach to health became the basis of development of a sustainable infrastructure in the country.

The four tiered health care delivery system starting at the Central Hospital Male' and decentralized to four regional hospitals, 23 community health centers at the atoll level and 212 health posts at the island level, provides preventive, promotive and curative care to the country's 200,000 population. This is complemented by preventive, promotive and supervisory based mobile team services of the Department of Public Health of the Ministry of Health and Welfare. In the national spirit of self reliance, increasingly every year, operational costs of these activities are being absorbed in the regular government health budget.

2. Child Education

The Maldives has been successful in achieving universal literacy and universal school enrolment as a result of conscious government efforts initiated in the early 1980's. During the decade, school enrolment has increased four fold. Every island in the country has at least one traditional or formal primary school. Efforts to universalize primary education have resulted in the construction of over 47 schools and training of 1009 teachers during the decade. The government has laid down the objective of achieving universal primary education in the country by 1995. Efforts are under way to ensure that every child in the country completes at least primary education by 1995, while facilities for middle and secondary schools are being developed in a decentralized fashion. To ensure relevance of the curriculum to the Maldivian context, unified national curriculum has been introduced in the country.

2.1 Access And Equity

The Maldivian children enjoy a high level of access to primary education with a gross enrolment ratio of nearly 96%. Beyond the primary level, gross enrolment ratios fall rapidly to around 34% and 9% at the middle and secondary levels, respectively. Unlike the situation in many neighboring countries, females have long enjoyed equal access to education in the Maldives. Current enrolment data confirm the situation. In the pre-primary grades, girls comprise nearly 52% of enrolment; in primary and middle schools, the rates are around 49%.

The trend of the past decade, which has seen an explosion in educational opportunity, explains the predicament of the atolls. There has been great quantitative growth but there is a looming qualitative problem.

Intake capacity at the primary school level is being expanded as a part of the programme of universalization of education up to Grade 5 level. Universal Primary Education will be achieved by 1995.

2.2 Quality Improvement of Primary Education

The present enrolment ratio is estimated at close to 100 percent in Male', while it stands 75 percent in the atolls, giving a combined enrolment ratio of 86.4 per cent. With the expansion of primary education in the atolls there has been significant improvement in the enrolment ratios. As the country approaches the target of universalization, the disparity between Male' and the Atolls may be reducing, but in terms of quality the gap is still large. Efforts, therefore are taken to achieve the qualitative breakthrough required in the atoll education.

The growth of enrolment in government schools in the atolls - from 59 students when the first school opened in 1978 to nearly 37,298 in 1988 - testifies to the level of commitment demonstrated by the Government of Maldives extending the benefits of the education system from Male' to the rest of the nation.

The educational system in the Maldives which has achieved not only quantitative improvements, is now widely recognized as having greatly contributed to narrowing the disparities in educational opportunities between Male' and the Atolls. During the past decade education at the primary level has received government attention and is recognized as a basic right of every child in the country. There has been impressive growth in quantitative terms at all levels of education in the Maldives during the past decade.

In response to the basic needs and demands of the community, and to help create a vital and self-reliant society prepared for future growth, the government launched a nation-wide programme for the modernization of the system which includes upgrading and the construction of educational facilities as well as changes in the curricula and teaching methods. Under this new programme, education was further improved, thanks to the Maldivian national character of placing high value on education, as well as to the improved level of people's income caused by high-level economic growth.

During the last 10 years, substantial progress has been made, with improvement of educational facilities in the Atolls, the establishment of several atoll schools and upgrading of school facilities, as well as provision of trained teachers.

Meanwhile, it can be anticipated that, in the coming years as we move into the 21st century, rapid social changes such as the advancement of science and technology and the progress of information technology will continue. Further, the improved level of people's living, has led to an increase in people's demand for educational and cultural opportunities, especially for diverse opportunities for education throughout life.

3. The Girl Child

The girl child in the Maldives has an equal opportunity for survival, growth and development, as her male counterpart. She has equal access to the family pot, education and health care and parental affection. This is supported by the facts that mortality rates for females in the Maldives have been consistently lower than that for males, till the age of 15 years - the target group of this discussion (See Fig.2). The analysis of the growth charts also shows no gender differences in growth patterns between the two sexes, health care and parental attention. School enrolment of girls is at par with those for boys, indicating equal access to education.

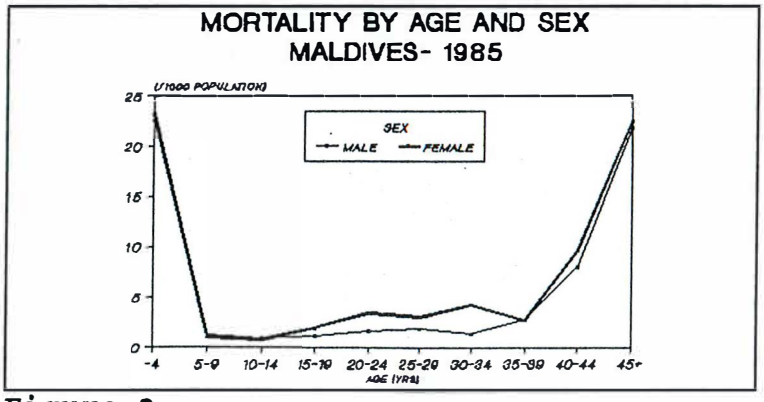


Figure 2

4. The Rights Of The Child

The constitution of the Maldives protects the rights of the child. It grants every person freedom of speech and expression within the provisions of the Islamic Shariath law. It considers education and health as the basic fundamental right of every child. Freedom to acquire knowledge and to impart it to others,is also guaranteed. The penal code of the Maldives maintains the presumption that a child below ten years is not capable of committing a crime. However, where a child between the age of 10 and 16 is accused of a crime, the courts are required to show leniency giving due consideration to the age. The Maldives has also enacted laws in 1978 for the registration of births and deaths and issue of the certificates.

The Maldives has been a strong supporter of the draft International Convention on the Rights of the Child, and has made its support clear in many international fora, including the SAARC.

5. Adjustment with Human Face in Context of the Child

The government has put the development of social sector, including health and education, as central to national development plan. This commitment has been reflected in the resource allocations for the social sector over the years. During the decade, the resource allocation to social sector has increased multifold. Table 1 gives the comparative expenditures on Health and Education in 1978 and 1988.

TABLE 1
COMPARISON OF ANNUAL EXPENDITURES ON HEALTH AND EDUCATION SECTORS
1978 AND 1988
REPUBLIC OF MALDIVES
(in million MRF)

EXPENDITURE	1978	%OF TOTAL	1988	%OF TOTAL
TOTAL	34.232	100.0	426.8	100.0
EDUCATION	2.415	7.1	45.2	10.6
HEALTH	2.415	7.1	58.7	13.8

TABLE 2

INDICATORS FOR THE DECADE OF THE CHILD

INDICATOR	1978	1987/88
IMR (/1000 LIVE BIRTHS)	120	49
U5MR(/1000 LIVE BIRTHS)	166	70
DIARRHOEA CASE FATALITY RATE (PERCENT)	9*	3
ACCESS TO ORS (PERCENT)	<25	100
ORS USAGE (PERCENT)	15	80
POLIO CASES@ (PERCENT)	NA	0
PERTUSSIS CASES@(PERCENT)	NA	0
IMMUNIZATION COVERAGE@ (PERCENT)		
BCG	-	99
DPT	-	85
OPV	-	85
MEASLES	-	80
TT (15-44)	-	80
SCHOOL ENROLMENT (PERCENT)	23	86
LITERACY (PERCENT)	70	94
PREVALENCE OF LOW BIRTH WEIGHT (PERCENT)	25**	<20

* FIGURES ARE FOR 1983

** 1981 FIGURES FOR MALE' ONLY. 1987 FIGURES ARE FOR THE ATOLLS.

@ EPI IN THE MALDIVES WAS LAUNCHED IN 1978. FIGURES FOR COVERAGE AND DISEASES IN 1978 IS THEREFORE NOT AVAILABLE.

FUTURE COURSE OF ACTION

The Government reaffirms its commitment to the philosophy of children first and to continue to make social development central to the overall national development process. As a result of internal, indepth decadal review undertaken, the following objectives have been laid out in the field of health and nutrition, and education.

Health and Nutrition

OBJECTIVES

By the end of 1995

1. Reduce Infant Mortality Rate to 42/1000 live births

2. Reduce under five mortality rate to 55/1000 live births

3. Reduce by half the still-birth rate

4. Reduce the Diarrhoea Case Fatality Rate to 2%

5. Maintain Polio Free status and implement strategies for global polio eradication by the year 2000

6. Maintain high levels of Tetanus Toxoid coverage and eliminate Tetanus cases

9. Reduce prevalence of low birth weight to 10%

10. Improve reach and use of decentralized health services

11. Reduce the crude birth rate to 35/1000 population.

12. Reallocation and increased mobilizing of public funds and local community resources, with a view to phasing out dependance on external support.

13. Reduce in childhood disability by preventive measures, early detection and treatment, using strengthened school health services and by increasing public awareness.

14. Assessment through operational research the prevalence of Thalassemia, Hepatitis B and congenital anomalies.

Education

OBJECTIVES

1. Improve the quality of education.
2. Sustain universal literacy and school enrolment levels.
3. Increase primary school completion rates to 80%.
4. Support provision of adequate educational facilities to 75% of the islands.
5. Reduce expatriate primary school teachers by 50%.
6. Enhance employment possibilities of school pass outs by 10% by providing job skills.
7. Development of non-conventional educational programmes to reach the educational targets for 1995.
8. Support the provision of trained teachers and text books to primary schools.

The quantitative targets for 1995 and the year 2000, are given in Table 3, on the following page.

TABLE 3
TARGETS FOR 1995 AND 2000

INDICATOR	TARGET	
	1995	2000
IMR (/1000 Live Births)	42	30
U5MR(/1000 Live Births)	55	40
CDR (/1000)	7	6
Diarrhoea CFR (%)	2	1
Malaria Incidence	Eradication	
Residual Polio(/1000)	0	Eradication
Neo-natal Tetanus(/1000)	0	0
Prevalence of Low Birth Weight(%)	10	8
CBR(/1000)	35	30
Growth Rate(%)	2.8	2.4
Immunization Coverage		
All Antigens(%)	85	90
TT 15-44 years (%)	100	100
ORT Usage Rate(%)	65	80
School Enrolment (%)	100	100
Literacy (%)	95	100
Primary Education Completion(%)	100	100
Schools With Adequate Physical Facilities(%)	60	100
Trained Teachers(%)	60	100