HOTEL

Maldives Human Development Report 2014

Bridging The Divide :
Addressing Vulnerability, Reducing Inequality

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Addressing Vulnerability, Reducing Inequality

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NATIONAL RESEARCH & WRITING TEAM

Aishath Raniya Sobir,
Lead Author, Blanco Private Limited
Fathmath Shiuna,
Blanco Private Limited
Lamya Ibrahim,
Blanco Private Limited
Shirana Shafeeq,
Blanco Private Limited

NATIONAL STEERING COMMITTEE

Abdul Haleem Abdul Ghafoor,
Deputy Minister, Ministry of Finance and Treasury (Chairperson)
Azusa Kubota,
UNDP Maldives Resident Representative a.i.
Dr. Mizna Mohamed,
Head of Research Center, Maldives National University
Mohamed Imad,
Assistant Executive Director, Department of National Planning, Ministry of Finance and Treasury
Mohamed Hunaif,
Under Secretary, Policy Office, President's Office
Mariyam Sidhmeen,
Director, Ministry of Health and Gender
Fathimath Shafeega,
Deputy Director General, Department of National Planning, Ministry of Finance and Treasury
Athifa Ibrahim,
Head of Policy and Inclusive Growth, UNDP

STATISTICAL ADVISORY COMMITTEE

Dr. Azeema Adam,
Governor, Maldives Monetary Authority (MMA)
Aishath Leeza,
Senior Statistical Officer, Department of National Planning, Ministry of Finance and Treasury
Ibrahim Naseem,
Monitoring and Evaluation Officer, UNICEF

PEER REVIEWER

Professor A.K. Shiva Kumar

EDITOR

Nandini Oberoi

PROJECT TEAM

Athifa Ibrahim,
Head of Policy and Inclusive Growth, UNDP
Mohamed Naahee Naseem,
Communications and Advocacy Associate, UNDP
Ali Shareef,
Project Assistant, UNDP
Ahmed Naeem,
Planning Officer, Department of National Planning, Ministry of Finance and Treasury

OTHER CONTRIBUTORS

Anusha Latheef
Animesh Purohit
Affan Abdulla Didi
Hussain Jinan

FOREWORD

Since the launch of its first National Human Development Report (NHDR) in 2001, the Maldives has undergone a period of significant economic growth and human development. This beautiful, small island nation graduated from the Least Developed Country (LDC) status to Middle Income Country (MIC) status in 2011, and has attained a Gross National Income (GNI) per capita of US$ 5,750 in 2012. Having met five out of the eight Millennium Development Goals (MDG) targets ahead of the agreed timeline of 2015, the Maldives is considered as a 'MDG plus' country, with life expectancy of 73 years for men and 75 years for women. The number of enrollment of school children for both primary and secondary schooling increased remarkably from 2004 onwards and has consistently been close to 100 percent among both girls and boys. At the same time, the Maldives also made strides in embracing multiparty democracy and consolidating democratic principles. A new constitution, ratified in 2008, paved the way for separation of state powers, introduction of multiparty elections, establishment of independent institutions, decentralized governance and a comprehensive bill of rights and freedoms for its citizens.

Amidst these notable achievements in the past decade, the second National Human Development Report for the Maldives – 'Bridging the divide: addressing vulnerability and inequality' – finds that ensuring equitable distribution of developmental gains amongst the Maldivian people has proved to be a challenge. At the same time, the country remains vulnerable to internal and external shocks, including the impact of climate change.

During the process of selecting the theme for this second NHDR, vulnerability and inequality were repeatedly mentioned by many as a relevant and suitable topic for the report, suggesting the growing awareness and concern among the Maldivian people. By establishing, for the first time, a sub-national Human Development Index, the report confirms that the spatial disparity between the capital, Malé and the atolls contributes greatly to the human development gap, mostly in the form of income and education choices. For instance, a person living in Malé is likely to complete three years more of schooling than someone living in the atolls, and the average income of a person living in Malé is nearly twice as high as that of a person living in the atolls.

In order to sustain the development gains of growth, decision makers are encouraged to implement appropriate policy interventions for greater equity and inclusivity. Incidentally, this year's Global Human Development Report, which is to be launched by the Human Development Report Office of UNDP New York in mid-2014 will share a similar theme, 'addressing vulnerabilities and building resilience'. This means that for a number of countries, particularly emerging economies with fast growth, ensuring equitable sharing of development gains while reducing vulnerabilities is a common challenge. The Maldives is not alone.

Of the many recommendations made in the NHDR, the report emphasizes the need to establish a framework on equality and vulnerability that can guide the development of inclusive policies and measures for action, and that which effectively target on helping vulnerable groups. Furthermore, to address vulnerabilities related to location, scarcity of resources, and accessibility to services demands, it recommends that the Government put in place improved spatial planning and policy-making mechanisms.

Throughout the long history of NHDRs, one fact remains consistent – that NHDRs are not simply publications. They are dynamic advocacy tools, which are created through a process of broad participation and active engagement within countries and across regions. The NHDRs offer flexibility, and because they are grounded in national perspectives and issues that matter to people, the Human Development Reports are ideally placed to make substantial impacts on policies and practices.

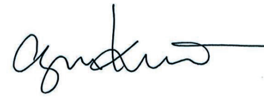
The second Maldives NHDR aspires to do the same. Countries around the world continue to produce the NHDRs, despite the fact that these efforts require considerable investment. They produce NHDRs because they find them useful. Development cannot be achieved without data. Data – both qualitative and quantitative – is important for understanding problems, tracking progress and analyzing policy impacts. Many studies indicate a strong correlation between national data collection and analysis capacity and the quality of public service delivery. NHDRs are aimed at influencing public policy discourse through the generation of evidence for sound policy formulation and often times, informed Government resource allocation for more equitable national development and attainment of MDGs.

The Maldives is facing a set of difficult fiscal challenges. At a time of resource limitations, informed decisions and evidence-based choices and targeting needs to be undertaken, in order to ensure the optimal use of available resources for greater impact. With the level

of commitment demonstrated by senior national policy makers and stakeholders throughout the process of making the second NHDR, I am confident this NHDR will bring about policy debates and informed decisions in moving forward.

We would like to sincerely thank members of the NHDR research and drafting team led by Aishath Raniya Sobir and the content editor, Nandini Oberoi, who worked tirelessly for the production of the report. This report would have not had the level of substantive richness and analytical rigour without the consistent guidance from the National Steering Committee, Dr. A. K. Shiva Kumar, an independent peer reviewer with many years of experience in the area of human development and the writing of human development reports, both at the global and at the national level, the National Statistical Advisory Committee, and UNDP colleagues from the Asia and the Pacific Regional Center in Bangkok, International Centre for Human Development in New Delhi and the Human Development Report Office in New York.

We also extend our gratitude to national stakeholders who contributed to the theme selection, data gathering and validation of data analysis. Bihura Studio and Novelty Printers & Publishers provided timely design and publication support. Lastly, I'd like to particularly thank the core-team comprised of Deputy Minister, Abdul Haleem Abdul Ghafoor, and his team members, Mohamed Imad, Fathmath Shafeega, Aishath Shahudha and Ahmed Naeem in the Ministry of Finance and Treasury and Athifa Ibrahim and Mohamed Naahee Naseem in the Policy and Inclusive Growth Unit of UNDP Maldives, who have coordinated various efforts to ensure the timely and quality publication of the report and the dissemination of knowledge.



Ms. Azusa Kubota,
Resident Representative a.i.
UNDP Maldives

FOREWORD

It is an honor and great privilege for me to introduce the second Maldives National Human Development Report (NHDR) – the first report of this nature was launched in the country more than a decade back.

Since the introduction of the idea of Human Development by the United Nations Development Programme (UNDP) under the leadership of late Mahbub-ul-Haq in the year 1990, the Human Development Reports that had been produced by UNDP have aimed at putting people at the centre of the development debate. Each report that has been published – regardless of the region of origin – has attempted to address key subjects and issues pertaining to developmental challenges that face the people and provided path-breaking analysis and policy recommendations.

In similar discourse, the second Maldives NHDR focuses on addressing inequality and vulnerability. Through critical analysis and the study of data obtained through a well-organized and strategic survey, the NHDR has painted a comprehensive picture of the country in terms of inequality and vulnerability. Based on its findings, the report has enumerated a number of key policy recommendations such as improving spatial planning, establishing efficient governance mechanisms and advocated focusing on improving the justice sector.

The Government of Maldives remains committed to serving its people. It realizes the aspirations, needs and hopes of the Maldivian people. The recommendations made in the report would further strengthen the Government's efforts in responding to these aspirations and to the needs and hopes of the people. The Government continues to be committed to work for sustainable development. The NHDR stresses that the key priority for the Government is to address the current economic situation and to achieve fiscal stability, a task that we are working towards.

On this note, on behalf of the Government of Maldives, I would like to thank the UNDP for their continued support and their role as a key partner in the development of the country. I also express my profound gratitude to the entire team behind the development of the second Maldives NHDR for their determination and perseverance in developing such a quality and informative document.

I am optimistic and hopeful that the second NHDR will provide a sound basis for the Government of Maldives to pursue the objectives and goals that are required for further improving the human development status of all citizens in the country.

Honorable Mr. Abdulla Jihad
Minister of Finance and Treasury
Government of the Maldives

PREPARING THE REPORT.

SELECTING THE THEME

In December 2012, a consultative process was initiated by UNDP Maldives, which included multiple stakeholders, representatives from ministries, Civil society organizations (CSOs), Non Governmental organizations (NGOs), youth and women's groups, independent institutions and academia, to select a suitable theme for the second NHDR of the Maldives. With the help of a national consultant and through a series of consultations and a multi-stakeholder workshop representing national policy makers, the theme of 'Equity and Vulnerability' was chosen for the report. Both equality and vulnerability have generated considerable development debate globally, particularly for the post-2015 agenda and have special relevance for the Maldives. Despite making commendable progress in economic growth, poverty reduction, attainment of MDGs and progress in human development, the Maldives continues to have a high degree of inequity and special vulnerabilities within the country at the sub-national level and at other different levels.

FORMATION OF NATIONAL STEERING COMMITTEE

A national steering committee was established in 2012, consisting of representatives from Government, the President's Office, the Department of National Planning, Maldives National University and UNDP to provide constructive comments, overall guidance and policy suggestions on the preparation of the NHDR. The theme was endorsed by the steering committee and relevant ministries such as Gender, Family and Human Rights, were added to the committee and the committee provided overall support and guidance as the report developed.

STATISTICAL ADVISORY COMMITTEE

The statistics advisory committee was established in August 2013 and consisted of statistical experts working at apex institutions such as the Statistics Bureau and the Research Unit of the Maldives Monetary Authority and data experts from the UN. The committee provided advice to the NHDR research team on ensuring the validity and representation sources used for statistical calculations, ensuring accuracy on the overall statistical analyses in consistency of data and information used.

PREPARATORY WORK

Initial work on the report involved taking stock of information and the literature available in the global and local context, and in conducting extensive consultations with a wide range of groups to better understand the concepts relating to the theme, particularly in the local context. Within a span of five days, the team concluded 40 meetings and with a total audience of 120 participants. The team facilitated a half-day inception workshop to confirm the understanding of the issues raised in the consultative meetings and to set the research framework and chapter outline for the report. Draft questionnaires that were prepared for field research and focus group discussions (FGDs) beyond the capital, Malé were tested.

The following core principles were integrated into the preparation of the report.

- Ensuring overall credibility through a participatory approach
- Integrating a people-centered approach to the research
- Undertaking robust and independent analysis
- Using creativity and innovation

Standard of living is measured by Gross National Income (GNI) per capita, expressed in constant 2005 international dollars converted using Purchasing Power Parity (PPP) rates.

RESEARCH ACTIVITIES

Consultations: The team continued with data and information collection and held consultative meetings with additional line ministries, social service providers, NGOs, private sector and youth groups using a standard interview format.

Field Visit - Focus Group Discussions: The team visited Laamu, Haa Alifu and Seenu atolls and focus group meetings were held with local councils, women's development committees, youth groups, NGOs, service providers and different vulnerable groups identified by the respective communities in the three atolls.

Phone Interviews: In order to get a better understanding of institutional service delivery, phone interviews were conducted with schools and health facilities in selected atolls, where field visits could not be undertaken. These include Noonu, Raa, Faafu, Gaafu Dhaal and Thaa atolls.

Case studies: A number of case studies were developed through one on one interviews with individuals in those groups that were identified as being 'vulnerable' in the consultation meetings. This was to provide further evidence of how risks and vulnerabilities impact the life choices of specific groups, as represented through the prism of members of these groups.

Social Media Outreach - In order to increase outreach of data collection and to connect particularly with youth, a social media platform was established through Facebook to get views, assess perceptions and collect information on the key aspects of the report. To date the Facebook page www.facebook.com/nhdrmaldives has been successful in getting more than 422 likes and interesting comments on a range of topics on education, health, governance, jobs, etc.

Statistical Computations – The team compiled the Sub National HDI and other HDI related measures including the Gender Inequality Index (GII), the Inequality Adjusted HDI and the Multi Poverty Index (MPI), using key data sets available including the Vulnerability and Poverty Assessments (VPAs) of 2004, the Household Income and Expenditure Surveys (HIES) of 2009/2010 and the Census 2006 and the Demographic Health Survey (DHS) 2009 as these were the most updated available national data sources to date. The measures were validated by the Statistical Advisory Committee.

COMPILING AND VALIDATING THE REPORT

The team compiled three drafts of the report and these drafts were worked and reworked through a series of consultations, iterations and feedback. The feedback was provided by the steering committee, UN Agencies, Government line ministries, the International Center for Human Development (IC4HD) in New Delhi and a Peer Reviewer. The report was validated by the steering committee at its meeting on 28 April 2014.

IDENTIFYING VULNERABLE GROUPS

This report presents a conceptual framework that will guide the identification of vulnerable groups in the Maldives such as those facing multiple levels of vulnerability that is spatial setting, income and identity. The reasons for not being able to identify these vulnerable groups in this report include lack of availability of any primary research or recent data on poverty and vulnerability at household level, challenges faced in gauging perceptions of vulnerable groups with empirical evidence and to encourage further research and support evidence based policy making on targeting programmes for vulnerable groups.

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OVERVIEW

The Maldives NHDR 2014 aims to understand the inequalities and vulnerabilities facing the Maldives. An assessment of the regional Human Development Index (HDI) and the human development dimensions of income, education and health indicate that inequalities in the Maldives are most apparent in income and education. The report presents a framework that links vulnerability and inequality to the Maldives context.

The second NHDR for the Maldives has been prepared 13 years after the first Maldives NHDR was published, in 2001. The first national HDR took stock of the progress recorded by the country and highlighted that people living in the Maldives are vulnerable to many external factors including small size of population and land area, physical vulnerability, scarcity of land-based resources, geo-physical constraints, population dispersion and governance. The report recommended expanding assistance beyond the capital, Malé to the islands, investing in children, given that children and youth account for 44 per cent of the population and enlarging employment possibilities that meet the aspirations of the growing youth. Other focus areas that were identified were managing the environment and natural resources and establishing responsive governance in the Maldives including an efficient administrative system, greater people's participation and improved access to justice.

Since the publication of the first NHDR more than a decade ago, the Maldives has recorded major gains and progress in human development indicators including in education, health and economic opportunities. Particularly impressive have been the gains in universal immunization and primary schooling. This period witnessed a major overhaul of the country's governance structure with the initiation of democratic transition in 2008. The decade witnessed major shocks to the country including the Tsunami in December 2004, which highlighted the country's physical and economic vulnerability to natural disasters. The global economic downturn in 2009 further demonstrated the country's economic vulnerability to external shocks, given its dependence on a narrow base of tourism. The country has seen major social change over this period with urbanization, explosion of youth population and unemployment, for instance, contributing to increasing drug use, crime and violence.

The second NHDR aims to understand the inequalities and vulnerabilities facing the Maldives. An assessment of regional Human Development Index (HDI) and the human development dimensions of income, education and health indicate that inequalities in the Maldives are most apparent in income and education. The report then presents a framework that links vulnerability and inequality to the Maldives context. Vulnerabilities are presented and assessed in terms of structural vulnerabilities that relate to the physical setting of the country and the over-reliance of the economy on tourism and imports. Other vulnerabilities assessed in terms of risks such as natural disaster incidents have been discussed in terms of the tsunami, the global financial

crisis, the ongoing macro-economic imbalances and the recent political and social transition in the country. The report argues that these vulnerabilities have an impact on inequality in the various human development dimensions directly, i.e. on individuals, households and communities. The framework presents a second channel through which vulnerabilities impact inequality. Vulnerabilities constrain the state's ability to address inequality in schooling or healthcare provisioning. For example to close the gaps in providing quality healthcare or schooling, the government faces major challenges given the dispersion of population and the geographic spread of the country over close to 200 inhabited islands, which is a core structural vulnerability. The report discusses social vulnerabilities facing the Maldives due to the fast-pace of economic and political change which has marginalized specific groups, through the emergence of a number of social issues such as drug use, existence of gangs, gender based violence and broken families.

Despite the gains made in incomes and poverty reduction, there is growing poverty and inequality in the capital, Malé, due to urban migration. Inequalities are driven by the high level of unemployment that puts young people and women at risk of being trapped in a social vulnerability cycle. The report finds that inequalities in education are evident in the mean years of schooling and quality of learning outcomes, while health inequalities relate to the quality of service and health risks among certain vulnerable groups such as the elderly. The report suggests examining various innovative financing and service provisioning options, capacity building and management, as well as other reforms that can help to bridge these gaps.

The report makes the argument that in order to address inequalities in human development, it is important to address the roots of these inequalities, i.e. the core physical, social and institutional vulnerabilities. It presents concrete policy options to bridge the gap and build the overall resilience of the population. This includes introducing spatial planning, integrating climate resilience measures, restoring macro-economic stability and stimulating growth, that reduces dependency on tourism and encourages employment among young people and women.

The Maldives HDR debates the identification of vulnerable groups in the Maldives, presents key parameters based on spatial setting, income and identity and recommends that instead of universal social protection programmes, targeted programmes be implemented based on assessments of the target groups. It presents a range of recommendations to address institutional vulnerability, which include enhancing law making, access to justice and promoting strategic and evidence based policy making that focuses on long-term benefits for the population beyond election cycles. The report concludes with a key recommendation on right-sizing the governance system where it is argued that despite democratic transition, Maldives is unable to fully operationalize the implementation of its constitution due to high administrative and financial burden. To enhance the democratic dividend, the choices and freedoms of Maldivians, it is critical that key steps be taken to address the proposed recommendations.

ABBREVIATIONS

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
BBS	Biological and Behavioral Survey
BPT	Business Profit Tax
CDP	Committee for Development Policy
CSO	Civil Society Organization
CVD	Cardio Vascular Disease
DALY	Disability Adjusted Life Years
DHS	Demographic Health Survey
DNP	Department of National Planning
EBP	Evidence Based Policy
FGD	Focus Group Discussions
FSW	Female Sex Worker
GDP	Gross Domestic Product
GER	Gross Enrolment Ratio
GII	Gender Inequality Index
GNI	Gross National Income
GGST	General Goods and Services Tax
GST	Goods and Services Tax
HDI	Human Development Index
HDR	Human Development Report
HIES	Household Income and Expenditure Survey
HRCM	Human Rights Commission of the Maldives
HSC	Higher Secondary Certificate
ICJ	International Commission of Jurists
ICT	Information and Communication Technology
IDP	Internally Displaced Populations
IDU	Injecting Drug User
IGMH	Indira Gandi Memorial Hospital
IGCSE	International General Certificate of Secondary Education
IHDI	Inequality-adjusted HDI
ILO	International Labour Organization
IMR	Infant Mortality Rate
IMF	International Monetary Fund
IPCC	Intergovernmental Panel on Climate Change
LDC	Least Developed Country
MDG	Millennium Development Goal
MIC	Middle Income Country
MICS	Multiple Indicator Cluster Survey
MPI	Multidimensional Poverty Index
MMA	Maldives Monetary Authority
MoFT	Ministry of Finance and Treasury
MoHF	Ministry of Health and Family
MoHG	Ministry of Health and Gender
MTDC	Maldives Tourism Development Corporation
MMR	Maternal Mortality Ratio
MNU	Maldives National University
MPND	Ministry of Planning and National Development
MSM	Men who have sex with men
MSME	Micro-Small and Medium Enterprises
MVR	Maldivian Rufiyaa
NCD	Non-communicable diseases
NDMC	National Disaster Management Centre
NER	Net Enrolment Ratio
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHDR	National Human Development Report
NSPA	National Social Protection Agency
ODA	Overseas Development Assistance
OECD	Organization for Economic Cooperation and Development
OOP	Out of Pocket Expenses
PBA	Public Bank Account
PHU	Primary Health-care Unit
PPG	Public and Public Guaranteed
PPP	Purchasing Power Parity
PV	Present Value
SAARC	South Asia Association for Regional Cooperation
SIDS	Small Island Developing States
SPC	Secretariat of Pacific Community
SPI	Social Protection Index
TGST	Tourism Goods and Services Tax
TVET	Technical and Vocational Education
UNDP	United Nations Development Programme
UNICEF	United Nations Children’s Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
WHO	World Health Organization
WTO	World Trade Organization
VPA	Vulnerability and Poverty Assessments

REGIONAL AND ATOLL CLASSIFICATIONS USED IN THIS REPORT

R1 - Region 1
HA - North Thiladhunmathi (HaaAlifu Atoll)
HDh - South Thiladhunmathi (HaaDhaalu Atoll)
SH - North Miladhunmadulu (Shaviyani Atoll)

R2 - Region 2
N - South Miladhunmadulu (Noonu Atoll)
R - North Maalhosmadulu (Raa Atoll)
B - South Maalhosmadulu (Baa Atoll)
LH - Faadhippolhu (Lhaviyani Atoll)

R3 - Region 3
K - Male' Atoll (Kaafu Atoll)
AA - North Ari Atoll (AlifuAlifu Atoll)
ADh - South Ari Atoll (AlifuDhaalu Atoll)
V - Felidhu Atoll (Vaavu Atoll)

R4 - Region 4
M - Mulakatholhu (Meemu Atoll)
F - North Nilandhe Atoll (Faafu Atoll)
DH - South Nilandhe Atoll (Dhaalu Atoll)

R5 - Region 5
TH - Kolhumadulu (Thaa Atoll)
L - Hadhdhunmathi (Laamu Atoll)

R6 - Region 6
GA - North Huvadhu Atoll (GaafuAlifu Atoll)
GDh - South Huvadhu Atoll (GaafyDhaalu Atoll)

R7 - Region 7
GN - Fuvahmulah (Gnaviyani Atoll)
S - Addu Atoll (Seenu Atoll)

Chapter 1

Mind the Gap-
Human Development in the Maldives

Chapter 1

Mind the Gap - Human Development in the Maldives

At the dawn of a new era in its history, the Maldives faces an unprecedented opportunity to close the gaps in human development and to address the vulnerabilities that leave many behind. Breaking the link between inequality and vulnerability through responsive policies, building institutions and empowering people can drive significant advances in human development for all.

This second Maldives Human Development Report comes 24 years after the first global Human Development Report (published in 1990) and 13 years after the first Maldives National Human Development Report, which was published in 2001. The report comes at a significant time, when the country is witnessing changes both in its economy and in its politics.

Globally, there has been a major shift in human development trends in the recent past, as developing countries appear to catch up with advanced economies. Countries at low levels of human development accelerated their achievements in health, education and income more in the past decade than in the preceding one. The number of countries with a Human Development Index (HDI) value below the 25th percentile dropped from 33 to 30 between 1990 and 2000 and was halved from 30 to 15 between 2000 and 2012[1].

The national-level Human Development Index (HDI) for 2012, shows that the Maldives ranks in the medium human development category, with a value of 0.688. From 2000 to 2012, Maldives experienced an average annual increase of 1.26 points in the HDI, positioning the country at number 104 out of 187 countries (for which the HDI is calculated). This value puts the Maldives above the average value of 0.64 for countries in the medium human development group and above the average value of 0.558 for countries in South Asia[2]. While the overall gains in human development at the national level are impressive, they mask various underlying inequalities.

In order to rebalance the human development performance of Maldives and foster human development acceleration similar to that of the global trajectory, it is important to understand both the nature of these differences and where these differences lie. This chapter aims to unpack human development outcomes in the Maldives, by assessing the performance at different levels. The report presents for the first time, the calculation of regional HDI for the Maldives, which indicates regions that have made progress and regions that are under-performers and attempts to analyse the reasons for these outcomes. By examining the gaps in human development in the Maldives, the chapter aims to draw a basis for understanding the nature of inequalities existing in the country.

BOX 1. The Maldives - A snapshot

The Republic of Maldives consists of 1,190 coral islands formed around 26 natural ring-like atolls in the Indian Ocean. Of these islands, 188 islands are inhabited by local people and close to a 100 islands have been developed as tourist resorts. The earliest settlers on these islands are believed to have included travelers and traders from India, South East Asia and Arabia. Culturally and ethnically the Maldivians are considered homogenous and speak the language Dhivehi, which derives from Sinhala and has influences of Arabic. The people are Muslims (they follow Sunni Islam); having converted to Islam in 1153, from Buddhism.

The total population of these islands is 330,652 people. Close to a third of the population lives in the capital Malé', in an area that is less than two square kilometres. The country itself is spread over 90,000 square kilometres, of which 99 percent is made up of the sea; the land area in the Maldives is less than 300 square kilometres. This makes it the smallest country in Asia, both in terms of land area and population. With an average ground level elevation of 1.5 metres (4 feet, 11 inches) above sea-level, it is the planets' lowest country.

THE BACKDROP

Over the last four decades, the Maldives has achieved significant growth. The shift came in the second half of the 20th century, when Maldivians started to trade small amounts of smoked tuna with Sri Lanka, send copra to India and began to import staple foods. During the years 1957 to 1978, the economy modernized with the development of a shipping fleet, the setting up of the first airport in the country, the introduction of tourism in the early 1970s, and with investments in communication. The economic policies of Maldives have been open to trade for long. In the 1970s, the laissez-fare policy helped Maldivians to import goods and consumables from East Asia and to trade with neighbouring countries, mainly Sri Lanka. This informal trade was an important source of foreign exchange for the country.

The drivers of the economic transformation have been the rapid development of tourism and related sectors, including construction, transport and telecommunication. Since 1970, the first year for which Gross Domestic Product (GDP) data is available, the country's economy has expanded by more than 18 times – at an average rate of about 8.4 percent per annum[3]. The structure of the economy has changed substantially with this transformation. For the last two decades, the tourism sector has accounted for nearly 30 percent of GDP.

The Maldives was a British protectorate till 1965, when it gained independence. However, it continued to remain a Sultanate until 1968, when the people voted in a referendum to become a republic. The first constitution of the Maldives was drafted in 1932 and this was later revised to a modern constitution in 1968. A further revision was made in 1997. Under the Constitution, the President has significant executive, judicial and legislative authority, and is both the head of Government and chief of state. Historically, the Maldives did not have a local Government system. It has established a two-tier de-concentrated system of local administration that encompasses the 26 atolls (in 20 administrative divisions) and all inhabited islands, with special arrangements for the capital island of Malé'.

A DECADE OF TRANSFORMATION

The decade since the first NHDR of the Maldives in 2001 has seen major gains and progress, both on the economic front and in human development indicators.

During the 2001 - 2010 period, the GDP increased substantially from US$ 0.80 billion to US$ 2.2 billion with an impressive average per capita GDP growth rate of 7.3 percent[4]. The gross national income (GNI) per capita almost doubled and now stands at US$ 7,690[5]. This performance comes despite two major external shocks to the economy, which includes the tsunami that struck on 26 December 2004 and the global financial crisis that began in 2008. Both these events resulted in negative growth for the Maldives in the years that followed, in 2005 and 2009 respectively. The tourism-dependent economy demonstrated resilience in the aftermath of these events and growth was restored within a year. However, in recent years, the Maldives has been struggling with critical macro-economic imbalances resulting from expansionary fiscal policies and fast growing debt levels while growth rates have slowed down from 7 percent in the preceding two years to 3.4 percent during 2012[6].

Social indicators in the Maldives have shown significant improvements in the last decade. The Maldives has met five of the eight Millennium Development Goal (MDG) targets ahead of the agreed timeline of 2015 and has been labeled as a 'MDG plus' country, showing potential to go beyond the agreed MDG targets. The Maldives lags behind on MDG 3 - Promoting Gender Equality and Empower Women, MDG 7 - Ensuring Environmental Sustainability and MDG 8 - Global Partnership for Development. During the ten-year period 2001 to 2011, life expectancy at birth increased from 70.2 years to 72.8 years for men and from 70.7 to 74.8 years for women[7]. Child survival has improved significantly with the Infant mortality rate (IMR) falling from 17 per 1,000 live births in 2001 to 9 per 1,000 live births in 2011[8]. The maternal mortality ratio (MMR) has come down from 143 per 100,000 births in 2001 to 56 per 100,000 births in 2011, owing to better obstetric care and antenatal care at the atoll level[9].

The Maldives achieved a major milestone in the education sector when in 2000, the goal of universal primary education was realized. Every child has access to a primary school in all the inhabited islands of the country. Between 2001 and 2011, enrolment of both boys and girls has been maintained close to universal level at the primary stage and has increased substantially at the secondary level as well. Girls' enrolment at the lower secondary level exceeded that of boys throughout this period.

The country has witnessed a major overhaul of its governance structure in recent times. The turning point came in August 2008, with the ratification of the current Constitution, when the Government system allowed separation of powers (of the executive, judiciary, and legislature), multi-party elections, decentralized governance and a comprehensive Bill of Rights and freedoms for its citizens. The Constitution led to the establishment of a series of independent institutions such as the Elections Commission, the Human Rights Commission, the Anti-Corruption Commission and the Prosecutor General's Office for the very first time.

In November 2008, the first democratically elected President of the Maldives was sworn into office after a multi-party election under the 2008 Constitution, ending a 30-year rule by the erstwhile President.

The Maldivian people saw some unprecedented events during this period. The tsunami in December 2004, which washed away 62 percent of the GDP in a matter of minutes, demonstrated the country's vulnerability to natural disasters and to climate change related calamities. The global economic downturn that began in 2008 highlighted the country's vulnerability to external economic shocks. The country has seen major social change over this period with urbanization, explosion of youth population and unemployment, for instance, contributing to increasing drug use, crime and violence. The impacts of these shocks and changes have been discussed in the next Chapter.

HUMAN DEVELOPMENT PROGRESS AND GAPS

The vision of 'putting people at the centre of development' has long been the focus of the United Nations. The first HDR stated that human development is the process of enlarging people's choices. The most critical of these wide-ranging choices are to live a long and healthy life, to be educated and to have access to resources needed for a decent standard of living. Additional choices include political freedom, guaranteed human rights and personal self-respect'[10].

In later reports and subsequent work, the concept has been refined and elaborated. For example, human development as a paradigm now emphasizes broadening choices and strengthening capabilities, based on conceptual and analytical work by Nobel laureate, Amartya Sen, and Martha Nussbaum, among others. In explaining capabilities, Sen has stressed the contrast between the great things that human beings can achieve and the limited lives most women and men end up having.
Human development is about the realization of human potential. It is about what people can do and what they can become — their capabilities — and about the freedom they have, to exercise real choices in their lives.

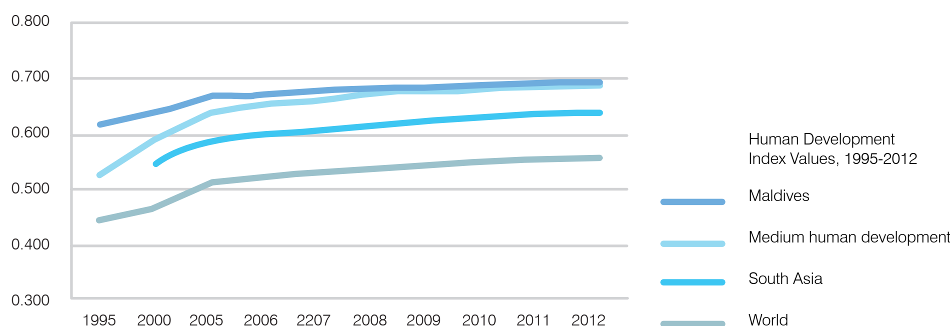
The HDI is a summary measure for assessing long-term progress in three basic dimensions of human development: a long and healthy life, access to knowledge and a decent standard of living.

- A long and healthy life is measured by life expectancy at birth.
- Access to knowledge is measured by: i) mean years of schooling for the adult population, which is the average number of years of education received in a life-time by people aged 25 years and older; and ii) expected years of schooling for children of school-entrance age, which is the total number of years of schooling a child of school-entrance age can expect to receive if prevailing patterns of age-specific enrolment rates stay the same throughout the child's life.
- Standard of living is measured by Gross National Income (GNI) per capita, expressed in constant 2005 international dollars converted using Purchasing Power Parity (PPP) rates.

In 2012, the global average HDI value was 0.694; South Asia had the second lowest HDI value after Sub-Saharan Africa[11]. The human development performance at the national level is categorized into Very High, High, Medium and Low Human Development. In 2012, the Very High Human Development group had an HDI value of 0.905, the High Human Development Group had a HDI value of 0.758, the Medium Human Development Group had an HDI value of 0.640 and the Low Human Development Group had an HDI value of 0.466. The Maldives with a HDI value of 0.688 is placed in the medium human development category and outperformed most of its neighbours in the South Asia region.

As evident in Figure 1, the Maldives has been a strong contributor to the progress of human development in the South Asia region. In 2012, the Maldives ranked second in South Asia region in terms of human development performance, behind Sri Lanka, which

Figure 1 Maldives catching up with the world



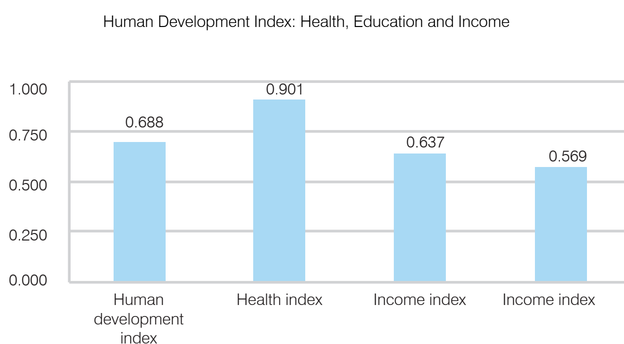
Source: UNDP, 2013

belongs to the High Human Development category, with an HDI of 0.715 in 2012.[12] The Maldives performed better than the Small Island Developing States (SIDS), whose average HDI was 0.648 [13].

The progress in the human development performance at the national level in the Maldives can be explained largely by the gains made in the health indicator, as illustrated in Figure 2. When unpacking the three components of the HDI, i.e. health, education and income, the highest contribution to the HDI comes from the health index (life expectancy), followed by income (per capita GNI), followed by the education index which includes mean years of schooling and the expected years of schooling. In 2012, life expectancy at birth stood at 77.1 years in the Maldives, while per capita GNI was US$ 7478 (PPP). People in Maldives can be expected to live 7.2 years longer than people who live in one of the other SIDS. On the education front, the mean years of schooling and expected years of schooling in a SIDS country are 7.5 years and 11.6 years[14] compared to 6.6 years and 12.3 years in the Maldives. In terms of income, the performance of the Maldives is somewhat less impressive, with the per capita income in the Maldives being roughly a third less than income in the SIDS. (Per capita income in SIDS was US$ 10,184 (PPP) in 2012). The main

Figure 2 Human development index and its components, Maldives 2012

Human Development Index: Health, Education and Income



Source: UNDP, 2013

reasons for the progress and the poor performance in the indices are discussed in detail in the chapters that follow.

BOX 2. From the people: What people In the North say about Inequality

- Malé, the capital, has piped drinking water, sewerage, tertiary medical care, university education, ICT facilities in schools.
- The islands' people lack basic services such as safe drinking water.
- Food prices in the islands are much higher than in Malé, due to high transportation costs and the small scale of operation of traders.
- Many felt that health and education sector did not see any positive change with the political reform process. Health services in the island have deteriorated over the last three years so much that even for minor illnesses people had to be referred to Malé hospital. This has led to a situation where much of the health budget is spent on evacuation of patients and the people have to spend a substantial amount of money on accommodation and food in Malé, which is relatively expensive.
- People said that society is no longer willing to accept such inequalities.

Source: Focus Group Discussions, Haa Dhaalu atoll, July 2013

INEQUALITY AND HUMAN DEVELOPMENT

Inequality is increasingly re-emerging as an important aspect of the development dialogue and discourse. It is recognized as a key cross-cutting issue that was neglected in the Millennium Development Goals (MDGs) and is central to the debates that discuss the post-2015 development agenda.

The human development approach is grounded in the notion of capability and freedom. This approach has particular implications on the issue of inequality. In a recent paper entitled 'Equity, Inequality and Human Development in a post 2015 Framework', for UNDP, Melamed and Samman state that 'inequality refers to differences, variation and disparities in the characteristics of individuals and groups. Human development depends on plural principles such as equality, empowerment and human agency, efficiency, sustainability and respect for human rights to become relevant to local and national experiences'.[15] All human beings should enjoy equal rights and opportunities without discrimination. A young girl living in a distant atoll should not be denied the opportunity of going to school because of where she lives.

The human development approach calls for looking at issues of equality (referred to as *hama-hama kan* in Dhivehi) within and across national borders and identifying development challenges and solutions. In what follows, an attempt is made to identify excluded groups defined by age, sex, income, ethnicity, location, physical or mental ability and other markers of disadvantage. It is to these vulnerable groups that policies and expenditures need to be directed, to reduce both poverty and inequality.

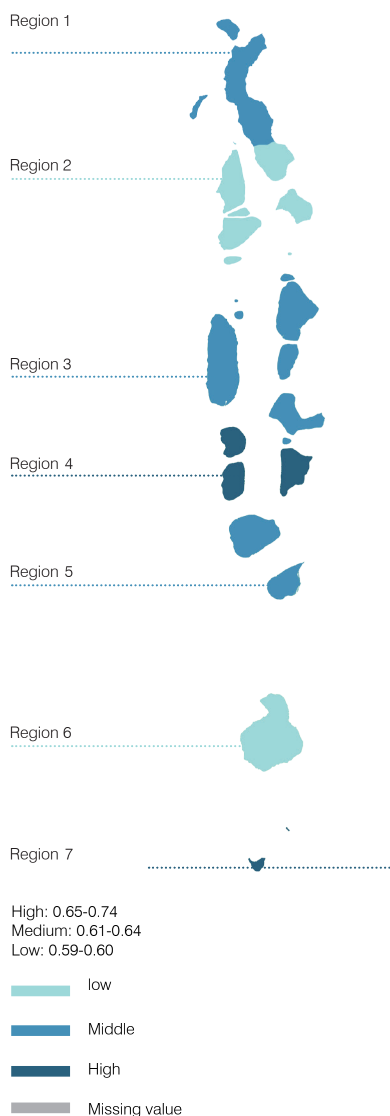
▶ UNMASKING INEQUALITY IN THE MALDIVES

Unpacking human development outcomes within the Maldives can reveal the underlying inequalities and their causes. This report presents for the first time the HDI at the regional level for the Maldives. The regional groupings follow that of the main data source, the Household Income and Expenditure Survey (HIES) 2012. What this analysis illustrates is disparities across regions, it is evident that not all areas of the country fare equally well. The HDI value for the capital, Malé is at 0.734 compared with the cumulative HDI value of 0.627 for all atolls, excluding the capital.

Among the regions, Region 4 (Meemu, Faafu and Dhaalu Atolls) tops the HDI performance with a HDI value of 0.654, followed by Region 7 (Gnaviyani and Seenu atolls) at 0.647. Region 3 (Kaafu, Alifu Alifu, Alifu Dhaalu and Vaavu atolls) comes in third at 0.644 [Figure 3]. Region 4 has the highest mean years of schooling and expected years of schooling, whereas the advantage that Region 7 has is mainly due to the relatively higher life expectancy and years of schooling. Income performance is higher in Region 3 compared to both Region 4 and 7; which is due to the concentration of tourism and tourism related services. The lowest HDI performance is found in Region 6 (Gaafu Alifu and Gaafu Dhaalu atolls), which is because of the low performance in the education index (the region has the lowest mean years of schooling). The performance of Region 2 is lowest in the income index.

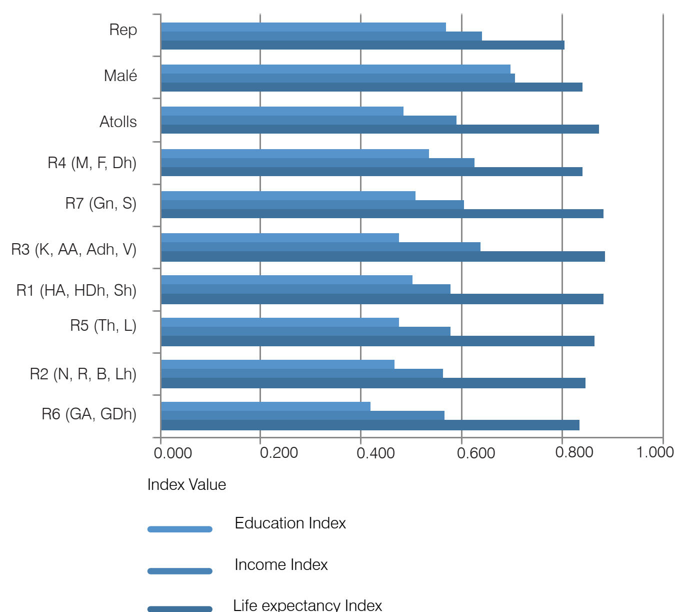
The regional human development portrait of the Maldives shows life expectancy as being high in all regions (Figure 4). The life expectancy index value remains consistently above 0.800 across all regions. The surprising result is that the atolls have a higher average life expectancy than that in Malé. For the atolls, the life expectancy index is 0.875, while for Malé it is at 0.841. This difference is due to the availability of better health services in Malé, which means that people come to the capital city for medical treatment and often die there. The lower life expectancy in the capital, is thus due to the high death rate in Malé, which can be explained by the presence of the country's only tertiary hospital in the capital and the high number of critical patients who are treated in Malé. It is important to note that there is lack of systematic data maintenance on death registration and on location of burials. The data for deaths is recorded by place of occurrence of death or by the island on which a person is buried. As many of the deaths take place in Malé rather than in the atolls, the mortality figures for Malé are higher.

Figure 3 Regional HDI in the Maldives



Source: Annex II, Table 1

Figure 4 Regional Human Development - Disparities in Income, Education and Health Indices



Source: Annex II, Table 1

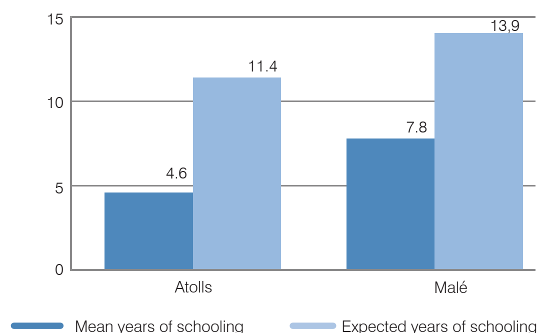
The results for income and education however, illustrate deeper disparities. Malé holds a significantly higher value for both these human development components than any of the other regions. In both the underlying indicators for the education index, expected and average years of schooling, Malé performs far better than the atolls. The largest difference exists in the mean years of schooling achieved between the two geographical areas. A person living in Malé is likely to complete three years more of schooling than someone living in the atolls (Figure 5). This is largely due to the lack of higher secondary and tertiary education facilities in the islands, a subject that will be examined further in Chapter 3. The figure for mean years of schooling is lowest in Region 6 (Gaafu Alifu and Gaafu Dhaalu atolls).

While the education achievements show stark inequalities, greater disparities are visible in the differences in income across the Maldives. The per capita income has been estimated at the regional level applying categorization of regional income variation from the HIES 2009/2010 to World Bank GNI per capita data for 2012, at PPP rates. The data shows that the average income of a person living in Malé (PPP US$ 4251.90) is likely to be more than one and a half times as high as that of a person living in the atolls (PPP US$ 2687.3).

An examination of more disaggregated data shows that even within the regions there are notable differences in incomes. Region 3 (Kaafu, Alifu Alifu, Alifu Dhaalu and Vaavu atolls) has the highest income per capita at the regional level, which can be accounted for by the high concentration of tourism operations in the region and the location of the capital Malé, which offers relatively higher paying employment and income opportunities compared to other regions. The second highest per capita income exists in Region 4 (Meemu, Faafu and Dhaalu atolls), and in third place is Region 7 (Seenu and Gnaviyani atolls) which can be explained by the high concentration of population, good connectivity (existence of regional airport and causeways between islands), availability of land space which increases concentration of commercial activities and income opportunities in the region, in addition to tourism and a high level of participation of the region's labour force in the tourism industry. Per capita income is lowest in Region 2 (Noonu, Raa, Baa and Lhaviyani atolls), which has poor connectivity and consists of highly dispersed small islands with a relatively low tourism presence in the region.

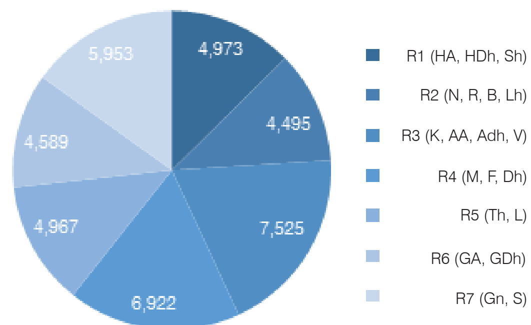
Income inequality, thus, represents one of the core manifestations of the inequitable opportunities across the Maldives—and has implications on how different locations, identities and groups are vulnerable to risks and external shocks that threaten the progress of human development.

Figure 5 Education Inequalities between Malé and the Atolls



Source: Annex II, Table 1

Figure 6 Tourism and Connectivity - Key Drivers of Income across the Regions



Source: Annex II, Table 1

RESOURCE DISTRIBUTION IN THE MALDIVES- HOW SATISFACTORY, HOW EQUAL

In order to assess the right to equality of access to services, the survey on human rights 'The Rights Side of Life' and 'The Rights Side of Life, Six Years On' by the Human Rights Commission of the Maldives (HRCM) in 2005 and 2012, assessed the satisfaction levels of the people with respect to various Government services, all of which have a human rights component. Overall, there has been a decline in satisfaction levels since 2005. In 2005, overall, 49.1 percent of respondents were satisfied with the education services (this decreased to 34.1 percent in 2012) and 38.1 percent were dissatisfied (this increased to 44.1 percent in 2012). In relation to hospital services, access to health services and access to medicines, the dissatisfaction was recorded at 69 percent, 65.5 percent and 63.7 percent respectively.[16] The average dissatisfaction rate (which refers to the percentage of people who were dissatisfied) for all three aspects combined, increased from 54.9 percent to 66 percent between the two surveys, in 2005 and 2012.

The survey also assessed peoples' perceptions regarding how fairly and equally distributed the resources were among the islands and atolls. There was considerable variation in the responses, and few patterns emerged in the answers. Overall, a majority of respondents across the country (57.4 percent vs. 33.5 percent) were of the opinion that resources were not distributed freely and fairly, though not surprisingly the opinion was divided between the different geographical regions. The further away the island was from the urban centres in the centre and the south, the stronger was the view that resources were not fairly or equally distributed. In urban centres, 49.1 percent of the people disagreed or strongly disagreed with the proposition whereas 22.2 percent of the respondents agreed with the proposition.[17]

INEQUALITY DRIVES HUMAN DEVELOPMENT LOSSES

As an average measure of basic human development achievements, the HDI masks inequality in the distribution of human development across the population, at the country level. The 2010 HDR introduced the Inequality-adjusted HDI (IHDI) to take into account inequality in all three dimensions of the HDI. It does so by 'discounting' each dimension's average value according to its level of inequality. This effectively shifts the interpretation of national-level average HDI as an index of 'potential' human development—and the IHDI an index of actual human development. The 'loss' in potential human development due to inequality is given by the difference between the HDI and the IHDI, and can be expressed as a percentage. (For more details see technical note.)

The HDI for Maldives for 2012 is 0.688. However, when the value is discounted for inequality, the HDI falls to 0.515, a loss of 25.2 percent due to inequality in the distribution of the dimension indices (Table 1). The average loss due to inequality for medium HDI countries is 24.2 percent and for South Asia it is 29.1 percent. [18]

The average overall loss to human development puts the Maldives just below the group of medium HDI countries—but the country continues to be ahead of other South Asian nations. This means that human development in the Maldives, in effect, suffers less from inequality than the average South Asian country. However, like all averages, this figure masks the inequalities within the underlying components. In this measure, the Maldives' case shows instructive differences.

Life expectancy at birth proves to be the most resilient to distribution across the Maldives. Dropping by 7.3 percent, the loss due to inequality in life expectancy is far less than the South Asian average loss of 27

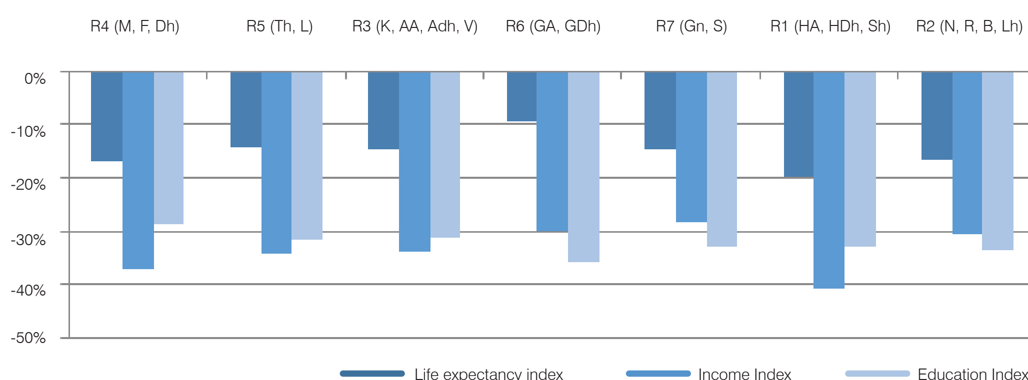
Table 1 The Maldives - Regional and Medium Human Development Perspective

	Inequality-adjusted human development index	Overall loss (%)	Loss due to inequality in life expectancy at birth (%)	Loss due to inequality in education (%)	Loss due to inequality in income (%)
Maldives	0.515	25.2	7.3	41.2	23.2
Sri Lanka	0.607	15.1	9.4	14.6	20.8
Bhutan	0.430	20.0	24.1	12.2	23.1
South Asia	0.395	29.1	27.0	42.0	15.9
Medium HDI Countries	0.485	24.2	19.3	30.2	22.7

Source: UNDP, 2013

percent.[19] However when income is looked at in terms of its distribution, it drops substantially in the Maldives. At a loss of 23.2 percent, it shows a larger drop than the 15.9 percent average for South Asia. The steepest drop in human development due to inequality occurs in education—showing a 41.2 percent change in the distribution of education achievements across the Maldives. This change puts the loss owed to differences in access to education opportunities in the Maldives substantially above the 30.2 percent average difference in medium human development countries.[20] As the human development analysis in this section shows – the education sector presents the greatest inequality and the steepest drop when inequalities in its distribution are included.

Figure 7 Inequalities in the Indicators across Regions in the Maldives



Source: Annex II, Table 3

Table 2 GII Performance Across Regions

GII Performance Across Regions	
Republic	0.243
Malé	0.232
Atolls	0.357
Reg 1 – HA, HDh, SH	0.697
Reg 2 – N, R, B, LH	0.401
Reg 3 – K, AA, ADh, V	0.341
Reg 4 – M, F, Dh	0.725
Reg 5 – Th, L	0.741
Reg 6 – GA, Gdh	0.723
Reg 7 – Gn, S	0.696

The losses due to inequality in each dimension of human development also differ across the regions of the Maldives (Figure 7). Overall the highest loss in human development performance due to inequality is experienced by Region 1 (Haa Alifu, Haa Dhaal, Shaviyani atolls), which is 30 percent, while the loss is the least for Region 7 (Seenu and Gnaviyani atolls). The loss in human development performance is driven by inequality in education in Region 2 (Noonu, Raa, Baa, Lhaviyani atolls) and Region 6 (Gaafu Alifu and Gaafu Dhaalu atolls).

GENDER INEQUALITIES HINDER HUMAN DEVELOPMENT

The disadvantages facing women and girls are significant, and an analysis of human development should identify and confront these disadvantages. All too often, women and girls are discriminated against in health, education and the labour market—with negative repercussions for their freedoms and capabilities, and for their society's human development. [21]

The UNDP Gender Inequality Index (GII) reflects women's disadvantage in three dimensions—reproductive health, empowerment and the labour market. The index shows the loss in human development due to inequality between female and male achievements in these dimensions. It ranges from 0, which indicates that women and men fare equally, to 1, which indicates that women fare as poorly as possible in all measured dimensions.

The world average score on the GII in 2010 was 0.56 in 2010, reflecting a percentage loss in achievement across the three dimensions due to gender inequality of 56 percent. Regional averages range from 32 percent in developed OECD countries, to 74 percent in South Asia. Sub-Saharan Africa, South Asia and the Arab States suffer the largest losses due to gender inequality.[22]

In the Maldives, while gender parity has been achieved in education (primary and secondary), women continue to face barriers to participation in public life. In politics,

women remain severely under represented, at both the national and the sub-national levels. Although there is no institutional discrimination against women to become a Member of Parliament or a local councilor, there is no quota for women representatives in these institutions. As a result these institutions present male dominated environments, which are difficult for women to gain entrance. Women have expressed challenges in securing the candidacy of political parties, financial endorsement for elections and campaigning for elected positions.[23] Maldives therefore continues to face challenges to meet MDG goal 3 on gender equality.

There is a substantial difference in the labour force participation rate between women and men as the GII figures indicate. Unemployment among women remains high. Women's presence in the country's largest industry, the tourism sector is very low. Cultural, religious and societal restrictions on mobility continue to limit participation of women in paid employment. The relatively low labor force participation rate of women is partly due to the unavailability of childcare services causing young mothers to exit the labour force to assume domestic roles. As recently as 2000, it was estimated that less than 4 percent of men contributed to household tasks of cooking, childcare, cleaning, washing or ironing. This may be linked to the fact that there is gender disparity in tertiary education, where male participation is 55 percent compared to 45 percent for females. More limitations exist for girls than for boys in migrating to access secondary education.

In the Maldives, there is a significant gap in the loss experienced due to gender inequality between Malé, the capital, and the atolls (Figure 8). The highest loss is experienced by Thaa, Laamu atolls (Region 5), Meemu, Faafu and Dhaalu atolls (Region 4) and Gaafu Alifu, Gaafu Dhaalu atolls (Region 6). This is mainly due to there being no female representative in the Parliament from these atolls, relatively low participation rate of girls in secondary education and high fertility rate among adolescent girls (below the age of 19) particularly in Thaa, Laamu, Gaafu Alifu and Gaafu Dhaalu atolls.

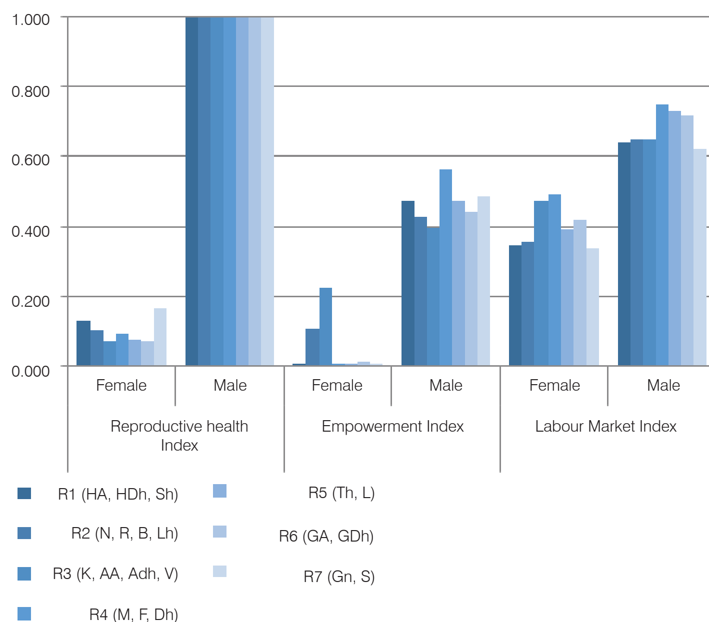
When we examine the three dimensions of the GII, we find that there is a major disparity between women and men in all three areas (Figure 8). Reproductive Health Index score is particularly low for the southern atolls except in Addu, which is a cause for concern. This may be linked to the lack of access to higher education in the atolls, particularly for girls, due largely to mobility constraints. Many parents do not allow their daughters to move to other islands or to the capital, Malé, for higher education due to safety concerns among other reasons.

Similarly, mobility constrains girls from accessing employment particularly after finishing school as most of the jobs that are available are on the tourist resorts and parents are hesitant to let girls take up jobs in the tourism sector due to societal pressure and image issues, in addition to safety concerns. As a result, after completing lower secondary schooling girls have limited options on their islands given the lack of jobs and/or educational choices. They are thus subject to early marriage and adolescent pregnancies, which accounts for the high fertility level among adolescent girls. The empowerment index suggests limited opportunities for women to participate in political life, when compared to men, particularly in the southern regions.

Women's participation in the political and public spheres remains low—a factor constraining human development and women's political freedoms. The 2008 democratic constitution removed the ban on women from running for the Presidency. According to the Second MDG Progress Report 2007, while gender parity has been achieved in education and the proportion of women in paying jobs is increasing, men still dominate decision-making. In the 2011 local council elections, out of 1,058 local councillors only 58 elected were women. For the 2014 local council elections, while there were 2,463 candidates in the fray, only 282 candidates were women and only 60 of them were elected. Similarly, out of 85 Parliamentarians only five women were elected to the country's legislature, in 2014.[24] In 2007, the first two female judges were appointed to the Maldivian judiciary. Since then, three more women judges and more women magistrates have been appointed. The appointment of five women judges over a five-year period indicates the slow pace of women's representation in the judiciary. With the total number of judges standing at 194, the representation of women in the Maldivian judiciary currently stands at a very low 3.8 percent.

Both structural and practical barriers limit the participation of Maldivian women in public life. In addition, a shift towards more conservative religious practices has resulted in increasing restrictions on

Figure 8 Reproductive Health, Empowerment and Employment Indices in the Maldives



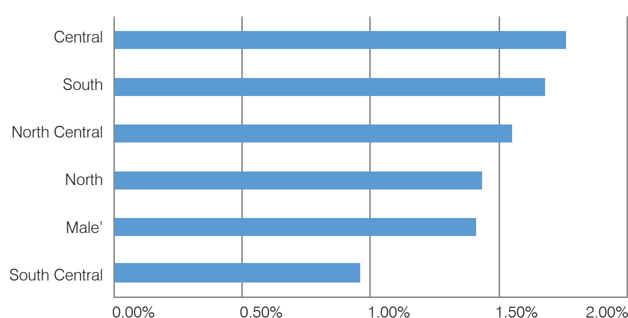
Source: Annex II, Table 4

women's role in the public domain. Tremendous challenges persist in an environment of limited democratic space where political competition is restricted. The Rights Side of Life Survey, conducted by the HRCM also asked if respondents agree or disagree that women should have equal rights with men to take part in the Government and be elected to political positions. In the 2005 survey, 24.5 percent of male respondents and 14.1 percent of female respondents disagreed and or strongly disagreed with the statement. In 2011, 23.3 percent of male respondents and 14.1 percent of female respondents disagreed or strongly disagreed with the statement showing that there had been no change in the attitudes towards women's political participation over the six years.[25] The reasons given by respondents for the lack of women elected in local councils varied from no female candidates, no qualified female candidates, lack of societal support for candidates, men do not want to vote for a female candidate, candidate's lack of funds, men were better than female candidates, lack of family support for candidates, lack of female support for candidates and women do not want to take part in political life.

POVERTY BEYOND INCOME

Income poverty provides very useful information. Yet poor people themselves define their poverty much more broadly to include lack of education, health, housing, empowerment, employment, personal security and more.[26] The Multi-dimensional Poverty Index (MPI) is an index designed to measure acute poverty through education, health and standard of living. The MPI measures Incidence of poverty: the percentage of multi-dimensionally poor people or headcount ratio, H; Intensity of poverty: the average number of deprivations poor people face at the same time, Composition of poverty: by each of the 10 indicators and their weighted contributions.

Figure 9 Low Multidimensional Poverty Prevalence Rate across Regions



Source: Annex II, Table 4

For MPI all the data must come from the same survey. Key findings on MPI show that in 2010 about 1.7 billion people in the 104 countries covered by the MPI, a third of their population, live in multidimensional poverty—that is, in acute poverty with deprivations in at least a third of the dimensions of health, education and living standard. This exceeds the estimated 1.4 billion people in those countries who live on US$ 1.25 a day or less (though it is below the number of people that live on US$ 2 or less).[27]

For the construct of the MPI in the Maldives, the data from Demographic Health Survey (DHS) 2009 was used, using the household as the unit of measurement. This is mainly because the calculation of MPI mandates all indicators to have the same data source, which was only available in the DHS. (It is to be noted that the regional categorization in the DHS differs from that of the HIES 2009/2010, which is the main source for estimating the regional HDI and other dimensions discussed above).

The estimated MPI values for the Maldives are at 0.015, while for Malé it is only slightly lower at 0.014 and for the atolls the value is at 0.015 (Figure 9). The highest prevalence of MPI is seen in the central (Alifu Alifu and Alifu Dhaalu atolls) and south regions (Gaafu Alifu, Gaafu Dhaalu, Gnaviyani and Seenu atolls), which fared well in per capita income measures discussed above. The south central region (Meemu, Faafu, Dhaalu, Thaa and Laamu atolls) fare best on the MPI, which interestingly fared less well when only per capita income was considered (for details see Chapter 3). This shows the importance of looking at poverty dimensions beyond income. It is important to note that overall, the Maldives demonstrates low MPI values across all the regions.

THE GAPS THAT REMAIN - INCOME AND EDUCATION

While the Maldives has demonstrated impressive outcomes in human development performance in the past decade and has been a big contributor to human development progress in the South Asia region, the country grapples with major inequalities that threaten human development progress for all and these differences are most apparent between Malé and the rest of country (the atolls). A person living in the capital is likely to earn nearly twice as much as someone living in the atolls and will have three more years of schooling than a person living in any other part of the country.

Unpacking human development drivers and performance at the sub-national level has helped to understand the question – 'inequality of what'. The assessment has revealed that major disparities occur in income and education. Education performance is lowest in Region 6 (Gaafu Alifu and Gaafu Dhaalu atolls) and consequently the region scores the least in overall human development performance. This is mainly attributed to lack of secondary and higher-secondary schooling opportunities in the region and

possibly due to high levels of migration of the student population from the region to the capital Malé or to other regions to seek better quality schooling. Income disparities across the regions can be explained largely by the concentration or lack of tourism. This is the case for Region 3 (Kaafu Alifu Alifu, Alifu Dhaalu and Vaavu atolls), a region that tops per capita income at the regional level and is the second highest performer in overall HDI at the regional level. Another noticeable factor responsible for income disparity is the lack of connectivity and accessibility or the absence of transport infrastructure. The lowest per capita income was found in Region 2 (Noonu, Raa, Baa and Lhaviyani atolls), which performed less well in overall HDI. The region has poor accessibility, particularly in its northern parts. Consequently, the region has relatively low concentration of tourism, against the size of population and there is high level of dispersion of population across the islands.

Having identified the nature and degree of inequalities that exist within the Maldives, the next chapter will look into the relationships of inequality and vulnerability and examine how these forces impact human development outcomes. At the threshold of a new era, the Maldives has the opportunity to fully realize its human development potential and launch new initiatives to close gaps in human progress.

Chapter 2

Inequality & Vulnerability – Connecting the Dots

Chapter 2

Inequality and Vulnerability – Connecting the dots

Fundamental to vulnerability is being at risk of long-term patterns or one-off events that threaten human development. A web of such risks already poses a significant threat to widening human development inequalities in the Maldives. This chapter explores the relationship between risk and vulnerability, on the one hand, and the more direct impact of vulnerability on inequality, on the other.

Vulnerability, referred to as '*heenarukan*' in Dhivehi, is the probability or risk today of being in poverty or of falling into deeper poverty in the future. Generally, the term vulnerability refers to exposure to contingencies and stress, and the difficulties in coping with them. These uncertainties arise from a wide range of risk factors: natural disasters, systemic political and market failures, external economic shocks, adverse technological and market changes. As the global Human Development Report 2007/2008 states the broad idea of vulnerability can be reduced to "some sense of insecurity, of potential harm people must feel wary of—something bad can happen and spell ruin".

Vulnerability adds an important dimension to the debate on poverty and inequality, bringing in a dynamic aspect to the understanding of poverty. It recognizes and captures change in systems, processes and relationships. Examining vulnerability is therefore important to understanding the dynamics of inequality. Vulnerability and inequality are concepts that are complex and multi-faceted. They are inter-linked and impact each other. Inequality increases the vulnerabilities of certain groups or individuals to shocks such as natural disasters or to economic stress such as joblessness. This vulnerability can further widen inequality and push these groups or individuals to more vulnerability in the future.

This chapter seeks to understand the vulnerabilities facing the Maldives and how these impact inequalities in human development outcomes. The analysis presents the type of vulnerabilities and their impact at both the micro and macro-level. The chapter argues that structural vulnerabilities such as the physical or geographical characteristics of the Maldives, the country's economic model and transitions or external shocks have an impact on the institutional capacity to address inequality, for example the Government's ability to close the disparities observed in years of schooling or incomes. Similarly, it is argued that these vulnerabilities directly impact different communities, households and individuals and have a direct bearing on inequality. The chapter concludes that spatial setting, income and identity are the main drivers of vulnerability and inequality in the Maldives. An understanding of human development capabilities based on where a person is located; what she or he does and who he or she is, can help to shape policies that promote equitable human development.

LINKING VULNERABILITY AND INEQUALITY – THE MALDIVES CONTEXT

According to Robert Chambers, 'Vulnerability has two sides; an external side of risk, shock and stress to which an individual is subject and an internal side which is defenseless, which is a lack of means to cope without damaging loss. Loss can take many forms - becoming or being physically weaker, economically impoverished, socially dependent, weaker, humiliated or psychologically harmed'.[1] Structural vulnerabilities such as risks or shocks affect internal and external aspects of vulnerabilities at the micro level. Moser uses a two-step model of sensitivity and resilience to understand vulnerability. 'Analyzing vulnerability involves identifying not only risks but also the resilience or responsiveness in exploiting opportunities and in resisting or recovering from a changing environment'.[2]

BOX 3. SIDS like the Maldives have Unique Vulnerabilities

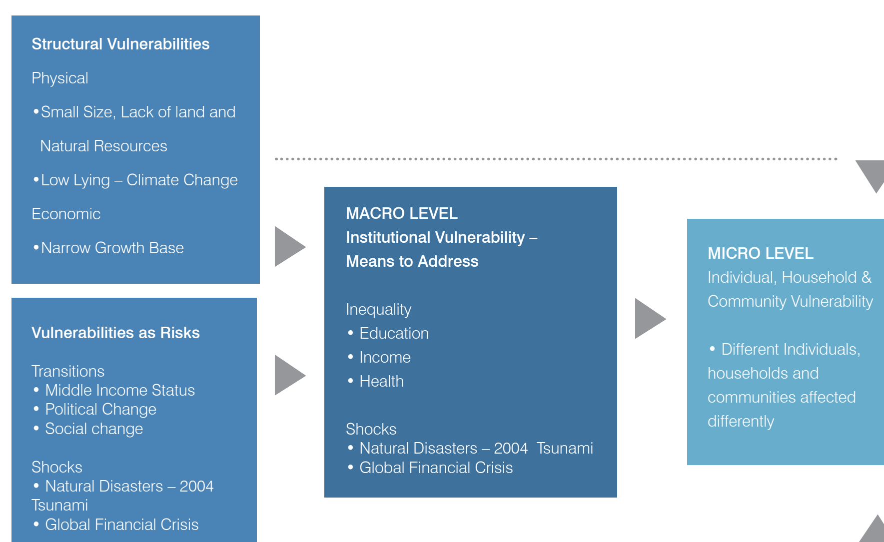
- Geographical isolation
- Small size
- Limited natural and human resources
- Cultural and ethnic diversity
- Aid dependence
- Vulnerability to climate change and natural disasters

Source: Secretariat of Pacific Community, 2012

The proposed framework (see Figure 10), aims to explore the relationship between vulnerability and inequality in the context of the Maldives. Vulnerabilities have implications for the capabilities of individuals, households and communities at the micro level. Vulnerabilities also affect inequality at the macro-level, through the impact on institutions and the ability of the state to address inequalities and inequities; these in turn affect individuals, households and communities. Vulnerabilities constrain the state's ability to close the inequality gaps in areas such as education. Rising inequality and poverty reinforces vulnerability and in turn affects choices of specific groups and people in society.

There are two types of vulnerabilities that will be considered. Structural vulnerabilities are those that Chambers refers to as the 'defenceless' aspects to cope with loss or mitigate loss or the 'internal side'. In the Maldives, these vulnerabilities are those that the country faces particularly as a SIDS [Box 3]. These include economic vulnerabilities due to high external dependency and narrow growth base and physical characteristics i.e. small size, lack of land and natural resources as well as the low lying geographical situation of the country, which makes it among the most vulnerable countries in the world to climate change and an increase in the sea level. The second type of vulnerability is defined in terms of risks, these are termed as the 'external side' by Chambers.These can be macro-economic shocks, natural disasters, health hazards, personal insecurities and even to social compulsions such as dowry. Chronic exposure to risk is a source of vulnerability, which in turn affects inequality, both at the institutional and individual level. These risks can be understood in the Maldives context through the multiple economic, political and social transitions that the country has seen in recent years. These include specific events like the tsunami and global financial crisis.

Figure 10 Vulnerability Links to Inequality at Macro and Micro Level



STRUCTURAL VULNERABILITIES

Structural vulnerabilities make addressing inequalities difficult and complex. The spatial dispersion of population and the scarcity of land due to topography constitute major challenges to delivering quality services to the population, particularly in terms of building of infrastructure to encourage economic activities. Expanding higher-secondary schooling to small remote populations has proved to be expensive and difficult, and this reinforces education inequality in the country.

The islands of the Maldives dot the sea for an area of over 860 kilometres in length and about 80 kilometres to 120 kilometres in breadth. The individual islands themselves vary in size, from 0.5 square kilometres to around two square kilometres. Land is a scarce resource in the Maldives. The total land area of the Maldives is estimated to be approximately 225.9 square kilometres and habitable land is limited.[3] Of the 1190 islands, 188 islands are inhabited. Some of the remaining 1,000 uninhabited islands are used for tourist resorts, others for industry and agriculture. Of the inhabited islands, only 39 islands have a land area of more than 100 hectares, while 151 islands have land areas of less than 50 hectares each.[4] The Exclusive

Economic Zone (EEZ)[5] of the country is approximately 859,000 square kilometres. As for natural resources, apart from the marine reserves, the country has few resources or vegetation that can be converted to economic or development opportunities.

The lack of land space and the low concentration of population in islands reduce the feasibility and potential for economic activity and investment in sectors other than tourism, except in the capital Malé. Regional disparities are due largely to the differential incidence and intensity of tourism. The expansion of tourism throughout the country has been slow due to the challenges of logistics in property development and the difficulties of operation in regions where there is limited connectivity and infrastructure. The lack of commercial activities on the islands further limits employment and income opportunities, putting the local communities at risk of low and unstable incomes or joblessness. They are particularly vulnerable when there are external shocks such as disasters or unforeseen events.

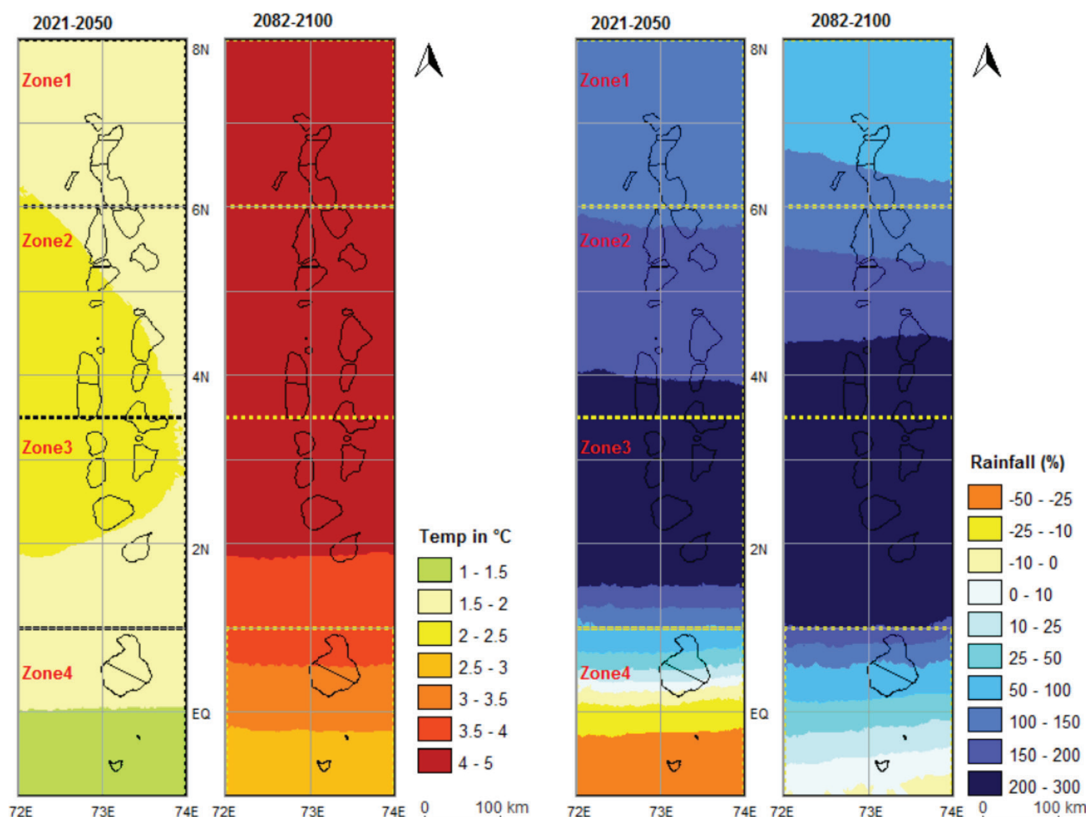
THE MALDIVES - ONE OF THE LOWEST LYING COUNTRIES IN THE WORLD

The Maldives is particularly vulnerable to climate change. The average ground level elevation is about 1.5 meters, less than five feet above sea level. The potentially adverse impact of climate change includes beach erosion, infrastructural damage, loss of biodiversity, drought and impact on human health and food security. The Intergovernmental Panel on Climate Change (IPCC) projects a sea level rise of 18 to 59 centimetres between 1990 and 2095. The World Bank further corroborates these results concluding that global warming of 4ºC may be seen as early as 2060 and says that a rise of the sea level less than two metres can be maintained only if the warming is kept below 1.5ºC.[6] Thus it is clear that if the predictions that have been made come true, it will have a devastating impact on Small Island Developing States (SIDS) such as the Maldives.

Downscaled global climate change scenarios on the local domain reveal similar results.[7] It is estimated that there will be an increase in temperature and rainfall over the entire country by 2100 [Figure 11] and a greater increase within central Maldives. Associated with this, extreme events of rainfall are expected to increase over the entire country, which could lead to high levels of flooding, which will in turn affect farming and infrastructure. It could lead to outbreaks of disease and may make certain groups more vulnerable or disadvantaged.

Similar to the increase in air temperature, an increase in the sea surface temperature is predicted. This could have an enormous impact on the marine environment. In addition to this, projections indicate a change in the maximum sea surface heights; it is estimated that

Figure 11 Temperature and Rainfall Predictions for the Maldives



Source: Adapted from Ministry of Environment, 2012

there could be a change of as much as 8.2 cms to 9.5 cms by 2080.[8]

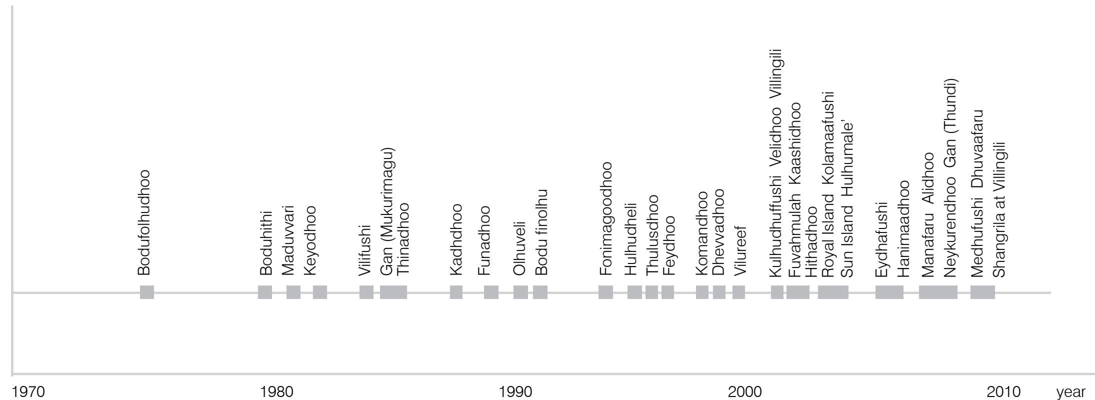
In the past six years, more than 90 percent of the inhabited islands have reported some flooding, with 37 percent of the islands reporting flooding as an annually recurring event. Ninety seven percent of the islands reported erosion of the shoreline; 64 percent of the islands indicated that erosion is a severe issue.[9] Close to half (45 percent) of the tourist resorts reported severe erosion. Erosion is impacting housing, infrastructure and business development on these islands, which in turn can affect and restrict human development acceleration in the communities that live on them. The chronology of reported erosion shows that this is a recent phenomenon as illustrated below [Figure 12]. In recent years, the Maldives has been experiencing high frequency low impact hydro-meteorological disasters[10] due to changes in weather patterns. These cause coastal flooding and storm surges. Most of the natural disasters that the Maldives is likely to face will result from climate variability and change. These will have implications for the country's economy and on the ability of institutions to respond to potential shocks or implement interventions to build the resilience of communities.

The impact of climate change will affect agriculture and pose the risk of food insecurity and may lead to worsening nutrition status of households. Sea level rise will damage agriculture crops and lands from saltwater intrusion, salt spray and flooding. Coastal vegetation and forest cover including coconut vegetation have already been severely affected due to erosion.

The fisheries sector has a set of issues and vulnerabilities too; these require specific and well-considered actions. Biological and ecological responses to physical changes (e.g. productivity, species abundance, ecosystem stability, stock locations, pathogen levels and impacts) and consequent adverse effects have been experienced by the sector.

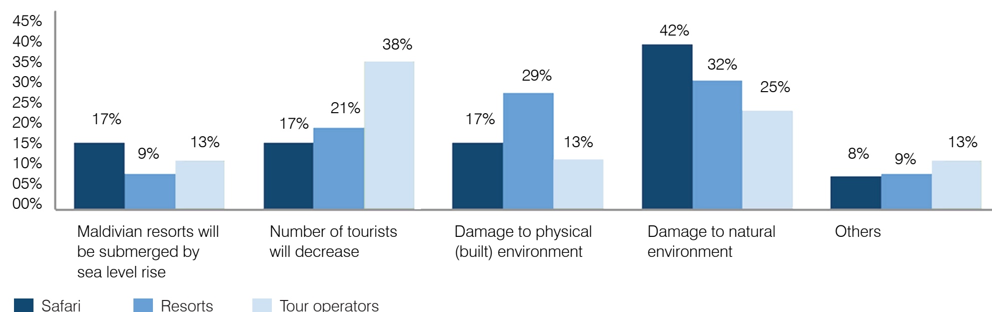
Figure 13 shows the perception of the tourism industry regarding the impact of climate change on the industry, the main growth engine in the Maldives. The potential impacts range from the submergence of resort properties, damage to man-made infrastructure and natural environment, to a decline in tourist arrivals.

Figure 12 Reports of Erosion on Survey Islands – 1970 - 2010



Source: Ministry of Environment, 2012

Figure 13 Perspective on the Potential Impact of Climate Change on the Tourism Industry



Source: Ministry of Tourism, 2012

Climate change impact can be seen in high rainfall, flooding and coastal erosion, which can affect housing, jobs, farms, fish stock, tourism properties and public infrastructure. The impact of climate change can leave many communities and households homeless and can reverse gains made in education or health services in certain regions or islands. Building resilience of the communities through sustainable adaptation mechanisms to contend with these issues is critical to the survival of the population in these islands.

The 2013 MDG Assessment prepared jointly by the United Nations and the Government of Maldives notes the criticality of addressing MDG 7, which refers to achieving environmental sustainability[11], and cites water, sanitation and waste management as immediate priorities. The public sector spends on average, less than two percent of its budget on environmental protection, despite the vital importance of this sector. Institutional challenges with respect to this sector are quite severe. There is a multiplicity of agencies, plans, laws and regulations, and programes. The division of mandates, responsibilities and standards is not always clear; a severe human resource crunch in the public sector has exacerbated the situation. Coordination in this sector requires the cooperation of many Government agencies and all the ministries, at both the central and local island levels.

THE 2004 TSUNAMI - A MAJOR SHOCK TO THE SYSTEM

A major tsunami struck the Maldives and a number of other countries in the region, on 26 December 2004. It was a major shock to the country and its people. The disaster, which affected the people living on the islands, exposed the country's vulnerabilities in an unprecedented manner. Close to two thirds of the GDP was washed away in a few long minutes. Although the economy bounced back within a year and demonstrated resilience, the physical vulnerabilities of the country posed major challenges in terms of the devastation caused and the time taken to reconstruct and restore infrastructure and the livelihoods of communities.

At the micro-level, the tsunami brought both damage and destruction for many island communities and households. Four islands were declared uninhabitable and the populations were classified as Internally Displaced Populations (IDPs). The ground water was contaminated and the rain-water harvesting infrastructure was destroyed, worsening the situation.

The Government's capacity to restore growth and human development was constrained by its limited resources. The economy experienced negative growth in 2005, minus 8.75 percent, for the first time. While the international community responded with substantial financial resources, channelling these resources to affected communities was not easy. Even more challenging was the process of recovery and the restoration of economic growth. Responding to the crisis, the Government set up the National Disaster Management Centre (NDMC), and moved to establish aid coordination mechanisms and revive local implementing agencies.

Damage to tourism-related establishments due to the tsunami was estimated at US$ 100 million.[12] Tidal waves damaged field crops on 2,103 farms, destroyed backyard crops and agricultural implements in 11,678 homesteads. Over 700,000 fruit trees were damaged on the inhabited islands. The damage to land and ground-water resources was reported as severe in 35 agricultural islands and saline water intrusion affected 112 inhabited islands.[13] Thirty percent of tourist beds in the Maldives were not operational. Tourist arrivals were down by 5,625 for the first 11 days in January 2005, as compared to the first 11 days in January 2004. By the end of 2006, however, bed occupancy rates were back to pre-tsunami levels.

It is interesting to note that the impact of the tsunami on poverty was not significant. The Tsunami Impact Assessment actually reported a fall in poverty incidence after 2004. In June 2004, 34 percent of the population had an income lower than MRV 15 per day, which was the national poverty line used in the 2004 Vulnerability and Poverty.[14] One year later, only about 20 percent of the population was classified as being under the poverty line. Mean incomes of the population continued to grow after the tsunami. This may be due to the relief and recovery support that the communities received and more importantly the resilience of the tourism industry, which recovered quickly and helped to restore incomes in affected communities and households.

The tsunami left many groups vulnerable in the Maldives and led to increased disparity within regions, chiefly with respect to the capital Malé. Although a direct attribution cannot be determined, the highest poverty incidence in the country was found in regions that were severely affected by the tsunami. These include Region 2 (Noonu, Raa, Baa and Lhaviyani atolls), Region 5 (Thaa, Laamu atolls) and Region 6 (Gaafu Alifu and Gaafu Dhaalu atolls) as per the HIES 2009/2010 data.[15] The most vulnerable groups of people were those engaged in the fisheries, agriculture and tourism sector, many of whom lost both their livelihoods and their houses, savings and other assets. Many of the families that were initially classified as IDPs, moved to the capital Malé, and have become permanent migrants and are increasingly being

BOX 4. Impact of Tsunami on Maldives

Number of People Dead: 82
Number of People Missing: 26
Internally Displaced Population: 30,000
Shelter: 8500 damaged & 2800 destroyed
Estimated Damage and Loss: US $470 million (equivalent to 62% of GDP)

subject to urban poverty.

The tsunami experience should be used by policy makers to build on the evident characteristics of resilience in the economy and amongst communities and people. At the same time design interventions should be planned to protect communities from future disasters or potential shocks from climate related events to the extent possible.

NARROW GROWTH BASE AND HIGH EXTERNAL DEPENDENCY ADDS TO VULNERABILITY

The economic vulnerability of the Maldives is characterized by a narrow growth base that is dominated by tourism and high external dependence, especially on fuel and food imports. Economic vulnerability is interlinked with physical vulnerability characteristics discussed earlier such as the lack of land, low population dispersion and the inadequacies of availability of supporting infrastructure and services.

The Maldivian economy has been dominated by the tourism sector since the 1970s. The share of tourism in GDP has remained high, at almost 30 percent for the past two decades. The share of the primary sector (including fisheries and agriculture) has declined over the years. In 1984, fisheries constituted 11.8 percent of GDP and agriculture accounted for 6.6 percent of GDP. In 2013, the figures stood at 1.6 percent and 2.3 percent respectively.[16] In contrast, the share of the manufacturing sector has risen rapidly with the growth of the tourism sector. In 1984, the share of the construction sector in GDP was 2.7 percent. In recent years, the sector has steadily grown and now accounts for 12.8 percent of GDP. The transport and communication sectors have grown in a similar manner with the expansion of tourism. The contribution of the primary sector declined to 3.4 percent by 2012, with the fisheries sector contributing 1.7 percent and agriculture an equal 1.7 percent.[17]

With a narrow economic base and minimal vertical and horizontal diversification, the economy is highly vulnerable to world travel trends. A decline in the tourism industry could have a serious impact on the cost and standard of living, development activities, provision of public services, level of economic activity and employment. In contrast, countries such as Mauritius and Singapore, both of which have shown resilience to the global economic crises have four or more sectors with a double-digit share in their GDP.[18]

HIGH EXTERNAL DEPENDENCY – SOURCE OF FOOD AND ENERGY INSECURITY

The Maldives has a very open economy. Key imports include petroleum products, boats, food products, textiles, and intermediate and capital goods. The country's imports are primarily obtained from Singapore, the United Arab Emirates, India and Malaysia. The Maldives continued to have a high current account deficit in the last decade due to growth of imports and their price volatility. From about 4 percent of GDP, the current account deficit widened to 16 percent in 2004 and further deteriorated to 39 percent in 2007, driven by a surge in construction-related imports and rising commodity prices, notwithstanding the contribution from strong tourism earnings. The deficit has continued to remain high and in 2012, the deficit stood at 27 percent.[19]

The Maldives is extremely dependent on food imports. It is self-sufficient in fish production but rice, wheat flour, fruits, vegetables and other food items are imported. It is estimated that the Maldives produces less than a tenth of its food requirements.[20] Most of the food products including all staples (rice, flour and sugar) are imported. Food production in the country is limited to horticultural crops and fishing. Both sectors are highly dependent on specific climatic factors, which are rapidly changing. To cater for the demands of the growing population and the expatriate communities, coupled with the large number of tourists visiting the country, the Maldives needs to import large quantities of food every year. In 2012, food items accounted for about 21 percent of the total imports and the food bill reached US$ 318.9 million, demonstrating huge implications for both food security as well as inflation.[21]

Food price spikes and volatility are a growing concern. There has been a consistent rise in food prices over the years. It has a direct impact on food security, economic growth and poverty reduction. Price volatility has a strong influence on food security since it affects household incomes and purchasing power. It limits the ability of people to eat well and enough, and increases the risk of vulnerable people becoming poor and food insecure.

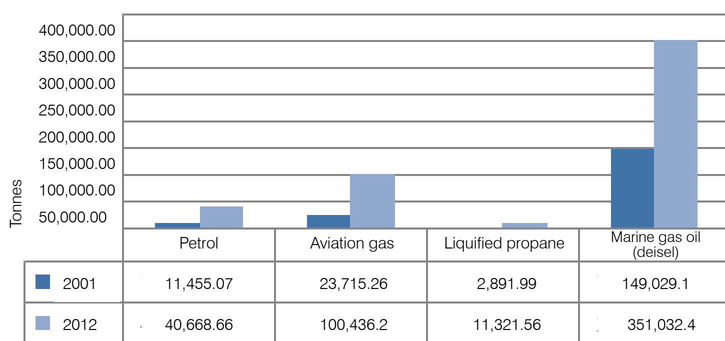
Traditionally the people of the Maldives have relied on renewable energy resources such as wind energy for transport (sailing boats) but with the growth of tourism and rapid economic development, fossil fuel now constitutes 98 percent of the total primary energy demand and is the dominant energy source for transport, electricity generation and other industrial activities.[22]

Table 3 Energy Bills - Burning the Pocket

Year	US$ (million)	% GDP
2009	193.3	14
2010	245.0	17
2011	340.2	26
2012	474.6	35

Source: UNDP, 2013

Figure 14 Fuel Imports - 2001 and 2012



	Petrol	Aviation gas	Liquified propane	Marine gas oil (deisel)
2001	11,455.07	23,715.26	2,891.99	149,029.1
2012	40,668.66	100,436.2	11,321.56	351,032.4

Source: UNDP, 2013

The two major areas of energy use are electricity generation and the transport sector. In Malé, for instance, electricity generation has increased from 42 million kWh in 1994 to over 201 million kWh in 2009, representing over 11 percent growth per annum.[23] The Maldives depends entirely on imported fossil fuel for meeting its growing energy needs. Being dependent on fuel imports makes the country vulnerable to international fuel price fluctuations, which threatens its energy security. This is evident from the sharp increase in fuel expenditures as a percentage of GDP in recent years (see Table 3). In 2012, the Maldives spent US$ 474.6 million on fuel-based imports (excluding bunker fuels), which accounts for about 35 percent of the GDP of the country. Major types of fuel imported in to the country include Liquefied Propane, Petrol, Aviation Gas and Marine Gas Oil (Diesel). [Figure 14] shows the amount of fuel imported in the years 2001 and in 2012. Of the total fuel imports, 70 percent is diesel fuel; about 44 percent of the diesel fuel is used for electricity generation.

The development of the energy sector has been hampered by the smallness of the majority of inhabited islands, which has led to a system of 'mini-grids', as opposed to one national power grid. Islands have their independent power-houses and electricity distribution networks. Although most of the island populations are connected to electricity, poor and unreliable electricity supply has constrained economic and social development. Due to their inefficiencies, high losses, and small size, average cost of electricity is high, with average tariffs of about MVR 4 to MVR 8 per kWh, while the average rate in Malé is MVR 3 per kWh.[24]

GLOBAL FINANCIAL CRISIS AND MIDDLE INCOME COUNTRY (MIC) STATUS INTERRUPTS DEVELOPMENT

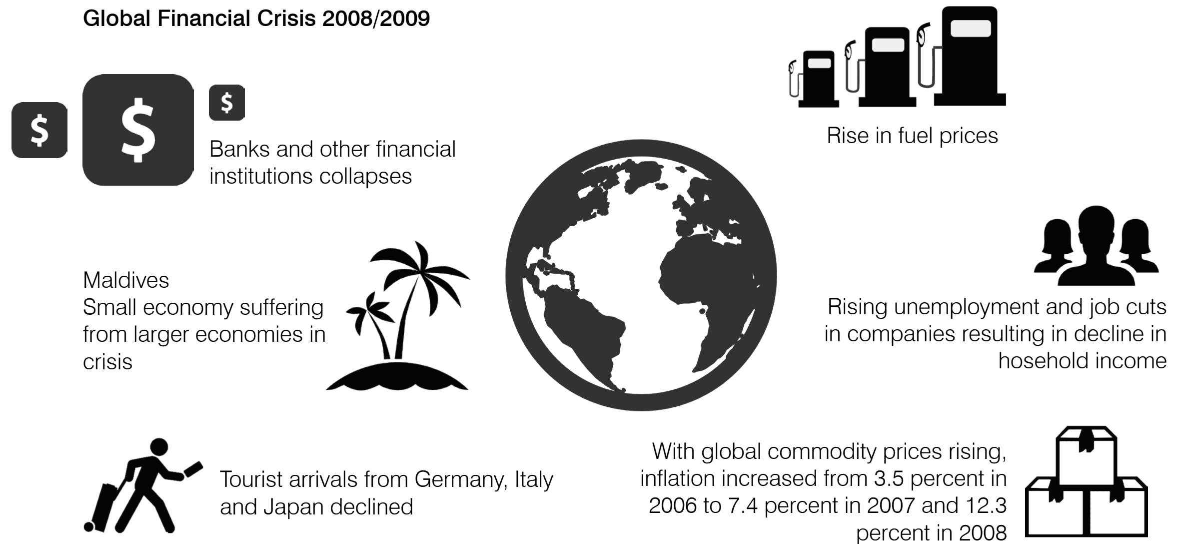
The Maldives has faced several events and transitions in the recent past. These have affected the economic growth path of the country and continue to exacerbate the Government's ability to close human development gaps and inequality. Such events continue to directly drive inequalities at the household and community level, as well.

The financial crisis of 2008 is considered to be one of the worst financial crises in recent history. The crisis started with the collapse of the U.S. financial sector and quickly spread to other financial markets. When the year 2008 ended, the world economy was declared to be in recession. At this time, the Maldives was already facing a domestic fiscal crisis, characterized by twin deficits of rising budget deficit and debt, due to high levels of post-tsunami expenditure as well as election related spending in the period 2007-2008. The global crisis aggravated the already difficult economic condition and drove the country into negative growth again.

There was a fall in tourist arrivals and tourism receipts and a decrease in foreign capital flows, which in turn tightened the credit and investment needed for tourism development. Sixty-four resorts that were under construction were put on hold. From July 2008 onwards, a decline was seen in tourist arrivals to the country in every month, except the months of September and November. As a result, the 12 percent growth in arrivals and the 10 percent growth in bed nights witnessed in 2007 fell to 1 percent and 3 percent respectively, in 2008. The cumulative figures from January 2009 to June 2009 show a 10.5 percent decline in arrivals and 9.1 percent decline in bed-nights. The capacity utilization rate fell from 82.8 percent in 2007 to 78.0 percent in 2008 and further to 72.6 percent in the first six months of 2009.[25]

The impact of the fuel crisis of 2007-2008 and the increase in diesel prices was significant for fishermen and the fish processing industry. With the increase in the size of fishing vessels, they have become less fuel efficient (70 to 80 percent of the average operation cost is on account of fuel in the vessels larger than 85 feet). As a result, although the Government has

Figure 15 Global Financial Crisis, Exogenous Shock to the Small Open Economy



introduced a subsidy for fishermen, that became operational in late 2008, fishing declined over the crisis period.

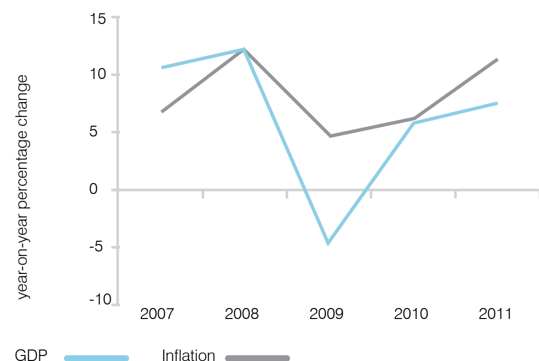
By September 2008, the construction industry in the Maldives was hard hit, on account of increased international prices coupled with a cutback in public sector projects. Fiscal constraints made it impossible for the new Government to honour a pledge made by the outgoing Government, to provide a one-off compensation package in 2009, to offset the estimated 35 percent loss to contractors during the previous year. This made the situation more difficult. The industry's main concerns in the immediate term were a lack of business in the foreseeable future, a lack of working capital and difficulties in obtaining foreign exchange.

The impact of the global financial crisis at the micro-level was undeniable but is difficult to quantify. While no official unemployment figures were recorded due to the crisis, there were reported redundancies in some of the resorts and in the construction sector, additional staff were sent on long leave. Tour guides and handicraft sellers noted a reduction in incomes.[26] However the impact on household incomes could not be assessed; it is however clear that declining household remittances from tourism and increased inflation would have affected purchasing power and quality of life. A survey conducted by UNICEF indicated that more than one in five respondents, especially in outlying islands, lacked an adequate quantity of food sometime during the previous year. About one in three households, particularly in Malé, stated that they had reduced food stocks compared to a year earlier, underscoring the urban impact of the crisis.[27] The study noted that fish and flour were the two commodities, which faced the most shortages, because of low seasonal catches and resultant low purchasing power.

At the macro-level, the international financial crisis had a severe impact on the Maldivian economy. The GDP experienced negative growth of 5 percent for the second time, after the tsunami. Public finances were strained by the fall in Government revenue (tourism revenue declined substantially as resort lease rents were waived for struggling properties and bed tax receipts fell from loss of arrivals).

Economic recovery picked up in 2010 and there was a gradual resumption of the levels of tourist arrivals.[28] On the other hand the economy continued to be weighed down with macro-economic instability. The budget constraints resulting from the worsening fiscal deficit and the debt conditions continuing from the impact of the global financial crisis, still pose major challenges. These impact the Government's ability to

Figure 16 GDP and Inflation, 2007-2011



Source: MMA, 2011

address issues of quality health care, education and unemployment especially in the far-flung islands.

MALDIVES GRADUATES TO A MIC

As the Maldives was recovering from the impact of the global financial crisis, it faced another major transition that may have an impact on its development trajectory. On 1 January, 2011, the Maldives graduated out of the Least Developed Country (LDC) status after a longer than usual transition period. The Committee for Development Policy (CDP) had found that the country met the graduation criteria in two successive triennial reviews in 2001 and 2004. The Maldives graduation process was postponed due to the tsunami until 2009, when it was agreed that it could not be deferred further. The impact of graduation to Middle Income Country (MIC) status can come in the form of loss of international trade, development finance and aid as well as incurring of additional costs. With the graduation, the Maldives loses preferential access to the European Union (EU) and the Japanese market for fish exports and may be disadvantaged in multi-lateral trade agreements such as World Trade Organisation (WTO) and South Asian Association for Regional Cooperation (SAARC) negotiations. The EU has extended tariff concessions till 2014 and the Maldives needs to seek similar concessions from Japan, Sri Lanka, Thailand and other south-south trade partners. Overseas Development Assistance (ODA), particularly grant allocations by donors is estimated to be declining. The Maldives may have to incur additional costs of travel to UN, WTO and increase its contributions to the UN budget and other UN bodies.

It is still too early to ascertain the impact of MIC graduation on the MDGs. The risk factors are mainly associated with the phasing out of LDC-specific concessions in ODA and trade. This is critical given the rising debt levels and the impact on public finances in debt servicing. There is a growing risk of the Government having to compromise social spending for debt servicing. The Maldives should therefore explore new initiatives under SIDS and SAARC trade and customs treaties that could provide space to maneuver trade and financial flows.

CONTINUED MACRO-ECONOMIC IMBALANCES – THREAT TO INVESTMENTS IN HUMAN DEVELOPMENT

The continuance of macro-economic imbalances is a critical threat to investments in human development. The Government's ability to invest in improving quality of schooling or placing qualified doctors in the remote parts of the country is constrained by financial resources. In a phone survey conducted with health service providers for this report, six out of 22 people felt that the main challenge for them is the lack of adequate resources. Consultations with service providers indicated that many of the facilities were unable to settle their payments due to the central Government's cash-flow crisis. As a result, the facilities lack resources to carry out simple medical procedures, tests and everyday medical consumables. This puts patients as well as staff at risk in the health facilities that exist. The main challenge facing health facilities in the islands was the issue of human resources, equipping facilities with qualified nurses and doctors, which translates to affordability and inadequacy of budgetary allocations.

The Maldives has been following expansionary fiscal policies since the post-tsunami recovery efforts in 2005. Government spending has remained high throughout the 2006 to 2008 period, while international aid withered off with the closure of the tsunami programmes and the graduation of the Maldives to a MIC. The fiscal and debt situation was accentuated by the global economic downturn and the loss of tourism revenue. According to the International Monetary Fund (IMF), the budget deficit reached 17.1 percent of GDP in 2008 and further went up to alarming levels of 29 percent of GDP in 2009. The estimated budget deficit has continued to remain high with an expected deficit rate of 18.8 percent in 2012.[29] Re-current expenses have always triggered a rise in public spending. The growth of public sector employment by 8 percent on average during the decade 1993 to 2003 and the regular rise in salaries has been responsible for the surge in current expenditure. Tsunami-related recovery and rehabilitation spending and expenditure related to democratic transition and implementation of the current Constitution has resulted in a steep rise in the current spending in the public sector. In recent years, both the increase in the number of public sector workers as well as their salaries and allowances has resulted in a significant fiscal burden, which is unlikely to be effectively addressed in the near future. This is partly a result of the change in the democratic governance system, where the parliament, the judiciary, local councils and independent commissions have all expanded, with high remuneration packages and operational costs.

As part of the fiscal consolidation steps to address the critical deficit levels, new revenue measures have been introduced along with tax reforms. A general Goods and Services Tax (GST) was introduced in 2010, which is now collected at 6 percent. A Tourism Goods and Services Tax (T-GST) was passed in August 2010 and is now collected at 14 percent. A Business Profit Tax (BPT) was passed in 2011 and became effective in 2012. Overall revenue collections have improved substantially from MVR 6.5 billion in 2010 to MVR 9.8 billion in 2012. However adjustments from previous tax collection methods such as elimination of customs duties, US$ 8 bed tax and delayed roll out of new tax implementation affected revenue generation and it failed to meet the proposed targets. Despite initial cost-cutting measures including civil service wage cuts in 2009 and downsizing efforts of the civil service, they did not yield any fiscal savings due to the hike in spending.

For much of the deficit financing in recent years, the Government has turned to the domestic markets, through sale of Government securities. This has seen a steady increase in treasury-bill (T-bill) yields, while the interest cost has more than doubled, from 1.2 percent of GDP in 2007 to 2.7 percent of GDP in 2012.[30] However, selling more T-bills to the market has become problematic, as its main subscribers are the commercial banks. They have become increasingly reluctant to hold Government paper, while efforts by the Government to promote its securities to the wider public have not been very successful.

BOX 5. Unsustainable and Unproductive Spending - Governance Reforms and Social Protection

- The Government's universal health insurance scheme, Aasandha, turned out to be more expensive than anticipated, with the entirety of the allocation for 2012 (MVR 720 million) being exhausted by mid-year, July 2012. The Government estimates total Aasandha claims to have reached MVR 1.2 billion by year end.
- The electricity subsidy has also proved to be more expensive than anticipated and is expected to have exceeded the total allocated budget of MVR 358 million, by around MVR 70 million by year-end. Further, the electricity subsidy benefits all households in Malé and both businesses and households in the atoll islands.
- Food subsidies provide essential food staples (rice, flour and sugar) to all at low administered prices. This implies that even the resort sector (which by and large caters to an extreme high-end niche segment of tourists) becomes eligible for food subsidies.
- New legislations on governance including the Decentralization Act and the Disability Act have resulted in considerable spending increases.

The Government has been forced into three very imprudent forms of financing which are likely to have far-reaching consequences for the economy. These are: (i) increased reliance on ad-hoc forms of borrowings from both the banking and private sector at high interest rates, (ii) increased monetization of the deficit, and (iii) build-up of payment arrears. In May 2012, the Government raised a MVR 300 million facility from the predominantly state-owned Bank of Maldives at a rate of 9 percent, much above the T-bill rate, while in July 2012 and again in January 2013 it undertook several borrowings (in both MVR and US$) from private-sector resort owners. Considerable recourse to monetization was also witnessed in 2012 with a buildup of large outstanding balances in the Public Bank Account (PBA) of the Government with the Maldives Monetary Authority (MMA).

Due to financing of higher fiscal and current account deficits, the Maldives has been experiencing a significant increase in external debt in recent years. According to the latest available external debt statistics, the official external debt stood at US$ 846.2 million (38 percent of GDP) at the end of 2012, as compared to 43 percent of GDP in 2011.The debt service ratio of public and publicly guaranteed debt increased during 2012 to 3.4 percent of total exports of goods and services, up from 2.8 percent in 2011.[31] A recent debt sustainability assessment by the IMF concludes that public debt would become unsustainable in the current scenario and the country faces a high risk of public debt distress. Four of the five external debt burden indicators breached the thresholds in the baseline scenario. In the absence of strong fiscal consolidation measures in the near term, both public and external debt will remain on an unsustainable trajectory, leading to financing needs over the long run that cannot plausibly be met. Under the baseline scenario, the Public and Public Guaranteed (PPG) external debt path is projected to worsen systematically through 2030, breaching all external debt stock burden thresholds along the way.[32]

The expansionary fiscal policies of recent years, the reduced tourism receipts and foreign exchange earnings began adding significant pressures on the Rufiyaa from 2008 onwards. As the Rufiyaa is pegged to the US$ under a fixed exchange rate regime, there was a major dollar shortage. A parallel market emerged with the unofficial exchange rate reached as much as 19 MVR to one US$. In 2011, the Maldivian Ruffiyaa was finally devalued to MVR 15.42 to a dollar, which has helped to stabilize the shortage to an extent although the parallel market still operates at a rate of approximately 16.50 MVR to a dollar.

As long as the unsustainable fiscal deficit persists, the Rufiyaa will be under pressure.The prospects of further printing of money threaten external stability and risk another possible adjustment in the exchange rate. The biggest risk posed by a further exchange-rate adjustment is the possible impact it could have on poverty, as imports including food and small businesses will bear the brunt of such a transition.

The current account is deteriorating due to high levels of imports. The prospect of a strong capital account is hindered by the bleak international scenario; especially with regard to the flow of private investment and aid.

During 2012, the overall balance of payments recorded a deficit of US$ 37.4 million, leading to a drawdown of reserves by the same amount. Gross international reserves, which stood at US$ 334.9 million at the end of 2011, declined to US$ 304.6 million at the end of 2012.[33] In terms of months of imports, gross reserves were equivalent to 2.4 months of imports at the end of 2012, compared to 2.7 months at the end of 2011.The depleting reserves call for a reduction in consumption; particularly in the public sector and the promotion of exports and maintaining export competitiveness.

Although the economy demonstrated high level of resilience in the aftermath of external shocks such as the tsunami and the global financial crisis, the prolonged macro-economic instability continues to be a major source of vulnerability for the country. Further, the limited foreign reserves, price instability, currency devaluation and risk of debt distress can all have lasting impacts on poverty, quality of social services and public infrastructure, that can in turn impact private sector development, foreign investments and job creation.

INSTITUTIONAL VULNERABILITY

Institutions and policies play a critical role in shaping a country's human development and growth trajectory. Institutions influence resource distribution, investments and delivery of services that impact human development outcomes and opportunities for the population.

Vulnerability analysis has not been extensively accommodated in the analysis of institutions where the concept may also have some practical relevance. Suffice it to say that although institutional vulnerability analysis is being incorporated in the work of some organizations to assess aspects of institutional capacity in conditions of environmental uncertainties and climate change, the linkages between policy management, the vulnerabilities of implementing institutions to social forces and development is yet to receive the level of attention it deserves.

In this analysis, it is argued that physical vulnerability and economic vulnerability and various shocks and transitions impact the state's ability to address inequalities and promote human development. For example, the geographic or spatial dispersion of the population poses major challenges to policy makers in the delivery of high quality services such as education, health and other infrastructure such as power, at economical costs. Similarly, economic vulnerability and the economy's high dependence on imports affect the country's overall economic performance, which in turn affects the Government's revenue sources and tax reserves and therefore its ability to deliver services or implement inequality-reducing interventions.

The discussion above shows the impact of shocks such as the 2004 tsunami and the global financial crisis of 2008-2009. These constraints on the state and policy makers have been influenced by the recent political transitions that Maldives has seen. The Government has been struggling with the teething problems of democracy, the setting up of independent institutions and ensuring the separation of powers and creating an enabling environment for the freedom of expression. The first few years have been characterized by political instability and constant friction between the executive, the legislature and the judiciary.

POLITICAL CRISIS, INSTABILITY AND POLARIZATION – ADDITIONAL RISKS TO POLICY MAKING

The first five years of democratic transition have been characterized by the build-up of a sense of instability, associated with a series of crises. For example, the tension between the executive and Parliament was evident from resignation of Cabinet members en masse in 2011. No confidence motions against Cabinet members have been frequent.

In August 2010, the judiciary was at the centre of a constitutional crisis. Due to deep political divisions, the *Majlis* (the name given to the Parliament in the Maldives) failed to pass necessary legislation on the judiciary (e.g. the Judges Bill) and failed to approve a new Chief Justice by the constitutional deadline of 7 August 2010 leaving the country in a constitutional vacuum. The Judges Bill was finally passed by the *Majlis* three days after the deadline and assented to by the President two hours later. The same evening, the Supreme Court bench and the Chief Justice were approved by the Parliament. This crisis exemplifies the challenges faced by a new democracy in trying to come to terms with new concepts such as separation of power and following the Constitutional mandate. When the legitimacy of the State is in question, institutions are weak with limited capacities or mandate, and legislation and policies cannot be passed to serve the expansion of human choice.

The unanticipated transfer of power on 7 February 2012 marked in stark terms the significant challenges facing the country in its nascent democratic transition. It illustrated the delicate state of the country's governing bodies, exacerbated an ongoing political stand-off, and aggravated already tense inter-group relations. The fragile political environment, polarization in society and institutional friction present considerable risks to restoring stability and focusing policies and decision-making on driving human development change and addressing inequalities. The abrupt Government transition spelled change in key policy measures including reversals on health corporatization, public health decentralisation among others. The shift meant new adjustments for the civil service, re-prioritization of policies, which resulted in delays in delivery of various Government programmes and projects.

The 2013 election process demonstrated these tensions further although a peaceful transfer of power has ended these uncertainties to some extent

BOX 6. 2013 Presidential Elections

The Presidential election in Maldives was held on 7 September 2013. Inspite of an 88 percent voter turnout, the results indicated no overall majority. The run off was scheduled for 28 September 2013. The election was observed by the Commonwealth and a group of Indian observers, as well as the local NGO, Transparency Maldives. All the observer groups declared that the election was conducted in a free and fair manner.

The candidate with the third highest votes filed a case before the Supreme Court of Maldives alleging irregularities relating to the Electoral Register and other matters that could jeopardise the outcome of the first round of the Presidential Election, held on 7 September 2013. The Progressive Party of Maldives whose candidate came second filed a case in the Supreme Court requesting a postponement of the election in order to ensure that the irregularities in the Electoral Register were properly rectified. On 7 October 2013, the Supreme Court of Maldives annulled the first round of the Presidential election held on 7 September 2013 based on these cases. The Supreme Court ruling directed that a first round of fresh Presidential Election be held before 20 October 2013 and the second round, if necessary, be held before 3 November of the of the votes.

The Court declared a16 point guideline on conducting the elections, including the sign off on voter lists by the candidates. The Election Commission tried to comply with the guidelines, despite time constraints. However, the scheduled first round of elections on 19 October 2013 was cancelled, due to the intervention of the Maldives Police Service on the ground that two candidates refused to sign the voter registry. The first round was finally held on 9 November 2013 indicating a run-off once again.

Meanwhile, the term of the President came to an end on 11 November 2013 and two conflicting directions were provided by the key democratic institutions to avoid a Constitutional breach. The Supreme Court ruled that the incumbent President and his Government will remain in office if a President is not elected by the Constitutional deadline of November 11.The resolution passed by the People's *Majlis* earlier to hand over Presidential powers to the Speaker of the People's *Majlis*, if a new President is not elected before November 11 was declared as being null and void.

During this period of uncertainty and fear of democratic reversal, statements were made by the UN Secretary-General, the United States, India, UK, Commonwealth, European Union, Australia and Canada calling for free and fair elections in the Maldives; and specifically asking the Supreme Court not to subvert the democratic process. The UN High Commissioner for Human Rights, Navi Pillay, in a statement on 30 October 2013 termed annulment of elections of 7 September 2013 by the Supreme Court as "subverting the democratic process and violating the right of Maldivians to freely elect their representatives" and "putting an onerous set of guidelines for the conduct of the election, which will be difficult to satisfy". As it turned out, the second round of elections concluded the electoral crisis with Abdulla Yameen (Progressive Party of Maldives) gaining a majority with 51 percent of the votes

The case demonstrates the vulnerable institutional set up of the country, public disappointment on the role of key institutions such as the Supreme Court and the Maldives Police Service, undermining the progress towards democratic consolidation.

[Box 6]. Strengthening capacities of state and civil society, promoting participatory democratic processes, and enhancing prospects for stability are crucial to restoring confidence in the governance system and in steering human development change.

TRANSITIONS COMPOUND SOCIAL CHANGE AND RISKS OF MARGINALIZATION

Beyond economic well-being and material deprivation, it is important to understand social change and the risks it poses to certain population groups, which include the inability to participate in society; from which the individuals affected are either excluded or exclude themselves. The fast pace of change in the Maldives, including steady economic growth, changing rural and urban dynamics, the high rate of migration to Malé and high rate of growth of population in the city as well as the rapid overhaul of the political and governance system of the country has meant that many adjustments are taking place in society.

Income inequality is on the rise as highlighted by HIES, particularly in the urban areas and is discussed in detail in the next chapter. Disparities in access to services, particularly education, health and jobs and uneven development reinforce divisions between those from the capital, Malé and the atolls. Many small islands are left with old populations, as the youth and men migrate to Malé or to work in the resort sector. In-migration to Malé has led to a sharp increase in living costs, poor housing conditions, overcrowding, pollution and a general sense of frustration and impatience in the public.

Similarly, the democratic transition in 2009 was a major change for the people of the Maldives with the birth of multi-party politics, an independent legislature and judiciary, and the increased freedom to express opinions and voice concerns. The fabric of society is being destroyed by divisive and partisan politics. Increased levels of political rivalry are seeping through communities, social groups, neighbours, and even through immediate and extended families.

A top down approach to governance, the lack of confidence in elected officials by civil society members and the lack of dialogue between official and non-official actors reflects the crisis of confidence in the existing democratic processes. Constrained freedom of expression has been an indirect by-product of this polarized and politicized environment, as people are unable to express themselves freely for fear of being judged or dragged into a confrontation.

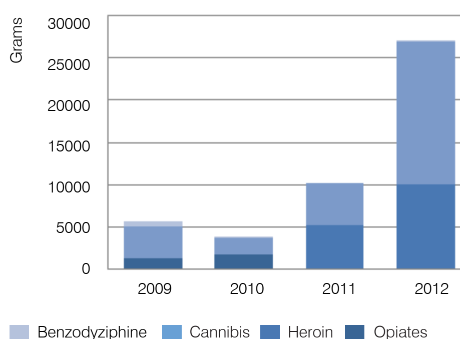
The social change associated with economic growth, inequity in distribution of services, resources and wealth as well as the growing frustrations with the political change and adjustments is changing the social fabric of the island communities. Historically, the sense of community, togetherness and cohesion was considered to be a major asset to societal and communal progress. There was a high spirit of voluntarism, community work and dedication to help those in need in times of crisis. These values seem to be eroding and many note that the loss of the social fabric is the biggest loss to the people and to the country. There is also growing concern about social issues such as drug use, gang violence, violence against women and children which occur due to various causes and subject certain groups in society to stigma and exclusion.

ESCALATING DRUG ABUSE

The patterns and increase of drug abuse and trafficking in the Maldives appear to closely parallel the escalation of drug abuse in the region. There has been a growing concern about the rapid increase in drug abuse among Maldivian youth in the past two decades. Drug abuse in the Maldives is reported to have increased 40-fold between 1977 and 1995.[34] One recovering addict interviewed by the MHDR team noted the free availability of brown sugar (heroin) made available to drug users in the late 1990s, which has led to many people becoming hard drug users eventually. The results of a study carried out by UNODC in 2012 on drug prevalence showed that there were 7,496 current drug users (4,342 in Malé and 3,154 in the atolls) aged between 15 to 64 years in the country. The estimated drug use prevalence for Malé and the atolls were 6.64 percent and 2.02 percent respectively.[35] Due to the use of different methodologies in estimating prevalence in different localities, estimating a single prevalence figure for the whole country was not possible.

Consultations with NHDR team indicated that drug abuse is widespread in both Malé and in the atolls visited, including Laamu and Addu atoll. Many identify drugs as one of the key problems facing their island and many people note that every family has at least one person affected by drugs. Three sources confirmed that number of drug users in Addu atoll, Hithadhoo Island alone vary between 600 and 1,000 people. The amount of drugs seized by the Police Services serves as a proxy indicator for drug use [Figure 17].

Figure 17 Drug seizures by Police, 2009-2012



Source: Maldives Police Service

The average age of a current drug user in the atolls was three years more than in Malé, 26 years versus 23 years. Consultations for this report indicate that younger children and school children are increasingly being exposed to drugs. Three schools visited in Addu confirmed suspected cases of drug use in school although they cannot confirm this, since tests cannot be done. The UNODC report noted that jail is the most common place where a sentence for a non-drug related crime is served by current drug users in Malé and the atolls. In Malé, all convicted drug users had been to rehabilitation centres, while in the atolls only 31 percent of drug users had been to a rehabilitation centre.

Drug use has major implications for society. The majority of drug users are unemployed and pose a major financial burden on the family and the opportunity cost for both the family and the economy is high. Drug users are engaged in drug trade and many drug related crimes have been on the rise including theft and gang crime, creating fear and insecurity in society.

Many women who are subject to domestic violence have drug-using partners and many children face neglect and even abandonment, as a result of drug-use among parents.[36] Drug use puts users at various other risks including unprotected sex; injecting drug users have high-risk behaviour for HIV/AIDS transmission. The societal impact of drug use is very high which makes it a serious concern for the community and the country.

The publication of the Maldives Study on Women's Health and Life Experiences in 2007 helped to highlight the issue of domestic violence and pointed out that one in three women aged 15-49 experiences physical and/or sexual violence at some point in her life, one in five women aged 15-49 experiences physical and/ or sexual violence by an intimate partner. Divorce, a serious problem in the Maldives, is common among drug users and this leaves women and children as being very vulnerable. Many atolls including the capital, Malé, have seen an increase in divorce rates.[37]

▶ INCREASING GANG VIOLENCE

Gang violence in the Maldives is becoming increasingly common. The nature of violence is more brutal, as new types of drugs and weapons are used. A recent study on gangs in Malé reported that there are between 20 and 30 different gangs operating in Malé with 50 to 400 members in each group.[38] Most members are under the age of 25 years and often first joined a gang while still in school. The most common type of gang is exclusively male, with high rates of drug abuse, unemployment and a high percentage of the members have a criminal record. More often than not, the gang is willing to receive money to carry out violent crimes on behalf of politicians or business people.

The report highlights several reasons for joining gangs, which were confirmed during our consultations with members belonging to gangs in Malé. A common idea that was voiced was that the gang was 'like a family.'

BOX 7. From the people: Perceptions of youth involved in Gangs

" Businessmen are not willing to give us jobs, but they would use us to settle debts or get their payments through us. Politicians and businessmen do not provide us any financial support or grant, even for a sports event without a 'favour' in return. There is always a string attached when it comes to helping or supporting us."

Source: Gang Member interviewed for Maldives NHDR 2014, July 2013

Related to the desire for belonging and brotherhood, another commonly cited reason for joining a gang was for protection. Younger children see older gang members as having a large group of friends to provide protection against threats. The search for identity is another key factor that drives young people to join gangs.

Gang members point out that they 'want to look cool and have many expensive and modern things' and joining a gang is a fast track way to the material lifestyle they aspire. Unemployment is a major factor that drives youth into gangs. Gang members report that even after completingtheir A level examinations, they cannot find employment. A significant barrier to employment for many gang members is the existence of a police record. In order to check whether a prospective employee has a criminal record, the law allows employers to access existing police records of job applicants. Even a brief police detention leads to a five-year police record. A number of members belonging to gangs mentioned that they join gangs to get revenge for being bullied at school. Members report that discrimination between poor and rich children in school often isolates and increases resentment among those children whose parents are not so rich. When these children grow up they often join gangs to overcome feelings of powerlessness and inferiority that begin in school. Family problems are another major reason for the involvement of young people in gangs. A number of gang members who were interviewed revealed that they joined gangs when their parents were divorced or after the death of a parent.

Gang related crime has resulted in a number of targeted killings. These crimes relate to settling conflicts between gangs, to protect or take revenge. Gang violence is increasingly being commissioned by politicians and businessmen. The report highlights that political and business elites exploit the gangs to carry out a range of illegal activities that serve their political or business interests in exchange for financing the

gangs. This aspect has worrying implications for the support for democracy among the young generation, as they are witness to first-hand corruption on the part of their political representatives.

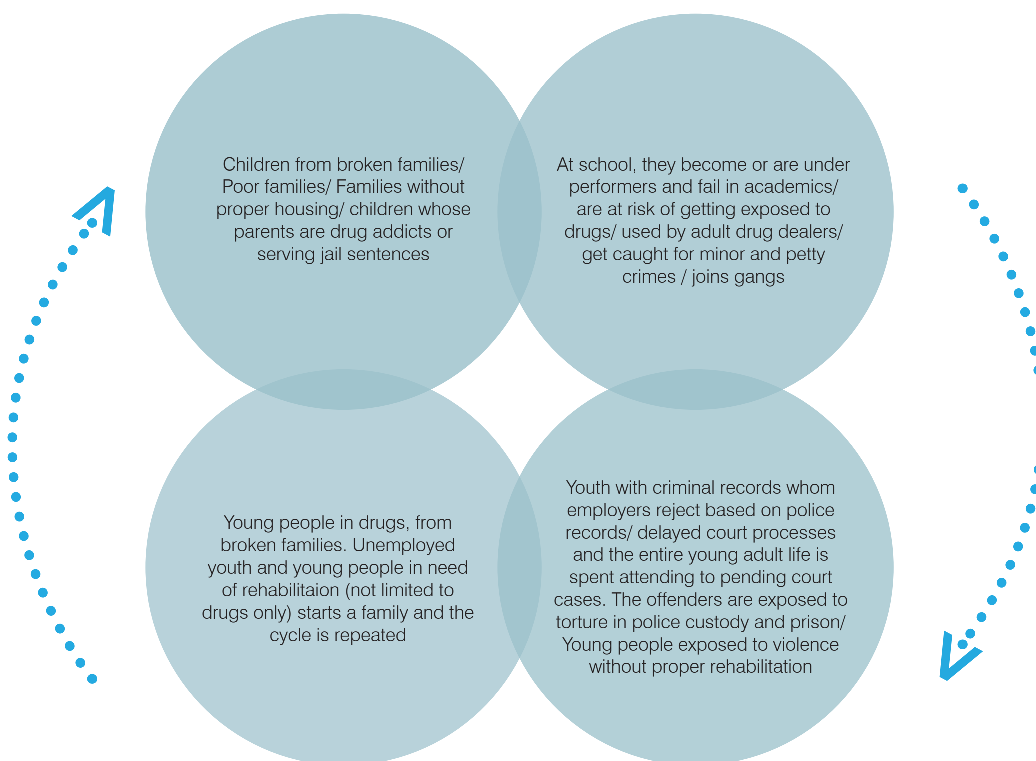
During the consultations of the NHDR team with groups and individuals, many noted that they are disillusioned with the Government, policy makers, researchers and society, as there is no willingness to stop these crimes. Many stated that they are not proud of the crimes that they have committed but they do it for monetary benefits. They noted that they met us unwillingly as they felt that researchers gather information from them but do not make any serious attempt to address the underlying problems, which are responsible for the existing situation.

A VICIOUS CYCLE OF SOCIAL VULNERABILITY

Interviews, consultations and observations conducted for this report, across the Maldives, depict a vicious cycle that children and youth often find difficult to break. Children from disadvantaged families or those with parents on substance abuse are affected very adversely. They face neglect and often become the centre of disciplinary issues in school. As a result they under-perform in school, face suspension, low attendance and the risk of expulsion. In a phone survey conducted for this report with selected atoll and island schools in the Maldives, 10 out of 13 schools interviewed identified students who belong to broken families as being vulnerable, while eight out of 13 schools felt neglected children were most vulnerable and seven out of 13 schools identified children who were underperforming at schools were among the three most vulnerable groups of students from a list of eight vulnerabilities identified in the questionnaire.[39]

Many drop-outs from school become exposed to drugs and drug dealing and become involved in crimes. With their criminal records, young people recovering from drug use or exiting gang life, find it difficult to find jobs, rehabilitation and or any other support system. Many feel that they are rejected by their families, friends and by society as a whole. Inability to break the cycle often leads to them facing problems in relationships like marriage and leads to domestic violence, which in turn affects their children and the cycle continues.

Figure 18 Vicious cycle of broken families and stunted futures: views collected for NHDR



DRIVERS OF INEQUALITY AND VULNERABILITY

The issues specific to the vulnerabilities facing the Maldives at the macro and micro-level have been discussed above. As a low-lying small island nation, geographic accessibility, external dependency of the economy and small population limits the availability of resources to accelerate human development. These characteristics increase the exposure of the Maldivian population to external risks such as natural disasters, climate change and global economic meltdown. Despite these structural characteristics, the Maldives has displayed resilience against shocks such as the tsunami and the global economic crisis. The economy's ability to bounce back within a short period have minimized the negative impact on poverty and incomes of households and communities. While the mentioned vulnerabilities restrict choices for equitable human development, it shows opportunities for improving resilience.

In order to address vulnerability and inequality in the Maldives, it is important to understand the common factors that drive vulnerability and inequality. The findings of this report suggest that spatial setting, income and age/gender are core factors which affect institutional vulnerability, the state's ability to address inequality which in turn drives inequality among certain groups, households and communities [Figure 19].

Figure 19 Spatial Background, Income and Identity: Interlocking Vectors of Vulnerability

The first – and most influential – driving factor is spatial setting or location. Where one is born within the Maldives determines many of the opportunities and choices available to a person. Remote islands with small populations have limited accessibility to services including schooling, healthcare, social services, job opportunities and face overall isolation. This is particularly true with respect to standard of living as evident in findings of HDI indicator performance discussed in Chapter 1. Spatial background poses major challenges for institutions and policies to impact communities, build up infrastructure such as airports and connectivity links to enable equitable human development. Low performing regions in HDI faced high dispersion of population across many islands as characterized by Region 2 (Noonu, Raa, Baa and Lhaviyani atolls).

A second tier of vulnerability arises from income, wealth and employment status and stability. Income status determines the ability to better services through enhanced capability to move and seek quality services where they are available. The main source of disparity between Malé and the atolls was found in income in the regional analysis of HDI performance in Chapter 1.

The third tier of vulnerability is ascribed to age and/or gender. Those in their school graduation years and the elderly are widely perceived to be the most vulnerable. Young people are at risk of facing joblessness and are exposed to substance abuse and related crimes. The elderly face health risks, neglect from families and low social status. Similarly women face extreme vulnerability due to multiple risks—acutely so if they do not hold jobs and are not financially independent or are single mothers. These include exposure to gender based violence, adolescent pregnancies and low participation in public life, as evident from the discussion on GII in Chapter 1.

The following chapters will look at the implications of these drivers of inequality and vulnerability and assess their impact on key human development indicators - income, education and health. Enhancing capabilities in command over resources, in education, health and in personal security can be made possible by empowering people, communities and institutions to overcome the risks and vulnerabilities that have been detailed.

Chapter 3

Levelling the Field for Growth and Income

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Till the 1970s, the Maldives had a subsistence economy with limited linkages with the outside world. Over the last four decades, the country has achieved a remarkable economic transformation. In the early 1970s, it was one of the poorest countries in South Asia. Today, it has the highest per capita income in the South Asia region. Tourism and related service industries have been the primary drivers of this transformation.

The preceding chapter highlighted the key vulnerabilities the population faces as a result of over reliance on tourism as well as by the scale and costs of food and fuel imports. Its core structural vulnerabilities notwithstanding, the Maldives has fared well in the face of external shocks. The tsunami and the global financial crisis did not lead to a sustained downturn; in either case tourism, the key driver of the economy recovered quickly, enabling the economy as a whole to do so too.

Increasingly evident, especially since 2008 and potentially detrimental to the principles and goals of human development are the continuance and rise of macro-economic and regional imbalances that Chapter 1 noted, and the fact that disparities in human development measures were most noticeable in income and other differentials between the capital Malé and the rest of the country.

This chapter identifies some of the initial lessons of the process and efforts towards income enhancement and poverty reduction in the Maldives. It includes an assessment of the successful policy interventions in the tourism sector that enabled its expansion and secured its resilience. It reviews the initiatives that led to a decade of macro-economic stability from the mid-1990s to mid-2000s and the efforts to expand education, health and social services.

Noting the success of efforts to reduce poverty, particularly in the atolls, the chapter highlights the fact of continuing disparities between regions. It provides an analysis of regional disparities and their causes. There is a discussion of growing urbanization and the emerging trends in urban poverty and of possible policy options.

The chapter provides an analysis of the growth of the tourism industry, pointing out the strong correlation between the level of tourism activity and economic performance in different regions. The chapter contends that policies to reduce income inequality in the Maldives should be tied to a strategy to increase the benefits of tourism to Maldivians and to reduce the leakages from this sector.

There is a discussion of the challenging labour market environment, which puts many young people and women at risk of lower incomes, poverty and of being trapped in the social vulnerability cycle discussed in the preceding chapter. The chapter concludes with possible policy responses to reduce unemployment through skill building, and labour governance.

EARLY LESSONS - GROWTH AND POVERTY REDUCTION MOVE TOGETHER

The economic success of the Maldives can be attributed to the steady growth and expansion of the tourism sector, and the series of fiscal consolidation measures to restore stability taken by the Government in the mid-1990s.

TOURISM EXPANSION – FROM 22 VISITORS TO 1 MILLION VISITORS

The Maldives began to emerge on the global tourism map in the early 1970s. An Italian tour organizer brought 22 Italian tourists on an Air Ceylon chartered flight. By

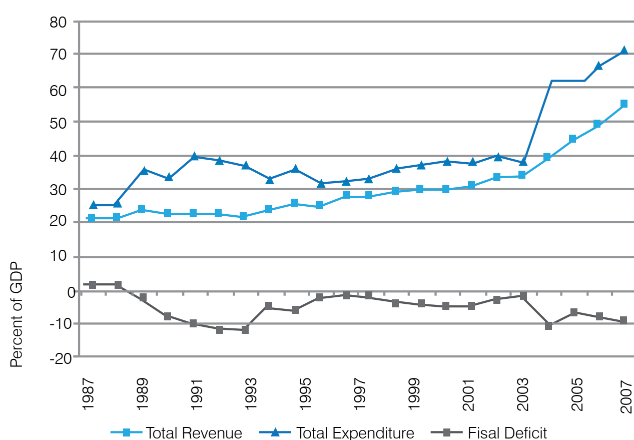
BOX 8. 40 Years of Tourism in the Maldives

	1972	2012
Resorts	2	105
Beds	280	22,648
Visitors	1,000	958,000

1972, resorts with a capacity of 280 beds had been developed on two islands. In that year, a thousand tourists visited the Maldives. By the late 1970s, tourism was firmly established as the engine of growth for the Maldivian economy. By 1980, tourism earnings were 60 percent of visible exports and 12 percent of the national income. The total Government revenues in 1980 were US$2.3 million.[1] The direct employment effect was the creation of 2,930 jobs in the sector. By 2012, tourist arrivals were close to a million, at 958,000 visitors. Necessarily matching this was the increase in resorts to 105, and bed capacity to 22,648 beds.[2]

The growth of tourism has been led by the private sector. It has been possible, however, because of the role played by the Government and the partnerships established by it with the private sector. Especially in its formative years, tourism in the Maldives benefited from the absence of taxes, and the fact that the land rent on islands was kept low. Islands were leased in a controlled manner to not overwhelm the private sector with investments in tourism development.

Figure 20 Fiscal Consolidation Up to 2003



Source: Khatiwada, 2009

Market development and product innovation contributed to the growth of the tourism sector. The unique 'one-island-one-resort' concept facilitated the development of high-end services. The Government, working closely with the private sector, positioned the Maldives as an exclusive destination offering 'sun, sand and sea'; successful and well-known campaigns projected the 'sunny side of life'.

The resilience of the tourism sector has been recognized. Diversification has been a key goal and a part of the strategy that enabled the Maldives to weather external shocks. Despite the slump in European economies since the 2008 global economic crisis, tourist arrivals have picked up in the Maldives. The sector has been kept buoyant by arrivals from alternative markets, primarily China and to a lesser extent, from India and Russia. From 2008 to 2012, the market share of visitors from the Asia and Pacific region grew at an average rate of 15.02 percent every year; their market share increased from 22.9 percent in 2008 to 40.1 percent in 2012.[3]

Tourism expansion has steered growth in related service sectors including transport, communication and construction. The transport and communication sectors of the Maldives have expanded steadily over the past decade with an average growth rate of 9 percent per annum. The communication sector grew at an average rate of 10 percent. Together, these sectors cover about five percent of all economic establishments (companies) and employ over 20,000 workers (equivalent to 11 percent of total employment) and 9.3 percent of GDP.[4] Both sectors have largely been driven by tourism activities, which creates demand for air and sea transport.

FISCAL PRUDENCE CONTRIBUTED TO ECONOMIC STABILITY

The public sector consists of the Government and fully and partially State Owned Enterprises (SOEs). It plays a significant and visible role in the Maldives. Public consumption accounts for more than half of the total consumption. Public servants represent one-third of the domestic labour force. The fiscal accounts of the Government of the Maldives have until recently been characterized by tax revenue that is largely limited to import duties, tourist bed-night tax and a bank profit tax. Non-tax revenues have been dominated by profit transfers from SOEs, and by resort lease rent.

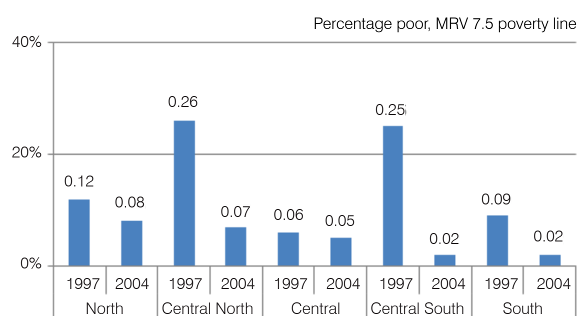
In the early 1990s, the Maldives suffered from severe macro-economic imbalances with large fiscal deficits and strong pressure on its balance-of payments position. The latter was substantially attributable to the sharp decline in tourist arrivals due to recession in the European economy, the Gulf War, and reduced world tuna prices. During 1994-95, the Government implemented a broader programme of fiscal and monetary consolidation that reversed the trend of rising fiscal deficits. The fiscal deficit as a percentage of GDP declined to about 2 percent in the mid 1990s (1996-97) from about 10 percent in the early 1990s (1990-93). This was achieved by enhancing Government revenue and trimming Government expenditure, including wages and salaries. The deficit was kept under control,at less than 5 percent from late 1990s until 2004.

POVERTY REDUCTION

As pointed out in Chapter 1, in the Maldives, poverty is primarily related to physical vulnerabilities. The smallness of the population and the dispersion of isolated islands makes economic activities and the growth of the private sector difficult and the provisioning of social services extremely challenging, as detailed in the preceding chapter.

The Vulnerability and Poverty Assessments (VPA) of 2004 showed that poverty has declined rapidly since 1997 and indicated that absolute poverty had effectively been eliminated, using a poverty line of US$ 1 per day at Purchasing Power Parity (PPP), or

Figure 21 Significant Decline in Poverty, 1997 to 2004



Source: MPND, 2004

MVR 4.34. However, if the poverty line is set at MVR 15 per day (approximately US$3 per day in PPP terms), which was broadly considered as the national poverty line, 19 percent of population lived in poverty.[5] Within the Maldives, substantial poverty reduction took place between 1997 and 2004, and the incidence of poverty at MVR 7.5 per day dropped from 26 percent to 7 percent in the Central North Region and from 25 percent to 2 percent, in the Central South region [Figure 21].

In recent years, the Household Income and Expenditure Survey (HIES) 2009/2010 data shows that using the MDG poverty line of US$ 1.25, the incidence of poverty dropped from 9 percent to 8 percent between 2003 and 2010. For the atolls (excluding Malé), poverty incidence dropped from 12 percent to 8 percent. This is mainly due to the increase in access to social services and spread of economic activity across the country such as tourism. Interestingly, poverty incidence increased in the capital Malé, from 2 percent in 2003 to 7 percent in 2010.

Poverty in the Maldives has been characterized by transient poverty[6], people moving in and out of poverty. Panel data from VPA I (1998) and VPA II (2004) show that during the six-year period, three out of five of the poor households in 1997 managed to escape from income poverty. At the same time, one in five of the non-poor households fell into poverty. Taking two poverty lines at MVR 15 per day and MVR 10 per day, the majority of those who were income poor in 1997 had escaped from poverty for both poverty lines. For instance, for poverty line MVR 15 out of the 49 percent poor in 1997, 33 percent escaped poverty in 2004. Similarly, for the poverty line MVR 10 out of the 26 percent poor in 1997, 22 percent had escaped poverty in 2004. Large movements between income groups indicate that the income poverty situation is quite dynamic.

There are many factors that contribute to households moving out and in to poverty.[7] (Box 9) Governmental interventions have helped to address many of the factors highlighted, for instance the efforts to establish universal primary schooling throughout the Maldives and the opening of secondary schools in parts of the Maldives, other than the capital, Malé.[8] Similarly, the Government has made efforts to expand tourism

BOX 9. Poverty Dynamics Explained

Enablers to escape from poverty:

I. Initial level of education
II. Proportion of members voluntarily
III. Participating in community activities
IV. Change in (and level of) the proportion of adults employed

Barriers to escape from poverty:

I. Proportion of household members not working due to bad health
II. Living in the two northern regions and
III. Proportion of female household members

Factors contributing to falling into poverty:

I. Living in the northern regions
II. Proportion of household members not working due to bad health
III. Number of young household members

Most important determinants preventing households from falling into poverty

I. Working in the tourism sector or Government sector
II. Taking out a loan to invest

Source: Rutten and Krujik, 2007

and enable its spread across the country. As a result employment in the tourism sector has increased and business opportunities from the growth of tourism have enabled local people to take loans and invest in productive activities. Strengthening of health services in the islands, particularly public health (as evident by achievement of universal immunization) and family planning interventions, has also benefited the outlying regions.

PERSISTING INCOME INEQUALITIES

There are continuing income disparities that are troubling and even threaten the medium term sustainability of efforts to improve the indicators of human development. The VPAs of 1998 and 2004 show a significant degree of spatial variation in poverty. Head

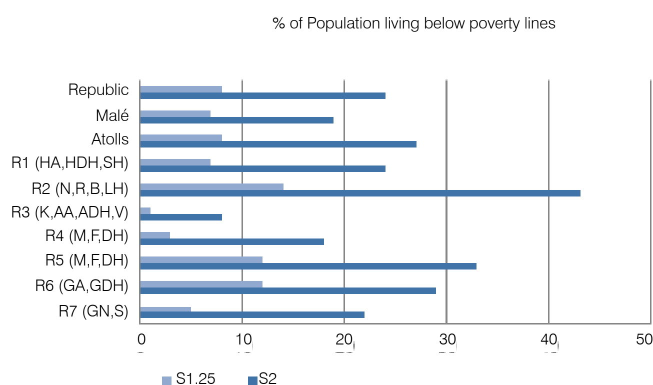
count ratios calculated on a continuum of MVR 7.5 to MVR 15 per person per day poverty lines, indicate that among all the regions, poverty is highest in Central North (Noonu atoll, Raa atoll, Baa atoll and Lhaviyani atoll), followed by Central South (Meemu atoll, Faafu atoll, Dhaalu atoll, Thaa atoll and Laamu atoll). These are atolls with limited infrastructure, accessibility and service delivery.

Connectivity and tourism operations are key determinants of incomes in a region. The region with the lowest headcount ratio of poverty is Region 3 (Kaafu atoll, Alifu Alifu atoll, Alifu Dhaalu atoll and Vaavu Atoll). This maybe attributable to several factors. Primarily, the heavy concentration of tourism in Kaafu, Alifu Alifu and Alifu Dhaalu atolls indicates close proximity to employment and different sources for income generation in the Central Region. This together with the easy access to services and facilities within the capital city may have contributed positively to the well-being of the people at the time.

Regional disparities in income have been confirmed by more recent surveys, for instance HIES 2009/2010 data. Income poverty at the International Poverty Line of US$2 per person per day and the Millennium Development Goal poverty line of US$1.25 per person per day, shows that poverty continues to be highest in the Central North Region (Noonu, Raa, Baa and Lhaviyani atolls) as defined in the VPA, Region 5 (Thaa and Laamu atolls) which is part of the Central South region as defined in VPA and Region 6 (Gaafu Alifu and Gaafu Dhaalu atoll) which is defined as South region in VPA [Figure 22]. These regions were most severely affected by the December 2004 tsunami.

Central North Region and Region 5 (Thaa and Laamu atolls) lack access to quality social services and transport infrastructure. Tourism in Region 5 has only recently developed. The emergence of poverty in Region 6 (Gaafu Alifu atoll and Gaafu Dhaalu atoll) may be explained by the decline in fishing, the main source of livelihood, especially in GaafuAlifu atoll. Similar to the VPA data, HIES data shows that poverty remains lowest in the Central region, Region 3, where the Capital Malé is located and tourism continues to be dominant. There appears to be more spatial variation of poverty in 2010 compared to the VPA 2004 data.

Figure 22 Percentage of Poor Across Regions



Source: Department of National Planning, 2012

INVESTIGATING INCOME INEQUALITY

The Gini coefficients[9] for the Maldives show a decline from 1997 to 2004 to 2009/2010 from 0.42 to 0.41 and further to 0.37.[10] This is contrary to inequality trends observed in South Asia from 1990s to 2000s, which appear to be increasing for most of the population, particularly in India, Bangladesh and Sri Lanka. A report by the Asian Development Bank (ADB) indicates that 11 of the 28 economies (which account for 82 percent of the region's population) with comparable data show an increase (worsening) in the coefficient in the last two decades.[11]

However, on closer examination of the Gini coefficient, it is seen that income inequality shows an increase in the capital Malé and shows a decline in the rest of the country (in the atolls), over the same period (1997-2004, and 2009/2010). This is consistent with global inequality trends that show an increasing urban-rural divide. The Gini coefficient was highest in Central South Region in 1997 and in the Central North Region in 2004 indicating a high level of income inequality in the atolls where income poverty incidence was high.[12]

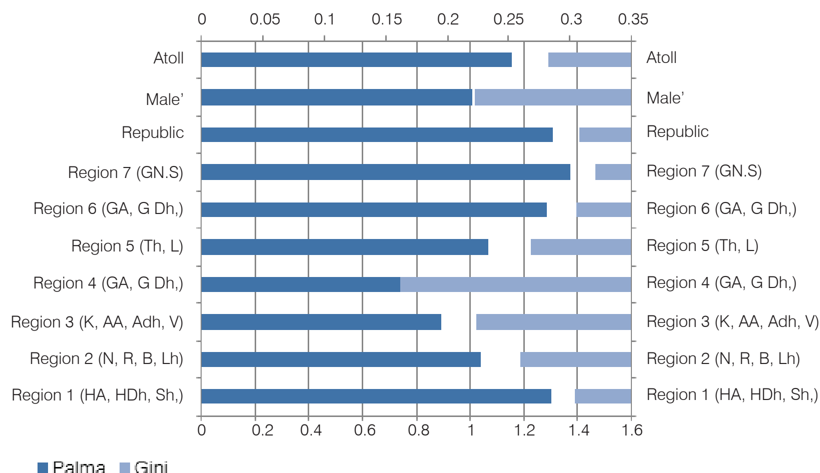
BOX 10. Gini and Palma Measures of Inequality

Gini Coefficient:
Gini = (0.581 * income share of top 10 percent– (1.195 * income share of bottom 40 percent) + 0.419

Palma Index – Calculated simply as share of the top 10 percent divided by the income share of the poorest 40 percent.

This report attempts to investigate inequality further by the study of the emerging measure of the Palma Inequality Index [Box 10]. This new measurement is in line with the use of inequality measures for policy frameworks, conditioned on the basis of policy criteria, not only the common technical criteria.The Palma is a measure of income inequality or income concentration - based on the observation of Gabriel Palma that the middle classes tend to capture around 50 percent of national income, so that distributional politics can be thought of, simplistically, as determining the split of the remaining half of national income between the richest 10 percent and the poorest 40 percent.[13] This simplicity makes it more meaningful to policymakers and analysis than the Gini and Theil measures, which are both relatively more difficult statistical constructs.

Figure 23 Comparing the Gini to the Palma Index 2009/2010



Source: Department of National Planning, 2012

For the Maldives, the Palma illustrates altogether steeper levels of inequality than does the Gini [Figure 23]. Inequality is higher when considering the concentration and variation of the income of the top 10 percent and the bottom 40 percent across the republic, the atolls and in the Capital Malé. Except for Region 4, (Meemu, Faafu, Dhaalu atolls), the region with the highest HDI, all regions show higher level of inequality when measured using the Palma index. This indicates that while the Maldives demonstrates overall positive performance in reducing income inequality, (when applying the commonly used Gini measures) one has to be cautious of the decomposition and movement between the income bands of the population, particularly that of the poorest income deciles.

EXPLAINING INEQUALITY - TOURISM 'TRICKLES SIDEWAYS'

As the determining and driving force behind growth, the nature, spread and structure of tourism is key to understanding the disparities in the Maldives. It is clear that the benefits of tourism have accrued inequitably, and have not percolated to many regions and sections of society.

Product selection, cited as one of contributors to the growth of tourism is a contributory factor. Most infrastructure is centred around the resorts, many of which follow the 'one-island-one-resort' concept. Most are five-star properties that operate self-sufficiently and are self-contained, with inevitably limited contact and interaction with communities in the vicinity. Resorts train their employees on-site and often have staff accommodation within the property. Resorts tend to have their own infrastructure including power, water supply and sanitation. The owners are usually large companies, international developers and local entrepreneurs, with varied experience levels.

A significant proportion of the income generated does not impact the local economy. There are leakages due to factors such as i) a high level of imports; ii) repatriation of wages by expatriate workers; iii) repatriation of profits, iv) provision of tourism services by foreign tour operators and travel agents, and v) dependence on foreign airlines.

An estimated 90 percent of resorts currently have their projects financed off-shore, necessitating outflows for debt servicing.[14] Some estimates, not necessarily substantiated by empirical studies, indicate that the percentage of tourism dollars that do not come into the hands of nationals may be as much as 60 to 80 percent of revenues.[15] Two of the main reasons for the leakage are the imports of consumption items and the engagement of a large proportion of expatriate labour.

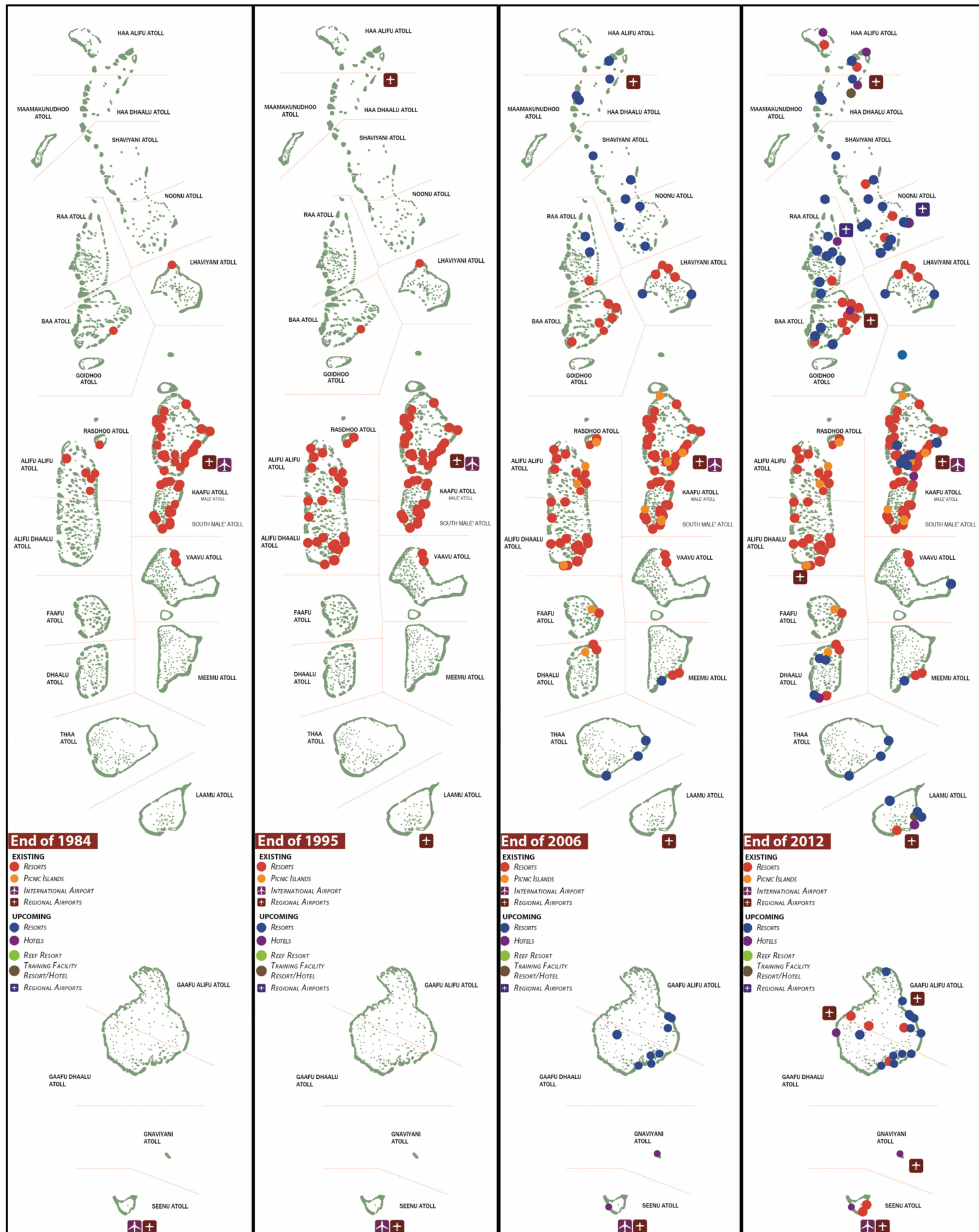
Other reasons that have prevented the trickle down:

SPATIAL VULNERABILITY DUE TO TOURISM CONCENTRATION IN THE MALÉ REGION

In the early 1970s, tourism was limited to a few resorts around Malé with advantages of access to and from the Malé International Airport. Beyond the Malé region, private sector led resort development concentrated in atolls around Malé, including South Ari Atoll and Lhaviyani Atoll. These atolls had easy access to support services such as transport, banking and communication. The introduction of seaplanes in the early 2000 facilitated the expansion of tourism beyond Malé. Resort development began to move to the far north and south of the country. From then on, the Government began auctioning uninhabited islands in different parts of the Maldives for resort development. It made efforts to operate regional airports in the north and south of the Maldives.

Despite this and although the share of bed capacity in Malé atoll has fallen, in 2012, 40 percent of bed capacity of the industry was still concentrated on Malé atoll. The share of four adjacent atolls (Malé, Lhaviyani, South and North Ari) was over 70 percent, indicative of a continuing high concentration of resort operations.[16]

Figure 24 Accumulated Development of Resorts and Hotels (including underdeveloped leased properties)



Source: Ministry of Tourism, 2013

TOURISM LEADS TO RICH-POOR DIVIDE

The local ownership of resorts is concentrated amongst five major resort groups who have been associated with pioneering tourism in the Maldives.[17] These groups have been able to consolidate and enhance their presence in the industry with the advantages of access to finance, business experience and networks. One view is that the industry today operates as a powerful oligarchy and has given rise to an elite class that owns much of the country's wealth. Some observers have argued that new local entrants are disadvantaged by increased foreign competition. Although most of the properties have local ownership legally, many are substantively operated by foreign companies or through joint venture partnerships.[18]

LIMITED OPPORTUNITIES FOR LOCAL LIVELIHOODS

In comparison with other countries, including island nations, local communities have had limited engagement in the tourism sector. Most resort tourism is located on uninhabited islands, operating on a self-contained basis. This has occurred largely by design, with the bulk of tourism activities taking place on uninhabited islands, which are physically separate and operate on a self-sufficient basis isolated from the population and the inhabited islands.

Food, furnishings, fixtures, interior décor and materials are largely imported. Services are managed in-house, including security, cleaning, maintenance and transport. Resorts often purchase goods directly from international suppliers instead of sourcing locally. Due to the physical isolation of local producers, there is a major information gap on what is available locally to meet the requirements of the resorts. This has led to the perception that tourism is a parallel economy in the Maldives, disconnected from the local context and population.

The tourism industry has evolved to serve the world's high-end, exclusive market. Local communities are not usually equipped to meet the needs and standards of this segment.[19] Most small businesses in the islands concentrate on retail trade, fish processing or small scale agriculture. More than 90 percent of 'Maldivian' souvenirs sold to tourists are imported from East Asia; causing a major decline in local artisanal industry. Efforts to incorporate mandatory market access for local Micro-Small and Medium Enterprises (MSMEs) in the MSME Act for local fruits, vegetables and souvenirs have been rejected by the Parliament. However, through various donor agencies support to develop the local MSME sector and to support its integration with the tourism industry, potential projects have yielded results to improve the supply chain and market arrangements. (These include local craft making, innovative agricultural production and value addition in fisheries).[20]

With recent policy changes, efforts have been made to introduce guest-house tourism in the Maldives for mid-and low budget travellers on inhabited islands.[21] Although the concept is very new, and various challenges exist in terms of support infrastructure and legal barriers such as the ban on serving alcohol and pork on inhabited islands, significant growth is evident in this sector.

There has been a three-fold increase in five years in the number of Guest houses, from 24 in 2008 to 74 at the end of 2012. This has contributed to an increase in bed capacity. The development of guesthouses to date has been supply-driven with not much attention given to market segments. Guest-house tourism, if it continues to expand may increase employment and business opportunities for the local people and the local economies.

▶ POLITICS AND LIMITED CAPACITY STALL WELL-INTENDED INITIATIVES

In 2006, the Government created the Maldives Tourism Development Corporation (MTDC), to provide an avenue for more Maldivians to invest in tourism. The company stated 'MTDC's main objective is premised on the basis that a more inclusive and beneficial development method is practiced in the Maldives, a tourism industry that ensures fairer distribution of benefits, diversify local industries and creates local employment in the communities'.[22]

BOX 11. MTDC - Broadening the Tourism Dividend to the People

'Some bold corrective measures should be taken, such as strengthening the management capacity of the company (by possibly even hiring international and local industry experts), establishing an independent advisory committee to provide support to fix the current problems facing the company and by demonstrating the will by the Government to insulate the company from political influence and manipulation. There is still hope to for the company to reach its intended goals for the benefit of the people'.

Interviewee for the Report, November 2012

The Government pledged to lease 15 resorts for development to MTDC, nine of which have been leased to date. Given the profitability of the industry at the time of the company's inception, the lease of 15 islands for development for the country's most lucrative industry demonstrated huge potential for success and built up public expectations. The company witnessed one of the most successful IPOs in the country's history with a good response from all sections of the population, including people from the remote islands participating in buying shares. The company has 51 percent public ownership and 49 percent Government ownership, with about 25,000 shareholders. Although proxy share buying by businessmen and politicians was reported, there was substantial participation from the public.

Out of the nine islands leased, the first property was completed on time and operational in 2009, which was Herathera island in the southern most Addu atoll. All other projects under-development faced major delays and five island resorts are still under construction. In the first two years (2008, 2009), the company paid handsome dividends. Since then, however, the company has not paid dividends for three consecutive years. In 2012, the company incurred a loss for the first time, of US$ 6.3 million.

Despite good intentions, many feel that the company's financial stress and poor performance is due to the lack of management capacity. There is no technical capacity and commercial understanding of how tourism businesses in the Maldives operate, the management has been operating more as a Government bureaucracy and lacks familiarity with various resort development and management practices. According to one interviewee, the company's management could not demonstrate capacity to many interested investors and hoteliers in the early years to negotiate such arrangements and as a result projects failed to materialize. In case of some other projects the company faced additional financial burden due to poor decision making. Many subleases were awarded on the basis of unsustainable rents quoted, which generated quick financial gains for the company but has not resulted in sustained revenues.

The company has not been able to raise capital for resort development partly due to the global economic slowdown in 2008 and the loss of investor confidence in the country as a result of political instability. The management and board have seen many changes since its inception. Similarly, during consultations with the NHDR team, industry experts suggested that the company was subject to political influence and manipulation since its inception by successive Governments, which in turn weakened management and affected managerial stability. This ranged from direct influencing through various political appointments to the board and indirect manipulation of board members and management to award bids and contracts to certain parties.

MORE TOURISM EMPLOYMENT AND REMITTANCES NEED TO BE LEVERAGED

Tourism remittance is an important source of household income especially for the people in the atolls and outlying islands, outside of the capital Malé. The VPAs conducted in 1997/8 and 2004 found that households with one or more members working in the tourism sector are more likely to escape the poverty thresholds than other households. However, in 2006, only 15 percent of employed Maldivian men and 4 percent of employed Maldivian women worked in the sector.[23] The share of tourism as a source of employment in 2010 stood at a mere 6 percent.[24] Although job opportunities in tourism have increased, most Maldivians have not benefited from these opportunities. The demand for employees remains on average 1.5 staff per tourist resort bed. High-end

tourist resorts require at least two employees per tourist bed. There have been concerns over the growth of the expatriate workforce.[25]

Even within the opportunities available to locals, there is an asymmetry. Women and the young do not appear to have benefited in proportion to their numbers and even their skills. Resorts tend to operate independently from each other and the local environment, hiring if at all through word of mouth and on the basis of recommendations.

Job security, a well-defined career path and benefits, non-discrimination and proximity to home-island or Malé are the primary motivating factors for Maldivian job seekers in tourism. The lack of opportunities at the managerial level deters many Maldivians from participating in tourism. For women, mobility and societal pressures inhibit seeking work in the tourism sector. However, if an attempt is made to provide skills training, better working facilities and access, local people can benefit from the tourism dividend.

▶ POVERTY AND INEQUALITY – AN INCREASINGLY URBAN PHENOMENON

Recent assessments show new trends in poverty and inequality in the Maldives. Opportunity, employment, inequality, poverty and work-force are all present in a disproportionately high measure in the capital, Malé. Addressing poverty and inequality in the Maldives is therefore a question of addressing urbanization and managing the demand for employment, housing, social services and infrastructure in the capital.

The poverty incidence increased for the capital Malé from 2 percent in 2003 to 7 percent in 2010.[26] The same trends are evident for other poverty lines, such as the International poverty line of US$2 per person per day and MVR 44 and MVR 22 per person per day, poverty lines. Similarly, while overall inequality levels for the country and that for the atolls appear to be falling, in Malé, the inequality has increased as per the Gini Index from 0.35 in 2002/2003 to 0.38 in 2009/2010. This means expenditure disparity still continues to be high within Malé.[27]

BOX 12. From the people

"If we had a choice I would return to my own island. But that would mean compromising my daughter's education. The education on my island in no way matches the standard in Malé. There are no teachers, no resources. I cannot do that to my daughter."

Zuhudha and her family moved to Malé when she was a teenager, in the 1990s. They come from the remote island of Maalhendhoo in Noonu atoll. At the time the island did not have a secondary school. Her parents decided to move to Malé to seek a better education for her and her five siblings. The family still lives together in one house which has three small rooms partitioned by plywood and affords limited privacy. The house is shared by 12 people and six of them are children. Married couples use the partitioned rooms, while the others sleep in the sitting area, including Zuhudha's elderly father. The total area of the house is about 800 sq.ft. and they pay MVR 15,000 (US$972) as monthly rent and have paid a large advance to the landlord for a long term lease. The landlord and his family are from Malé' but live in Sri Lanka. Zuhudha's family has three working members, including her father, husband and one brother. Her father is unable to retire due to financial pressures facing the family. The women in the house earn some money by making food items that are sold in shops. They manage to pay the children's tuition fees with the money they earn. As a migrant family they face two major challenges. One is that they cannot afford an apartment or house that has adequate space with enough rooms and washrooms for all the members. The other challenge is that they do not have any savings after paying for rent and utilities. The family has limited coping ability against any potential shock such as a job loss or medical incident or even an accident. As long as the quality of services does not change on her own island, Zuhudha and her family will be migrants living in crammed conditions in Malé.

The main reason for these trends may be explained by the influx of migrant families to Malé from the atolls. This is driven by disparities in education, health and employment opportunities, which are concentrated in the Malé region. In 1995, 45 percent of the population in Malé consisted of migrants. In 2006, the proportion of migrants in Malé was 53 percent.[28] The figure is likely to be higher now. Over one third of the population of the Maldives is concentrated in the capital city Malé, an island with an area of less than five square kilometres.

The 2006 Census showed that all atolls except Malé, Kaafu and Alifu Dhaalu had net migration losses. Almost all of the net migration gains were in Malé. Malés net migration gain for Malé was 50,924. The atoll with the highest net loss was Seenu with 8,525 followed by Gaafu and Dhaalu atolls. Interestingly, women and youth are disproportionately represented amongst migrants, especially in Malé. Many women move to Malé due to marriage or as a parent or guardian of children seeking schooling in Malé, while their husbands stay on a resort to work.[29] Almost half of all migrants in the Maldives in 2006 were in the age group 15 to 35 years, of which 38 percent were in the age group 20 to 29 years. With regard to reasons for migration, the main reason that was stated by the people for change of residence in the 2006 Census was for educational purposes. (About a third of all migrants cited education as their reason for migration.) This was the main reason for migration to Malé as well.

The rapid rate of migration to Malé has added pressures on housing, employment, water and sanitation facilities as well as on schools and hospitals in the capital. In 2006, there were 14,107 households in Malé compared to 9,700 in 2000. The average household size was 7.4 persons per household. The increase in number of households over the six-year period is a result of subdivision of housing plots and families sharing a single housing unit. This has worsened the standards of housing, sometimes living conditions are reaching slum-like conditions. The 2006 Census used the density of household units rather than housing units or structure, which gives an unrealistic average household size of size of 7.4 people per household. If density is calculated by housing unit or structure, it will be much higher in Malé. A three-bedroom house would typically house 17-20 people, many of whom would be migrants.

WEALTH AND INCOME INEQUALITY IN THE CAPITAL

The demand for housing and the increase in rents explains the growth of the middle class in Malé, often at the expense of migrants from the atolls that pay these prices. The HIES survey data confirms that there has been a doubling of expenditures on housing and household operations over the seven year period preceding 2010, in real terms.

In 2010, a major portion of household expenditure was spent on housing in Malé, while in 2003 this was spent largely on food expenses. Due to an increase in the demand for housing and the increase in rentals, particularly in Malé, the proportion of households spending less than MVR 5,000 as rent had declined in 2010 compared to 2003, while the proportion of households spending MVR 5,000 and more as rent increased substantially, except in the class of people paying a monthly rent of MVR 12,500- MVR 14,999.[30]

Many families in Malé have invested in apartments and flats and rent out the units, which give them a high return on investment. Many families that own land or housing in Malé, rent out their property and migrate abroad to neighbouring Sri Lanka, India or Malaysia. The increase in property value and rent prices have increased the wealth and income status of landowners in Malé, while migrant families struggle to meet rent and other expenses with the incomes they earn in the capital.

A study of urbanization can help to understand the inequality trends in the capital. The report recommends that the issue be studied for policy debate on addressing income and wealth disparities in the country and to address urban poverty issues facing the residents in Malé, particularly migrant families.

ADDRESSING URBAN POVERTY AND SOCIAL VULNERABILITY

Poor housing conditions and high unemployment rates have pushed many youth in the capital to substance abuse and increasingly into gangs. The discussion of drugs and gang culture shows the high concentration of these practices in the capital compared to the rest of the country. As a result many youth especially migrant youth and children are trapped in a vicious cycle, where broken families and parental neglect put them in difficult conditions. Many turn to substance abuse and gang activities. Addressing urbanization and managing the transition for the migrant population is therefore key to reducing both inequality and vulnerabilities specific to the Maldives.

To address urban poverty, it is important to collect more information and investigate the nature of poverty facing the urban population in the Maldives. Currently there is a lack of data on migration, the duration of stay and conditions of stay. The Government needs to recognize the importance of the issue and integrate urban planning and urban management as a priority policy. Similarly, given that the country has limited experts in the sector, it is important to mobilise their knowledge and expertise in policy making and planning. To relieve congestion in the capital, Malé, it is important for the Government to make long term plans to reverse migration by developing alternative growth hubs in the country.

COMPLEX LABOUR MARKET ADDS TO WIDENING DISPARITIES

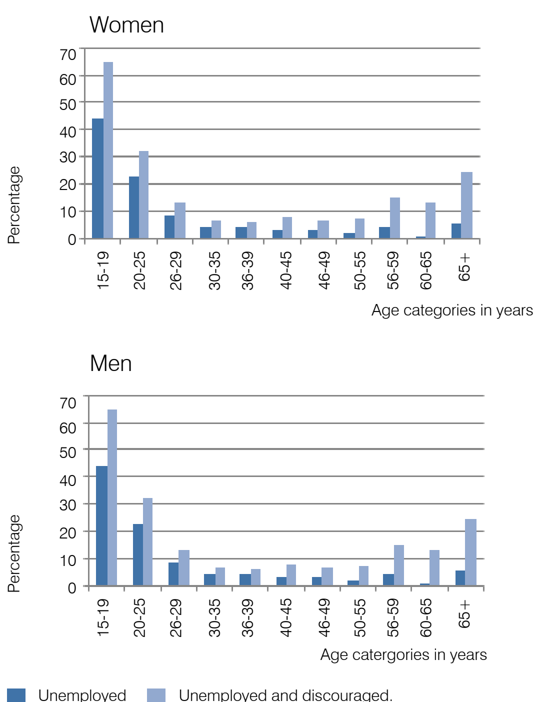
Rising unemployment can aggravate the divide between the rich and the poor; women, youth and urban populations are in particular likely to be affected if this trend continues. Unemployment has spatial as well as identity-based impact for specific groups and populations. Depending on where you are born, or living the chances of available employment opportunities vary. Women and young people face high risks of unemployment.

Demography is a key variable and determinant. The working age population has increased at an average annual rate of 3.9 percent over the period 2000-2006, and by 10 percent each year, in the 2006-2010 period. The growth rate of the population above 15 years of age is much higher in Malé compared to the atolls. The labour force participation rate[31] has increased from 59.8 percent in 2000 to 64.1 percent in 2006.[32] There is a major disparity in labour force participation amongst men and women. The labour force participation rate for men in 2000 was 74 percent compared to 45.3 percent for women. In 2006 the labour force participation rate of men remained the same at 74 percent while for women, the figure increased to 52.9 percent.

According to the international definition, an unemployed person is one who is willing to work and available to do so at short notice and is 'actively looking for work'. By this definition, unemployment rates in the Maldives are very low. This is because although many people who are not currently working, they are not 'actively seeking work'. They may not be doing so for two very practical reasons. First, on a very small island, they already know the job opportunities and so seeking work is often redundant. Second, it is very difficult for them to seek work elsewhere on a weekly basis, in Malé or in the resorts, due to the high cost of travel.

Discouraged workers are those individuals of working age, who are not in education, retired or doing household or care activities, but who have not sought employment during the last two weeks, because they have been unable to find suitable work, or because opportunities are lacking.[33] Discouragement appears widespread among women and young people (15-24 year age group). Figure 25 shows a comparison of unemployment using the international definition and using the broad definition for both men and women by age group.

Figure 25 Unemployment and Discouragement in the Maldives



Source: ILO, 2013

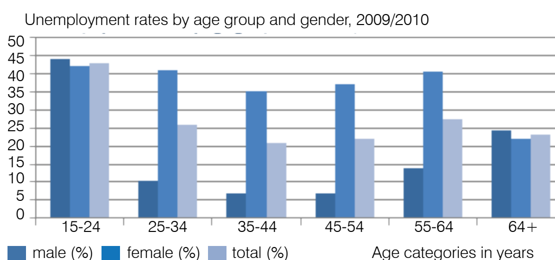
Under the broad definition of unemployment, which includes discouraged workers and is most relevant to the context in the Maldives, unemployment has risen significantly in recent years. The unemployment rate among atolls is even higher at 34 percent compared to 17 percent in Malé, in 2010. Similarly, the female unemployment rate is much higher at 31 percent compared to male unemployment rate of 24 percent in 2010. The female unemployment rate stood highest in the atolls, in 2010 at 42 percent.[34]

The Maldives has been unable to create new jobs for the young generation and for women [Figure 26]. Women seem to be struggling for employment at all age groups whereas men seem to be looking for jobs most in the 15-24 year group. This youth age group accounts for 43 percent of unemployment. Of the 17,083 unemployed, 51 percent are males. Both genders seem to be easing off employment voluntarily from 65 years onwards. The data on reasons for being unemployed in the youth age group (15–24 year age group) and for both male and females in 2009-2010, indicated the unavailability of suitable work ranked the highest followed by household chores. Lack of opportunities was rated as the third most common factor. Although these factors may vary in various locations, these reasons are the foremost factors listed by the people as reasons for unemployment.

In 2009-2010, most Maldivians worked in the Government sector, in wholesale and retail trade, in fisheries, manufacturing and education. The share of jobs in the manufacturing sector reduced by nearly half, while employment by the Government rose 3 percent to a total of 18 percent.[35] Most of the service industries have grown in terms of employment. In tourism, the major contributor to GDP, local people only have a six percent share in employment. Sectors that do not contribute so significantly to GDP, provide greater employment opportunities to local people.

Expatriates have come to dominate the labour market. In 2006, there were 53,901 expatriate workers in the Republic, compared with 98,941 employed Maldivians. By 2009-2010, this figure had risen to 73,840, while the number of employed Maldivians had dipped to 95,085. The expatriate labour force is expected to be even higher, if the number of illegal migrants is taken into

Figure 26 Youth Unemployment High—especially for Women



Source: ILO, 2013

account.[36] Jobs in the sectors that are expanding are increasingly being taken up by expatriates rather than by Maldivians.[37] While jobs in construction grew by 66 percent over the period (2006 to 2009/2010), the share of Maldivians halved from 25 percent to 12 percent. In contrast, the share of Maldivians in the tourism sector increased from 24 percent to 28 percent in the period. Maldivians appear to have held on to greater shares of employment in agriculture, wholesale and retail trade, education, health and in Government administration.

The high level of unemployment and discouragement has implications for potential widening of inequality of households and can drive disparities in quality of living in the future. This is particularly true when considering the social vulnerability cycle where unemployment and discouragement pushes young people into substance abuse or drug trade which can yield them quick windfalls or to gang activities [Box 13]. The drug survey and the study on gangs both reveal 'lack of job opportunities' and /or inability to find employment as a major determinant for these activities.

Consultations with the NHDR team indicated that employment opportunities are limited for differently-abled persons. The most obvious gap in services provided to people with different abilities is the lack of employment opportunities. There is no evidence of any Government or other organized support or services to people who are differently-abled in finding jobs. The survey conducted in Haa Alifu and Haa Dhaalu atolls showed that 71 percent of working age men with disabilities and 93 percent of working-age women with disabilities were not in work.[38]

BOX 13. From the people: Employment essential for Rehabilitation

'I come from a broken family and developed tensions with my mother and step father, when my younger sibling was born. I felt neglected. I started using drugs at 15 with my cousin and friends and eventually dropped out of school. In 2000, after completing a jail sentence, I went into rehab and was able to break the habit. In 2002, I got married and when my wife got pregnant, pressure built up, as she had health complications. I could not afford the medical bills because I did not have a job. I ended up peddling drugs and then slipped back into addiction. After many relapses, I finally made up my mind. I found a job a year ago and I am now getting back on my feet. Without a job, rehab cannot help people like me to break out of this trap.'

Source: Interviewee for the NHDR, July 2013

UNDERSTANDING UNEMPLOYMENT AND DISCOURAGEMENT IN THE MALDIVES

The complex labour market and high levels of unemployment are driving income inequalities and vulnerabilities among youth and women. The HIES study indicated that among the reasons for unemployment in the youth group (15 – 24 years), 'unable to find suitable employment' ranks the highest, followed by 'lack of opportunities', followed very closely by the youth being 'engaged in studies'. For the population as a whole, the number one reason for unemployment is inability to find employment, followed by obligations for household chores and thirdly due to the lack of opportunities. Among the demand and supply-side reasons that have been discussed are: lack of skills required by the present configuration of economic activities; lack of access to information; social and cultural barriers; lack of motivation and incentives, and wage structures that are not attractive and the absence of work ethic among Maldivians.[39]

The most common explanation for unemployment is the skills mismatch. Maldivians have always had a preference for white-collar jobs, administrative and managerial professions. There is limited demand to enter semi-skilled or unskilled professions such as construction, mechanical work and even work in the tourism sector. Contrary to the demand for skilled work, the share of Maldivians in the professional and technical categories is low where expatriate workers account for 44 percent and 21 percent of employment in these grades.[40] This on the contrary suggests a substantial mismatch in the skills required in the job market, and the unavailability of these skills among locals. The fact that Maldivians have not been able to increase their share of higher skilled jobs over the years appears to be mainly due to the lack of skills, and due to weaknesses in the education system. These issues contribute to the skills mismatch where local youth although completing primary and lower secondary schooling are not absorbed due to lack of skills such as language skills necessary for the tourism industry.

The attitude towards work and job ethics is another important issue. The private sector often reports that Maldivian employees lack ambition, job interest, commitment and reliability and this point was repeatedly made during consultations with the NHDR team as well. Job turnover of locals is high and many leave abruptly, without serving the notice period. There is a general acceptance that the provision of 'sick leave' in the employment act provides for additional holidays and the maximum number of 30 days often becomes an objective more than provision, which is

seen as a reflection of the lack of motivation to work. On the other hand, empirical work suggests that employers prefer migrant workers because they can be more easily controlled and managed than Maldivian employees.[41] Many observe the lack of interest of young Maldivians to move down into the labour market and to hold unrealistic job expectations.[42] This leads to the loss of jobs to a readily available class of migrant workers, who are forced to work in exploitative conditions. Besides, since unskilled jobs are taken up by an exploited group of migrant workers, these jobs carry with them the image of the abused foreign worker, which few Maldivians want to be associated with.

It is argued that the absence of the necessity to 'work for a living' creates a challenge for the country. There is often societal and family acceptance of staying economically in-active. Family and other networks often supplement the unemployed or the discouraged worker with income, shelter, food and other consumable goods. Societal and cultural attitudes reinforce high job expectations particularly among youth. Despite not having suitable qualifications for skilled jobs, taking up manual work for example in construction or becoming waiters, chefs, cleaners are seen as 'degrading work' or 'low status' work. Not being economically inactive or productive does not carry comparable labelling. There is a long-standing image among locals of the tourism sector, the country's economic driver. Tourist resorts are viewed as places that are not suitable for local people. This is particularly true for girls, which is the reason why female employment in the sector remains almost negligible.

Female unemployment is high due to domestic responsibilities that women have to shoulder particularly after childbirth. The HIES 2009-2010 data indicates that 40 percent of the females interviewed said that the main reason for not working was because they were unable to find suitable work, whereas 22 percent stated that it was due to household chores.[43]

POLICY OPTIONS - CREATING AN INCLUSIVE LABOUR MARKET

An employment strategy, as argued in ILO (2012), would require an integrated development policy framework and articulation of multi-dimensional policies, including macroeconomic, sectoral and institutional. Currently, there is a lack of a conducive policy environment to foster employment according to most people who were interviewed during the research carried out for the report. Policy priorities have not resulted in focused, consistent and long-term plans. Limited dialogue exists between strategic stakeholders such as Ministry of Tourism, Arts and Culture, Ministry of Education, Ministry of Human Resources Youth and Sports and Ministry of Economic Development and with the private sector. According to most informants, policy making bodies including the Ministry of Human Resources, Youth and Sports experienced a number of mandate changes over the past years and the issue of unemployment has not been taken up as a priority for policy action and planning.

Besides, policy efforts have to be made to strengthen labour governance. The current Constitution (2008) grants the right to work, organize trade unions, the right to strike and prohibits forced labor and discrimination. An Employment Act has been in force since July 2008, and its implementation has helped improve labour market conditions. The Act sets basic regulations relating to employment as well as the rights and responsibilities of employers and employees, based on the fundamental principles of the ILO. Further developments resulting from the act include establishment of a Labour Tribunal and Labour Relations Authority. It is therefore important for the Government to address labour administration, increase labour market data and information and set up mechanisms to deal with labour relations and dispute resolution in a transparent and fair manner.

The unemployment issues specific to the Maldives can be addressed through revisions in the education system and through skill development programmes, which target the gaps in the various industries. The education system and curriculum needs to encourage skills and talents beyond academic grades. The school system should integrate vocational skills building. At the same time, it is important for the Government and the private sector to agree on target sectors for promoting local employment, so that investments can be leveraged to facilitate professional development and skills development in specialized areas such as banking and finance, engineering and architecture and the hospitality industry.

Another intervention to address attitudes and perceptions about employment should be advocacy to reduce voluntary unemployment and discouragement. This should be targeted to school children, parents, teachers, employers and the public. Society should be encouraged to respect those employed and not dismiss semi-skilled or non-white colour jobs. This will have to be designed as a behavioural change campaign aiming to increase respect for productive citizens in the country and productive members within the family.

To make the labour market inclusive, interventions in two specific areas are critical. One is to target rehabilitating or recovering drug offenders and juvenile offenders. Our consultations indicate that crime records prevent young people from getting employment for at least five years. As a result it is extremely difficult for recovering addicts and

BOX 14. From the people:

"A police record is easy to get and hard to get rid of."

Gang Member

Source: Naaz, 2011

rehabilitating young offenders to re-integrate to work and social life, which in turn increases their chances of relapse. A report by Asia Foundation has highlighted that a significant barrier to employment for many gang members is the existence of a police record. In order to check whether a prospective employee has a criminal record, the law allows employers to access existing police records of job applicants. Even a brief police detention will lead to a five-year police record. Other issues that have been highlighted are that foreigners (Indians and Bangladeshis) are taking up all the jobs, and that the salaries in available jobs are often not sufficient to cover living costs. For example, in the report,it is argued that a person needs to earn MVR 5,000 (US$328) a month to live and support a family and ordinary jobs do not pay this amount. Members in gangs can easily earn higher incomes and make a 'quick buck', which makes it harder for them to break away.[44] Being part of a gang enables them to have affluent lifestyles.

Reintegration programmes should be designed taking into account these issues and the Government should build strategic partnerships with the private sector to facilitate employment placement for rehabilitating drug users and criminals. Similarly, given the high proportion of youth facing the problems detailed above and the high cost to society of a large part of the population being trapped in a cycle of social vulnerability that pushes them to exclusion, it is important that the Government puts in place policies to target employment of such youth in the civil service. In this way the Government can demonstrate youth and rehabilitation friendly policies to the private sector.

To make the labour market inclusive, employment policies for those who are differently-abled have to be promoted. It is imperative to challenge assumptions about what differently-abled persons can and cannot do. Positive discrimination needs to be introduced to enable both full-time and part-time jobs for such persons. The Draft National Policy on Disability recognizes the rights of persons with disabilities to work on an equal basis with others. It proposes a system of quotas for Government Ministries. Some of this may need equipment and workplace modifications to be effective and allow people with different abilities the chance to work to their full capacity, or to retain a job following an accident. Accessible transport to and from work and accessible workplaces are critical factors in ensuring people can work.The Government can introduce public employment schemes as a temporary bridge to address pockets of unemployment such as that among persons with disability or rehabilitating offenders.

TOWARDS EXPANDING JOBS AND BALANCING GROWTH

A research paper on inequality and human development by UNDP presents evidence of particular countries that have succeeded in pro-poor growth that is inequality-reducing and argues that these results depend crucially on the strategy adopted. Countries that have enacted growth policies favouring disadvantaged groups mentioned include Bangladesh, Bolivia, Brazil, Burkina Faso, El Salvador, Ghana, India, Indonesia, Romania, Senegal, Uganda, Vietnam and Zambia. These policies centered on investments in rural infrastructure and markets, public expenditures and safety nets, and credit provision, in a context of economic, political and environmental stability. China and India, countries in which growth has been highly dis-equalizing, provide notable counter-examples according to the paper.[45] In the case of the Maldives, similar interventions have proved to be successful in reducing poverty through investments in health and education across the islands.

The chapter highlights the critical role of fiscal consolidation and macro-economic stability in assisting the Government to expand investments in health and education. Given the emerging pull of income inequality and poverty in the urban area (in Malé) and the cost of unemployment on productivity and social stability of the country, urgent policy attention is necessary to mitigate the negative human development impact for the future.

Chapter 4

Education and Health: Identifying the Vulnerable

Chapter 4

Education and Health - Identifying the Vulnerable

The Constitution of the Maldives enshrines 'education without discrimination of any kind' as a basic right for all. The country has made impressive gains in literacy and access to education. Universal primary education has been achieved and lower secondary enrolments remain consistently close to 100 percent. Gains in health have been equally notable. Life expectancy in 2011 was 74 years.

The basic purpose of development is to enlarge people's choices. In principle, these choices can be infinite and can change over time. People often value achievements that do not show up at all, or not immediately, in income or growth figures i.e. greater access to knowledge, better nutrition and health services, more secure livelihoods, security against crime and physical violence, satisfying leisure hours, political and cultural freedoms and sense of participation in community activities. The objective of development is to create an enabling environment for people to enjoy long, healthy and creative lives.

The most critical is to live a long and healthy life, to be educated and to have access to resources to maintain a decent standard of living. Additional choices include political freedom, human rights and self-respect. As Amartya Sen has pointed out in his article on Capability and Well being,[1] 'the freedom to live different types of life is reflected in the person's capability set. The capability of a person depends on a variety of factors, including personal characteristics and social arrangements. Human capabilities constitute an important part of individual freedom'. Capabilities refer to the range of things that people can do or be in life. The most basic capabilities for human development are to lead long and healthy lives, to be knowledgeable, to have access to the resources needed for a decent standard of living and to be able to participate in the life of the community. Without these, many choices are simply not available, and many opportunities in life remain inaccessible.[2]

The capability to enjoy a long and healthy life requires that health facilities and schools exist, that they are staffed, that staff come to work, that resources are available and medical supplies are available and that people are not refused schooling or treatment because they cannot pay or because of their gender, race or religion.

The first National Human Development Report for the Maldives notes the rapid gains made in education and health in the Maldives. Achievements were led by high levels of literacy (standing at 98 percent in 1998) and universal access to primary education.[3] The report noted the inability of the education system to produce enough skilled graduates to meet the internal demand in the Maldives. Many school-leavers found they were inadequately or inappropriately equipped with the requisite skills for the opportunities available. This continues to be a major challenge even today. The report noted the lack of availability of upper secondary education and limited opportunities for tertiary education. Many students have no option but to seek education abroad.

Life expectancy went up from 43.6 to 70 years, during the period 1960 - 1997. The infant mortality rate (IMR) was 156 deaths per 1,000 live births in the 1960s; it declined to 20 per 1,000 live births in 2001. Yet some of the challenges identified in 2001 remain today. The first Maldives HDR noted the increasing trends in 'lifestyle'-related diseases and in non-communicable diseases. It recommended prioritizing preventive health action against high-risk diseases including tuberculosis, HIV/AIDS, reproductive health risks, heart disease, respiratory diseases, drug abuse, cerebro-vascular diseases, kidney disease and cancer. The report highlighted reproductive health inequalities, particularly those that face women, arising from early marriage and early child bearing, putting both the mother and the infant at risk; as the average age of marriage at the time was 16 years. Another health issue cited was malnutrition, which continues to pose a challenge today.

This chapter takes a close look at the gains in human development achieved through education and health and attempts to identify those most likely to be left out. It then looks at how to reduce the exposure to vulnerabilities and examines how these gaps can be closed. In so doing, it details the issues that need urgent attention in addressing inequality in both education and health.

A. ENHANCING EDUCATION CHOICES IN THE MALDIVES

Knowledge expands people's opportunities and potential. It promotes creativity and imagination. In addition to its intrinsic value, it has substantial value in expanding other freedoms. Being educated empowers people to advance their interests and resist exploitation. Educated people are more aware of how to avoid health risks and to live longer and more comfortable lives. They tend to earn higher wages and have better jobs. Many uneducated parents value schooling because they believe education will enable their sons and daughters to overcome the indignities that their families faced. Traditionally, Maldivians place a high priority on education.

STRUCTURE OF EDUCATION SYSTEM IN THE MALDIVES

The education system of the Maldives consists of three stages: primary education (grades 1-7, age 6-12), lower secondary education (grades 8-10, age 13-15) and higher secondary education (grades 11-12, age 16-17).[4] In addition, there is a pre-primary stage of nursery and kindergarten education.

There are 408 schools that provide education for about 86,510 students, constituting almost a quarter of the national population. There are 7,640 trained teachers of which 31 percent are expatriates. Government schools cater to around 72 percent of the total student population. Malé accounts for 7 percent of the schools in the country but upto 30 percent of the enrolment, as the schools in Malé have a considerably higher enrolment rate than the average for the country.

PATH TO PROGRESS – POSITIVE INTERVENTIONS IN EDUCATION

There has been continuous expansion in the access to education and building up of human capital in the Maldives. Enabling the community to have access to free education in Government schools and ensuring a comprehensive network of schools on every inhabited island have been important contributory factors. Significant progress towards equitable access to education has been achieved through overcoming barriers including geographical, income and identity (age and sex).

FORMALIZATION OF SCHOOL SYSTEM – A SOUND FOUNDATION

One of the earliest attempts to achieve equitable access to education in the Maldives was through the formalization of the education system. The public school system in English medium schools in Malé was initiated in 1960: with this system came expatriate teachers and English textbooks. Prior to this, the traditional school system in the Maldives comprised of three types of schools: *edhuruge* (neighbourhood Quranic School), *makthab* (learning institution) and *madhrasa* (school). Traditionally, schools were self-financed, and run privately or run by island communities.

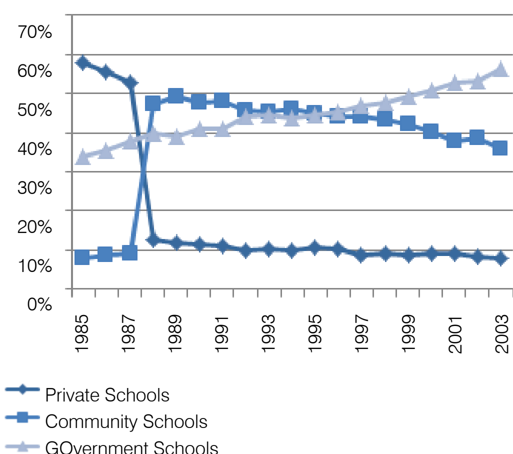
In 1978, a significant step was taken to establish a unified and formalized national education system, to promote more equitable distribution of facilities. The focus of the policy was on a unified curriculum for grades 1-7, improving teacher training and upgrading or establishing new schools in the atolls. Increased enrolment in the Government schools accompanied the growing formalization of the school system. As evident from Figure 27, since the mid 1980s, enrolment

Table 4 School Infrastructure (2012)

Education Infrastructure		Schools			
		Government	Community	Private	Total
Republic	Schools	213	79	116	408
Malé		13	4	10	27
Atolls		200	75	106	381
Republic	Students	62,151	12,402	11,957	86,510
Malé		15,770	6,275	4,538	26,583
Atolls		46,381	6,127	7,419	59,927

Source: Department of National Planning, 2013

Figure 27 Enrolment in Educational Institutions in the Maldives- 1985-2003



Source: Department of National Planning, 2013

in private schools has declined and enrolment in community schools and Government schools has been increasing. In 1988, there was a huge jump in the enrolment in community schools and the enrolment figures overtook those in Government schools. In the early 1990s, the enrolment in both community schools and Government schools was roughly equal and subsequently, the enrolment in Government schools has surpassed that in community schools. Starting from an initial share of about 58 percent in 1985, the share of private schools in student enrolment declined to 8 percent in 2003.[5]

The private schools in Malé primarily cater to migrant students from the atolls, who move to Malé and face difficulties enrolling in state schools, because often they do not meet the higher standards. Private and community schooling systems also account for pre-school enrolment, which is not provided by the Government.

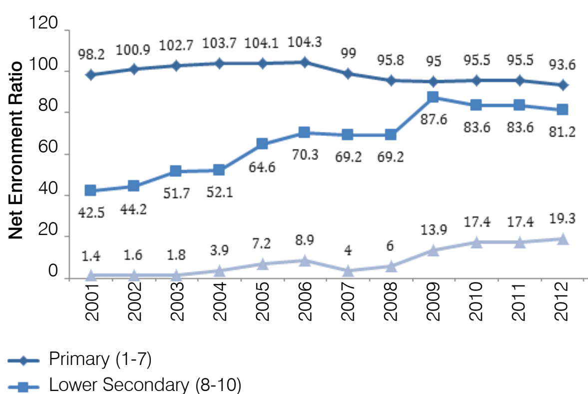
UNIVERSAL PRIMARY EDUCATION – ENABLING EXPANSION

A milestone towards achieving equitable access to education came at the turn of the millennium. The Maldives achieved universal primary education in the year 2000. Primary education was available in all the inhabited islands of the country. Today, every child in the Maldives has access to a primary school.

The Maldives enjoys higher primary enrolment than is predicted for the country's level of per capita income and outperforms many small island nations that are considerably wealthier, such as Antigua and Barbuda, the Bahamas, Malta, Mauritius, Seychelles, and Trinidad and Tobago, in primary education attainment. Lower secondary education enrolment is also high. The net enrolment rate[6] at lower secondary education is 83.6 percent, with the net enrolment rate for boys at 81 percent and girls' enrolment at 87 percent.[7]

To enable these achievements, the income barriers to education were successfully overcome. Primary and secondary education is free. Since 2008, the Government provides textbooks and learning materials. Special facilities are available for families who need assistance to cover the cost of school uniforms. For all students, who are enrolled in public schools, the examination fees are paid by the Government. Since 2007, the Ministry of Education has been covering the costs of ferries, which are in operation to islands where there are no schools. This has reduced the financial burden for poor parents and led to sustained high enrolment rates.

Figure 28 Total Net Enrolment Ratio by Level, 2001-2012



Source: Department of National Planning, 2013

INCREASE IN PUBLIC SPENDING ON EDUCATION

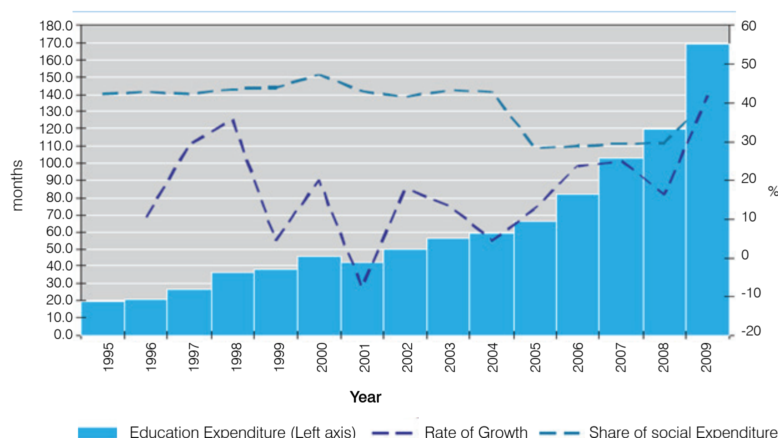
Spending by the Government on education increased significantly in the 1990s [Figure 29]. In 1992, approximately 20 percent of Government revenues went to finance education, a significant increase over the 1982 figure of 8.5 percent. Government expenditures for education increased from US$ 18.9 million in 1995 to US$ 169.4 million in 2009, a nine-fold increase.[8]

Growth rates have fluctuated widely during the period 1995-2009. However the average annual education expenditure has grown from US$ 50.7 million during the 2000-2004 period to US$ 108 million for the period 2005-2009, a 113 percent increase between these two time periods. During the four year period, 2005-2009, the average annual per capita education expenditure was US$ 352.1; which is almost twice the level of US$180.3, in the period 2000-2004.

GENDER PARITY IN EDUCATION

The Maldives has done exceptionally well in providing equitable access to education and in ensuring the absence of gender discrimination in school enrolment. For the period 2001 to 2011, enrolment of both boys and girls has been maintained at close to universal level at the primary stage. It has increased substantially at the secondary level over this period. Girls' enrolment at the

Figure 29 Expenditure on Education, 1995 - 2009



Source: Department of National Planning, 2013

lower secondary level exceeded that of boys through this period. With respect to gender parity in education, the Maldives is at par with Sri Lanka and Malaysia and way above its neighbours. The proportion of girls achieving a given number of years in school is higher than that of boys, at all levels of education.

INEQUALITIES IN EDUCATION - THE CHALLENGE

The main drivers of inequalities relate to interlocking vectors of vulnerability in the Maldives. These consist of structural vulnerability factors of spatial setting, income and identity, which are gender and age based in this assessment. Vulnerability due to spatial setting is the largest driver of inequality followed by identity and to a lesser extent by income.

Table 5 Educational Attainment, Selected Levels of Education – An Overview

Category	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka	Malaysia
Share of population aged 15–19 who attained at least grade 5								
Male	70	55.1	81.9	95.1	74.5	67.5	95.1	96.3
Female	78.4	41.4	71.6	95.7	56.3	46.7	95.8	96.4
All	73.8	48	77.2	95.4	65.1	56.9	95.4	96.3
Share of population aged 20–29 who attained at least grade 10								
Male	28.9	19.3	35.8	34.4	33.5	33.7	45.7	62.9
Female	18.5	9.5	23.6	37.1	17.2	19.5	51.1	71.3
All	23.2	13.7	29.7	35.5	23.9	26.3	48.4	67
Share of population aged 20–29 who attained at least grade 12								
Male	16.4	5.7	21.3	22.2	9.2	16	16.8	25.2
Female	8.7	2.9	14.6	24.6	4.2	10	22.9	32.2
All	12.2	4.1	18	23.2	6.3	12.9	19.9	28.6

Source: The World Bank, 2007

SPATIAL SETTING, INCOME AND IDENTITY: INTERLOCKING VECTORS OF VULNERABILITY

As discussed earlier, geography or spatial setting has been the biggest barrier to equitable access to education in the Maldives. Expanding schooling across the country was therefore critical. Income inequality has negative effects on attaining education.[9] Left unaddressed, these inequalities transmit across generations[10]. The effect of inequality appears to be transmitted not through family income or economic segregation, but rather through levels of state spending on schooling[11]. In the Maldives, income is a lesser driver of inequality in the education system due to the Government's efforts to promote free schooling.

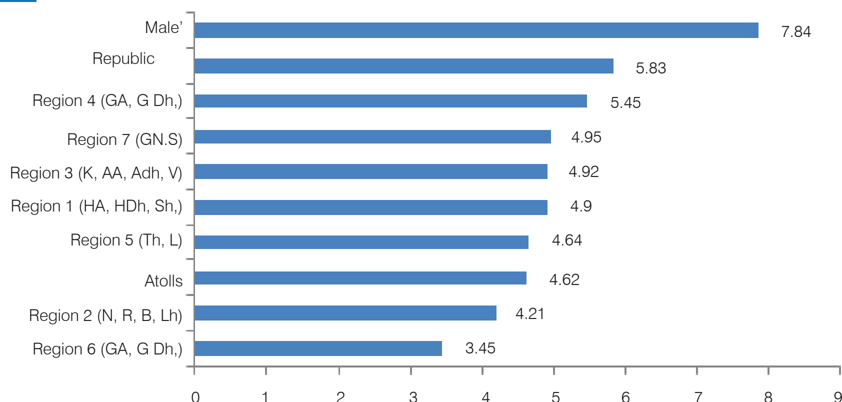
Identity as a vulnerability factor has been discussed in the light of gender and age. Inequality in education based on identity factors can significantly slow economic growth, for instance.[12] In the Maldives, gender gaps occur at higher secondary and tertiary education levels (particularly for girls living outside Malé, though the combined figures for the Republic do not reflect this situation). Anecdotal evidence points to potential threats of refusing schooling to girls. Age poses risks, in particular in the adolescent schooling years, where dropping out of school results in difficulty in accessing higher secondary schooling and acquiring the skills needed to participate in the labour force.

YEARS OF SCHOOLING AND ENROLMENT

Inequalities exist despite the impressive gains in education outcomes. The largest inequality is based on geography and access to higher education. Those who live in Malé have far greater advantages in accessing upper-secondary and tertiary education than those in the other islands.

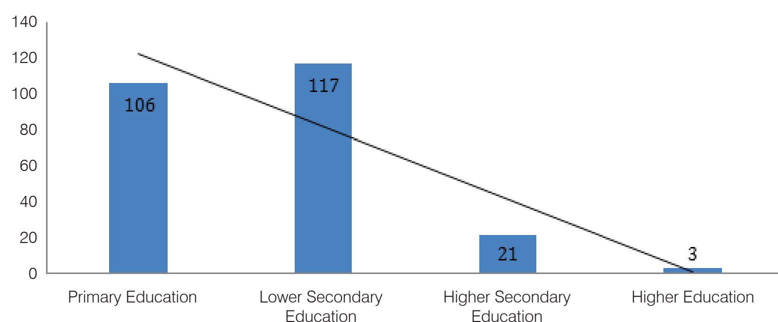
This is evident by the mean years of schooling, which is much higher for the capital Malé compared to the national average and the average of the outer regions [Figure 30]. While children in Malé complete on average almost eight years of schooling, in the republic the figure is about six years. The lowest number of years of schooling was seen in Region 6 (which consists of Gaafu Alifu and Gaafu Dhaalu atolls) 3.45 years and Region 2, (Noonu, Raa, Baa and Lhaviyani atolls) where the figure was 4.21 years. The average for the atolls is 4.62 years. One reason for these extremely low figures could be the high levels of out-migration from these atolls to the capital Malé, especially among children and families seeking better quality education.

Figure 30 Mean years of schooling differ across regions



Source: The World Bank, 2007

Figure 31 Enrolment at different education levels



Source: The World Bank, 2013

One of the challenges facing the Maldives is the sharp drop in the enrolment rate after secondary education. From an enrolment of 106 percent at the primary school level, enrolment first increases to 117 percent at the lower secondary level, after which there is a sharp drop at the higher secondary school level to 21 percent and then to as low as 3 percent at the higher education level [Figure 31]. The main reason for the sharp drop in participation at the higher secondary level is the limited number of schools offering education at grades 11-12 and the result of the Government policy which focused initially on the attainment of universal primary education, and then the development of lower secondary schools to cater for the age group 13-15 years, while postponing the challenge of higher secondary education for policy consideration at a later date.

The participation rate for tertiary education is even lower, with the gross enrolment figures (GER) at 13 percent of the eligible population, in comparison to GER for the world, which is 27 percent, less than half the rate for High Income Countries (68 percent). However, it is equal to the South Asian tertiary enrolment rate and is higher than the rate for Small States.[13] After 2004, the enrolment rate in higher secondary has increased almost three fold from 1622 (2004) to 4267 (2012) students.[14]

Efforts have been made to introduce and expand tertiary education opportunities in the country. The Maldives National University (MNU) was established in 2011 and has been expanded to three regions, to provide tertiary education and training for tertiary level students. Over the last 10 years, a number of private institutions (like Villa College), which provide higher education to the outer regions and offers a diverse range of affiliated programmes have been set up. These institutes provide post-secondary level programmes such as diplomas, advanced diplomas, bachelor's degree and graduate/postgraduate diplomas.

Table 6 Participation in Tertiary Education, Maldives and other regions

	Least Developed Countries	Small States	Maldives	South Asia	World	High income countries
GER (%)	6	11	13	13	27	68

Source: The World Bank, 2013

INEQUALITIES PERSIST IN LEARNING OUTCOMES

In the last two decades, the focus was on increasing access to education, an urgent need now exists to improve the quality of both primary and secondary education. National assessments indicate low achievements at all levels of education — a major difference exists in the quality of education between Malé and the atolls.

Lower secondary attainment rates are of great concern. Lower secondary achievement rate for Cambridge IGCE/GCE was only 27 percent of students achieving a passing grade (Grades A-C in 5 subjects or more) in 2008. There has been some improvement in the achievement rates from 2009 onwards till 2011. But 16 percent of the students did not achieve a single pass in 2011 despite an 8 percent improvement since 2008.[15]

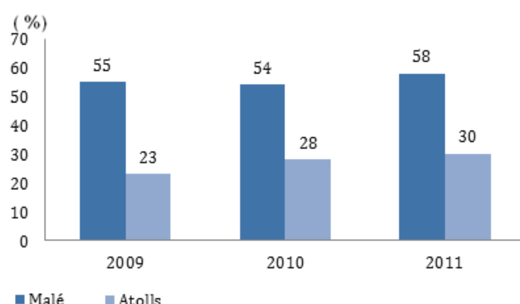
BOX 15. From the people:

- Parents play a minimal role in the educational process of their children.
- Under-performing students are often perceived to be neglected by the school management.
- A widespread view was that there was a lack of qualified teachers.
- No schooling for children with special needs was perceived as being available.

Source: Focus Group Discussions in Laamu atoll, Fonadhoo and Gan islands

Not surprisingly, there is a major difference in the achievement rates between Malé and the atolls as seen in [Figure 32]. The success rate in the atolls was only 30 percent in 2011 compared to 58 percent in Malé. Atoll level success rates show Laamu and Raa atolls as poor performing and Faafu, Baa, Seenu and Gnaviyani atolls as better performing. Learning outcomes in both primary and secondary education are modest.

Figure 32 Achievement rates for O' level examinations (2009-2011) (Pass percentage)

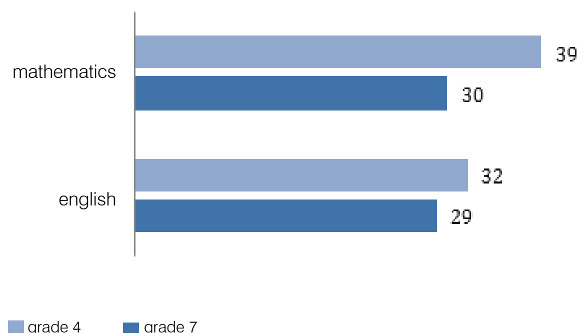


Source: Department of National Planning,2012

National assessments show that learning outcomes at Grade 4 and Grade 7 are unsatisfactory, as there are low average scores for both English and Mathematics. This suggests that the learning levels in both primary and lower secondary education are weak [Figure 33].

There are wide regional disparities in learning outcomes as well as achievement levels in English language skills at both primary and lower secondary education level. These are significantly higher in Malé than in the atolls. Although Seenu, Lhaviyani and Gnaviyani have learning outcomes that are well above the rest of the country and Raa atoll is seen to be at the bottom. In Mathematics the regional disparities are less but gaps among the atolls still exist.

Figure 33 Performance in English and Mathematics, 2008



Source: Ministry of Education, 2008

A baseline study by UNICEF on student performance showed that the level of learning of Maldivian students is lower than average international levels.[16] The assessments covered 17,000 students across Grades 4, 7 and 9 from about 220 schools. The students were given different test papers for English, Mathematics, EVS/ Science[17] and Social Studies. The performance in English is notably low, with Maldivian students in Grade 9 performing lower than the international average of Grade 4 students. In Mathematics and Science, the gap is higher at Grade 4, while students appear to catch up in Grade 8, which is more due to the strength of their performance on questions that do not involve deep conceptual understanding.

Quality of teachers is of vital importance to the performance of schools and the quality of education. In 2011, 15 percent of teachers were untrained, although this figure has dropped to 5 percent in 2012[18], due to intensive training programmes undertaken by the Government.

The majority of untrained teachers were located in the atolls (336 out of 370 untrained teachers) as most of the trained teachers prefer to work in Malé (in the atolls, 13 percent of teachers were untrained as compared to two percent in Male).[19] Most of the untrained teachers were found to be teaching in primary schools. Out of

the 370 untrained teachers in the Maldives, 213 were teaching in primary schools and 98 were teaching in pre-primary schools. Consultations by the NHDR team with diverse groups of people including education professionals, youth groups and focus groups discussions with community representatives including councils and NGOs unanimously confirmed that the lack of availability of quality teachers is the prime factor responsible for less than satisfactory educational quality and standard, particularly in the atolls.

There is an acute shortage of local teachers which results in high reliance of expatriate teachers. Close to 30 percent of teachers were foreigners and 84 percent of expatriate teachers were deployed in the schools in the atolls in 2012, as local teachers were less willing to work outside of the capital, Malé. Expatriate turnover is high which poses costs to the system and the students in terms of loss of school days and school-work. The perception from the FGDs was that expatriate teachers, especially those deployed in the atolls, often lack commitment and motivation. It was felt that expatriate teachers sometimes do not engage sufficiently to understand the local curriculum and the cultural context and the quality of education may suffer as a consequence. The Maldives is often regarded as a transit point for foreign teachers to get sufficient experience after which they seek jobs in other places/countries.

VULNERABILITIES AND EMERGING RISKS

GEOGRAPHICAL DISPERSION AND FALLING STUDENT POPULATIONS

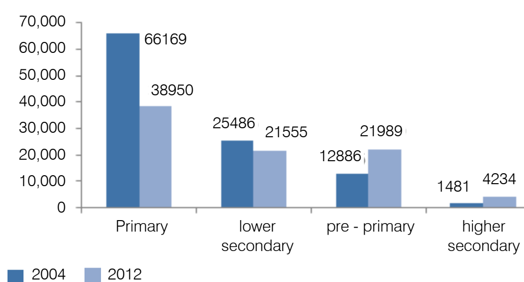
One of the major challenges facing the education sector is to maintain access to schooling and address the issues of quality of education across the islands. The geographical dispersion and low student populations make it expensive and complex to deliver services. The Maldives had a student-teacher ratio of 11:1 in 2012, which is amongst the world's lowest ratios and the main reason for this is the small communities in many islands leading to small student populations.[20]

Statistics show four schools with a population of less than 30 students, 10 schools with a population ranging from 31 to 50 students, 31 schools with a population ranging between 51 to 100 students and 42 schools with a population ranging from 101 to 150 students. All these 87 schools will have on average, a teacher student ratio which is 1:20 or less, given that all schools teach up to Grade 7[21]

It is to be noted that the overall shifts in the demographics of the country are resulting in a significant fall in primary enrolment, where universal access has been achieved [Figure 34]. Between 2004 and 2012, enrolment almost halved from 66,169 to 38,590, and this will continue to lower school population and student-teacher ratios, making it even more expensive to run schools on small islands. These trends are less visible at the secondary and higher secondary categories, as coverage is still limited and any expansion in schooling in these categories will push the enrolment trends upwards.

Overall however the student population can be expected to decrease significantly in the coming years, which will undermine the feasibility of the current school system of delivering to each and every island. There is a high level of migration of student populations to Malé, which is reducing the student population in the atoll schools. Statistics show that 45.9 percent of the student population in the schools in Malé are from other atolls.[22]

Figure 34 Enrolment in School at different levels, 2004 - 2012



Source: Ministry of Education, 2012

To overcome geographical barriers and low school populations, the Government has introduced a school ferry system. This has shown mixed results, according to the Ministry of Education. Usually students and parents are apprehensive about taking a ferry to the next island to attend school. They feel that schooling should be available on their respective island. There is only one case noted by the Ministry, where the ferry system was functional. All the other ferries have been stopped, either because the service is not reliable or because the students refuse to use the ferry.

BOX 16. From the people:

Incentivizing Learning

"I think students need to be incentivized to commit to their education and learning. No matter which grade you are in, education should be fun, it should inspire minds, it should challenge accepted norms and it should make demands on current learning and scholarship boundaries. Reaching this end requires an overhaul of our education system. Having 3 O-Level or A-Level passes should not be the yardstick by which we measure success. We must improve not just the quality of education, but how we participate in education."

Source: NHDR Facebook Page Respondent

SCHOOL DROP OUTS, LOW ATTENDANCE AND EDUCATION REFUSAL

Although school enrolments are close to 100 percent, attendance levels are lower. There is major disparity between attendance ratios for boys and girls and between regions according to the Demographic Health Survey (DHS) 2009. Interestingly enough, the highest primary school net attendance among girls was found in the poorest North region (86.7 percent), while the highest attendance among boys was found in the North Central, the richest region (85.7 percent).

School attendance of girls was higher in the wealthier households, while for boys the opposite pattern was found – higher household wealth was accompanied by lower school attendance. Simultaneously, there is concern about high numbers of drop-outs, which is seen across all levels of education. As such it is important to monitor and analyse the reasons for dropping out and students not completing their studies to thwart the slide.

BOX 17. From the people:

Voices on vulnerabilities:

Challenges:

- Fall in number of students
- Inadequate budget
- Lack of qualified teachers
- What needs to be done:
- 11 out of 13 schools interviewed felt that the most important thing needed for school is better trained and qualified teachers
- Competent management including qualified principals and monitoring systems is top priority
- Monitoring of schools on a continuous basis is needed
- Proper screening of foreign teachers' recruited and more stringent recruitment needs to be in place

Source: Phone Survey of Selected Schools in the Maldives

Drop-out rates are small for all grades except Grade 7. At this grade, the drop-out rate for males is higher than for females (4 percent compared with 1 percent). Rural children drop out of school at Grade 7 more often than urban children. Across regions, the Grade 7 drop-out rate ranges from 4 percent in the North Central and the Central regions to 2 percent in Malé. There is no uniform pattern for Grade 7 drop-out rates across wealth quintiles.

Cases lodged in 2011 with the HRCM revealed that 82 percent of children who were in conflict with the law were not attending school. Of these 37 percent of children were dropouts from lower secondary (grade 8) and only 8 percent of these juvenile offenders end up completing school.[23]

Field consultations revealed that there are many anecdotal cases of children being taken out of mainstream schooling and being enrolled in Islamic schools. Many pre-schools focus on strict Islamic schooling and concerns were raised regarding this issue and the lack of attention given to gather evidence regarding this aspect. This is an issue that needs further investigation.

Consultations with school managements and community groups indicated that neglect is common among students, which discourages them from attending school. This is common among children who are from broken families, children living with single parents, children who live with relatives as parents are serving prison sentences and/ or children whose parents are into substance abuse. One school visited noted that 85 percent of the students came from broken families.

It is important that the Government study the issue of children dropping out of school and take appropriate action to address this problem.

ENHANCING EDUCATIONAL CHOICES - THE WAY FORWARD

IMPROVING QUALITY OF EDUCATION

An important aspect of the debate on education is related to the pedagogy of teaching and the highly examination-oriented system that is followed, which leads to high competition among schools to have their students ranked in the top ten positions in the Republic. It is argued that overall pass rates and performance of students are compromised, as attention gets focused on individual top achievers for schools.

The current challenges that have been identified by the Ministry of Education through consultations with various stakeholders are: attracting qualified individuals into the teaching profession, retaining qualified teachers, and motivating them to work hard. In the Maldives, teacher salaries have declined, in recent years, relative to the salaries of other public services and the private sector. Hence, the best school leavers and young graduates are reluctant to enter the teaching profession. Often mid-career teachers leave for more attractive jobs in the private sector and elsewhere in the Government sector.

Policy makers have to strengthen the motivation and incentives for teachers to perform well. For instance, a hardship allowance was introduced in 2005, in order to encourage local teachers to work in the atolls. This incentive did have some positive results. The Government now needs to develop a systematic

set of policies to strengthen teacher motivation and performance drives. A well-designed incentive system is important to attract promising young people into the teaching profession, retain good quality teachers over the career-cycle, and motivate teachers to perform well in classrooms.[24] It is important for policy makers to assess top performing schools and to see if best practices can be replicated elsewhere.[25]

INNOVATIVE FINANCING- FINDING THE MONEY

From 2008 onwards, education expenditures have been declining in the Maldives. In real terms, public education expenditure fell from MVR 1,248 million in 2008 to MVR 1,098 million in 2011. This is a 12 percent decrease over the three-year period.

Recurrent education expenditures declined from MVR 1,123 million in 2008 to MVR 1,056 million in 2011 constant prices — a 6 percent decline.[26] The fall in capital expenditure means that the Government of the Maldives has been unable to invest adequately in expanding the school network to cover higher secondary education, and in providing modern teaching-learning technology and material in recent years. School maintenance and the replacement of equipment have also suffered.

There is an increasing involvement of public-private partnership in the education system. One higher secondary institution (Villa College) in the capital, Malé and a primary/secondary school (Ghiyasuddin) also in Malé, have been operating on public-private partnership basis since 2010. Private sector providers have entered both primary and secondary schooling and 2010 saw the setting-up of the first international school in Malé. Private sector provision of tertiary education has increased in recent years with internationally endorsed qualifications being available.

The Government should explore innovative financing and investments to scale-up investments in the education sector. This could be through commercial or business models as highlighted above and could be by establishing affiliations with international education providers and setting up international campuses.

EXPANDING HIGHER EDUCATION: TARGETING WOMEN AND STUDENTS FROM REMOTE LOCATIONS

Expanding higher education and tertiary education opportunities is a challenge.[27] While many students migrate to the capital, Malé, or go abroad for further studies, on the islands, education opportunities particularly for girls remain limited. The number of women continuing their studies beyond secondary education is low compared to men. Limited access to educational institutions at the island level, domestic responsibilities and hesitance to allow women to study in other islands compound the problem. However, with the setting up of the Maldives National University (MNU) as a tier II higher education institution along with Maldives Polytechnic (MP) and other private sector colleges there are positive signs of higher participation from women. For example, MNU figures indicate the proportion of female graduates to males in August 2013 was 256:104, so the number of female graduates was two and a half times the number of male graduates.

Higher education opportunities have a link to employment opportunities and better incomes as well. The DHS 2009 showed that the percentage of females in households who have completed more than secondary schooling is only 0.3 percent for the lowest wealth quintile, whereas the percentage was much higher at 9.7 percent for the highest wealth quintile. This shows the direct link between wealth/income status of a household and education for girls. Not surprisingly, education for girls especially at the secondary level and after is more common among the better off households.

In 2012, financial assistance to support students pursuing higher education was initiated and a trust fund was created. It has a cross cutting criteria that each applicant must be poor or needy (unable to meet the cost of education on his/her own). The major part of this fund is given for higher education loans to students who qualify, based on the required criteria. However, there is a lack of awareness among people regarding the existence of this fund, especially in the islands, and most of the applicants and beneficiaries of this fund are people of Malé. It is important therefore that higher education opportunities be made available, and financial assistance and access for women and those residing in remote islands be provided through targeted programmes.

EDUCATION FOR EMPLOYMENT - FINDING JOBS

The unemployment rate in the Maldives is the second highest among the small island countries, at over 14 percent. The unemployment rate for females is significantly higher at 23.8 percent; (male unemployment rate is just under 8 percent).

Technical and Vocational Education (TVET) is another important category, as it aims to create a skilled workforce to meet the labour market demands, which is critical for the Maldives, given low labour force participation rates particularly among youth and women. Since the inception of the TVET programme in 2006, trainings on a range of areas including hospitality and tourism, construction and engineering, agriculture, electrical wiring and handicrafts have been offered.[28] However, it is important that the TVET programme applies a strategic approach by developing the right skills required by the market and ensuring that participants find employment by providing strong placement linkages.

Like the rest of South Asia, Maldivians consider the pursuit of vocational training and skills as being inferior to pursuing academic degrees, because white-collar jobs are preferred by the general population. Due to this, the demand for vocational subjects in colleges and institutes is lower than for academic subjects. The development of soft skills, especially in schools, through a variety of activities like co-curricular and extra-curricular activities is essential for employment

Table 7 Unemployment in the Maldives and Comparator Small Island Countries, 2010

Country	Total	Male	Female
	(% of total labour force)		
Maldives	14.4	7.9	23.8
The Bahamas	14.2	14.4	14
Malta	6.9	7	6.8
Trinidad and Tobago	5.3	3.5	6.2
Barbados	8.1	6.8	9.4
Seychelles	5.5	6.1	4.9
Mauritius	7.3	4.4	12.3
Belize	8.2	5.9	13
Tonga	1.1	n.a.	n.a.
Sao Tome and Principe	16.7	11	24.5

Source: South Asia HDU, 2012.

as employers value these skills. It is important that the national curriculum acknowledges these skills and creates a demand for them from an early stage. At the same time, the school system should encourage students and parents to respect gainful employment, irrespective of the job category - academic and white-collar based or vocational.

Strengthening the capacity and availability of skilled teachers requires a significant push across the atolls. Constructing school infrastructure and providing basic teaching tools are critical issues that need support. Ensuring the positive trends in spending on education are channelled towards building equitable and lasting results is imperative.

B. HEALTH SERVICES - DELIVERY AND ACCESS

By reviewing tranistions in the health system and the emerging health risks the country has experienced, this section argues that effective governance and policy-making must address these shifting dynamics, to produce positive health outcomes for the vulnerable. Focusing on vulnerability can help promote more equitable health standards for all people in the Maldives.

▶ STRUCTURE OF THE HEALTH SYSTEM

The health system in the Maldives consists of three levels: the primary, secondary, and tertiary care layers. Government health facilities include one main referral general public hospital, the Indhira Gandhi Medical Hospital (IGMH), six regional public general hospitals, 13 atoll hospitals, 132 health-care centres and 108 health aid posts.[29] In the private sector, there is one major tertiary hospital and approximately 50 clinics throughout the country. The Government of Maldives is the only provider of inpatient care in the atolls, at the sub-national level. The NGOs actively working in health are limited in number and are largely concentrated in Malé.

The Ministry of Health and Gender (MoHG) is responsible for developing the national health policy of the country, public health protection, health service delivery as well as regulation and quality assurance of health services. The Health Protection Agency is responsible for prevention and control of communicable diseases and for the promotion of health and well-being. The Health Services division is responsible for organizing and delivering curative services to the regions, atolls and islands. The Health Protection Agency (under the Public Health Act) regulates public health protection.

Some health-related national legal instruments, such as the Social Health Insurance Act and Health Protection Act (December 2012), have been passed by the Parliament and are being implemented. The Health Professionals Bill and Medicines Bill, the Health Services Bill and the Medical Negligence Bill are either being developed or are awaiting approval of the Parliament.

▶ PATH TO PROGRESS – POSITIVE INTERVENTIONS IN HEALTH

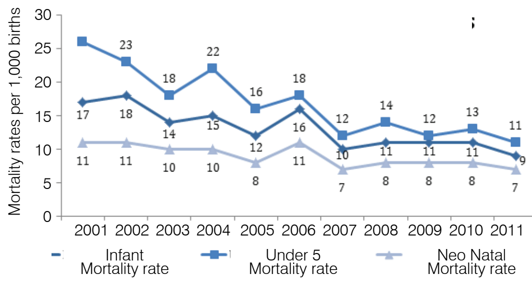
Significant advances underlie the advance in health in the Maldives. The life expectancy at birth increased from 70 to 72.6 years for men and from 70.1 to 74.4 years for women, during the 2000 - 2010 period. There has also been a positive decline in the mortality indicators in the Maldives since 2001. The infant mortality rate (IMR) fell from 18 per 1,000 live births in 2001 to 9 per 1,000 live births in 2011, the result of a considerable decline in IMR in both in Malé and the atolls [Figure 35].

The under-five mortality rate (U-5 MR) has similarly declined from 26 per 1,000 live births to 11 per 1,000 live births since 2001, and here the atolls have shown a tremendous achievement of reducing the U-5 MR from 30 per 1,000 live births to 10 per 1,000 live births, since 2001.[30] In neonatal mortality, the rates have seen a similar trend, with the rate in the atolls declining by almost a third since 2001. This trend has led the Maldives to come in second only to Sri Lanka, in child mortality gains in South Asia, over the last decade or so.

▶ PROGRESS TOWARDS IMPROVED HEALTH

Progress towards equitable healthcare came with three successful strategies, universal immunisation, high per capita health spending and service extension

Figure 35 Declining child mortality rates, 2001-2011



Source: Ministry of Health, 2012

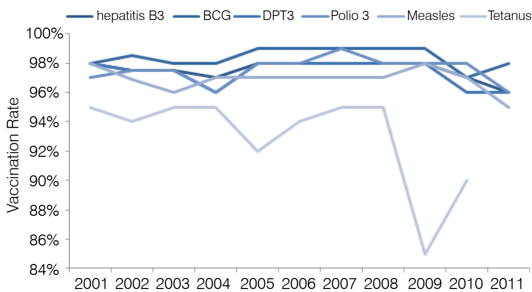
to the atolls. These three strategies will be examined in detail in the discussion that follows.

UNIVERSAL IMMUNIZATION

The Maldives has maintained almost universal coverage for all vaccines for preventable childhood diseases for nearly two decades [Figure 36]. Data shows that of children aged 12-23 months, 89 percent were fully vaccinated by 12 months of age.[31]

With the EPI programme, polio, diphtheria, pertussis (whooping cough) and neonatal tetanus have been almost eliminated and immunization service delivery functions well, including vaccine distribution and cold chain management. However, consultations held with health professionals in Malé and the atolls did raise potential risks to these achievements due to observance of vaccine refusal. Although reasons given by parents in the refusal forms do not explicitly

Figure 36 Vaccination rates in the Maldives, 2001- 2011



Source: Ministry of Health, 2012

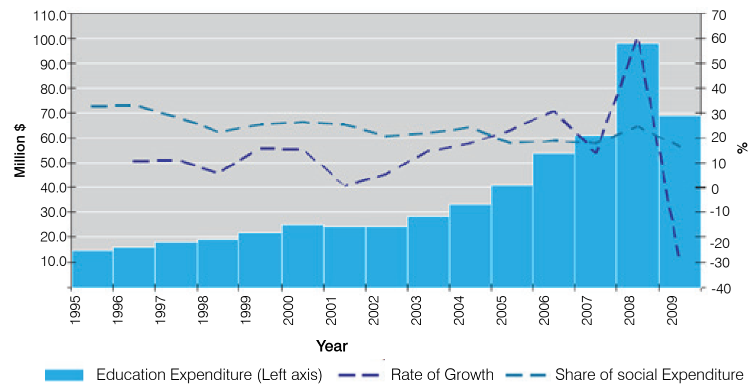
state religious reasons, many officials note that these choices are made because there are preachers who discourage vaccination and immunization.

HIGH PER CAPITA HEALTH EXPENDITURE

The per capita expenditure on the health sector in the Maldives is cited as a 'best practice' in the South East Asia region. In the period 2005-2011, per capita health expenditure increased from US$ 136 to US$ 247.[32] Notable achievements have been made in the control of communicable diseases as a result.

Expenditure on the health sector has increased in nominal terms, from US$ 14.6 million in 1995 to an estimated US$ 69 million in 2009 [Figure 37]. After 2006, however, the growth rate of health expenditure has been volatile. Health expenditure increased on average at about 10.7 percent per year, during the period 2000 to 2004. Following the tsunami, health expenditure began to grow at an annual average of

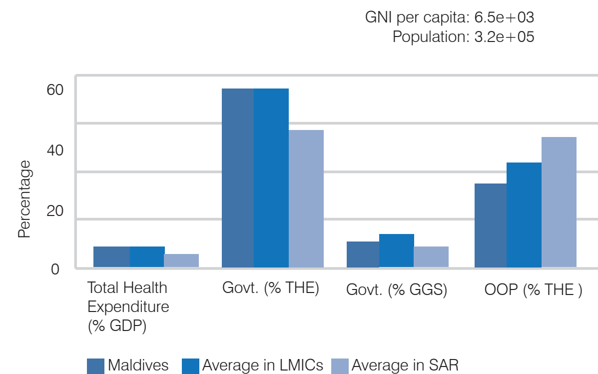
Figure 37 Health care expenditure from 1995 - 2009



Source: UNICEF, 2009

Source: Department of National Planning, 2013

Figure 38 Comparative Health spending in South Asia Region (SAR) and Low Medium Income Countries (LMICs)

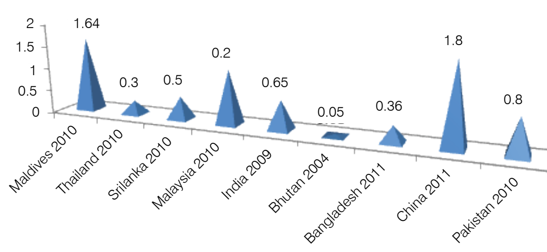


Source: World Bank, 2013

19.7 percent – most of the increase being accounted for by planned budgetary expenses of about $ 69.0 million in 2009 compared to $53.8 million in 2006.

Per capita expenditures on health have risen steadily from about US$ 60 in 1995 to an estimated US$ 200 in 2007 (there was, however, a dip in the year 2001). Most of the increases took place in the years after the tsunami, with per capita spending doubling to an average of US$ 211 during the period 2005-2009, from an average of US$ 97 for the years 2000-2004. Expenditures made included upgrading buildings for island health posts and additional staffing, especially in 2008 and 2009 (some of these expenses were also undertaken because it was an election year).

Figure 39 Density of Physicians per 1,000 population (2004 -2011)



Source: WHO, 2014

EXTENSION SERVICES ACROSS ATOLLS

Recent years have seen a major expansion of health service delivery in the country with more focus on curative health care. The Maldives has one of the best doctor-to-population ratios amongst its neighbours and other small island countries as seen in Figure 39. In 2005, there were 379 medical doctors with a doctor-to-population ratio of 1:775, while in 2010 there were 525 doctors with a doctor-to-population ratio of 1:609, making the physician density (per 1,000 population) as 1.642. In 2005, the number of nurses was 974 with a nurse-to-population ratio of 1:302, whereas in 2010, with the total number of nurses being 1868, the nurse-to-population ratio was 1:171. The nurse-to-doctor ratio was about 4:1. Medical services are provided mainly by an expatriate workforce that accounts for about 48 percent of the services, both in the public and private sector. This progression in the health resources has been extended to the atolls making health centre facilities available in all the inhabited islands of Maldives.

The health system, however, faces major human resource challenges partly due to lack of trained professionals available locally and partly due to problems of allocating doctors in the out-lying islands. As indicated in Table 8, 98 percent of the doctors in the atolls were expatriates in 2010. In the out-lying atolls, many problems occur with doctor-patient communication and there is a high turnover of expatriate health professionals, which affects health service delivery. Many health service outlets in the islands as well as at the tertiary hospital in the capital, Malé, face constant shortages of doctors and staff.[33] Furthermore, skilled professionals in small islands are underutilized and inadequately sensitized to the changes in the demographic and epidemiological profile.

Moreover, there are skills-to-job mismatches of trained personnel in the health system, suggesting the need to build capacity for health system management. Civil service hiring practices, pay structure and political interference and influence in recruitment have also been highlighted as major problems facing the health sector.

DRIVERS OF INEQUALITY AND VULNERABILITY IN HEALTH

The dispersed geographical nature of the Maldives means that distance and travel are significant barriers to reaching health services, especially in cases where specialized services may be needed. In 2011, it was reported that 21 percent of atoll-based hospitals faced problems in accessing medicines, as compared to 9 percent of hospitals in Malé. Further, 38 percent of inhabited islands had no health centre, hospital or private clinic.

Significant disparities exist between the quality of health care in the atolls and Malé. The factors that determine these spatial setting-driven inequalities are —first, the fact that fewer and less qualified doctors and nurses are available in the atolls and second, the widespread lack of basic infrastructure, medicines and materials in many health facilities.

This report argues that three factors drive vulnerability—and in turn, widen disparities access to health facilities in the Maldives. The main vulnerability factor driving inequality is spatial setting, followed by income and to some extent identity. Affordability of health care

Table 8 Malé and Atolls: Doctors and Health Professionals – 2009, 2010

Health resources	2009			2010		
	Republic	Malé	Atolls	Republic	Malé	Atolls
Doctors	526	204	322	525	219	306
Doctor expats (%)	83	57	99	82	58	98
Pop per practicing doctor	-	-	-	610	470	709
Pop per practicing nurse	-	-	-	171	156	180
No. of paramedical workers	609	287	322	629	358	276
No. of community health workers	230	2	228	278	2	803
No. of family health workers	283	0	283	313	0	313
No. of traditional birth attendants	119	0	119	214	0	214

Source: Ministry of Health, 2012

BOX 18. From the people:

Perceptions from the North - Main Problems in Health Services

- Lack of equipment and resources in the regional hospital in the North
- Dependence on Ministry of Health in procurement and budgeting
- Lack of medicines in store/ Pharmacy
- Lack of qualified doctors in the islands (doctors sometimes fail to diagnose minor diseases, hence people have to travel to Malé.
- Many sick persons could have been treated on the island had they been diagnosed properly.

Source: Focus Group Discussion, Haa Dhaalu

becomes critical particularly when overseas medical care is sought, and out of pocket (OOP) expenses are high. Identity vulnerability can be observed among women, the youth (particularly drug users), elderly, disabled and migrant workers.

Fundamentally, where drivers of vulnerability overlap, the largest inequities persist. In the Maldives, low-income families living in remote locations are therefore the most vulnerable in terms of health opportunities and achievements. Here the risks that can potentially impact and reverse or block progress in health outcomes are the greatest.

PERSISTING HEALTH INEQUALITIES

Spatial setting figures as the largest driver of inequality and vulnerability in the Maldives. These can be expressed along multiple dimensions, overlapping with vulnerabilities defined by income and identity.

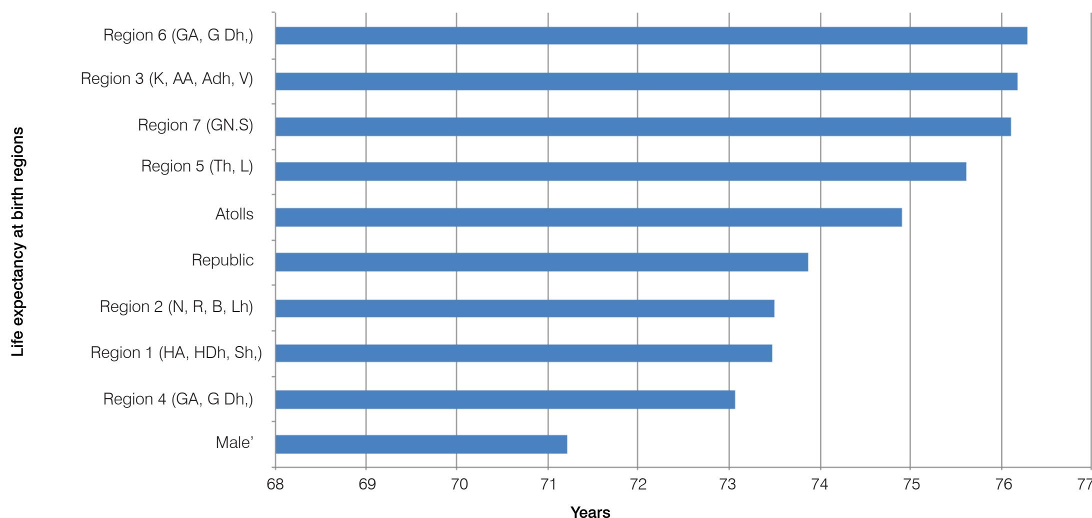
REGIONAL DISPARITIES IN LIFE EXPECTANCY

The life expectancy map of the Maldives reveals striking contrasts: the region with the best quality of life and health services holds the lowest life expectancy at birth. In contrast to the quality of life and medical services available in the capital Malé, life expectancy is lowest here, at a little over 71 years. This is largely explained by the location of the country's only tertiary hospital in Malé and as a result a significantly higher number of deaths are recorded in Malé. In contrast, life expectancy is highest in Region 6 (Gaafu Alifu/Gaafu Dhaalu atolls). Life expectancy at birth is above 76 years for Regions 6, 3 (Kaafu, Alifu Alifu, Alifu Dhaalu atolls) and 7 (Gnaviyani and Seenu atolls). Five years of life divide Maldivians between Malé and Region 6.[34]

NUTRITION REMAINS A HUGE CHALLENGE

Inadequate nutrition affects the way people, particularly children, acquire knowledge and participate in society. It hampers the ability to work and be productive and thus limits the ability to earn income needed to lead a decent life. More income does not always guarantee proper nutrition, and people who are not poor may still have poor dietary intake that may not provide sufficient nutrients. This under-nutrition accelerates frequent bouts of illness and impaired cognitive development, which adversely affects the country's productivity and growth.

Figure 40 Life expectancy at birth in the Maldives



Source: Ministry of Health, 2012

These conditions are most significant in the first two years of life, highlighting the importance of nutrition in pregnancy as the window of opportunity for preventing under-nutrition from conception to 24 months of age. In the Maldives, although child survival has improved over the years, two issues threaten progress: increasing disparity in nutrition status and under-nutrition rates. Three important indicators of malnutrition in children are general malnutrition (low weight-for-age), stunting (low height-for-age) and wasting (low weight-for-height). Stunting reflects chronic malnutrition; wasting reflects acute malnutrition; underweight reflects chronic or acute malnutrition or a combination of both. The Multiple Indicator Cluster Survey (MICS)-2 2001/ Maldives DHS 2009 surveys revealed that amongst children general malnutrition declined from 30.4 percent to 17.3 percent, stunting reduced from 24.8 percent to 18.9 percent and wasting reduced from 13.2 percent to 10.6 percent over the period 2001 to 2009.

Regional variation in nutritional status of children is substantial, with stunting being highest in the North Central Region (23 percent) and lowest in Malé and the North (16 percent).[35] The North Central Region reports the highest level of wasting (15 percent) and Malé reports the lowest level (7 percent). With regard to children under the age of five, 17 percent are underweight for their age. Once again, there are substantial geographical variations. The proportion of children who are underweight is higher in rural than in urban areas. At the regional level, children in Malé are the least likely (11 percent) to be underweight, while children in the North Central and South Central regions are the most likely (24 percent and 20 percent respectively) to be underweight.[36]

Nutrition remains a major challenge as most of the irreversible damage due to malnutrition happens during gestation and in the first 24 months of life. Factors contributing to child malnutrition include: anaemia among reproductive age (15.40 percent), low birth weight (9.8 percent), low levels of exclusive breastfeeding (47.8 percent), inappropriate feeding practices of the mother (32.6 percent of children receive bottle feeding before four months of age) and prevalence of common infectious diseases like diarrhoea among children under five (42.3 percent).[37] Vitamin and mineral deficiencies are also common in the Maldives. Overall 4.7 percent of women of reproductive age were severely deficient in Vitamin A, while 39.3 percent were moderately deficient. Among children six months to five years of age, 5.1 percent were found to be severely deficient and 50.1 percent moderately deficient in Vitamin A.[38]

Children who are undernourished between conception and age two are at high risk for impaired cognitive development. The economic costs of under-nutrition and overweight include direct costs such as the increased burden on the health care system and indirect costs of lost productivity. Stunting and other forms of under-nutrition are reduced through a series of simple and proven steps such as improving women's nutrition, early and exclusive breastfeeding, providing additional vitamins and minerals as well as appropriate food – especially in pregnancy and the first two years of a child's life.

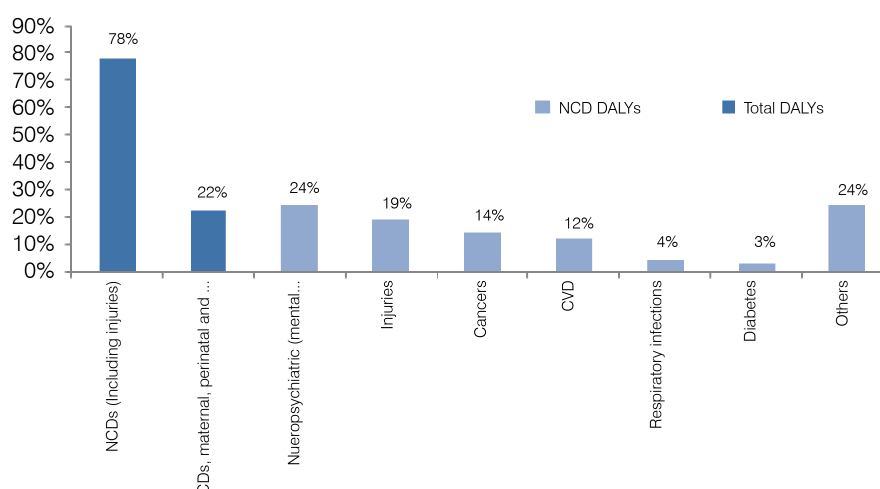
A higher proportion of boys (20 percent) were found to be stunted compared to girls (17 percent), which indicates that the earlier disparity witnessed in stunting and wasting by sex has disappeared. Adequate intake of micronutrients, particularly iron, vitamin A, iodine and zinc, from conception to age 24 months is critical for a child's growth and mental development.[39]

Reduction in undernourishment has not been commensurate with health developments. Among countries with comparable rates of under-five mortality, the Maldives shows persistent levels of under-nutrition in respect of all three indicators of nutrition status.

POOR QUALITY OF SERVICE ESPECIALLY FOR NON-COMMUNICABLE DISEASES

Non-communicable diseases (NCDs) impose the largest health burden in the Maldives, in terms of the

Figure 41 Non-communicable diseases in the Maldives – 2004



Source: Ministry of Health, 2012

number of lives lost due to ill-health, disability, and early death. NCDs require specialized and expensive service including health experts, machines and infrastructure. As pointed out earlier, there is a major disparity in the quality of services available to address NCDs between the capital, Malé and the islands. Many of the islands have well developed buildings but the health resources are missing. Quality of service is largely constrained by the lack of competent doctors and nurses available and their willingness to reside in the islands. Other issues include the lack of maintenance of infrastructure and machinery in the health facilities on these islands.

NCDs inclusive of injuries account for 78 percent of the total disease burden. Only 22 percent of the disability-adjusted life years (DALYs) come from communicable diseases, maternal and child health, and nutrition issues all combined [Figure 41].

In the Maldives, major NCDs include mental health (neuropsychiatric conditions) disorders, injuries, cancers, and cardiovascular diseases (CVD) [Figure 41]. Road accidents are one of the main sources of injuries; they account for 4 percent of all NCD DALYs[40] lost. Hypertension, diabetes and high cholesterol are all prevalent. All this is compounded by poor nutritional status. Smoking, a major risk factor for NCDs, is very prevalent. In fact, the proportion of smokers in the Maldives is one of the highest in South Asia, with a prevalence of 45 percent for males and 12 percent for females. Another NCD risk factor, obesity is important for the Maldives, particularly among women. Prevalence in the female population reaches 17 percent - against 9 percent for males. Prevalence increases with age: approximately 50 percent of women over 35 years are overweight and/or obese.[41]

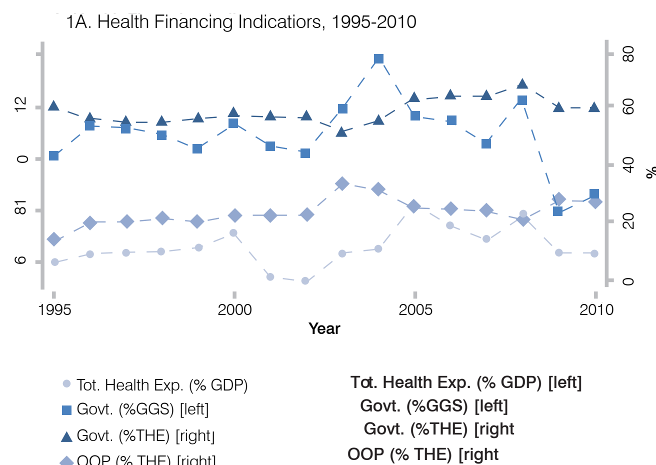
Cardiovascular disease, cancer, chronic lung disease and diabetes are the major NCDs and the main causative factors are tobacco use, unhealthy diets and sedentary lifestyles. The NCD epidemic is driven by ageing of populations and by powerful determinants outside the health sector, such as urbanization and globalization. There has been successful control of communicable diseases, but lifestyle changes associated with rapid socioeconomic development have prompted the growth of chronic NCDs, which have emerged as the main cause of morbidity and mortality in the country. Estimates by WHO suggest that 36 percent of all years of life lost in the Maldives in 2002 were due to NCDs.

The Maldives has one of the highest known incidences of Thalassemia in the world. It is estimated that one in six Maldivians carry the carrier trait and about 60-70 children are born with the disease every year, although only one-sixth of them are diagnosed.[42] Apart from this, mental health and substance abuse pose great challenges to the health status of the population.

VULNERABILITIES AND EMERGING RISKS

An important issue is the fairness or equality of a country's health financing arrangements. The amount people pay for health care through the various sources of financing — OOP payments, private insurance, social insurance, and taxes — affect the amount of money they have to spend on things other than health care. Since OOP payments reflect — at least to a degree — health shocks, they are typically seen as involuntary.

Figure 42 Significant Out of Pocket Expenditure



Source: World Bank, 2013

AFFORDABILITY OF HEALTHCARE

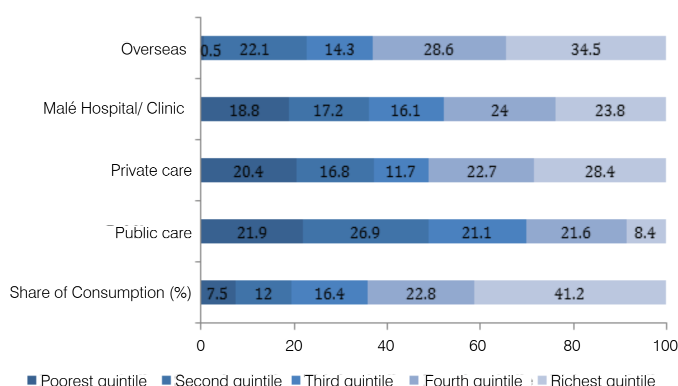
The Maldives has seen health expenses rising through the decade, as the trends in health expenditure for households suggests, and household expenditure increased at a much faster pace than Government expenditure. As a result, OOP expenditure for Maldivian households in 2011 reached 49 percent of the total health expenditure in the country.[43] This high percentage is due to a variety of reasons including higher cost of pharmaceuticals and high expenditures for treatment abroad, as evident from the HIES 2009-2010. The amount of US$ 277 OOP spending per capita is extremely high compared to most of the countries in the region and such high expenditures for households can have a serious impact on poverty and vulnerability. Almost 53 percent of household expenditure on health was spent on public providers and 47 percent on private providers, including for medicines.[44]

A study on disparities in the health sector noted that the use of public facilities outside Malé is pro-poor, with the wealthiest quintile making the least use of public facilities.[45] As indicated below the report shows that the overall use of all providers in Malé and overseas treatment increases with socio-economic status. The

higher use of providers in Malé by households that are better off may be for several reasons. One is that better off households are more likely to live in Malé, and the other reason is that that these households are in a better position to be able to afford to travel from outlying islands to Malé, when they need treatment.

However, the increase in overseas treatment with higher socio-economic status is far more marked, with

Figure 43 Share of total healthcare consumption by place of treatment and socio-economic status



Source: Ministry of Health, 2009

a concentration index of +0.34, which indicates that the ability to travel overseas for treatment is largely related to income and capacity to pay.[46] Overall, the distribution of health-care use increases with socio-economic status (concentration index +0.029), indicating that the non-poor make greater use of all healthcare services (public and private combined) than the poor. Given that the poor might be expected to be sicker than the non-poor, this might indicate some inequity in the overall use of health care [Figure 43]. The report further notes that this gradient in the use of health care is less unequal than in most other Asian countries, such as Bangladesh, India, China and Indonesia, but it is more unequal than in some, such as Sri Lanka, Malaysia and Hong Kong.

It is common to hear of households being impoverished as a result of large OOP spending due to an illness—that is, in the absence of this large OOP spending, their living standards would have been high enough to keep them above the poverty line. The NHA results highlight the total household expenditure on health in 2011, which amounts to MVR 1.3 billion (US$ 88.5 million) or 49 percent of total health expenditure in the Maldives.

Travel costs account for a significant portion of OOP expenditures for people and the people located in the remotest and geographically most vulnerable have to bear more costs to access healthcare given the lack of public sea transport in the country. Catastrophic and impoverishing health payments[47] lead to the issue of financial protection and health insurance.

In 2012, Aasandha, a Health Insurance Plan, was introduced with free universal access to the scheme for the entire population and with annual individual financial limits. A number of issues are expected to impact the financial viability of the universal health insurance plan, such as above-average usage of most outpatient services, irrational use of medicines and supplier-induced demand for specialized interventions. These issues are discussed together with social protection in the section that follows.

ACCESSIBILITY OF HEALTHCARE

Women across the different regions in the Maldives tend to live longer than men [Figure 44]. The exception to this is Region 3 (Kaafu, Alifu Alifu and Alifu Dhaalu), where men live longer. This may be due to the high proportion of men living in this region, because of the high concentration of tourism in the region. In all the other regions women tend to live longer by about two years—roughly in line with the demographics in most of the world. Yet, the gendered pattern of economic livelihoods can strikingly influence longevity in the Maldives.

The DHS 2009 report states that 83 percent of women reported having one or more problems in accessing health care for themselves. The main problem in accessing health care was the concern that there would be no medicines available (72 percent). Two-thirds of the women were concerned that there would be no provider, and 57 of women were concerned that there would be no female provider available at the health-care facility. More than a quarter of the women reported that the distance to the health facility and

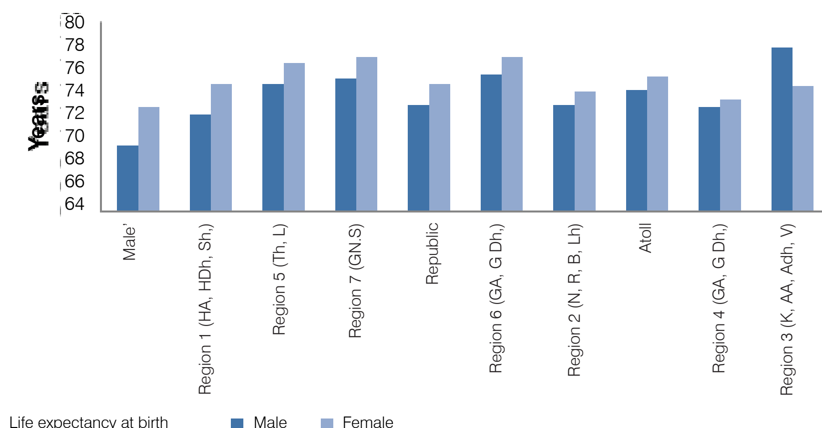
BOX 19. From the people:

Eighty year old Aimina's story

Aimina suffers from total visual impairment. She got married at the age of 30 to Moosa and had a son, her only child. Fifteen years later, she was widowed at the age of 45 years. Her son grew up and took to substance abuse. As Aimina aged, she started losing her vision and by the age of 55, she was totally visually impaired, unable to see anything. As her vision worsened, Aimina became a victim of sexual assault.

Today, Aimina is supported by neighbours around her home, who help her financially and provide her meals. The disability benefit of MVR 2000 introduced in 2009 came as a relief for her. However, her son's drug addiction drove him to start stealing from her and his behavior added an additional burden on her shoulders. Most of her household items have been sold and she has no savings.

Figure 44 Women outlive men—except in region 3



Source: Ministry of Health, 2012

having to take transport was a problem (26 percent and 28 percent, respectively).

Older women, women with more children, women who are no longer married, those who are employed but not for cash, those who live in rural areas, those who live in the North Central region, women with no formal education, and women from the poorest households report problems in accessing health care more than other women. Women who are not currently married mention problems related to lack of money for treatment more often than women who are married. As expected, rural women cite access and non-availability of health services more often than others, mainly highlighting problems like distance to the health facility, availability of female providers and lack of medicines.

The population demographics of the country as per the 2006 census indicated that 37 percent of the population was between 10 and 24 years old. In 2013, estimates show that the population in this age group is about 30 percent. Hence health issues and specific needs of this population segment, such as adolescent sexual and reproductive health and nutrition, psychological status, education, employment and socio-economic problems that often lead to tobacco and drug use, are a concern and need attention.

The increasing prevalence of drug abuse among young people is disturbing and impacts adversely on health outcomes. The young are most vulnerable to the spread of blood-borne diseases like HIV/AIDS and hepatitis. They are subjected to issues of mental health and psychological problems, which is an emerging trend noted by many health service providers across the country.

The Maldives has reached the stage of quick population ageing. The proportion of the population 65 years and older will almost double, from 3.5 percent in 2000 to 6.3 percent in 2025. Older populations are more likely to be affected by NCDs. Thus, the health burden from NCDs will rise as the population ages.

HIV/AIDS– INCREASING RISKS OF POTENTIAL EPIDEMIC GROWTH

Compared to many countries in the region, Maldives has low HIV prevalence – less than 0.1 percent. The first case of HIV in the Maldives was reported in 1991. In 2012, 18 HIV-positive cases were reported among Maldivians (16 male, 2 female) and 311 cases were reported among expatriates. All these cases were identified through case reporting and majority of the infections were reportedly acquired through heterosexual transmission. Currently, there are seven people living with HIV in the Maldives. A few cases have been reported in the Maldives in 2011 and 2012 that can be traced to men who have sex with men (MSM) and injecting drug users (IDU) communities. Twelve of the 18 HIV-positive Maldivians died of AIDS. Until recently, in Maldives, HIV infections were imported. However, the most recent infections are local. The Government provides lifelong care and anti-retroviral (ARV) treatment to all those who require it, free of charge.

BOX 20. HIV TESTING AND COUNSELLING SERVICES

- Eight facilities provide HIV counselling and testing in country
- Majority of testing is mandatory (pre-surgical, pre-employment) and counselling is negligible
- HIV testing among key at-risk populations remains very low
- Antenatal opt-out HIV testing (with informed consent) is routine

However, there is the potential for a concentrated HIV epidemic, at-risk populations such as IDUs, female sex workers (FSWs) and MSM are present in the Maldives. According to the Biological and Behavioral Survey (BBS) 2008,[48] out of 97 percent of youth who have ever heard of HIV/AIDS, only 51 percent of young women and 62 percent of young men have correct knowledge about HIV transmission.

The challenge for the Maldives is to ensure it remains a low HIV prevalence country despite increasing high risk behaviour among some population groups. As per a survey in 2008, a sizeable number of people belonging to high-risk groups (FSW, Male clients of FSW, MSM, IDU and youth) were found in Malé, Addu and Laamu atolls. HIV infection was found among the male clients (who are resort workers) of FSW. During the study, sexually transmitted infections (STIs), particularly, syphilis, an ulcerative STI was detected among the resort workers with a prevalence of 1.2 percent.

Likewise, Hepatitis B was detected among the resort workers, MSM, sea farers, construction workers and IDU. One of the ominous signs of the spread of HIV in Asia is the existence of injecting drug use coupled with commercial sex. The study detected Hepatitis C circulating among the IDU in Malé and Addu, and found that commercial sex among this group is prevalent. It must be noted that Hepatitis C implies widespread needle and syringe sharing and this is the most efficient way of transmitting the virus.

BOX 21. From the people:

Perceptions of a health worker

'Procurement of even basic materials takes very long, due to the centralized finance system and lack of financial resources in the health facility. I have had to buy disinfectants from my own pocket owing to major complaints from nurses and doctors here.'

Source: Health Manager, Regional Hospital, Interviewed for NHDR, July,

In addition, stigma and taboos related to sex work and MSM are widespread, putting the Maldives at risk of spread of STIs, HIV and hepatitis. Therefore, Maldives needs to invest in prevention efforts targeting key populations who are at risk.

POLICY OPTIONS—ENABLING ENHANCED HEALTH CHOICES

The financial feasibility of the national health system based on curative service being provided to inhabited islands is discussed in the section that follows. The growing cases of NCDs and the ageing population trends poses a major financial burden for the national health system. To address on going financial constraints in the health sector and potential pressures in the future, it is recommended that innovative financing schemes and the use of technology be explored in the Maldives.

INNOVATIVE FINANCING AND TECHNOLOGY CHOICES

Most of the public health care centres face budget constraints. Consultations with the management of health centres and hospital staff in Malé and the atolls revealed two main problems. The first is the centralized public financial system of the Government, operated through the Ministry of Finance and Treasury. Due to the overall Government budget deficit and day to day cash flow issues of the public account, payments get severely delayed and disbursements to health service providers particularly in the islands are inevitably delayed. The highly centralized finance system involves long bureaucratic procedures through the Ministry of Health and the Ministry of Finance and Treasury, which often leaves the health service outlets not being able to purchase basic materials and medicines. As a result, many health centres lack basic materials such as bandages or surgical dressings.

The second reason for the financial constraints faced by the public health service providers may be attributed to the introduction of Aasandha, the universal health insurance scheme, introduced in 2012. Given the rapid increase in claims for health services and shortage of budget and funds, the Government has been paying out money to private sector service providers for health insurance costs at the cost of public service providers. Forty four percent of the Health fund is paid for by the Government. Almost half of the health expenditure in the Maldives is accounted for by the people's OOP expenses (inclusive of the premium for health insurance deducted from their salaries). This is extremely high and carries the risk of catastrophic expenditure for households.[49]

Innovative financing options can be explored by establishing partnerships with the private sector. For example, the Maldives Economic Diversification Strategy discusses opportunities to leverage investments in the health sector through health tourism.[50] According to the report 'health tourism is already established in South Asia and the Maldives has potential to tap on its natural beauty, pristine environment, and serenity to establish itself as a future destination for wellness and health tourism. This can also reduce the leakages in the health sector caused by medical care sought abroad by the local people themselves'.

Another option to address health financing is to explore the use of technology in service delivery. One such channel is telemedicine, which can help to extend

BOX 22. Telemedicine: good potential, poor performance

Telemedicine is a combination of medical and telecommunication equipment that allows doctors to examine patients hundreds of kilometres away, usually with the assistance of a trained nurse at the patient's end. For a country like the Maldives, where geographical dispersion and spatial setting pose major barriers to accessing quality health service, this innovation can enable solutions for emergency medical assistance, long distance consultation, administration, logistic supervision and quality assurance and even support education and training for health professionals on the islands. The data on telematics can be used for health care planning and administration.

In 2002, the first telemedicine project was developed in the Maldives by the Government, funded by WHO and a second initiative was undertaken in 2004, funded by the World Bank. These projects did not materialize as planned due to issues of poor project management. The third telemedicine project was established in 2010 with support from the Telecom company Dhiraagu on Gaaf Dhaal atoll Thinadhoo Island at a cost of MVR 2 million (US$155,000). This expanded to 39 health facilities in the country with support from Khaleefa Foundation, at a cost of more than US$1 million. The facilities in the telemedicine network in atolls are connected to the country's only public tertiary hospital in Malé, IGMH via dedicated data link. All the 39 facilities linked in the telemedicine network are equipped with telemedicine equipment needed for transmission of data between the facilities. Field research for the NHDR has shown that none of the telemedicine facilities are operational in the country, the equipment is left idle and the telemedicine room or unit is locked. Some facilities have a staff/technician on board to operate the system but no services are provided. Interviews with staff at a health centre and regional hospital with the facility indicated that the main reason is the lack of management arrangement for operating the system. 'We only managed to do test trials and most of our staff got trained but that was about it – there is no roster for consultations and no communication or coordination arrangement with IGMH, the central point of service' said a Manager at a regional hospital. Health professionals who were interviewed both in the islands and in Malé felt that there is no commitment to make this work and the IGMH is facing major financial and human resource constraints and cannot invest personnel in this service. Some even stated that the project's failure reflects the bigger picture of a dwindling health system with no clear mechanisms or systems for coordination, reporting and service delivery.

The case shows how an innovative healthcare initiative to bridge the location gap has not materialized despite substantial investments in infrastructure and capacity building. Broader issues of management and political will are critical to have any impact. The telemedicine initiative would have benefitted vulnerable groups such as the elderly and the poor and helped them to seek medical attention without having to travel and bear substantial out of pocket expenses. Similarly, the system is a cost-effective model for the Government to respond to emerging health risks particularly for NCDs, where specialist consultation can be extended throughout the country without having to place specialist doctors on each and every island.

Source: Field visit to the hospitals, July 2013.

consultations and service provisioning to remote locations. Unfortunately in the Maldives, despite heavy investments telemedicine service has not been operationalized. Given the demand for specialized health services particularly relating to NCDs, it is recommended that the project be revived and its potential be tapped (see Box 21).

IMPROVE GOVERNANCE AND INSTITUTIONAL CAPACITY

The health sector in recent years has seen multiple transitions. These include the transition to a curative based system, corporatization of the health sector in 2009 and its subsequent reversal in 2011 (when the corporatization strategy was rolled back) as well as the impact of decentralization on health service delivery.

The reorganization of the health system to a curative based system poses many challenges

for effective service delivery. Many believe that the strong foundation of primary health care, which was successfully established in the Maldives over the past three decades, is now disintegrating as primary health care is no longer the focus of the health sector. This is also evident from the expenditure on primary health care as a proportion of the total health expenditure in 2011. At the same time, the current system of curative care in every island is highly costly.

BOX 23. Perceptions from a Health Professional

'I have spent 28 years in this sector. The situation has never been this dire. The health system has simply collapsed, it is no more.'

Source: Senior Health Professional

Many of the resources and much of the infrastructure remains unutilized, due to the small size of population. For example, the average hospital bed occupancy rate for atoll hospitals was 20.40 percent in 2011. Similarly, regional hospitals had an average bed occupancy rate of 45.66 percent in 2011.[51] Most of the machines and equipment in the island health facilities do not receive satisfactory maintenance, as the islands do not have technicians who can attend to them and this causes depletion and abandonment.

In 2009, eight health corporations were formed. All regional hospitals reported to a health corporation, which operated as 'for profit' entities. The corporations took over ownership of all assets related to health services. With the roll out of the health insurance scheme, these health corporations allegedly abused the system by not choosing the most cost effective medical treatments and recommending patients return for follow up visits more frequently than required.
Poor supply chain management of medical supplies affected the quality of health services. The new Government, which took office in February 2012, initiated a de-corporatization of the health sector. During the consultations for the NHDR, some health service providers noted that the advantage of the corporations was the ability to retain revenue and speedily make payments whereas now they have to depend on centralized finances, which causes major delays. Separate procurement of services, supplies and equipment by eight corporations led to higher costs of consumables and services due to dis-economies of scale.

The Decentralization Act mandates that Island Councils provide primary health care and this was the first function to be decentralized to the Island Councils in 2010. Although there is no evidence of the negative impacts of these changes, the report on decentralization stated that some of the Councils visited were unhappy that Primary Healthcare Units (PHUs) are no longer under their control. They felt that the PHUs worked well under the Councils; however officials in the health sector felt that when the PHUs were under the Island Councils they were disconnected from the health system and had difficulty accessing specialized health support when it was needed.[52]

These frequent changes have caused a lack of clarity on the direction of the country's health system and the reporting and accountability mechanisms. Consultations held with health care service providers indicated that the changes have affected health service delivery to a large extent with increased sense of uncertainty and confusion among health professionals. Coordination between the atoll health facilities and the central Government and tertiary hospital appear to be limited. Reporting arrangements are not clear and there is an absence of standards or common practices, which are to be followed between the health facilities across the country.

Many health workers face job insecurity and disillusionment as public health programmes are curtailed; such as health awareness programmes including programmes relating to family planning, nutrition and communicable diseases. Worrying trends can be seen in the health statistics, such as the drop in contraceptive use in some parts of the Maldives, but little attention is being paid to these issues.

It is therefore recommended that immediate priority be given to revitalize the national health system, to establish channels for coordination and reporting and that this be communicated clearly to all health facilities. It is also recommended that middle-management capacity in the sector – including in the ministry and in the service providers – be strengthened to be able to withstand sector transitions and to ensure the system remains intact for reporting, accountability and service delivery.[53]

REORIENTING SERVICE DELIVERY TO ADDRESS EMERGING HEALTH RISKS

Health service delivery is particularly strained by the lack of priority or the lack of common understanding among health professionals, policy makers and service providers on the priorities of the health sector. Assessments by the NHDR Consultancy team show that the following areas should be prioritized for better health outcomes:

- Although most communicable diseases appear to be under control, new emerging risks emphasize the need to have a strong preventive care system. One such issue is related to the problem of vaccine refusal discussed earlier and the drop in contraceptive use in some parts of the country. For example, from 2010 to 2011, in Haa Alifu, Meemu, Seenu and in Malé, there was a drop in contraceptive use, although overall contraceptive use increased at the aggregate level for the country.

- Climate-related health risks impact on disease

vectors as a result of the on-going changes in the weather and climate. They demand enhanced community action and prevention. Newly emerging vector-borne diseases particularly during the rainy season include dengue. In the recent dengue epidemic in 2011, 32 people faced dengue shock syndrome.[54] This is particularly critical given that the most vulnerable people—children, the elderly, the poor, and those with underlying health conditions—are at increased risk. Once again, multiple, overlapping dimensions of vulnerability interlock to widen inequities and slow or reverse human development progress.

- The increase in 'life style' diseases demands better awareness raising and prevention methods of NCDs including mental health, injury and disability prevention, with risk factors and the surveillance of NCDs. As mentioned earlier cardiovascular disease, cancer, chronic lung disease and diabetes are the major NCDs and the main causative factors are tobacco use, unhealthy diets and sedentary lifestyles. For most households in the Maldives, access to calories is not a problem. However, the 'double burden' of under-nutrition and obesity is an imminent danger for the overall health status of the country. Rapid urbanization and the adoption of Western diets high in refined carbohydrates, saturated fats and sugars, combined with a more sedentary lifestyle are the major contributors to the increase in obesity and chronic diseases in the Maldives.

- The high prevalence of drug use increases the incidence of psychological problems, which require counselling and community level support in rehabilitation and recovery. It is therefore critical that preventive health care be considered a priority and that public health services and professionals be reoriented to address the emerging health issues mentioned above.

- Taken together, these emerging health risks have the potential to widen disparities between the atolls and Malé, as well as among the atolls themselves. Institutions and policies focused on strengthening the health insurance scheme and the quality of health access are critical to tackle the emerging health risks in the Maldives. In addition, targeting policies to the vulnerable can help ensure gaps and vulnerabilities do not expand.

ADDRESSING NUTRITIONAL VULNERABILITY

One of the areas in which inequalities in health status is evident is undernutrition, which is prevalent more in the islands than in the capital, Malé. There is an emerging trend of more boys being stunted than girls.[55] It is therefore critical that policies be oriented to close the gaps in nutrition among girls and boys, as well as between the capital, Malé and the islands.

Health facilities and public health units possibly in collaboration with community groups and NGOs should be encouraged to promote iron-folic acid supplementation for pregnant women, de-worming, provision of multiple micronutrient supplements to infants and young children, and fortification of staple foods are effective strategies to improve the iron status of these vulnerable groups.

Undernutrition is caused by poor dietary intake that may not provide sufficient nutrients. Lack of awareness, availability and affordability of nutritious food and good sources of micronutrients for the whole family are the reasons for malnutrition. Among all the fruits and vegetables imported into the Maldives, the largest proportion goes to tourist resorts and the second largest to Malé. Very few, if any, imported fresh foods arrive on the islands inhabited by the local population. Home gardening and fresh vegetable diets should be encouraged, through better advocacy and awareness programmes on the islands.

Another issue discussed was the income vulnerability resulting from high OOP expenses for medical treatment. This can adversely affect low-income groups and those living in remote locations, who have to bear major transport costs to access health care which can upset budgets and push families into poverty. The universal health insurance scheme (Aasandha) introduced by the Government in 2012, to address healthcare affordability, turned out to be more expensive than anticipated, with the entire allocation for 2012 of MVR 720 million was exhausted by July 2012. The actual expenditure on Aasandha, at the end of 2012, stood at MVR 782 million, which exceeded its initial allocation. The Government estimates that the total Aasandha claims would have reached MVR 1.2 billion by the end of 2012. Given that the Government is facing a fiscal crisis, which in turn has put extreme financial pressure on health service providers, it is recommended that targeting be considered for the programme.

The IMF and the World Bank recommend targeting to address the Government's unsustainable budget deficits and to lower the risk of the country going into debt distress. An analysis by the NHDR team suggests that the health insurance scheme be restructured by levying an insurance fee on all citizens in the programme. Low-income families and the elderly should be exempt from the insurance fee and families residing on remote locations should be entitled to more compensation for travel costs. This restructuring will improve the financial viability of the programme and will have positive benefits and impacts on vulnerable groups.

THE GOAL - BETTER HEALTH AND BETTER ACCESS

Many of the people consulted for this report felt that the health situation in the Maldives is unsatisfactory. Yet, the achievements for the health sector, starting with the overall progress on life expectancy at birth, are many. The views collected represent the direct perceptions of inequity, from different vantage points,

and it is clear that the health system does not deliver equitable health services to all.
Closing the gap in the five-year difference in life expectancy across the different regions of the country and ensuring that quality, skilled services are available on all the atolls is a powerful next step in reducing health inequities in the Maldives.

Consolidating and deepening the gains that have been made so far is critical. Focusing on achieving equality in the distribution of health services and on producing equality in health outcomes should be a direct policy direction so as to ensure that progress on health choices and freedoms reach every Maldivian. Addressing income vulnerabilities, due to the high share of expenses – in particular when international travel is required to seek life-saving services – can serve as a guiding priority.

Chapter 5

Bridging the Divide, Building Resilience

Bridging the Divide, Building Resilience

The solution lies in addressing the root of the problem (locally expressed as 'kamuge aslu belun'), in building resilience through improved spatial planning, increasing targeting and effectiveness of social protection measures, restoring fiscal and macro-economic stability and diversifying the growth base. Most importantly, policy making needs to be strengthened and institutions made stronger. A national vision has to be developed and endorsed by both the institutions and the people.

Chapter 1 outlines the inequalities apparent in the Maldives, most evident in income and education. Chapter 2 provides an overview of the vulnerabilities that face the Maldives. These include structural vulnerabilities, stemming from the country's physical characteristics and economic dependence on tourism and imports. There is the possibility and impact of external shocks; in the recent past this has been seen in the tsunami, the global financial crisis, political transition and the subsequent crisis, and the persisting macro-economic imbalance. The discussion on income and poverty trends, education and health outcomes in the subsequent chapters deal with policy options on addressing inequalities and emerging risks. Chapter 3 recommends prioritizing urban planning and management to attend to the emerging inequality and poverty trends in the Capital Malé. The chapter highlights the issue of unemployment, and puts forward policy options to enhance employment and labour governance. Chapter 4 discusses the disparities in education and health and suggests ways to address these issues, through innovative financing, improved quality of service provisioning, targeted interventions and other reforms.

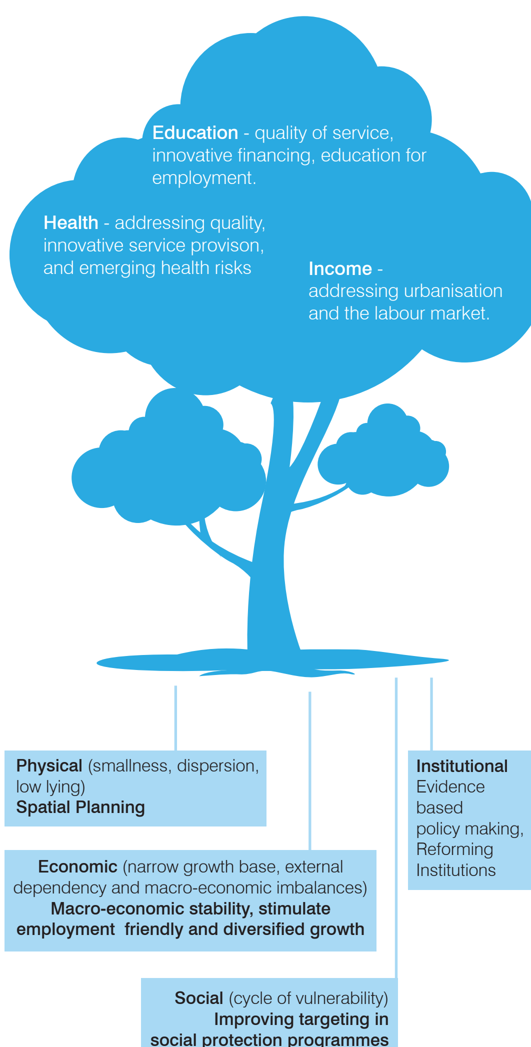
The report stresses the importance of addressing the core vulnerabilities facing the Maldives in an attempt to reduce inequality. It emphasizes that issues of physical,

BOX 24. Conceptions of Inequality

'An expansive conception of inequality across multiple dimensions of development and on multiple levels—within countries, among people regardless of where they live, and encompassing both present and future generations.'

Source: Samman and Melamed, 2013

Figure 45 *'Kamuge Aslu Belun'*
A Framework for Addressing the Roots of Inequality i.e Vulnerability

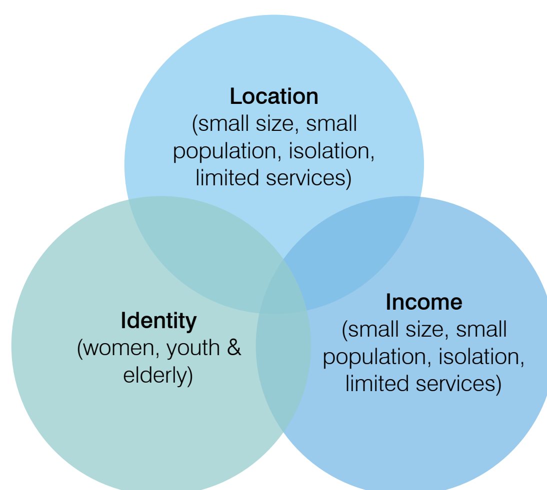


economic, institutional and social vulnerability must be addressed to implement policy reforms in the health, education, labour and urban sector and to sustain policy actions in these sectors.

IMPROVING CHOICES FOR THE VULNERABLE

The report presents a framework on equality and vulnerability that can guide the development of inclusive policies and measures for action. It identifies spatial factors, income status and identity, gender and demography, as the key variables that impact on vulnerability and inequality.

Figure 46 Interlocking Vectors of Vulnerability and Inequality



According to this report, those who are adversely affected by multiple factors are the most vulnerable. A single woman from a low-income family, living on a remote island with small population and area will in all probability, face the most difficulties in obtaining quality education for her children or in accessing adequate health care.

PERCEPTIONS AND EVIDENCE

In the course of the preparation of the report, it has been important to gauge the perceptions of people belonging to the vulnerable groups; and to support this with evidence and data. This has not been an easy task and data has often not supported perception or anecdotal evidence.

The most socially vulnerable groups have been identified as belonging to broken families, being subject to neglect, social exclusion, stigma and abandonment. The NHDR research team was however unable to establish the degree of vulnerability that these groups face and the extent of prevalence of the issues they confront. An example is drug use; consultations and anecdotal data, especially at the island level confirmed drug use being a serious problem. The data from the National Drug Use Survey 2011/2012 put prevalence at less than seven percent of the population; however in the FGDs conducted for the NHDR, the public perception was that drug use may be as high as 70 to 80 percent among the youth.

The report shows that the most vulnerable groups are those that face more than one impediment, for example location, income and identity. It is therefore recommended that this framework be studied and built upon further, to better understand the vulnerable groups in the Maldives, the types of risks they face, their coping mechanisms and how development programmes and safety nets can be targeted towards improving their situation.

BOX 25. Who are the Vulnerable?

- Children especially those facing parental neglect, abuse, family break up
- Women – especially those subject to violence or divorced
- Elderly – especially those facing neglect, poor health with no care
- Youth – unemployed, subject to substance abuse
- Persons who are differently abled
- Urban poor

Source: Research/ Interviews for Maldives NHDR, July 2013

EFFECTIVELY TARGET THE VULNERABLE

The current basket of social protection programmes in the country is not designed in an integrated manner. It lacks an assessment of the social protection needs of the citizens. Cash transfer programmes for specific groups of vulnerable persons have only recently been initiated (since 2009 -2010). There has not been so far an assessment of their impact. Most programmes lack an objective basis for identifying target groups and beneficiaries. It is therefore important that this be developed. The National Social Protection Agency

(NSPA) does not have an estimate of how many persons in the country are eligible for the various social transfer schemes, and no estimates therefore on how many eligible beneficiaries remain outside the ambit of the schemes.

The design of the programmes including estimates of the benefits appears to be ad-hoc, partly because of the lack of information on the poor and vulnerable groups. For example, the figure of MVR 1,000 as the

single parent allowance (or the figure for foster parent allowance) appears to have been arbitrarily set. There is no systematic mechanism for verification of eligibility or for monitoring of the use of allowances or continued eligibility of approved applicants.

A study of the Social Protection Index (SPI)[1] for 2009 showed that the overall SPI in the Maldives was estimated at 0.073.[2] This indicates that the social protection expenditures of the Government are about 7.3 percent of the poverty line expenditures. The study's results for SPI show that the depth and breadth of coverage of social protection programmes are relatively low. The disaggregation by poverty status for the country suggests that the social protection programme expenditure disproportionately and unnecessarily reaches the non-poor population.

Recent reforms in social protection involved introduction of universal programmes, the universal health insurance scheme (Aasandha) and blanket subsidies for electricity. Although universal programmes are easier to administer, these programmes have some negative implications. The first is the fiscal burden of these programmes. The Aasandha scheme turned out to cost more than anticipated; the allocation for 2012 (MVR 720 million) was exhausted by mid-year i.e. July 2012. The electricity subsidy, a blanket subsidy with no targeting, has proved to be more expensive than anticipated. It is expected to have exceeded the total allocated budget of MVR 358 million, by around MVR 70 million by year-end.[3]

BOX 26. From the people

Youth-focused policy making absent

" We all recognize that young people in this country are vulnerable. But when it comes to policy making, I feel our needs are ignored and the National Youth Council does not advocate our cause. Youth focused policy making is simply non-existent. "

Source: Interviewee for NHDR, July 2013

Another implication is the absence of a redistributive effect of these schemes on the population. For example, the food subsidies provide essential food staples (rice, flour and sugar) to all, at low administered prices. As a result, even the resort sector (which by and large caters to an extremely high-end tourist segment) is eligible for food subsidies. Similarly, the electricity subsidy benefits all households in Male and households as well as businesses in the atoll islands. The World Bank estimates from data in DHS 2009 show that 30 percent of the electricity subsidy benefits the richest income quintile, and only 12 percent of the benefits are received by the poorest quintile.[4]

It is therefore recommended that the social safety net programmes be restructured to account for various vulnerabilities facing the population, particularly based on location, income and identity, develop criteria and preferences around these aspects and improve the feasibility and impact of the programmes through targeting.

PROMOTE ASPIRATIONS OF YOUNG PEOPLE AND WOMEN

The report maintains that identity, based on gender and age, is a key variable in determining the level of vulnerability and inequality a person faces in the Maldives. Women and young people face higher risks of unemployment than men who are 35 years and above, decreasing their chances of earning an income. Girls are less likely to access higher secondary and tertiary education than boys in the atolls, given constraints on mobility.

Young people have higher risks of being falling into substance abuse and criminal activity. Older people on remote islands face higher levels of health risks and if subject to neglect from family, these groups can become highly vulnerable. Hospitals in Malé and health centres in the islands confirmed an increase in cases of elderly patients being abandoned in the health facilities by their families. This increases the burden on service providers, given that there are no elder- care homes in the Maldives.

It is important that the risks faced by women, the young and the elderly are recognized and accounted for in the design of development programmes. The needs of these different groups of people should be assessed and the impact of interventions on them should be understood. The participation of women and youth in development planning, policy design and programme design is essential to ensure that the specific inequalities and risks they face are taken into account.

SAFEGUARDING AGAINST 'ISLANDNESS'

As a SIDS, the Maldives faces a range of vulnerabilities that are structural and unique to the country, due to its geographical characteristics, the smallness, the remoteness and the dispersion or 'islandness'. Improving spatial planning, facilitating climate resilience and dispersal of urban concentrations can all help mitigate some of the current issues. Similarly, restoring macro-economic stability and stimulating growth through economic diversification is critical for ensuring sustained investments in human development. The report strongly recommends policy dialogue and development planning, centring on the structural vulnerabilities to be initiated in the immediate future.

IMPROVE SPATIAL PLANNING

The geographic location of the islands, scarcity of resources such as land and people, accessibility to services, limited operational scale for basic and commercial/job opportunities are all important factors. People from remote and smaller islands are more disadvantaged; their inclination to move to Malé can result in enhanced urban poverty and add to pressures on the high cost of living, housing and joblessness in the capital.

Discussions particularly during the inception workshop and later confirmed through consultations with people living in both Malé and the islands, indicated the need for putting in place improved spatial planning and policy-making mechanisms. This is imperative in order to manage the quality of life on both rural and urban locations and to counter the rural to urban migration. The model discussed involved developing a hierarchy of services for various categories of islands and clearly informing people of the availability of services at each level. People should then be enabled to move freely to seek services and should be given various incentives, connectivity and support to settle. For example, the model involves central hub islands that provide tertiary services and periphery islands that provide selected services. In this way the Government will not face resource constraints that would inevitably result if it tried to provide all the services on all the inhabited islands, a task that is proving to be extremely challenging. Even if infrastructure is established on all islands, it will not be feasible for the Government to manage and sustain services in the long-term, in a close to 200-island setting.

There is the need to facilitate economic growth and commercial development outside of the capital, Malé and surrounding areas; in addition to public services in order to relieve in migration to Malé and increase people's choices for migration and living across the country. Hub islands can be developed with specialized economic activities, allowing the private sector and an investment scale that allows the feasibility to build support infrastructure and businesses. Hub islands can provide higher education and quality tertiary health care services. Preferential policies that target vulnerable groups who are constrained by location, income and identity also need to be put in place.

One of the challenges that the country faces is the strong connection that people have with the island of their birth and the expectation that services and growth should 'come' to them on their island. A FGD with more than 30 councillors and NGOs, representing different parts of the country spoke positively of the need for better spatial planning, population and service concentration in selected locations as detailed above. This shows that with better information and sensitization, leaders and active community groups at the island level can be mobilized to support the model of hierarchical service provisioning discussed earlier.

It is equally important to integrate climate resilience building measures in spatial planning, given the country's high level of vulnerability to climate change and sea-level rise. The case for enabling migration and population concentration through improved spatial planning to selected parts of the country increases the feasibility of putting in place sustainable adaptation measures. Currently, the Government is struggling to address coastal erosion, flooding from sea swells and water contamination across the islands and developing water management. Coastal protection infrastructure on small islands for small populations is expensive and inefficient. Alternatively, through spatial planning that identifies hub islands for growth and service provisioning, comprehensive climate resilient infrastructure can be developed in a more sustainable manner, because it will be provided and maintained in locations where population is concentrated.

BOX 27. From the people

'*Misraab*' towards development

" Our direction or 'misraab' is towards places where development takes place. We are no longer bound to stay on our birth islands as is often assumed. People should be free to choose where they live and enjoy life."

Source: Research/ Interviews for Maldives HDR, July 2013

RESTORING MACRO-ECONOMIC STABILITY

In order to address inequalities in human development outcomes in the Maldives, it is important that the country's fiscal situation be restored to a sustainable path. The current level of deficit spending, high rates of inflation, cash flow crisis of the national public accounts and high risk of debt distress warned by international agencies including the IMF and the World Bank as detailed in Chapter 2, indicates the existing and potential limitations on the Government's ability to spend on education, health and other services. There is empirical evidence of how the Government was able to achieve key milestones in education and health, such as universal primary education and immunization, extension of health services in the atolls, in the late 1990s to mid-2000s, when the country demonstrated fiscal discipline, reduced expenditures and budgetary deficits. These lessons are critical for the current policy makers, to make progress in education, health and job creation. The Government should consider cutting down its expenditures and putting the economy on a recovery path. The current trends including slowdown in GDP growth and macro-economic imbalances pose major risks to the country's investments in improving quality of education, health and addressing disparities.

This is particularly true given the susceptibility of the economy to external shocks; as is evident any disturbance to the international travel market can drive the country into another domestic crisis.

REDUCE INEQUALITY BY CONTINUING TAX REFORMS

Another key intervention that can directly contribute to reducing income disparities is income tax. The Government has initiated important tax reforms in the recent past, which have served as important revenue instruments for the Government. Tax reforms particularly in the tourism sector has meant fairer systems for land rent and the tax on Goods and Services (GST) for tourism sector has been differentiated from taxes on public consumption. Previously, the same rate of import duty was levied for imports for the tourism sector and on imports for public consumption. An important tax instrument that has yet to be put in place is income tax. Income tax has a redistributive effect and more importantly, it can generate regular and systematic data on incomes and wealth status of the population if implemented comprehensively. Income tax can help to reduce the income inequality trends in the Maldives, particularly in the capital Malé, where it is increasing.

ECONOMIC DIVERSIFICATION AND STIMULATING GROWTH

Although the tourism sector has demonstrated resilience to the global financial crisis and to natural disasters (like the 2004 tsunami), the high dependence on tourism and imports, (particularly imports of fuel and food) make the country and its people highly insecure. To stimulate growth, production and build resilience of the economy, it is critical that the Government develops alternative growth sectors. This policy can be tied up to the spatial planning strategy, where economic zones or alternative growth hubs with infrastructure, population concentration and tertiary services can attract foreign and domestic investments and industries. The Maldives Economic Diversification Strategy outlines key comparative advantages the country holds in terms of location, skills and resources and presents strategies for investments and commercial development of a range of sectors including transport, energy, education, health, financial services, Information and Communication Technology (ICT), etc.[5] It is important that the Government select one or two key sectors, set targets to increase their share in GDP and employment, design policies (such as tax breaks, specialized skill development) and laws (land ownership or alternative jurisdiction points for commercial sectors e.g. to foster a financial centre) to attract investment and development.

EMPLOYMENT FRIENDLY GROWTH

Given the high levels of unemployment, which puts young people and women in particular at risk of being trapped in a social vulnerability cycle and low income status or poverty, it is proposed that the economic diversification and growth strategy should focus on developing alternative sectors that can attract youth and provide employment for women. For example, reviving fisheries and agriculture may not foster employment and entrepreneurship opportunities where as financial services and/ or ICT can be an attractive option for young people. Similarly, the economic diversification strategy with selected sector development should be tied to a skills development strategy that will set targets, build programmes, direct investments and lead to the absorption of youth and women into the growth sectors. Employment friendly growth will involve skills programmes, providing incentives for small and medium-sized enterprises, putting in favourable labour policies such as minimum wages to create wage competitiveness for these selected sectors and put in place barriers for expatriate replacements.

ENHANCING CAPACITIES TO EXPAND FREEDOMS

Political institutions can influence and play an important role in the process of development in a country. An institution might enhance the 'pro-poor' slant of public policy in a country, thus directly aiding the least advantaged citizens whose situation is largely responsible for a country's aggregate inadequate performance on human development indicators. The post-democratic transition context in the Maldives provides an opportunity to enhance the capacity of institutions to design and implement policies that foster human development. Specific recommendations include promoting strategic and evidence based decision making culture in institutions, strengthening

BOX 28. Need for Empirical Evidence on Poverty

One of the challenges faced in the preparation of this report was the non availability of up to date information on incomes and poverty status of households. Since the VPAs of 1998 and 2004, the country lacks comprehensive data on poverty. Recent surveys do not provide sufficient information and follow different methodologies, making the data non – comparable.

For example, the two main datasets available for the report, the HIES and DHS followed different regional categorization. There is no clear and accepted poverty line established and the incidence of poverty is not monitored on a regular basis. Different reports refer to different poverty incidence and provide vague analysis, given the lack of data. The lack of data availability has meant that it has not been possible to determine the intra and inter-household poverty dynamics and the impact of safety net programmes on the poor.

For comparative and trend analysis, it is critical that data collection on poverty be standardized. Detailed research on who the urban poor are, as well as income and poverty status of local migrant families, at source and destination, and an analysis of whether poverty relates more to income or other elements such as housing, joblessness, cost of living, etc is required.

It is therefore recommended that systematic data collection on income and poverty be initiated and mainstreamed into national surveys such as the census or DHS, if poverty surveys cannot be conducted separately.

the new established democratic institutions, including the legislature, judiciary and the local governance mechanisms through training, sensitization, improved institutional cooperation and reform to suit the size and needs of the population.

ENHANCE STRATEGIC POLICY MAKING AND EVIDENCE BASED DECISION-MAKING

One of the critical changes needed is to promote long-term visioning and strategic policy and law-making among the political leadership of the country. Political parties and political leaders need to start thinking beyond the ballot. With democratic transition, the country's long-term development planning process has been side-lined. For example, the Seventh National Development Plan (2006-2011) was replaced with the Strategic Action Plan (2009-2013) based on the election manifesto pledges made in 2009. This has meant that the country's development planning has become tied to the election cycle and development priorities are centred on election pledges. It is important that policy makers and development partners have the space and the environment to do more in-depth policy analysis, planning and long-term visioning, beyond a five year cycle to address structural problems facing the country.

Similarly, in law making, while core legislative pieces such as the Penal Code has been shelved from the Parliament's agenda for years, ad-hoc and reactionary legislations have been passed to address the vacuum. Law-makers show less sensitivity to the country's fiscal environment and growing economic problems when they set pay and remuneration packages for various institutions including their own and introduce measures which can serve as major setbacks to the country in the medium to long-term fiscal framework. For example, despite good intentions, the recent Social Health Insurance Bill, the Disability Act and the Parliament decree to include subsidies for fishermen have increased the fiscal burden manifold. The Parliament needs to focus on strategic law-making that will enhance the overall legal framework and provide the enabling environment accelerating human development for everyone.

In addition to sensitizing policy makers in strategic policy making that focuses on long-term benefits, it is equally important to enhance Evidence Based Policy (EBP) making. A recent paper on EBP in the Maldives states the following: 'Policy processes in the Maldives are neither linear nor cyclical, as they are subject to multiple influences' - an observation made earlier based on a diagnostic survey where `value-based' decision making was the prevailing norm. The paper suggests that it may be useful for Government institutions in the Maldives to break the decision-process into the following steps:

(1) identification of issue
(2) construction of alternatives
(3) selection of optimal or preferred alternative(s)
(4) design
(5) implementation,
(6) monitoring and evaluation.[6]

It is also important that evidence gathered particularly through research, monitoring and evaluations be fed into the policy making process. This is particularly true at a time when the country is facing a fiscal crisis and the Government is under pressure to streamline expenditure. Policies, projects, programmes and budgets need to be result-oriented, the results or targets being determined using evidence and data. One example is the social protection programmes mentioned earlier. The impact effectiveness of social protection programmes such as health insurance have not been studied in a systematic manner, while the investments for these programmes are very high.

REFORMING INSTITUTIONS TO TAKE HUMAN DEVELOPMENT TO THE LAST MILE

LAW-MAKING TO EXPAND CHOICES

In order to address inequalities and vulnerabilities, the country's laws have to be designed and implemented taking into account the various inequalities and vulnerabilities that exist, such as those in incomes or in years of schooling. It is therefore extremely important

to improve the understanding and knowledge of vulnerabilities, resilience building, human development and inequality concepts and issues among Parliamentarians. They should be sensitized to the local context and encouraged to pass laws that favour inequality reduction such as the Income tax law mentioned earlier. Similarly, it is important for the Members of Parliament to strengthen their relationship with the constituents to understand these dynamics. Members should increase the channels to consult with the population and receive feedback on the challenges they face. One positive step was the decision to televise Parliament sessions, so that the public is informed of the performance of law-makers, the progress made on different legislation and the potential implications. Similarly, two NGOs have been formally engaged with the People's Majlis to assist in law-making and in facilitating broader participation in furthering certain selected legislation. These initiatives need further expansion so that there is a positive influence on law-making that can in turn impact constructively on enhancing people's choices.

ADDRESSING VULNERABLE GROUPS IN THE JUSTICE SYSTEM

Many stakeholders consulted during the research identified people living on remote islands with limited connectivity, women and expatriate labourers as those affected most adversely by the weak system. Many stated that juveniles who come in contact with the law, young people who are associated with drugs and crime, victims of gender based violence and women involved in cases of family law (those trapped in a social vulnerability cycle) are typically the people who find it difficult to access justice. There are some laws that do not favour women, such as the punishment for adultery. Available data from the Criminal Court shows that in 2010, there were 67 women and 19 men who were served the punishment of *'hadd'* (public flogging) for adultery in the Maldives. The Human Rights Survey in 2012 shows the increased levels of dissatisfaction with the courts, judges and magistrates.[7] The reasons given include corruption, unfair/unjust decision making, lack of security of judges, unavailability of lawyers and competence of judiciary. Dissatisfaction with the judicial system, judges and magistrates is higher in rural areas, partly because of accessibility issues for appeal and the lack of qualified judges or absence of judges on the islands. All cases (lower courts, High Court and Supreme Court) are heard in the capital, the atolls only have magistrates' courts. Any appeal has to be made in the capital, Malé. People living outside the capital are therefore disadvantaged in accessing justice.

In order to strengthen access to justice in the country particularly for the vulnerable, the most critical interventions relate to establishing transparent hiring and firing practices for the judiciary, increasing investments for training and qualification of justice sector personnel including prosecutors, judges, magistrates, investigators, court officials, court administrators and legal professionals. According to the report by International Commission of Jurists (ICJ), capacity needs to increase within the judiciary to apply the laws compliant to human rights and constitutional principles in the new democratic context.[8] Additionally, it is important that judges and the justice sector personnel be trained and sensitized to the inequalities in accessing justice that vulnerable groups face due to accessibility and affordability. For example, legal aid will improve access to justice for low income families, particularly those from remote islands, who have to bear high expenses for any appeal filed in the High Court (in Malé) against cases decided in the lower courts.

Other interventions include putting in place necessary laws, statutes and regulations for the judiciary to function effectively including for example the Penal Code, a Criminal Procedure Code, a Civil Procedure Code, and an Evidence Act which can improve the criminal justice system, its standards and procedures which can help relieve the social vulnerability cycle discussed earlier. The underdeveloped legal framework has enhanced judicial discretion without the capacity to exercise it in a professional fashion and the result seems to fit the stereotype of '*qadi justice*', a term coined by the German sociologist, Max Weber to describe the judicial decision-making that was inconsistent from case to case and not based on the internal requirements of law.[9] There is no clear legislative framework governing the performance, conduct and administration of the judicial system, which adds to the confusion and lack of transparency in the operation of courts. The courts do not have a case data management system, which leads to inefficiency and lack of evidence-based decision making, as the cases progress from lower courts to the appeal stages. At a broader level, the justice chain needs to function in a coordinated manner. At present, the police services, the Prosecutor General's Office and the Attorney General's Office and the courts remain disconnected. The ICJ report confirmed significant confusion about the scope of powers and the relationships not only among the different branches of Government but also within each branch. This confusion creates disputes, leads to political interference, results in delay and paralysis in developing and implementing urgent policy.

DECENTRALIZED SERVICE DELIVERY

Decentralization can have positive effects on human development. The benefits include an increase in the participation of communities in decision-making, bringing governance closer to the people and enhancing accountability and access to services; and efficient use of funds in accordance with the needs and priorities of communities at the local level. The Constitution entitles councils to a grant from the central Government and allows them to raise their own revenues. The purpose of decentralization according to the Decentralization Act is to 'allow the island communities to make their own decisions in a democratic and accountable manner'. The Decentralization Act details the functions that should be assigned to Councils, the fees they can charge and grants them the right to establish and operate businesses.

It is important to address key challenges faced in the decentralization transition including clarity on mandates, harmonizing laws and strengthening the

capacity of the council personnel including elected officials. The decentralization of public health was the first service to be transferred to the local bodies, in 2011. During consultations, health professionals in regional hospitals and health centres expressed concern over the lack of clarity of accountability and monitoring of the health sector with the transfer of mandate between the central Government and local councils, particularly relating to public health. It is important that legal gaps be addressed to fully operationalize decentralization. For example, the Decentralization Act identified land management as a core responsibility of the councils. However, this contradicts the Land Act, which provides that the Ministry of Housing and Infrastructure manage land distribution. Similarly, the Decentralization Act and the Constitution make provision for fiscal decentralization, revenue generation and management of own revenues by councils. This contradicts the Finance Act, which mandates all revenues collected from any Government body be deposited in the Government's central public account. Legal challenges pose difficulties for councils to deliver services as per the mandate. As a result, councils are constrained to raise their own financial resources to invest in development initiatives.

At the institutional level, there is a lack of expertise and no experience to put in place legal, fiscal, and administrative elements of a properly functioning local Government system, as well as how to elicit value addition in social, environmental, economic and business activities. Given that it is a new concept, the elected officials lack awareness and understanding about how to promote the ideas of local governance by increasing public participation. The councils have only seen traditional forms of leadership under island and atoll chiefs, who were directly appointed by the President and who controlled all aspects of island and atoll development for decades. The operations of councils continue to remain politicized, as membership is party based, and political bickering between council members often lead to stalemates and no decision-making. Councillors require capacity-building in terms of leadership, management, and development planning; with a focus on building resilience and reducing inequalities. The Local Government Authority as well the Institute of Local Governance, a private institution, run regular programmes for councillors on local planning, management and leadership. It is important to integrate subjects such as inequality, vulnerability and their impact on human development into these training programmes.

OPTIMAL GOVERNANCE TO REDUCE INEQUALITY AND VULNERABILITY

Human development cannot be sustained without democratic and participatory governance. Governance cannot be sound unless it sustains human development. Although the Maldives has adopted a highly democratic Constitution, which integrates good governance principles, the Maldivian state carries extraordinarily high costs for a small country. As mentioned earlier, the 2008 Constitution guarantees that the islands will have electricity, water and sewage infrastructure, as well as mandates a decentralized local Government administration. The constituency size of only 5,000 people for a seat in the Parliament has resulted in a large Parliament. The decentralization programme implies sizable recurrent costs to the Government budget (in terms of holding local elections every three years, salaries and the like). As of 2012, there were 265 councils and 1091 councillors. The Constitution also gives any arrested or detained citizen the right to be brought before a judge within twenty-four hours, leading the *Majlis* to legislate that every inhabited island must therefore have a judge and magistrate. As per the Constitution, more than 19 independent commissions have been established to provide oversight and execute independent work on a range of areas including human rights, elections, corruption, etc. Yet the processes for oversight, transparency, accountability and protection of the rights of the people require more reforms.

The enlarged bureaucracy of state institutions has not been able to fully function, partly due to financial and resource constraints and partly due to the lack of expertise and familiarity with the new concepts of democracy, institutional independence and mandates on human rights, anti-corruption, free and fair elections, etc. The bureaucracy is highly politicized, given that membership of these commissions and institutions are

Table 9 Average expenditure on Members of Parliament 2011 - 2012

Description	2011 Actual Expenditure (MVR)	2012 Expected Budget (MVR)
Annual average expenditure per Member of Parliament	1,016,738	1,516,276
Monthly average expenditure per Member of Parliament	84,728	126,356
Total Parliament Expenditure	124,922,574	144,115,266
Local Councils Expenditure	44,840,129.75	

Source: Department of National Planning, 2013

political in nature. Beyond the bureaucracy, the current system poses a major barrier to fiscal consolidation and to bring the macro-economic indicators in order and sustain investments in education and health. In the absence of a pay commission, the Parliament members have set their own salary. The salary/ remuneration and retirement packages for judges, members of independent commissions are quite high. The *Majlis* subsequently set its own salary on par with the Members of Parliament in economically developed countries, despite the Constitution prohibiting members from exploiting their positions for their personal benefit. Table 9 shows the increase in budget spending on members and the institution as a whole, from 2011 to 2012. Consequent to this, the other independent commissions then raised their own salaries to indicate a status comparable to Government ministers. Along with an overstaffed civil service employing close to ten percent of the population, the net result has been an unsustainable payroll. Similarly, the total Government expenditure on councils for 2012 was MVR 944.13 million, out of which 70 percent was spent on salaries and allowances of councillors and council staff. The share of salaries and allowances as a percentage of the council budget was usually above 60 percent, across atolls in 2012.[10] When salaries and allowances and other administrative costs are taken into account, the council is left with negligible resources for development programmes and initiatives.

For a small country like the Maldives, with mounting pressures, fiscal crisis and high debt distress, it is time that political parties, institutions, civil society and the public engage in debate; and agree to right-size the governance system, to make it more sustainable and to maximize the democratic dividend and enhance the freedoms and choices for the people.

Notes and References

Notes

CHAPTER 1

[1] UNDP, 2013
[2] UNDP, 2013
[3] Khatiwada, 2009
[4] The World Bank 2012
[5] The World Bank 2012
[6] MMA, 2012
[7] Department of National Planning, 2011
[8] Ministry of Health and Family, 2012
[9] Ministry of Health and Family, 2012
[10] UNDP, 1990
[11] UNDP, 2013
[12] UNDP, 2013
[13] UNDP, 2010
[14] UNDP, 2013
[15] Melamed and Samman , 2013
[16] Human Rights Commission of the Maldives , 2012
[17] Human Rights Commission of the Maldives , 2012
[18] UNDP, 2013
[19] UNDP, 2013
[20] UNDP, 2013
[21] Seth, 2011
[22] Reproductive health is measured by the maternal mortality ratio and the adolescent fertility rate. The empowerment dimension is measured by two indicators: the share of parliamentary seats held by each sex and by secondary and higher education attainment levels. The labour dimension is measured by women's participation in the work force. See UNDP (2013).
[23] Seth, 2011
[24] UNDP, 2011
[25] Elections Commission of Maldives, 2014
[26] Human Rights Commission of the Maldives, 2012
[27] UNDP, 2011
[28] UNDP, 2011

CHAPTER 2

[1] Chambers, 1989
[2] Moser, 1998
[3] UNDP, 2013
[4] UNDP, 2013
[5] According to the United Nations Convention on the Law of the Sea, 'the exclusive economic zone is an area beyond and adjacent to the territorial sea, subject to the specific legal regime established in this Part, under which the rights and jurisdiction of the coastal State and the rights and freedoms of other States are governed by the relevant provisions of this Convention'. In the exclusive economic zone, the coastal State has: (a) sovereign rights for the purpose of exploring and exploiting, conserving and managing the natural resources, whether living or non-living, of the waters superjacent to the seabed and of the seabed and its subsoil, and with regard to other activities for the economic exploitation and exploration of the zone, such as the production of energy from the water, currents and winds;(b) jurisdiction as provided for in the relevant provisions of this Convention with regard to: (i) the establishment and use of artificial islands, installations and structures;(ii) marine scientific research;(iii) the protection and preservation of the marine environment; (c) other rights and duties provided for in this Convention. See United Nations (1982).
[6] The World Bank, 2012
[7] Ministry of Toursim, 2013
[8] Ministry of Toursim, 2013
[9] UNDP, 2013
[10] Hydro-meteorological hazards refer to natural hazards - their origin and the mitigation of their effects. Among these hazards – the results of natural processes or phenomena of atmospheric, hydrological or oceanographic nature - are floods, tropical cyclones, drought and desertification.
[11] United Nations and Department of National Planning, 2013
[12] Department of National Planning, 2009
[13] Ministry of Fisheries and Agriculture, 2005
[14] MPND, 2005
[15] Department of National Planning, 2009
[16] Department of National Planning, 2013
[17] MMA, 2012
[18] Ministry of Economic Development, 2013
[19] MMA, 2012
[20] Ministry of Environment and Energy, 2012
[21] Ministry of Economic Development, 2013
[22] UNDP, 2013
[23] UNDP, 2013
[24] UNDP, 2013
[25] Sattar, 2009
[26] Sattar, 2009
[27] Didi, 2009
[28] MMA 2011
[29] IMF, 2011
[30] The World Bank, 2013
[31] MMA, 2012
[32] The World Bank, 2013
[33] MMA, 2012
[34] UNODC, 2012
[35] UNODC, 2012
[36] For example, the majority of children at the orphanage centre in Villingili have been abandoned because their parents were involved in drug-use and were serving prison sentences.
[37] Department of National Planning, 2013
[38] Naaz, 2012
[39] These eight vulnerabilities are: children from broken families, neglected children, children from poor families, children with disabilities, children who get exposed to drugs, underperforming students, children who have been a victim of child abuse or other forms of violence and orphans

CHAPTER 3

[1] While the Maldives started off with fairly basic resorts when tourism first began, some recent investments have reportedly been in the range of US$ 150 million.
[2] MMA, 2011
[3] Ministry of Tourism, 2013
[4] MMA, 2011
[5] MPND, 2004
[6] Transient poverty is distinguished from chronic poverty, it refers to the situation where people may fall in and out of poverty, due to volatility in incomes. As noted by Cruces, Guillermo and Wodon (2003). Jalan and Ravallion (2000) pointed out that while some households remain poor for long periods of time, others are poor only on a temporary basis. In addition, even among the persistently poor, variations in income or consumption imply that households can become more or less poor over time, for example due to employment losses. See Cruces, Guillermo and Quentin T. Wodon, (2003)
[7] Rutten, Kruijk and Martine, 2007
[8] See Chapter 4.
[9] Gini coefficient is a measure of income inequality. Inequality is measured on a scale from 0 (complete equality) to 1 (complete inequality). Gini coefficients run from about 0.25 for the most equal countries in the world (Denmark, Sweden, Belgium, Hungary and Japan) to about 0.70 for the most unequal country (Namibia).
[10] MPND, 2002/2003 and Department of National Planning, 2012 and MPND, 1997/1998.
[11] ADB, 2012
[12] MPND, 2004
[13] Sumner, Cobham and Andy, 2011
[14] Ministry of Tourism, 2013
[15] Ministry of Tourism, 2013
[16] Ministry of Tourism, 2013
[17] In the early years, lease rents were extremely low to protect the infant industry and until the mid-1980s no taxes were levied on tourism. As a result the small numbers of groups that invested and developed tourism were able to grow within this protected framework.
[18] The number of resorts leased to local parties remained at 74 from 2008 to 2011. Number of resorts leased to foreign operators has increased steadily from 8 resorts (1086 beds) in 2008 to 13 resorts (2114 beds) in 2012. Ministry of Tourism, 2013
[19] A survey in 2010 indicated that the share of tourism related Small and Medium Enterprises (SMEs) is only one percent outside of the capital Malé. MED, 2010
[20] A successful example is the Addu-Meedhoo Cooperative Society that supplies fresh fruits and vegetables to Shangri La resort on a contractual basis, which has revived agriculture on the island of Hulhudhoo-Meedhoo and substantially improved

the incomes of farmer families on the island.
[21] Guesthouses on an inhabited island are only permitted on land designated for residential use.
[22] MTDC, 2007
[23] MPND, 2006
[24] Department of National Planning, 2011
[25] In 2011, the stipulated local to expatriate staff ratio of 50:50 for tourist resorts was reviewed and an increase of expatriates allowed to 55:45. Ministry of Tourism, 2013
[26] Department of National Planning, 2011
[27] Department of National Planning, 2011
[28] MPND, 2006
[29] MPND, 2006: About 34 percent of women migrants in Malé had moved for a combination of family related reasons.
[30] Department of National Planning, 2011
[31] The labour force participation rate refers to the proportion of population above 15 years of age, that is economically active or is participating in the labour force.
[32] MPND, 2006
[33] ILO, 2013
[34] Department of National Planning, 2011
[35] ILO, 2013
[36] One-third of the migrant workers in the Maldives are illegal immigrants. Robinson (2011).
[37] ILO, 2013
[38] HRCM, 2010
[39] Behzad, 2011
[40] ILO, 2013
[41] Najeeb, 2011
[42] Behzad, 2011
[43] Department of National Planning, 2011
[44] The report quoted that to break a shop window a gang member can get paid MVR20,000(US$1,310).
[45] Melamed and Semman, 2013

CHAPTER 4

[1] Sen, 2008
[2] UNDP, 2007
[3] The report states 'today, every inhabited island has at least one school' and sustained literacy rate of 99 percent.
[4] There are two public examinations at the end of lower secondary education; General Certificate of Education Ordinary Level (GCE O/L), International General Certificate of Secondary Education (IGCSE) or Senior Secondary Certificate (SSC) examinations. At the end of higher secondary education students sit for the General Certificate of Education Advanced Level (GCE A/L) or Higher Secondary Certificate (HSC) examinations.
[5] Department of National Planning, 2012
[6] Net Enrolment Rate is a measure of the education coverage in a specific level of a country's education system. The net enrolment rate at secondary level for example refers to the number of children of official secondary school age who are enrolled in secondary education as a percentage of the total children of the official school age population.
[7] The World Bank, 2012
[8] UNICEF, 2009
[9] Smeeding and Haveman, 2006
[10] Inequality is inversely related to scores on reading and math scores both internationally (among developed countries) and within the 50 US States, as well as to high-school 50 US States, as well as to high-school dropout rates in the United States. See Pickett and Wilkinson, (2009).
[11] Mayer, 2001
[12] A recent study concludes that gender gaps in education and employment, proxied by the gender gap in labour force participation, significantly reduced growth from 1960 to 2000, particularly in South Asia and Middle East North Africa. See Klasen and Lamanna, (2009).
[13] The World Bank, 2012
[14] The World Bank, 2012
[15] Department of National Planning, 2012
[16] UNICEF, 2013a
[17] EVS refers to Environmental Studies
[18] Ministry of Education, 2012
[19] Ministry of Education, 2012
[20] For Vaavu atoll, for example, for every six students there is a teacher and in four atolls the average student-teacher ratio was 8:1. See Ministry of Education, (2012)
[21] Ministry of Education, 2012
[22] Ministry of Education, 2012
[23] Human Rights Commission of Maldives, 2011
[24] The World Bank, 2011b
[25] In order to address the quality of education, an effective quality assurance system needs to be in place. The Ministry of Education has introduced quality indicators for Child-Friendly Baraabaru Schools (CFBS) in 2011. CFBS is a new model that provides a comprehensive toolkit for the evaluation of school performance. The main objectives of CFBS are to facilitate the assessment of education processes by schools (self-assessment) and by provincial and national authorities (external assessments). See Ministry of Education and UNICEF (2010).
[26] The World Bank, 2012
[27] The World Bank estimated that the higher education system (degree or above and pre-degree level) has total enrolment of about 11,000 – 12,000 students within the Maldives (The World Bank, 2011a).
[28] A total of 1,351 people had graduated from TVET as of 2010 and an additional 4,767 students were being trained through 82 training providers. See Department of National Planning, (2012).
[29] Ministry of Health and Family, 2011
[30] Ministry of Health, 2012
[31] Ministry of Health and Family, 2010
[32] UNICEF, 2009
[33] Consultations with Hithadhoo regional hospital for example revealed that one reason for the poor performance or negligence by doctors is that any action or suspension against a doctor will probably lead to a long period without any doctor. So poor performance often goes unnoticed (or is tolerated) because the replacement time for doctors on the islands is extremely high.
[34] Ministry of Health, 2012
[35] Ministry of Health and Family, 2010
[36] Ministry of Health and Family, 2010
[37] Ministry of Health and Family, 2010
[38] Ministry of Health and Family, and UNICEF, 2007
[39] Ministry of Health and Family, 2010
[40] The disability-adjusted life year (DALY) is a measure of overall disease burden, expressed as the number of years lost due to ill-health, disability or early death.
[41] Ministry of Health, 2012
[42] Data source: Society for Health Education, 2013
[43] Ministry of Health and Family, 2011
[44] Ministry of Health and Family, 2011
[45] WHO, 2010
[46] WHO, 2010
[47] What people have left to spend after paying for health care is a measure of their discretionary incomes. The way a country finances its health care affects the distribution of discretionary income: if the financing system relies on regressive sources of financing (that is, one that absorbs a larger share of a poor household's income than of a rich household's income), the health financing system will increase inequality in discretionary income; if the system relies on progressive sources, it will reduce inequality in discretionary income.
[48] Ministry of Health and Family, 2010
[49] Ministry of Health and Family, 2011
[50] Ministry of Economic Development, 2013
[51] Ministry of Health, 2012
[52] UNICEF, 2013b
[53] The absence of a clear functioning system appears to have given rise to corruption, particularly in health procurement. During the interviews most people refused to comment on this issue although they agreed that there was corruption in the sector. This issue needs to be investigated further.
[54] Ministry of Health, 2012
[55] WHO, 2010

CHAPTER 5

[1] The SPI is calculated by Total Social Protection Expenditures per Total Potential Beneficiaries by
[2] percent of the GDP per capita (representing average poverty line expenditures). In other words, the total social-protection expenditures spread across all potential beneficiaries are compared to poverty-line expenditures in each country. The SPI index can be disaggregated into two components, one for the 'depth' of coverage and the other for the 'breadth' of coverage of social protection programs. The first indicator is the Total Social Protection Expenditures divided by the Total Actual Beneficiaries (i.e., the average size of benefits actually received or 'depth'). The second indicator is the Total Actual Beneficiaries divided by the Total Potential Beneficiaries (i.e., the proportion of potential beneficiaries actually reached or 'breadth').
[3] Ibrahim, 2012
[4] World Bank 2013
[5] The World Bank, 2013
[6] Ministry of Economic Development, 2013
[7] Bonnerjee, 2013
[8] Human Rights Commission of the Maldives, 2011
[9] International Commission of Jurists, 2011
[10] Ginsburg, 2012
[11] Department of National Planning, 2011

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Annex I
Technical Notes

Annex 1 - Technical Notes

HUMAN DEVELOPMENT INDEX

The Human Development Index (HDI) is an index to measure and rank countries' levels of social and economic development based on three basic dimensions of human development; a long and healthy life, access to knowledge and a decent standard of living. A long and healthy life is measured by life expectancy at birth. Access to knowledge is measured by mean years of schooling and expected years of schooling. Standard of living is measured through gross national income per capita. The HDI makes it possible to track changes in development levels over time and to compare development levels in different countries.

This technical note describes the steps to calculate the HDI, data sources and the methodology used.

DATA SOURCES

- Life expectancy at birth: National Health Statistics
- Mean years of schooling: Household Income and Expenditure Survey (2009/2010)
- Expected years of schooling: Maldives Population and Housing Census (2006)
- Gross national income (GNI) per capita: World Bank(2010) and Household Income and Expenditure Survey (2009/2010)

CREATING THE DIMENSION INDICES

The first step is to set minimum and maximum values (goalposts) inorder to transform the indicators into indices between 0 and1. The maximum values are set to the actual observed maximumvalues of the indicators from the countries in the timeseries, that is, 1980–2010.The lowvalue for income can be justified by the considerable amount of unmeasured subsistence and nonmarket production in economies close to the minimum, not captured in the official data.The minimum values can be appropriately conceivedof as subsistence values. Table 1 shows the goalposts used in the calculation of HDI in this report.

Indicator	Observed Maximum	Minimum
Life expectancy (years)	83.6 (Japan, 2012)	20.0
Mean years of schooling	13.3 (US, 2010)	0
Expected years of schooling	18.0 (capped at)	0
Combined education index	0.971 (New Zealand, 2010)	0
GNI per capita (PPP USD)	87, 478 (Qatar, 2012)	100

This sets the minimum and maximum values for the indices. Hence, the subindices are calculated as follows:

$$\text{Dimension index} = \frac{\text{actual value-minimum value}}{\text{maximum value-minimum value}}$$

For education, equation 1 is applied to each of the sub twoindices. Then a geometric mean of the resulting indices is created. Final step is to reapply equation 1 to the geometric mean of the indices using 0 as the minimum and the highest geometric mean of the resulting indices for the time period under consideration as the maximum.

According to Anand and Sen(2000) each dimension index is a proxy for capabilities in the corresponding dimension. Hence, the transformation function from income to capabilities is likely to be concave. Therefore for income the natural logarithm of the actual, minimum and maximum values is used.

An aggregate of these sub-indices (HDI) is obtained in terms of their geometric mean as follows:

$$HDI = \sqrt[3]{I_{Life} * I_{Education} * I_{Income}}$$

The same methodology was applied in calculating HDI for Republic, Malé, Atolls and for the seven Regions.

Example:

HDI calculation for Republic

Indicator	Value
Life expectancy (years)	73.87
Mean years of schooling	5.8
Expected years of schooling	12.5
GNI per capita (PPP USD)	7690

Life expectancy index = $\frac{73.87-20}{83.6-20} = 0.847$

Mean years of schooling index = $\frac{5.8-0}{13.3-0} = 0.438$

Expected years of schooling index = $\frac{12.5-0}{148.0-0} = 0.695$

Education index = $\frac{\sqrt{0.438*0.695}-0}{0.971-0} = 0.568$

Income index = $\frac{\ln(7690)-\ln(100)}{\ln(87478)-\ln(100)} = 0.641$

Human Development Index = $\sqrt[3]{0.847 * 0.568 * 0.641} = 0.676$

The HDI estimations for all the seven regions, Malé and Atolls has been done using the same methodology.

METHODOLOGY USED TO EXPRESS INCOME

The World Bank has estimated Gross National Income (GNI) per capita (PPP USD) for the Maldives for 2012 at PPP USD7,690.The Household Income and Expenditure Survey (HIES) 2009/10 estimated the average per capita income in Male is MVR4,252 – 55% higher than the national average of MVR. 2,746. Similarly, the average per capita income intheAtolls is MVR 1,940 – 29% lower than the national average. These same proportions have beenapplied to obtain comparative estimates of real GNI per capita (PPP USD):

Estimated real GNI per capita for Male':55% higher than PPP$2,746 = PPP$ 11,906.

Estimated real GNI per capita for the Atolls: 29% lower than PPP$ 2,746 = PPP$ 5,432

Similarly, estimates were made for the 7 Regions using HIES data.

Region	Per capita income from HIES 2010	Percapita (PPP USD)
R1 (HA, HDh, Sh)	1,776	4,973
R2 (N, R, B, Lh)	1,605	4,495
R3 (K, AA, Adh, V)	2,687	7,525
R4 (M, F, Dh)	2,472	6,922
R5 (Th, L)	1,774	4,967
R6 (GA, GDh)	1,639	4,589
R7 (Gn, S)	2,126	5,953

INEQUALITY-ADJUSTED HUMAN DEVELOPMENT INDEX

The Inequality-adjusted Human Development Index (IHDI) adjusts the Human Development Index (HDI) for inequality in the three basic dimensions of human development (income, life expectancy, and education). The IHDI equals the HDI when there is no inequality across people but falls further below the HDI as inequality rises. In this sense, the IHDI is the actual level of human development (taking into account inequality), while the HDI can be viewed as an index of the "potential" human development that could be achieved if there was no inequality. The "loss" in potential human development due to inequality is the difference between the HDI and the IHDI and is expressed as a percentage.

Inequality-adjusted estimates corresponding to the three dimensions are obtained using the following estimator:

$$I_{I_X} = (1 - A_X) * I_X$$

Where IIX is the inequality-adjusted dimension index, IX is the dimension index and AX is the Atkinson inequality measure for `x'th dimension. The IHDI draws on the Atkinson (1970) family of inequality measures and sets the aversion parameter A equal to 1. In this case the inequality measure is A = 1 – g/μ, where g is thegeometric mean and μ is the arithmetic mean of the distribution. This can be written as:

$$A_X = 1 - \frac{\sqrt[n]{X_1 * X_2 \ldots . * X_n}}{\overline{X}}$$

Where {X1…Xn} denotes the underlying distribution of dimension X, and Xits arithmetic mean.

Finally, the inequality-adjusted HDI is obtained as the geometric mean of the threedimensionindices adjusted for inequality as follows.

$$IHDI = \sqrt[3]{I_{Life} * I_{Education} * I_{Income}}$$

The percentage loss in the HDIdue to inequalities is calculated as:

$$Loss = 1 - \frac{IHDI}{HDI} = 1 - \sqrt[3]{(1 - A_{Life}) * (1 - A_{Education}) * (1 - A_{Income})}$$

DATA SOURCES

Income

HDI uses the estimate of Gross National Income per capita (PPP US$) for Maldives from the World Bank. Per capita income estimates for Malé, Atolls and for the 7 regions are computed using the Household Income and Expenditure Survey (HIES, 2010).

Taking a similar approach, the inequality in standard of living dimension used estimates of Atkinson measure of inequality. The HIES data on per capita income distribution for the year 2009/10was used as a proxy for corresponding inequality estimate of income. Income inequality measures was computed, as per UNDP (2010), after truncating the top 0.5 percentilegroup of the distribution, and replacing zero expenditure with minimum value of income of the bottom 0.5-percentile group.

Education

The mean years of schooling of the adult population (aged 25 years and above) are estimatedusing the HIES data on educational attainment. The same datasource is used to obtain estimate of Atkinson inequality in levels of education.

Health

The estimates of life expectancy were calculated using the death information obtained from Ministry of Health. The estimates of inequality have also been derived

from the Life Tables, which also provides a profile of mortality across age-intervals for the regional level.

Example:
IHDI calculation for Republic

Indicator	Indicator	Dimension index	Inequality measure (A1)	Inequality-adjusted index
Life expectancy (years)	73.87	0.841	0.201	(1-0.201)*0.841=0.677
Mean years of schooling	5.83	0.368		
Expected years of schooling	12.51	0.647		
Education index		0.503	0.319	(1-0.319)*0.503=0.387
Logarithm of gross national income	8.95	0.641	0.370	(1-0.370)*0.641=0.404

Human Development Index		Inequality-adjusted Human Development Index	Loss (%)
HDI	$\sqrt[3]{0.841 * 0.503 * 0.641} = 0.676$	$\sqrt[3]{0.677 * 0.387 * 0.404} = 0.473$	100*(1-0.473/0.676) =30.0

The IHDI estimations for all the seven regions, Malé and Atolls has been done using the same methodology.

GENDER INEQUALITY INDEX

Gender Inequality Index (GII) reflects women's disadvantage in three dimensions—reproductive health, empowerment and the labour market. The index shows the loss in human development due to inequality between female and male achievements in these dimensions. It ranges from 0, which indicates that women and men fare equally, to 1, which indicates that women fare as poorly as possible in all measured dimensions.

DATA SOURCES

- Maternal Mortality Rate (MMR): National Health Statistics
- Adolescent Fertility Rate (AFR): Maldives Population and Housing Census (2006)
- Share of parliamentary seats held by each sex: Parliamentary database
- Attainment at secondary and higher education (SE) levels: Barro and Lee (2010) and Household Income and Expenditure Survey (2009/10)
- Labour market participation rate (LFPR): Household Income and Expenditure Survey (2009/10)

GENDER INEQUALITY INDEX CALCULATIONS

There are five steps to calculating the GII.

STEP 1. TREATING ZEROS AND EXTREME VALUES

Because a geometric mean cannot be computed from a zero value, a minimum value of 0.1% is set for all component indicators. In this regard, the maternal mortality rate was truncated systematically at minimum of 10 and maximum of 1,000. Regions with parliamentary representation at 0 is coded as 0.1% because of the assumption that women have some level of political influence.

STEP 2. AGGREGATING ACROSS DIMENSIONS WITHIN EACH GENDER GROUP, USING GEOMETRICMEANS

Aggregating across dimensions for each gender group by the geometric mean makes the GII association-sensitive. The maternal mortality rate and the adolescent fertility rate are only relevant for females the males are only aggregated with the other two dimensions.

For women and girls, the aggregation formula is

$$G_F = \sqrt[3]{\left(\frac{10}{MMR} * \frac{1}{AFR}\right)^{\frac{1}{2}} * (PR_F * SE_F)^{\frac{1}{2}} * LFPR_F}$$

and for men and boys the formula is

$$G_F = \sqrt[3]{\left(\frac{10}{MMR} * \frac{1}{AFR}\right)^{\frac{1}{2}} * (PR_F * SE_F)^{\frac{1}{2}} * LFPR_F}$$

The rescaling by 0.1 of the maternal mortality ratio in equation 1 is needed to account for the truncation of the maternal mortality ratio minimum at 10.

STEP 3: AGGREGATING ACROSS GENDER GROUPS, USING A HARMONIC MEAN

To compute the equally distributed gender index the female and male indices are aggregated by the harmonic mean of the geometric means to capture the inequality between females and males and adjust for association between dimensions.

$$HARM(G_F, G_M) = \left[\frac{(G_F)^{-1} + (G_M)^{-1}}{2}\right]^{-1}$$

STEP 4: CALCULATING THE GEOMETRIC MEAN OF THE ARITHMETIC MEANS FOR EACH INDICATOR

Obtain the reference standard by aggregating female and male indices with equal weight, and then aggregating indices across dimensions.

$$G_{\overline{F,M}} = \sqrt[3]{\overline{Health} * \overline{Empowerment} * \overline{LFPR}}$$

$$\overline{Health} = \left(\sqrt{\frac{10}{MMR} * \frac{1}{AFR}} + 1\right)/2,$$

$$\overline{Empowerment} = \left(\sqrt{PR_F * SE_F} + \sqrt{PR_M * SE_M}\right)/2, \text{ and}$$

$$\overline{LFPR} = \frac{LFPR_F + LFPR_M}{2}$$

STEP 5: CALCULATING THE GENDER INEQUALITY INDEX

To compute the GII compare the equally distributed gender index from Step 3 to the reference standard from Step 4.

$$1 - \frac{HARM(G_F, G_M)}{G_{\overline{F},\overline{M}}}$$

Example:Republic

	Health		Empowerment		Labour market
	Maternal mortality ratio	Adolescent fertility rate	Parliamentary representation	Attainment at secondary and higher education	Labour market participation rate
Female	13.5	7.5	0.065	0.294	0.382
Male	na	na	0.935	0.354	0.680
$\frac{F+M}{2}$	$\frac{\sqrt{\left(\frac{10}{13.5}\right)*\left(\frac{1}{7.5}\right)}+1}{2} = 0.657$		$\frac{\sqrt{0.065*0.294}+\sqrt{0.935*0.351}}{2} = 0.357$		$\frac{0.382+0.680}{2} = 0.531$

Note: na is not applicable

Using the above formula, it is straightforward to obtain:

$$G_F = \sqrt[3]{\sqrt{\frac{10}{13.5} * \frac{1}{7.5}} * \sqrt{0.065 * 0.295} * 0.382} = 0.255$$

$$G_M = \sqrt[3]{1 * \sqrt{0.935 * 0.354} * 0.680} = 0.731$$

$$HARM(G_F, G_M) = \left[\frac{1}{2}\left(\frac{1}{0.255} + \frac{1}{0.731}\right)\right]^{-1} = 0.378$$

$$G_{\overline{F},\overline{M}} = \sqrt[3]{0.657 * 0.357 * 0.531} = 0.499$$

$$GII = 1 - \left(\frac{0.378}{0.499}\right) = 0.243$$

The GII estimations for all the seven regions, Male' and Atolls has been done using the same methodology.

▶ MULTIDIMENSIONAL POVERTY INDEX

The Multidimensional Poverty Index (MPI) is an index designed to measure acute poverty through education, health and standard of living. For MPI all the data must come from the same survey. For the construct of the MPI the data from Demographic Health Survey (DHS) 2009 was used using household as the unit of measurement.

METHODOLOGY:

The MPI is composed of three dimensions made up of ten indicators. Associated with each indicator is a minimum level of satisfaction, which is based on international consensus (such as the Millennium Development Goals or MDGs). This minimum level of satisfaction is called a deprivation cut-off. Two steps are then followed to calculate the MPI:

Step 1: Each person is assessed based on household achievements to determine if he/she is below the deprivation cut-off in each indicator. People below the cut-off are considered deprived in that indicator.
Step 2: The deprivation of each person is weighted by the indicator's weight (an explanation on weighting can be found in UNDP technical notes 2013). If the sum of the weighted deprivations is 33 per cent or more of possible deprivations, the person is considered to be multi-dimensionally poor.

The MPI has ten indicators: two for health, two for education and six for living standards. The education and health dimensions have two indicators each, so each component is worth 33/2, or 16.7%. The standard of living dimension has six indicators, so each component is worth 33.6/6, or 5.6%. The thresholds are as follows:

- Education:

1. Years of schooling- deprived if no household member has completed five years of schooling.
2. School attendance- deprived if any school- age child (up to grade 8) is not attending school.

- Health:

1. Child mortality- deprived if any child has died in the family
2. Nutrition- deprived if at least one household member is malnourished

- Standard of living:

1. Electricity- deprived if the household does not have electricity.
2. Drinking water- deprived if the household does not have access to clean drinking water or clean water is more than 30 minutes' walk from home.
3. Sanitation- deprived if the household does not have access to adequate sanitation or if their toilet is shared.
4. Flooring- deprived if the household has a home with a dirt floor.
5. Cooking fuel- deprived if the household uses 'dirty' cooking fuel (dung, wood or charcoal).
6. Asset Ownership- deprived if the household does not own a car, truck or similar motorized vehicle while owning at most one of these assets: bicycle, motorcycle, radio, refrigerator, telephone or television.

To identify the multi-dimensionally poor, the deprivation scores for each household are summed to obtain the household deprivation, c. A cut-off of 33.3 percent, which is the equivalent of one-third of the weighted indicators, is used to distinguish between the poor and non-poor. If c is 33.3 percent or greater, that household (and everyone in it) is multi-dimensionally poor. Households with a deprivation score greater than or equal to 20 percent but less than 33.3 percent are vulnerable to or at risk of becoming multi-dimensionally poor. Households with a deprivation score of 50

percent or higher are severely multi-dimensionally poor. The MPI value is the mean of deprivation scores c (above 33.3 percent) for the population and can be expressed as a product of two measures: the multidimensional headcount ratio and the intensity (or breadth) of poverty.

The first component is called the multidimensional headcount ratio (H):

$$H = \frac{q}{n}$$

Where q is the number of people who are multi-dimensionally poor and n is the total population.

The second step is the calculation of the intensity of poverty (A), reflects the proportion of the weighted component indicators in which, on average, poor people are deprived and can be expressed as:

$$A = \frac{\sum_{i=1}^{n} c_i(k)}{q}$$

Whereci(k) is the censored deprivation score of individual i and q is the number of people who are multi-dimensionally poor.

Hence, the MPI is the product of both:

MPI = *H* × *A*.

Annex II:
Statistical Calculations

Table 1 Human Development Index and its components

Locality	Human development index (HDI) value	Life expectancy (years)	Mean years of schooling (years)	Expected years of schooling (years)	Gross national income (GNI) per capital (PPP 2008 $)
Republic	0.676	73.87	5.83	12.51	7,690
Malé	0.734	71.21	7.84	13.97	11,906
Atolls	0.627	74.90	4.62	11.43	5,432
Region 1 (HA, HDh, Sh)	0.625	73.48	4.90	11.64	4,973
Region 2 (N, R, B, Lh)	0.604	73.50	4.22	11.69	4,495
Region 3 (K, AA, Adh, V)	0.644	76.18	4.92	10.33	7,525
Region 4 (M, F, Dh)	0.654	73.07	5.45	11.92	6,922
Region 5 (Th, L)	0.622	75.62	4.64	11.05	4,967
Region 6 (GA, GDh)	0.594	76.28	3.45	11.56	4,589
Region 7 (Gn, S)	0.647	76.10	4.95	11.80	5,953

Table 2 Inequality-adjusted Human Development Index

	Indicators				Inequality-adjusted dimensional indices						
Locality	Life expectancy at birth (years)	Mean years of schooling for ages 25 and above (years)	Expected years of schooling (years)	GNI per capita (PPP 2008 $)	Life expectancy index (Value)	Education index (Value)	Income index (Value)	Inequality-adjusted Human Development Index (IHDI) (Value)	Human development index (HDI) (Value)	Loss due to inequality (%)	Gini coefficient
Republic	73.9	5.8	12.5	7,690	0.677	0.387	0.404	0.473	0.676	30.0	0.37
Malé	71.2	7.8	14.0	11,906	0.677	0.521	0.479	0.552	0.734	24.7	0.38
Atolls	74.9	4.6	11.4	5,432	0.729	0.324	0.384	0.449	0.627	28.3	0.36
Region 1 (HA, HDh, Sh)	73.5	4.9	11.6	4,973	0.707	0.338	0.341	0.434	0.625	30.6	0.35
Region 2 (N, R, B, Lh)	73.5	4.2	11.7	4,495	0.706	0.310	0.391	0.441	0.604	27.1	0.32
Region 3 (K, AA, Adh, V)	76.2	4.9	10.3	7,525	0.756	0.327	0.421	0.470	0.644	27.0	0.37
Region 4 (M, F, Dh)	73.1	5.4	11.9	6,922	0.699	0.383	0.394	0.472	0.654	27.8	0.29
Region 5 (Th, L)	75.6	4.6	11.0	4,967	0.739	0.326	0.379	0.450	0.622	27.6	0.33
Region 6 (GA, GDh)	76.3	3.4	11.6	4,589	0.756	0.269	0.396	0.432	0.594	27.4	0.37
Region 7 (Gn, S)	76.1	5.0	11.8	5,953	0.754	0.342	0.433	0.482	0.647	25.6	0.34

Table 3 Gender Inequality Index

Locality	Gender Inequality Index (Value)	Maternal mortality ratio (deaths per 100,000 live births)	Adolescent fertility ratio (births per 1000 women ages 15-19)	"Seats in parliament held by (% of total)"		Population with at least secondary education (% ages 25 and older)		Labour force participation rate (%)	
				Female	Male	Female	Male	Female	Male
Republic	0.243	13.5	7.5	6.5	93.5	29.4	35.4	38.2	68.0
Malé	0.232	0.0	2.3	18.2	81.8	46.8	58.6	37.6	69.8
Atolls	0.357	37.4	11.3	4.5	95.5	19.9	22.1	38.5	66.8
Region 1 (HA, HDh, Sh)	0.697	117.5	5.4	0.0	100.0	19.6	22.5	34.8	64.2
Region 2 (N, R, B, Lh)	0.401	0.0	10.2	7.1	92.9	16.0	19.7	35.6	64.9
Region 3 (K, AA, Adh, V)	0.341	0.0	20.3	22.2	77.8	22.4	20.0	47.3	65.0
Region 4 (M, F, Dh)	0.725	0.0	11.4	0.0	100.0	19.7	31.6	49.3	75.1
Region 5 (Th, L)	0.741	0.0	18.7	0.0	100.0	20.4	22.4	38.9	73.3
Region 6 (GA, GDh)	0.723	0.0	20.7	0.0	100.0	15.5	19.4	41.9	72.0
Region 7 (Gn, S)	0.696	0.0	3.7	0.0	100.0	28.4	23.9	33.5	62.2

Table 4 Multidimensional Poverty Index

Locality	Multi-dimensional Poverty Index (MPI)	Percentage contribution of deprivations of each dimension to overall poverty…			Proportion of people who are poor and deprived in …										Population below income poverty line	
					Education		Health		Living standards							
		Educa-tion	Health	"Living stan-dards"	Years of School-ing	Child School Atten-dance	Nutrition	"Mortality (any age)"	Electric-ity	"Drinking Water"	"Im-proved Sanita-tion"	Flooring	"Cooking Fuel"	"Asset Owner-ship"	PPP $1.25 a day	National poverty line (MVR 22 per day)
	(Value)	% Contribution													(%)	(%)
Republic	0.0115	42.2	53.9	3.9	5.7	36.5	33.5	20.3	0.0	0.5	0.9	0.5	1.9	0.1	7.8	14.6
Malé	0.0086	49.1	50.9	0.0	0.3	48.8	38.4	12.5	0.0	0.0	0.0	0.0	0.0	0.0	6.7	12.0
Atolls	0.0121	41.3	54.2	4.4	6.4	34.9	32.9	21.3	0.1	0.6	1.0	0.5	2.1	0.1	8.4	16.0
R1: North	0.0127	41.3	48.8	10.0	5.7	35.6	27.2	21.5	0.0	1.1	2.7	1.5	4.7	0.0	-	-
R2: North central	0.0138	35.5	60.3	4.2	7.3	28.1	39.3	21.0	0.1	0.1	0.4	0.7	2.8	0.1	-	-
R3: Central	0.0146	48.2	50.0	1.8	4.0	44.2	28.7	21.3	0.0	0.3	0.0	0.0	1.5	0.0	-	-
R4: South Central	0.0093	36.5	59.9	3.6	9.6	26.9	38.0	22.0	0.1	1.4	1.2	0.1	0.4	0.4	-	-
R5: South	0.0105	44.4	51.7	3.9	5.9	38.5	30.8	20.9	0.1	0.2	1.3	0.7	1.4	0.2	-	-

Table 5 Population 15 years of age and over by type of activity, cross classified by region, 2009/10 (with unemployed including discouraged workers)

Locality	Total 15 years of age & over	Economically active			Not economi-cally active	Not stated	Labour force participation rate	Unemploy-ment rate
		Total	Employed	Unemployed				
Republic	213,872	136,886	98,393	38,493	75,157	1,829	64	28
Malé	82,289	52,153	39,775	12,378	29,478	658	63	24
Atolls	131,584	84,733	58,618	26,115	45,679	1,172	64	31
Region 1 (HA, HDh, Sh)	25,920	16,723	14,215	2,508	8,615	582	65	15
Region 2 (N, R, B, Lh)	27,748	17,966	15,347	2,619	8,855	927	65	15
Region 3 (K, AA, Adh,V)	23,387	17,663	16,182	1,481	4,480	1,244	76	8
Region 4 (M, F, Dh)	8,769	6,098	5,101	997	2,432	239	70	16
Region 5 (Th, L)	13,148	8,925	7,196	1,729	3,351	872	68	19
Region 6 (GA, GDh)	11,803	7,825	6,066	1,759	3,544	434	66	22
Region 7 (Gn, S)	16,427	9,860	7,153	2,707	5,973	594	60	27

Source : Household Income and Expenditure Survey (HIES 2009/2010), Department of National Planning

Table 6 Population 15 years of age and over by type of activity, cross classified by age group and locality, 2009/10 (with unemployed including discouraged workers)

Age group	Total 15 years of age & over	Economically active			Not economi-cally active	Not stated	Age specific activity rate	Unemploy-ment rate
		Total	Employed	Unemployed				
Republic	213,872	136,886	98,393	38,493	75,157	1,829	64.0	28.1
15-19	38,443	13,588	5,530	8,057	24,520	335	35.3	59.3
20-24	34,248	26,198	17,172	9,026	7,829	221	76.5	34.5
25-29	27,600	21,053	15,239	5,814	6,133	413	76.3	27.6
30-34	21,387	15,973	12,348	3,625	5,225	189	74.7	22.7
35-39	19,725	15,084	12,248	2,836	4,579	61	76.5	18.8
40-44	18,950	15,178	12,090	3,088	3,718	54	80.1	20.3
45-49	14,537	11,425	9,072	2,353	2,976	136	78.6	20.6
50-54	11,915	9,037	7,560	1,477	2,778	99	75.8	16.3
55-59	6,483	4,311	3,141	1,169	2,152	20	66.5	27.1
60-64	4,678	2,311	1,986	325	2,334	33	49.4	14.1
65+	15,520	2,523	1,913	610	12,812	186	16.3	24.2
Age not stated	387	206	95	111	100	81	0.0	0.0

Malé	82,289	52,153	39,775	12,378	29,478	658	63.4	23.7
15-19	15,920	5,404	2,655	2,749	10,394	122	33.9	50.9
20-24	15,831	11,868	8,751	3,117	3,830	133	75.0	26.3
25-29	11,459	8,784	6,940	1,844	2,567	108	76.7	21.0
30-34	8,262	6,160	5,214	946	2,065	36	74.6	15.4
35-39	7,031	5,112	4,099	1,013	1,886	33	72.7	19.8
40-44	7,464	5,764	4,904	860	1,700	0	77.2	14.9
45-49	4,576	3,503	2,953	550	1,044	29	76.6	15.7
50-54	4,323	3,043	2,404	639	1,200	80	70.4	21.0
55-59	2,432	1,327	977	350	1,105	0	54.6	26.3
60-64	1,433	649	522	127	784	0	45.3	19.6
65+	3,295	355	283	72	2,903	36	10.8	20.3
Age not stated	263	182	71	111	0	81	69.1	60.8
Atolls	131,584	84,733	58,618	26,115	45,679	1,172	64.4	30.8
15-19	22,523	8,183	2,875	5,308	14,127	213	36.3	64.9
20-24	18,417	14,329	8,421	5,909	3,999	89	77.8	41.2
25-29	16,140	12,269	8,299	3,970	3,566	306	76.0	32.4
30-34	13,125	9,813	7,133	2,680	3,159	153	74.8	27.3
35-39	12,694	9,972	8,148	1,824	2,693	28	78.6	18.3
40-44	11,486	9,414	7,186	2,228	2,018	54	82.0	23.7
45-49	9,961	7,921	6,119	1,803	1,932	107	79.5	22.8
50-54	7,592	5,994	5,156	838	1,579	19	79.0	14.0
55-59	4,051	2,984	2,164	820	1,047	20	73.7	27.5
60-64	3,245	1,662	1,464	198	1,550	33	51.2	11.9
65+	12,226	2,167	1,630	538	9,909	150	17.7	24.8
Age not stated	124	0	24	0	100	0	0.0	0.0

Note: Includes only the local population but excludes those locals working in resorts and industrial islands
Source : Household Income and Expenditure Survey (HIES 2009/2010)
Department of National Planning

Table 7 Student enrolment in Malé and Atolls by type of level and institution, 2012

Locality	No. of Students	Pre - Primary			Primary Level 1_/			Lower Secondary Level			Higher Secondary Level		
		No .of schools	Both Sexes	% of Females	No .of schools	Both Sexes	% of Females	No .of schools	Both Sexes	% of Females	No .of schools	Both Sexes	% of Females
Republic	86,510	236	22,049	49.1	207	38,780	48.1	195	21,444	48.8	35	4,237	50
Malé	26,583	14	7,025	49.0	15	10,511	49.0	19	6,358	49.0	5	2,689	50
Atolls	59,927	222	15,024	48.7	192	28,269	47.8	176	15,086	48.0	30	1,548	55
Region 1 (HA, HDh, Sh)	13,605	45	3,285	149.0	42	6,568	145.0	42	3,484	146.0	6	268	163
Region 2 (N, R, B, Lh)	13,382	50	3,115	201.0	45	6,333	194.0	41	3,527	194.0	9	407	213
Region 3 (K, AA, Adh,V)	7,167	33	2,061	193.0	30	3,389	186.0	29	1,691	173.0	1	26	46
Region 4 (M, F, Dh)	4,563	20	1,204	150.0	19	2,059	140.0	16	1,106	143.0	5	194	141
Region 5 (Th, L)	6,624	30	1,730	103.0	26	3,093	94.0	23	1,721	95.0	4	80	110
Region 6 (GA, GDh)	6,410	25	1,451	98.0	19	3,182	94.0	17	1,638	99.0	3	139	118
Region 7 (Gn, S)	8,176	19	2,178	102.0	11	3,645	97.0	8	1,919	99.0	2	434	129

Note: Sum of schools in this table does not add up to total number of schools as schools overlap in levels
1_/ Includes children with special needs.
Source : Ministry of Education

Table 8 Human Development Index and its components

	1998	1999	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Both sexes														
Primary (1 - 7)	99.2	98.7	98.2	100.9	102.7	103.7	104.1	104.3	99.0	95.8	95.0	95.5	95.5	93.6
Lower Secondary (8 - 10)	22.3	28.2	42.5	44.2	51.7	52.1	64.6	70.3	69.2	69.2	87.6	83.6	83.6	81.2
Higher Secondary (11 - 12)	2.0	1.0	1.4	1.6	1.8	3.9	7.2	8.9	4.0	6.0	13.9	17.4	17.4	19.3
Male														
Primary (1 - 7)	99.9	99.4	98.9	101.4	104.0	105.0	105.3	104.5	97.9	95.2	94.7	95.3	95.3	93.7
Lower Secondary (8 - 10)	20.7	26.3	38.4	40.3	47.2	46.3	58.8	63.9	65.2	64.4	83.4	81.0	81.0	83.0
Higher Secondary (11 - 12)	na	na	1.3	1.5	1.7	3.5	6.7	8.7	5.1	5.9	13.1	18.4	18.4	19.6
Female														
Primary (1 - 7)	98.4	98.1	97.4	100.4	101.3	102.3	102.9	104.2	100.2	96.6	95.3	95.8	99.8	93.6
Lower Secondary (8 - 10)	24.0	30.1	46.7	48.3	56.4	58.2	70.7	77.0	73.5	74.5	92.1	86.5	86.5	79.3
Higher Secondary (11 - 12)	na	na	1.4	1.8	2.2	4.3	7.8	9.1	2.8	6.1	14.8	16.4	16.4	19.0

Note: Net Enrolment above 100 is as a result of using estimated population in the calculation, Source: Ministry of Education

Table 9 Population 6 years of age and over by literacy, locality and sex, 2006

Locality	Total			Literate			Illiterate			Not stated			Percent literate*			Percent illiterate*		
	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female
Republic	267,283	135,248	132,035	250,804	125,727	125,077	4,579	2,495	2,084	11,900	7,026	4,874	93.8	93.0	94.7	1.7	1.8	1.6
Malé	94,970	47,551	47,419	85,745	42,435	43,310	741	366	375	8,484	4,750	3,734	90.3	89.2	91.3	0.8	0.8	0.8
Atolls	172,313	87,697	84,616	165,059	83,292	81,767	3,838	2,129	1,709	3,416	2,276	1,140	95.8	95.0	96.6	2.2	2.4	2.0
Region 1 (HA, HDh, Sh)	36,552	16,820	19,732	35,143	16,047	19,096	1,110	590	520	299	183	116	96.1	95.4	96.8	3.0	3.5	2.6
Region 2 (N, R, B, Lh)	38,271	18,715	19,556	36,834	17,869	18,965	944	521	423	493	325	168	96.2	95.5	97.0	2.5	2.8	2.2
Region 3 (K, AA, Adh,V)	28,332	18,375	9,957	26,774	17,203	9,571	609	359	250	949	813	136	94.5	93.6	96.1	2.1	2.0	2.5
Region 4 (M, F, Dh)	11,915	6,033	5,882	11,556	5,813	5,743	201	114	87	158	106	52	97.0	96.4	97.6	1.7	1.9	1.5
Region 5 (Th, L)	18,058	9,138	8,920	16,888	8,477	8,411	374	222	152	796	439	357	93.5	92.8	94.3	2.1	2.4	1.7
Region 6 (GA, GDh)	16,703	8,281	8,422	16,198	7,996	8,202	231	125	106	274	160	114	97.0	96.6	97.4	1.4	1.5	1.3
Region 7 (Gn, S)	22,482	10,335	12,147	21,666	9,887	11,779	369	198	171	447	250	197	96.4	95.7	97.0	1.6	1.9	1.4

**Percent Literate & Illiterate for male and female has been calculated by using total population in each age group as the denominatator*
Source : Census 2006, Department of National Planning

Table 10 Population 6 years of age and over by literacy age group and sex, census 2006

	Total			Literate			Illiterate			Percent literate*			Percent illiterate*		
	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female
Total	267,283	135,248	132,035	250,804	125,727	125,077	4,579	2,495	2084	93.83	92.96	94.73	1.71	1.84	1.58
6-9	24,353	12,503	11,850	22,343	11,371	10,972	1,055	659	396	91.75	90.95	92.59	4.33	5.27	3.34
10-14	36,999	19,111	17,888	35,942	18,521	17,421	387	242	145	97.14	96.91	97.39	1.05	1.27	0.81
15-19	39,904	20,155	19,749	38,758	19,549	19,209	286	164	122	97.13	96.99	97.27	0.72	0.81	0.62
20-24	34,809	16,933	17,876	33,552	16,240	17,312	223	110	113	96.39	95.91	96.84	0.64	0.65	0.63
25-29	24,581	11,915	12,666	23,657	11,398	12,259	194	94	100	96.24	95.66	96.79	0.79	0.79	0.79
30-34	20,635	10,022	10,613	19,842	9,598	10,244	195	89	106	96.16	95.77	96.52	0.94	0.89	1.00
35-39	18,174	8,780	9,394	17,503	8,403	9,100	176	87	89	96.31	95.71	96.87	0.97	0.99	0.95
40-44	15,871	7,828	8,043	15,222	7,453	7,769	211	115	96	95.91	95.21	96.59	1.33	1.47	1.19
45-49	13,569	6,872	6,697	12,985	6,558	6,427	226	103	123	95.70	95.43	95.97	1.67	1.50	1.84
50-54	7,936	4,147	3,789	7,580	3,945	3,635	151	82	69	95.51	95.13	95.94	1.90	1.98	1.82
55-59	5,859	3,046	2,813	5,575	2,900	2,675	148	68	80	95.15	95.21	95.09	2.53	2.23	2.84
60-64	5,566	2,852	2,714	5,203	2,681	2,522	234	99	135	93.48	94.00	92.93	4.20	3.47	4.97
65+	13,944	7,790	6,154	12,607	7,094	5,513	1,090	581	509	90.41	91.07	89.58	7.82	7.46	8.27
Age not stated	5,083	3,294	1,789	35	16	19	3	2	1	0.69	0.49	1.06	0.06	0.06	0.06

Source :Department of National Planning

Table 11 Estimated immunization coverage, 2012

Locality	Measles	MMR	Bacillus Climate Guerin (BCG) Dozes	Diptheria Partasis Tatnus (DPT) Dozes			Tetanus Toxide (TT) Dozes *					Hepatitis B			Oral Polio Vaccine (OPV) Dozes			
				1st	2nd	3rd	1st	2nd	3rd	4th	5th	1st	2nd	3rd	1st	2nd	3rd	4th
Republic	7,516	7,430	6,517	6,640	6,801	6,804	2,705	2,244	1,591	1,349	1,131	6,517	6,717	6,893	6,454	6,593	6,782	6,948
Malé	2,792	2,740	3,643	2,071	2,205	2,190	1,044	852	25	0	1	3,688	2,069	2,227	3,683	2,041	2,188	2,343
Atolls	4,724	4,690	2,874	4,569	4,596	4,614	1,661	1,392	1,566	1,349	1,130	2,829	4,648	4,666	2,771	4,552	4,594	4,605
Region 1 (HA, HDh, Sh)	1,246	1,259	881	1,170	1,097	1,127	521	324	456	383	301	870	1,103	1,120	870	1,090	1,087	1,126
Region 2 (N, R, B, Lh)	1,023	1,137	608	1,020	1,073	1,067	614	299	448	461	414	549	1,032	1,089	549	1,035	1,048	1,092
Region 3 (K, AA, Adh,V)	606	521	164	532	559	574	81	66	140	134	129	180	541	562	161	524	576	585
Region 4 (M, F, Dh)	369	370	160	315	353	314	215	251	195	133	107	144	356	314	121	340	337	331
Region 5 (Th, L)	524	498	313	507	477	564	205	210	189	164	137	314	559	521	316	495	516	510
Region 6 (GA, GDh)	445	466	269	447	466	459	220	219	113	59	32	298	469	484	271	483	462	452
Region 7 (Gn, S)	511	439	479	578	571	509	48	21	19	8	5	474	588	576	483	585	568	509
Children vaccinated	7,516	7,430	6,517	6,640	6,801	6,804	2,705	2,244	1,591	1,349	1,131	6,517	6,717	6,893	6,454	6,593	6,782	6,948
Eligible children	7,566	7,501	6,535	6,670	6,840	6,836	2,720	2,260	1,600	1,380	1,150	6,537	6,745	6,935	6,478	6,626	6,822	6,996
Coverage	99	99	100	100	99	100	99	99	99	98	98	100	100	99	100	100	99	99

** TT Dose is given to 15 - 49 yrs woman*
Estimated coverage based on data's received from atoll health facilities
Note:
BCG -Bacillus Climate Guerin
OPV - Oral Polio Vaccine
DPT - Diptheria Partasis Tatnus
TT - Tetanus Toxide

At Birth: BCG, Hepatitis B1, OPV0
6 week: OPV1, Hepatitis B2, DPT1
10 week: OPV2, Hepatitis B3, DPT2
14 week: OPV3, DPT3
9 Months: Measles, Vitamin A 1
18 Months: Measles-Mumps-Rubella (MMR), Vitamin A 2
Childhood vaccine not completed: TT1st dose, TT2nd dose, TT3rd dose, TT4th dose, TT5th dose
Childhood vaccine completed: TT3rd dose, TT4th dose , TT5th dose
1st Pregnancy: TT1, TT2
Source: Health Protection Agency / EPI program

Table 12 Gross Domestic Product (at constant prices), by kind of activity, 2003-201BY KIND OF ACTIVITY, 2003 - 2012

ISIC	Industry / Economic Activity	(In Million MVR , at 2003 constant prices) Estimates									
		2003	2004	2005	2006	2007	2008	2009	2010	20111_/	20121_/
	GDP at basic price	12,158.3	13,675.8	12,489.4	14,935.5	16,512.2	18,526	17,853.0	19,113.2	20,351.0	20,621.8
	Primary	727.4	742.3	786.2	820.8	722.9	698.3	681.1	675.2	682.3	682.0
A & C	Agriculture and mining	314.5	327.7	300.1	331.4	341.4	344.8	336.9	350.6	361.2	363.2
B	Fisheries	412.9	414.5	486.1	489.4	381.5	353.5	344.3	324.6	321.0	318.8
	Secondary	1,680.6	2,203.1	2,431.0	2,680.8	3,284.8	3,597.4	2,657.4	2,771.5	3,107.8	3,143.7
D	Manufacturing	716.6	824.4	793.1	849.3	894.1	1,016.5	814.9	759.0	780.1	815.8
	fish preparation	370.2	446.1	478.2	497.9	494.0	595.8	452.5	377.0	372.9	404.7
E	Electricity and water supply	254.0	290.4	339.7	382.8	439.9	502.8	539.8	588.6	633.5	654.3
F	Construction	710.0	1,088.2	1,298.3	1,448.8	1,950.8	2,078.1	1,302.8	1,423.9	1,694.3	1,673.6
	Tertiary	10,005.4	10,993.8	9,477.3	11,659.6	12,729.0	14,446.1	14,689.9	15,864.9	16,783.2	17,022.1
G	Wholesale and retail trade	456.7	565.6	608.6	702.8	762.5	862.7	765.4	770.0	850.1	907.0
H	Tourism (Resorts, etc)	3,929.0	4,488.1	2,971.5	4,287.6	4,704.3	4,870.0	4,608.1	5,335.4	5,824.6	5,820.2
I	Transport	1,013.6	1,169.8	1,043.5	1,319.4	1,436.6	1,521.3	1,539.8	1,800.9	1,926.9	1,893.9
I	Communication	762.2	782.1	808.6	965.8	1,113.6	1,446.7	1,769.9	1,803.1	1,954.2	2,045.3
J	Financial services	337.3	391.6	343.0	424.6	475.3	513.0	488.0	512.4	527.8	530.5
K	Real Estate	1,614.4	1,638.2	1,598.7	1,608.3	1,587.9	1,519.1	1,517.0	1,568.3	1,596.9	1,617.8
K	Business services	142.5	165.5	145.0	179.4	200.9	216.8	207.7	216.7	224.0	225.2
L	Government Administration	1,061.4	1,090.5	1,214.5	1,323.3	1,481.7	2,047.0	2,251.8	2,290.0	2,279.0	2,345.1
M	Education	395.6	391.2	406.6	468.9	513.9	740.7	796.3	812.7	836.4	862.8
N	Health	175.6	188.8	205.0	239.4	304.5	494.2	564.4	571.9	577.7	583.8
O	Social services	117.1	122.5	132.4	140.1	147.9	214.7	181.4	183.6	185.7	190.5
	Fisim	-255.13	-263.31	-205.03	-225.57	-224.48	-215.35	-175.48	-198.36	-222.24	-226.06

Memorandum items:

Item	2003	2004	2005	2006	2007	2008	2009	2010	20111_/	20121_/
Mid-Year Population (inclusive of expatriates)	318,831	327,893	338,591	354,367	374,944	390,414	384,801	393,578	406,359	419,998
GDP at 2003 constant prices (Million US$)	949.9	1,068.4	975.7	1,166.8	1,290.0	1,447.4	1,394.8	1,493.2	1,589.9	1,611.1
GDP per capita at 2003 constant prices (MVR)	38,134	41,708	36,886	42,147	44,039	47,453	46,395	48,563	50,081	49,100
GDP per capita at 2003 constant prices (US$)	2,979.2	3,258.4	2,881.8	3,292.7	3,440.6	3,707.3	3,624.6	3,794.0	3,912.6	3,835.9
GDP per capita at 2003 constant prices (PPP$)	4,489.4	4,910.1	4,342.5	4,961.8	5,184.6	5,586.5	5,462.0	5,717.1	5,895.9	5,780.3

Note:
Published in October 2013
1_/ Revised in October 2013
MVR 8.4942617 per PPP$ (2003)
Source: Department of National Planning

Table 13 Dependency Ratio, 2006

Indicators	Census Year				
	1985	1990	1995	2000	2006
Dependency ratio	99	99	98	81	57
Young Dependency	-	94	92	74	50
Old Dependency	-	5	6	7	7

Source : Census 2006
Department of National Planning

Table 13 Dependency Ratio, 2006

Locality, sex & age	Total 15 years of age & over	Economically active			Not economically active	Not stated	Labour force participation rate	Unemployment rate
		Total	Employed	Unemployed[1]				
Republic								
Both Sexes	205,931	128,836	110,231	18,605	63,642	13,453	62.6	14.4
15-19	39,904	14,055	9,913	4,142	23,730	2,119	35.2	29.5
20-24	34,809	25,420	20,802	4,618	7,932	1,457	73.0	18.2
25-29	24,581	18,379	16,056	2,323	5,187	1,015	74.8	12.6
30-34	20,635	15,559	13,896	1,663	4,211	865	75.4	10.7
35-39	18,174	13,697	12,193	1,504	3,740	737	75.4	11.0
40-44	15,871	11,944	10,608	1,336	3,270	657	75.3	11.2
45-49	13,569	10,346	9,132	1,214	2,709	514	76.2	11.7
50-54	7,936	5,892	5,267	625	1,756	288	74.2	10.6
55-59	5,859	4,192	3,795	397	1,469	198	71.5	9.5
60-64	5,566	3,500	3,171	329	1,888	178	62.9	9.4
65+	13,944	5,847	5,393	454	7,718	379	41.9	7.8
Not stated	5,083	5	5	0	32	5,046	0.1	0.0
Male	103,634	75,682	69,701	5,981	20,648	7,304	73.0	7.9
15-19	20,155	7,730	5,819	1,911	11,366	1,059	38.4	24.7
20-24	16,933	14,022	12,579	1,443	2,200	711	82.8	10.3
25-29	11,915	10,563	9,933	630	837	515	88.7	6.0
30-34	10,022	9,104	8,732	372	505	413	90.8	4.1
35-39	8,780	8,075	7,764	311	375	330	92.0	3.9

Table 13 cont.

40-44	7,828	7,176	6,903	273	362	290	91.7	3.8
45-49	6,872	6,285	6,002	283	365	222	91.5	4.5
50-54	4,147	3,692	3,514	178	314	141	89.0	4.8
55-59	3,046	2,618	2,479	139	335	93	85.9	5.3
60-64	2,852	2,240	2,096	144	526	86	78.5	6.4
65+	7,790	4,174	3,877	297	3,448	168	53.6	7.1
Not stated	3,294	3	3	0	15	3,276	0.1	0.0
Female	102,297	53,154	40,530	12,624	42,994	6,149	52.0	23.7
15-19	19,749	6,325	4,094	2,231	12,364	1,060	32.0	35.3
20-24	17,876	11,398	8,223	3,175	5,732	746	63.8	27.9
25-29	12,666	7,816	6,123	1,693	4,350	500	61.7	21.7
30-34	10,613	6,455	5,164	1,291	3,706	452	60.8	20.0
35-39	9,394	5,622	4,429	1,193	3,365	407	59.8	21.2
40-44	8,043	4,768	3,705	1,063	2,908	367	59.3	22.3
45-49	6,697	4,061	3,130	931	2,344	292	60.6	22.9
50-54	3,789	2,200	1,753	447	1,442	147	58.1	20.3
55-59	2,813	1,574	1,316	258	1,134	105	56.0	16.4
60-64	2,714	1,260	1,075	185	1,362	92	46.4	14.7
65+	6,154	1,673	1,516	157	4,270	211	27.2	9.4
Not stated	1,789	2	2	0	17	1,770	0.1	0.0
Malé								
Both Sexes	78,729	43,776	38,971	4,805	26,392	8,561	55.6	11.0
15-19	15,656	4,998	3,522	1,476	9,666	992	31.9	29.5
20-24	15,535	10,101	8,693	1,408	4,466	968	65.0	13.9
25-29	10,176	7,206	6,660	546	2,339	631	70.8	7.6
30-34	8,137	5,789	5,428	361	1,850	498	71.1	6.2
35-39	6,616	4,661	4,375	286	1,538	417	70.5	6.1
40-44	5,529	3,730	3,488	242	1,446	353	67.5	6.5
45-49	4,394	2,902	2,673	229	1,196	296	66.0	7.9
50-54	2,601	1,666	1,569	97	767	168	64.1	5.8
55-59	1,863	1,122	1,042	80	631	110	60.2	7.1
60-64	1,520	738	695	43	691	91	48.6	5.8
65+	2,790	863	826	37	1,795	132	30.9	4.3
Not stated	3,912	0	0	0	7	3,905	0.0	NA

Table 13

cont.

Male	39,248	26,883	24,902	1,981	7,712	4,653	68.5	7.4
15-19	7,457	2,763	1,990	773	4,212	482	37.1	28.0
20-24	7,401	5,597	5,015	582	1,331	473	75.6	10.4
25-29	5,054	4,271	4,063	208	465	318	84.5	4.9
30-34	4,089	3,597	3,478	119	247	245	88.0	3.3
35-39	3,381	3,042	2,963	79	144	195	90.0	2.6
40-44	2,731	2,432	2,369	63	134	165	89.1	2.6
45-49	2,207	1,949	1,894	55	123	135	88.3	2.8
50-54	1,415	1,204	1,171	33	121	90	85.1	2.7
55-59	987	811	784	27	121	55	82.2	3.3
60-64	752	544	527	17	163	45	72.3	3.1
65+	1,361	673	648	25	648	40	49.4	3.7
Not stated	2,413	0	0	0	3	2,410	0.0	NA
Female	39,481	16,893	14,069	2,824	18,680	3,908	42.8	16.7
15-19	8,199	2,235	1,532	703	5,454	510	27.3	31.5
20-24	8,134	4,504	3,678	826	3,135	495	55.4	18.3
25-29	5,122	2,935	2,597	338	1,874	313	57.3	11.5
30-34	4,048	2,192	1,950	242	1,603	253	54.2	11.0
35-39	3,235	1,619	1,412	207	1,394	222	50.0	12.8
40-44	2,798	1,298	1,119	179	1,312	188	46.4	13.8
45-49	2,187	953	779	174	1,073	161	43.6	18.3
50-54	1,186	462	398	64	646	78	39.0	13.9
55-59	876	311	258	53	510	55	35.5	17.0
60-64	768	194	168	26	528	46	25.3	13.4
65+	1,429	190	178	12	1,147	92	13.3	6.3
Not stated	1,499	0	0	0	4	1,495	0.0	NA
Atolls								
Both Sexes	127,202	85,060	71,260	13,800	37,250	4,892	66.9	16.2
15-19	24,248	9,057	6,391	2,666	14,064	1,127	37.4	29.4
20-24	19,274	15,319	12,109	3,210	3,466	489	79.5	21.0
25-29	14,405	11,173	9,396	1,777	2,848	384	77.6	15.9
30-34	12,498	9,770	8,468	1,302	2,361	367	78.2	13.3
35-39	11,558	9,036	7,818	1,218	2,202	320	78.2	13.5
40-44	10,342	8,214	7,120	1,094	1,824	304	79.4	13.3
45-49	9,175	7,444	6,459	985	1,513	218	81.1	13.2

Table 13
cont.

50-54	5,335	4,226	3,698	528	989	120	79.2	12.5
55-59	3,996	3,070	2,753	317	838	88	76.8	10.3
60-64	4,046	2,762	2,476	286	1,197	87	68.3	10.4
65+	11,154	4,984	4,567	417	5,923	247	44.7	8.4
Not stated	1,171	5	5	0	25	1,141	0.4	0.0
Male	64,386	48,799	44,799	4,000	12,936	2,651	75.8	8.2
15-19	12,698	4,967	3,829	1,138	7,154	577	39.1	22.9
20-24	9,532	8,425	7,564	861	869	238	88.4	10.2
25-29	6,861	6,292	5,870	422	372	197	91.7	6.7
30-34	5,933	5,507	5,254	253	258	168	92.8	4.6
35-39	5,399	5,033	4,801	232	231	135	93.2	4.6
40-44	5,097	4,744	4,534	210	228	125	93.1	4.4
45-49	4,665	4,336	4,108	228	242	87	92.9	5.3
50-54	2,732	2,488	2,343	145	193	51	91.1	5.8
55-59	2,059	1,807	1,695	112	214	38	87.8	6.2
60-64	2,100	1,696	1,569	127	363	41	80.8	7.5
65+	6,429	3,501	3,229	272	2,800	128	54.5	7.8
Not stated	881	3	3	0	12	866	0.3	0.0
Female	62,816	36,261	26,461	9,800	24,314	2,241	57.7	27.0
15-19	11,550	4,090	2,562	1,528	6,910	550	35.4	37.4
20-24	9,742	6,894	4,545	2,349	2,597	251	70.8	34.1
25-29	7,544	4,881	3,526	1,355	2,476	187	64.7	27.8
30-34	6,565	4,263	3,214	1,049	2,103	199	64.9	24.6
35-39	6,159	4,003	3,017	986	1,971	185	65.0	24.6
40-44	5,245	3,470	2,586	884	1,596	179	66.2	25.5
45-49	4,510	3,108	2,351	757	1,271	131	68.9	24.4
50-54	2,603	1,738	1,355	383	796	69	66.8	22.0
55-59	1,937	1,263	1,058	205	624	50	65.2	16.2
60-64	1,946	1,066	907	159	834	46	54.8	14.9
65+	4,725	1,483	1,338	145	3,123	119	31.4	9.8
Not stated	290	2	2	0	13	275	0.7	0.0

1 Unemployed persons are those seeking and available for work during the census reference period. Persons who were not working during the census reference period for the reasons "unable to find a suitable employment" and "lack of employment opportunities" were classified as unemployed, even though they were not seeking and available for work.
NA: Not available
Source : Census 2006, Department of National Planning

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