WHO
Country Cooperation Strategy
2007-2011

Republic of Maldives

World Health Organization
Country Office for Maldives

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Country Cooperation Strategy
2007–2011

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Country Office for Maldives
Malé

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Preface

The collaborative activities of the World Health Organization (WHO) in the South-East Asia (SEA) Region are in support of efforts to improve the health status of the population in its Member States. Country Cooperation Strategies (CCS) identify how WHO can best support health development in its Member States.

In the case of Republic of Maldives, the previous CCS was implemented starting in 2002. Since then many changes have taken place in the country, in terms of the health situation, the government's own health development efforts and those of its key partners. Furthermore, the tsunami in late December 2004 had an extensive impact on the work of WHO. The Maldives Country Office (CO) has now developed a new CCS reflecting these changes, covering the period 2007–2011.

An analysis of the current health situation, likely health scenario in the next five years and the new priorities of the Ministry of Health, identified in its Health Master Plan 2006-2015, form the basis for the priorities outlined in this CCS.

We appreciate the inputs and suggestions from the Ministry of Health, key health experts and our health development partners in the country, especially those in the United Nations Country Team. This consultative process will help ensure that WHO's inputs provide the maximum support to health development efforts in Maldives.

To help achieve the objectives of this CCS, we recognize the importance of a strong WHO Country Office working closely with key counterparts who are familiar with local conditions. In addition, since the CO is small, support from both the Regional Office and Headquarters is essential to assist the CO in implementing this CCS. The Regional Office is fully committed to support both the Ministry of Health and the Country Office to achieve these objectives.

I would like to thank all those who have contributed to developing this Country Cooperation Strategy. Our joint efforts should be aimed at achieving the maximum health benefits for the people of the Republic of Maldives.

Samlee Plianbangchang

Samlee Plianbangchang, M.D., Dr.P.H.
Regional Director

Foreword

The Republic of Maldives has made remarkable strides in human development in the period following the formulation of the first Country Cooperation Strategy (CCS) in 2002. Substantial progress has been made since then in the health situation. The tsunami of December 2004 had a major impact not only on the landscape but also on the overall development of the country. Therefore, the need was felt for a new CCS to reflect these changes in the country.

The tsunami exposed the inherent acute vulnerability of Maldives to natural disasters as well as the obstacles on the road to achieving sustainable development. The social and economic development of recent years was undone or reversed in many islands and the resilience levels of Maldivian people were severely tested by the enormity of the tsunami. The people of Maldives have now recovered from the shock and committed themselves again to live better and safer lives.

Maldives has made considerable progress in the achievement of the health-related Millennium Development Goals, especially in the area of child and maternal mortality. The focus on prevention and on the public health aspects of health service, together with access to primary health care at the level of the individual islands remain the main factors contributing to these achievements. Nevertheless, the remoteness of some islands and the difficult and costly transportation makes it a challenge to sustain these achievements in the area of child and maternal health.

Maldives has also achieved remarkable successes in communicable disease control. Malaria was eradicated in 1984, leprosy and filaria have been reduced to elimination levels and tuberculosis remains under control. High immunization coverage has ensured the low prevalence or elimination of vaccine-preventable diseases. No transmission of the indigenous wild polio virus has been reported since 1981 and neonatal tetanus has been eliminated. However, the real test will be to sustain these achievements over time.

The Ministry of Health must also meet the challenge of providing equitable services to populations scattered over many islands. The reorganization of the health system, with the introduction of atoll hospitals and placement of doctors at health centres, has enabled increased access to curative services for the island communities. This, however, has led to a shift in health services from preventive and public health-oriented to the curative. The logistical problems to provide the services include infrequent transport links and high operational costs. Providing curative services at the island level has almost doubled the cost of health services delivery.

Maldives is in a period of transition in health-care financing. The government is committed to establishing a universal health insurance scheme for its entire population. It is envisaged that universal coverage will be achieved over different stages of implementation, starting with the introduction of a health insurance scheme for government employees and their dependants. Expansion of either public or private health insurance would then cover private-sector employees and their dependants and, subsequently, the rest of the population.

New priorities of the Ministry of Health have been identified in the Health Master Plan 2006-2015. This and other development policy priorities in the country's Vision 2020 have been taken into consideration in finalizing this CCS. The main purpose of this document is to outline priority areas for the work of the World Health Organization in Maldives. Eight major priority areas of work were identified after a comprehensive review of the epidemiological and health situation of the country through a series of consultations with key stakeholders and partners in health. This process also helped review past and current cooperation between WHO and its partners and has provided an opportunity to look ahead at future challenges in the coming five years.

As the WHO Representative to Maldives, it is my pleasure to present this document to the Ministry of Health and the other ministries and development partners concerned. I fully endorse the priority areas identified and am confident that in focusing our work on these WHO will continue to provide the greatest possible contribution to the development of health in the Republic of Maldives.

Dr J.M. Luna
WHO Representative, Maldives

Executive Summary

- The WHO Country Office-Maldives developed its first Country Cooperation Strategy (CCS) in 2000. Since then, substantial progress has been made in the health situation. Moreover, the country context has changed, thus the need of the CCS to be updated.
- The Republic of Maldives has enjoyed decades of relative political and social stability, and economic growth until the end of the twentieth century. However, social tensions have increased in recent years because of unresolved developmental issues. In order to address these challenges His Excellency President Maumoon Abdul Gayoom launched his Reform Agenda in June 2005 and later, in 2006, elaborated a road map to implement it.
- In this climate of reform, there has been an increased demand from the public for services and the government has been challenged to meet the expectations. An area of increasing concern is the rising cost of health care and inequitable access to services. The government has initiated a health insurance scheme this year and has taken steps towards introducing a social security net.
- Being a small island developing nation, Maldives faces special challenges. These include climate change and rise in sea level, beach erosion, high dependency on imported oil, foods and essential daily goods, oil pollution of marine life, over-reliance on tourism development for economic growth, migratory fish stocks and the seasonal nature of fisheries.
- While women in Maldives are at par with men in areas such as life expectancy, literacy and access to primary education, empowerment continues to be constrained in some areas, with low participation in the labour force.
- The Maldivian population is characterized by a very large population of youth, adolescents and children, with about 60% of the population under the age of 24. According to the 2006 census, population growth is 1.7%. This young age structure has profound implications for social services delivery, employment, urbanization and other development issues for decades to come.
- Substance abuse has become a serious threat to the young population of the country and evidence points to increasing numbers of intravenous drug users, which could lead to a sudden increase in the number of HIV/AIDS cases.
- Maldives has seen a rapid increase in the number of medical personnel in the last 10 years. The establishment of the Indira Gandhi Memorial Hospital (IGMH) in 1995, the expansion of regional hospitals, the introduction of

atoll hospitals and the recruitment of doctors to health centres and some health posts saw an influx of medical personnel. In 2005 there were 379 doctors including specialists. This represents a ratio of 1:775 practicing doctors per population. However, 77% of the doctors are expatriates and only 14 of the local doctors are working in the atolls out side of Malé.

- Training of nurses and other paramedical staff is on the increase through the Faculty of Health Sciences. However, they still do not surpass the number of expatriates working in these areas. All community health workers in the public health fields are locals.
- At the end of 2005, the bed capacity in the country was 784, representing one hospital bed for 375 people.
- The government policy on health expenditure has remained steady for the past decade. The expenditure on health (as a percentage of the national budget) was 11.26% in 1996 and 9% in 2005 (or about 7% of GDP). While this appears to be a minor decline, the actual amount allocated (rufiyaa per capita) has increased considerably, from Rf 221 million (US$ 17.3 million) in 1999 to 390 million (US$ 30.6 million) in 2005. The per capita health expenditure increased from 975 rufiyaa (US$ 76.5) in 1999 to 1731.1 rufiyaa (US$ 135.8) by 2005[1].
- During the last 10 years Maldives has achieved commendable progress in reducing child mortality. The infant mortality rate decreased from 34 per 1000 live births in 1990 to 12 per 1000 live births by 2005. Nevertheless, more needs to be done in the area of newborns which, it is estimated, contributes to 60% of the IMR. The under-five mortality rate for 1000 live births by 2005 was 16 compared to around 48 in 1990 and 30 in 2000 showing it has reached the level of the Millennium Development Goals (MDGs), but still leaving newborn mortality as a challenge that needs to be overcome.
- Maldives appears to have already achieved the MDG target 6 to reduce maternal mortality. However, there are challenges to ensure the sustainability of this target. Maternal death audit reports and the introduction of atoll hospitals with a specific focus on maternal health (through emergency obstetric care) have contributed significantly to this achievement.
- Focus on prevention and public health aspects of health service together with access to primary health care at island level remain the main contributing factors to the above achievements. The high level of literacy and community participation were the other significant contributors. Nevertheless, the remoteness of some islands as well as the difficulty and high cost of transportation pose a challenge to sustain these achievements in the area of child and maternal health.

- Maldives has achieved remarkable success in communicable disease control. Malaria was eradicated in 1984, leprosy and filaria have been reduced to elimination levels and tuberculosis is under control. High immunization coverage has ensured low prevalence or elimination of the EPI-targeted diseases. No transmission of indigenous wild polio virus has been reported since 1981, and neonatal tetanus has been eliminated. However, a major challenge would be to sustain these achievements over time.
- Under-nutrition is an issue. The 1994 National Nutrition Survey estimated underweight as measured by two standard deviations below the universal weight for age measurements to be 43%. The 2004 Vulnerability and Poverty Assessment (VPA) showed that the figure had decreased to 31%.
- WHO assistance to the country amounts to approximately US$ 2 million per biennium, of which around 50% goes to support office operational costs, and the remaining 50% for country activities, covering the following programme areas:
  (1) Essential health interventions
  (2) Health policies, systems and products
  (3) Determinants of health
  (4) Enabling programme delivery
- Since the first Health Master Plan (HMP) 1996-2005 was developed in 1995, there have been shifts in the responsibilities of the organizational sections and units that implement the programmes. There have also been new developments in the area of health as well as on new emerging issues such as SARS, avian flu and the risk of a human influenza pandemic.
- New priorities of the Ministry of Health (MoH) have been identified in the Health Master Plan 2006-2015. This and other developmental policy priorities in Vision 2020 of the country offer WHO a potential role to support policy relevant to four strategic directions and six core functions, and promote appropriate technologies to implement health sector reforms in the country. Thus, the time is opportune for WHO to initiate a consultative process to revise and adapt its CCS to be in tune with the present context of Maldives. Proposed priority areas for the WHO Country Cooperative Strategy for the period 2007 to 2011 include the following:
  (1) Strengthening health systems, including human resource development
  (2) Integrated communicable disease surveillance
  (3) Noncommunicable diseases, mental health and health promotion
  (4) Newborn health
  (5) Emergency preparedness and response

(6) Food safety

(7) Environmental health

(8) Information and research

- Implementing the CCS will require some realignment of staff in the WHO Country Office to ensure adequate support to the proposed priority areas. In addition, since the Maldives Country Office is small, there must be sufficient support from both the Regional Office and Headquarters to implement the proposed CCS priority areas. Finally, resource mobilization efforts will be undertaken to obtain voluntary contributions to those programmes where WHO Regular Budget funds are inadequate to provide the required level of support from WHO.

1

Introduction

The formulation of WHO Country Cooperation Strategies (CCS) started in 1999 using the approach of learning by doing. The strategies were later refined and published in two reports on improving WHO's work at country level presented to the WHO Executive Board (EB) in January 2000[2] and 2003[3].

Following the guidance provided in the WHO-Corporate Strategy (WHO-CS) presented by the Director-General (DG) to the WHO Executive Board in 1998, in May-June 2000 a mission visited Maldives to evaluate the WHO collaborative programme and identify key national priority issues in which WHO had a comparative advantage of fulfilling its normative core functions under the then-new strategic directions. The mission jointly identified nine priority areas which were incorporated in the WHO CCS for Maldives. The nine areas were: inadequate human resources for health; increased public health demands on health delivery; high maternal mortality rate; environmental health; nutrition; food safety; increased burden of diseases; health promotion; and development of health sector reforms. These priority areas also matched the country Health Master Plan 1996-2005 and were used for planning and implementation of the 2002/03 and 2004/05 WHO Country Programme Budgets.

Since the Health Master Plan (HMP) was developed in 1996, there have been shifts in responsibility of the sections and organizations that implement the programmes. There have also been new developments in the area of health as well as on new emerging issues such as SARS, avian flu and the risk of a human influenza pandemic. Finally, MoH is now finalizing its new cycle of the Health Master Plan (HMP) 2006-2015. The new CCS would attempt, as much a possible, to contribute to achieving the HMP goals, and will look closely at how this approach has impacted on the progress of HMP goals as well as the seventh National Development Plan (NDP) and the MDGs.

The need for a new CCS

Maldives made great strides in human development in the period following the formulation of the first CCS. Most of the targets set during the CCS process have been achieved and thus, in the new CCS, one would have expected to set higher targets, were it not for the tsunami, which had a big impact not only on the landscape but also on the development of the country.

On the fateful and catastrophic 26 December 2004, one out of every three residents was affected by the tsunami. More than 29 000 residents were displaced and 12 000 lost their homes. Homes, schools and hospitals were damaged on 69 out of the 199 inhabited islands. Livelihoods were lost. The damage amounted to more than 60% of GDP.

The tsunami exposed the inherent special vulnerability of Maldives and the obstacles to sustainable development faced by the country. The social and economic development was totally shattered in many islands and the resilience of the Maldivian society was severely tested. The people have recovered from the shock and are committed to live better and safer lives than before. The economy is improving and the tourists are back. Yet, it will take time to assess the full magnitude of the impact of the tsunami on human development and where the country stands in achieving the MDGs.

In the area of health, about 30 facilities (including one regional hospital, two atoll hospitals, eight health centres and 11 health posts) were damaged to varying degrees. Infrastructural damage occurred in some health facilities, and essential medical equipment and supplies were destroyed in almost all of these facilities.

With ongoing political reforms and increased political awareness, people are exercising their democratic rights and there is more demand for better services, challenging the government to meet their expectations. There is a wide network of health care outlets, but they are often challenged to meet quality standards. Emerging diseases like dengue fever are taking a heavy toll with consequent increasing concerns from the tourist sector (although this has not shown signs of any decline). The cost of health care is a major issue. The government has initiated a health insurance scheme this year covering all government employees and has also taken steps towards introducing a social security net.

The UN Development Assistance Framework (UNDAF) is geared to coordinate the efforts of the UN system at the country level in order to assist the government to achieve the global targets of the eight Millennium Development Goals (MDGs) for 2015. The government's Vision 2020 and the recently finalized Seventh National Development Plan will provide the overall framework for the UNDAF. This will encourage public participation and partnership and will pay particular attention to the social dimensions of adjustment, prioritizing democratic governance and basic rights. Traditional indicators fail to capture the true vulnerability of Maldivians, the insecurity of the population and the extraordinary challenges for ensuring sustainable human development. The people of Maldives remain extremely vulnerable both environmentally and geophysically, and there is considerable poverty in the outer atolls as well as in Malé. Six areas have been identified as part of the 2006-2010 UNDAF Result Matrices which is being finalized by the UN Country Team. WHO has actively participated in the UNDAF process and the areas where WHO exercises comparative

advantage have been identified in order to reflect the UNDAF output where WHO will be able to contribute ("The UN system will focus on supporting efforts to promote equitable access to comprehensive quality reproductive health and nutritional services for the most vulnerable and marginalized people, including HIV/AIDS information and services to high-risk groups").

With all these challenges, WHO Maldives needs to further review its Country Cooperation Strategy in order to harmonize the country priorities set in the seventh NDP and Health Master Plan 2006-2015 with the WHO (regional and organizational-wide) strategic orientation and priorities.

2

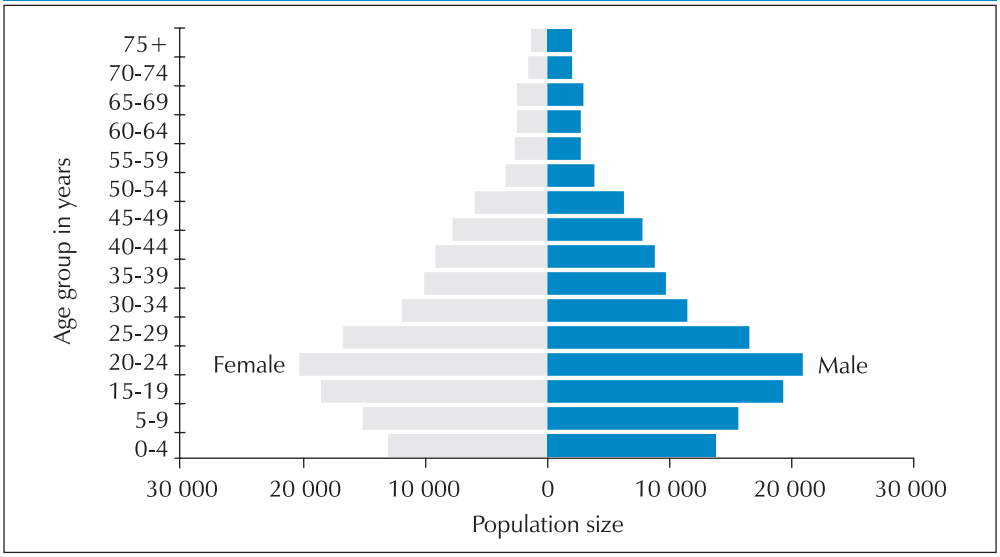
Country health and development challenges

Geography and population

Maldives is a group of atolls located southwest of the Indian subcontinent stretching 860 km north to south and 80-129 km east to west. In 2006 the population of Maldives was 300 000, with about 104 000 living on the island of Malé, the capital. The remaining two-thirds of the population are spread out over 198 islands.

As the economy has developed over the last two decades, the birth rate has decreased. The number of children under five years of age, estimated to be about 37 000 in 1995, decreased to about 26 000 in 2005 (see Figure 2.1). At the same time, the number of people aged 10-19 years has increased to nearly 80 000, or over 25% of the population.

Figure 2.1: Population pyramid of Maldives, 2005*



*Based on projected mid-year population.
Source: Maldives, Ministry of Planning and National Development, Statistical yearbook, 2006.

Economic development

Maldives has a narrow economic base relying on two key sectors: tourism and fishing. Despite this, the economy has been growing steadily with a GDP growth rate of 7.9%

over the last 15 years. Per capita income in 2004 was US$ 2514. The country was scheduled to graduate, over a three-year transition period, from LDC status at the end of 2004. However, it was plunged into a crisis following the tsunami of December 2004; because of the tsunami, graduation from LDC status has been deferred for an additional three years.

For Maldives, poverty reduction primarily means reducing regional disparities. Poverty in the country is related to remoteness of the islands from Malé and a lack of services in the atolls. The government continues to prioritize the promotion of regionally balanced economic growth, with benefits spread more widely and equitably. Actions to start a number of atoll development projects have been initiated and several projects have been implemented.

Maldives has achieved high levels of education and literacy. In 2004, literacy rates were estimated at over 97% for both males and females. Primary school attendance is 100% and lower secondary education has increased rapidly with the target of 10 years of education for all by 2020. Upper secondary school has lower attendance because high secondary education is available on only 14 islands.

Maldivian women enjoy higher social status and greater freedom than women in many countries, reflected in positive rankings in the Gender Development Index. While women are at par with men in many areas, such as life expectancy, literacy and access to primary education, their empowerment continues to be constrained in some areas, with low participation in the labour force and reduced opportunities in pursuing higher secondary and tertiary education.

The prevailing pattern of economic development, combined with the geography of Maldives and certain cultural factors, have marginalized women from participation in development. New avenues have opened up for men in the tourism sector, but this has not been the case for women. Increasing household incomes across the country also have enabled the reinforcement of roles of women as family caretakers and men as salary-earners.

Women's participation in decision-making remains low, and women account for only 12% of elected members of parliament. Traditional attitudes, low access to higher secondary and tertiary education and limited employment opportunities largely limit women to the unpaid tasks of family and community life. According to the 1998 Vulnerability Poverty Assessment (VPA), women head one in three households. Enactment of the Family Law 2001 is a milestone in promoting gender equality and protecting the rights of women and children in Maldives. The act incorporates a number of positive changes with regard to marriage, divorce and custody and establishes a legal minimum age at marriage of 18 years for men and women.

At the national level, continued efforts are being made to ensure women's role in development by mainstreaming gender concerns across all social and economic sectors.

Most significant in this regard are the preliminary steps taken to strengthen intersectoral collaboration by establishing the Gender Equality Council and gender focal points in all government ministries and departments.

Whereas Maldives has made substantial inroads in meeting the economic rights of the people, the challenge now is to ensure the protection of civil and political rights of its people. Of the seven main international treaties on human rights, Maldives is now signatory to six. Maldives signed the Convention on the Rights of the Child (CRC) in 1991 and Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1993. Within the context of political reforms, Maldives signed the Convention Against Torture (CAT) in 2005, International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) in 2006. These are important milestones for the country. Other important achievements include the introduction of political parties in Maldives, the opening up of the media, and the establishment of a human rights commission. Health issues and health rights are a key focus in the dialogue on political reforms. An overwhelming majority of the population rated health as the topmost human right in a human rights survey done in 2005. Also, despite the progress made by the health sector, the same survey also showed that a significant percentage of people (54.9%) were dissatisfied with access to health services, medicines and hospitals.

The Ministry of Gender and Family recently completed the data collection phase of the Study on Women's Health and Domestic Violence. Initial results showed that one in three Maldivian women aged 15-49 reported experiencing some form of physical or sexual violence at least once during their lifetime.

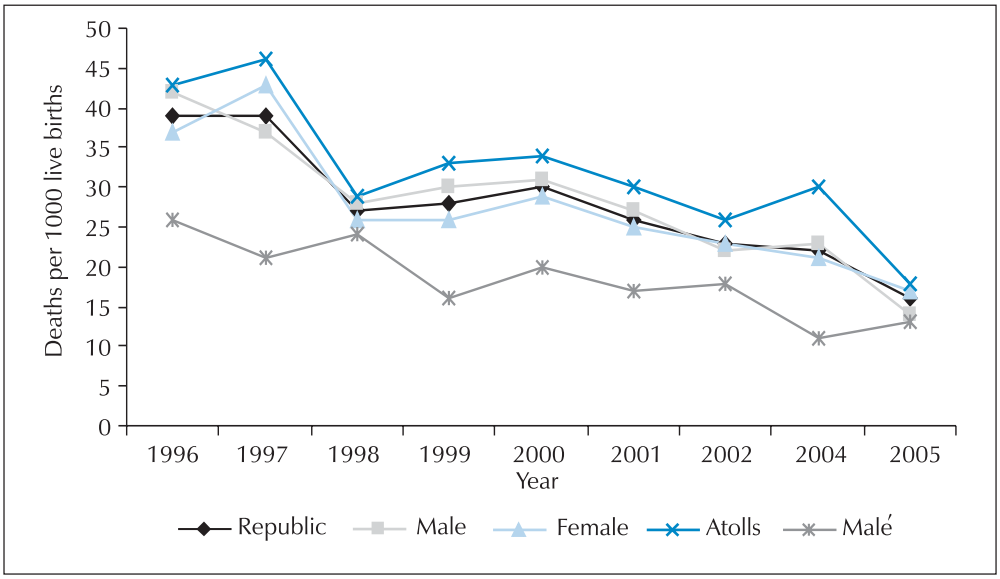
Recognizing gender-based violence as a public health issue, the Maldives tertiary hospital, the Indira Gandhi Memorial Hospital (IGMH), established the Family Protection Unit under the Department of Obstetrics and Gynaecology in August 2005. Since the completion of the pilot phase, the unit has become a permanent establishment providing medical examination, including forensic investigation, in-hospital, short-term counselling, and referral to outside agencies. The Unit has dealt with 85 cases of gender-based violence since August 2005.

Health of mothers and children

During the last ten years Maldives has achieved commendable progress in reducing child mortality and is on track to achieve the MDG target of reducing by two-thirds the under-five mortality rate of 1990 by 2015. The under-five mortality rate stood at 48 per 1000 live births in 1990. By 2005 the rate had been reduced to 16 per 1000 live births, which is within the MDG target for the year 2015[4] (see Figure 2.2). The decline in under-five mortality shows no difference between the rates between the sexes.

Achievements in reducing the infant mortality rate (IMR), closely related to child mortality, show significant progress over the past 15 years. IMR has been reduced from

Figure 2.2: Trends in under-five mortality rate in Maldives, by sex and atoll, 1996-2005



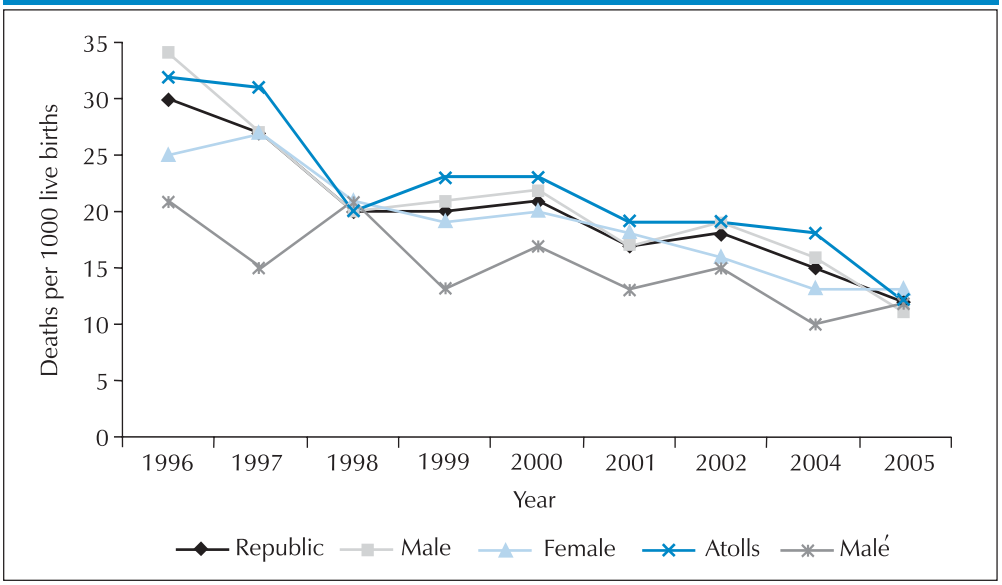
Source: Maldives, Ministry of Health, Vital Registration System, 2005.

34 per 1000 live births in 1990 to 12 per 1000 live births by 2005. Once again, it is a remarkable achievement that the difference between the IMR of girls and boys is relatively small (11/1000 compared to 13/1000). In addition, the gap in the rates between Malé and the atolls was eliminated by 2005 (see Figure 2.3). The key challenge is in reducing newborn deaths in Maldives (8/1000), which represent nearly 66% of infant deaths.

Maldives has already achieved the MDG target 6 (to reduce maternal mortality by three quarters by 2015 from the 1990 baseline). The 1990 baseline for maternal mortality ratio (MMR) was estimated to be 500 per 100 000 live births, although MMR figures were not reliable prior to 1997 when the maternal death audit was introduced. By 2005 the rate fell to 72 per 100 000 live births, well below the MDG target to reduce the MMR to 125 per 100 000 live births.

The policies that contributed to this achievement include: providing easy access to services for all groups of people; special emphasis on atoll populations and maternal health; focussing on awareness creation on high-risk pregnancies; antenatal and postnatal care; ensuring that all pregnant women receive a minimum of four antenatal checkups; and that all deliveries be conducted by skilled personnel. The 2005 routine vital statistics show that 64% of deliveries were conducted by doctors, 25% by nurses, 2% by health workers and 9% by traditional birth attendants. Nevertheless, the remoteness of some inhabited islands and difficulty in transportation remain a challenge to be addressed.

Figure 2.3: Trends in infant mortality rate in Maldives, by sex and atoll, 1996-2005



Source: Maldives, Ministry of Health, Vital Registration System, 2005.

Immunization

Maldives has sustained coverage levels of more than 90% for all vaccines. The impact of immunization is reflected in the reduced burden of vaccine preventable diseases: No case of indigenous wild poliovirus has been reported since 1981 and neonatal tetanus has been virtually eliminated, although measles remains sporadic and sometimes epidemic. In 2005, based on a 2003 Risk Assessment for Rubella Congenital Syndrome, a MR (measles-rubella) immunization campaign was launched targeting children 5-14 and women in childbearing ages, achieving more than 85% coverage. Measles, mumps and rubella (MMR) vaccine is to be introduced from 2007. Furthermore, the country has attained self-procurement of all EPI vaccines, thus further strengthening the immunization programme.

Nutrition

Surveys in 1994 and 1997 showed that 45-47% of children under-five were underweight as measured by weight-for-age. Although these rates fell to about 30% in surveys conducted in 2001 and 2004, a high proportion of children are still malnourished. Nevertheless, this does not seem to be a consequence of food shortages or poverty, but is likely due to feeding practices with infants and young children. It is estimated that only 18% of infants are breast-fed for six months[5] and the failure to introduce adequate complementary foods after that time may be the cause of poor growth in these children.

Communicable diseases

Maldives has achieved remarkable successes in communicable disease control. Malaria was eradicated in 1984, a unique achievement in the control of communicable disease for a South-East Asian country. Leprosy and lymphatic filariasis (LF) have been reduced to elimination levels. In 1995 the case fatality rate from tuberculosis stood at 5% and was reduced to zero by 2002. Tuberculosis remains under control although the overcrowding in Malé is still a major threat for the spread of this disease. High immunization coverage has ensured low prevalence or elimination of the EPI-targeted diseases. However, a major challenge is to sustain these achievements over time.

Although mortality due to diarrhoea and acute respiratory infections are extremely low, they continue to cause significant morbidity in children and adults. Dengue and scrub typhus have emerged as major communicable diseases of public health concern.

Maldives is a low-prevalence country for HIV/AIDS, with the first HIV-positive case reported in 1991. Since then there have been only 13 HIV-positive cases reported among Maldivians and 168 cases among expatriates. All infections were reportedly acquired through heterosexual transmission, despite the high level of drug use and the increasing popularity of injecting drug use. The main challenge is to ensure sustained low prevalence of HIV/AIDS in the country. Efforts are required to further strengthen the awareness programmes and to continuously measure their impact.

Substance abuse

There has been a growing concern about drug abuse among Maldivian youth. Different country reports and assessments indicate the presence of a high percentage (about 20%) of young drug abusers between 16 and 20 years of age. Opioids (primarily heroin or "brown sugar"), hashish oil and other cannabinoids are the most frequently seized and abused drugs.

Injection of drugs sometimes starts as early as 9-12 years of age (HIV/AIDS Assessment[6], DPH/MoH, WHO, UNICEF – 2006) with other studies showing the median age at which injecting drug use had been observed at 17 years. Although the 2003 Rapid Situation Assessment[7] reported that drug injecting was not common in the Maldives (~6% among drug users), the 2006 HIV/AIDS assessment estimates this at 20%.

Noncommunicable diseases

With the control of communicable diseases and lifestyle changes associated with development, chronic noncommunicable diseases have emerged as the main cause of mortality in the country. Cardiovascular diseases have become the major cause of death in the adult population, accounting for 25–30% of all deaths every year.

Maldives carried out the STEP Survey to collect risk-factor surveillance data for noncommunicable diseases. The major risk factors are tobacco use, high levels of

physical inactivity, low consumption of fruits and vegetables, prevalence of obesity and excess body fat, which together lead to conditions of cardiovascular diseases, hypertension, stroke, cancer, renal diseases and diabetes. Diabetes is emerging as one of the leading causes of morbidity, estimated to be as high as 6-8% of the population.

Also of concern is thalassaemia. It is estimated that 18-20% of the population is a carrier of the condition.

In addition, Maldives has a growing problem of accidents and injuries leading to death and disabilities. With the country becoming more and more industrialized, occupational health and safety will become an important issue.

Essential medicines

The government of Maldives is committed to a vision of safe, effective, high-quality essential medicines being available at affordable cost at all times to the entire population of Maldives. This commitment is emphasized in the Vision 2020, the Sixth National Development Plan 2001–2005, Health Master Plan 1996–2005, and the National Reproductive Health Strategy 2005–2007. Moreover, access to essential medicines is in line with governments commitments to reach the Millennium Development Goals. The National Medicine Policy was finalized in March 2007. The document contains guidance necessary for developing an uninterrupted supply of safe, effective and good quality essential medicines at affordable prices and promoting their rational use in the country. The three main goals of the National Medicine Policy for the Government of Maldives are:

(i) To ensure that all medicines authorized imported or locally manufactured, distributed and sold in Maldives are effective, safe and of good quality.

(ii) To ensure that adequate quantities of high-quality essential medicines, based on the needs of the population, are available at affordable cost at all times to the entire population.

(iii) To promote rational use of medicines.

Environment and health

There are several challenges to ensure environmental sustainability in Maldives. Some of these are related to the geography of the country, where the low elevation of islands makes them vulnerable to any rise in sea level. The depletion of freshwater aquifers, global warming and possibly related bleaching of the coral reefs and poor sanitation and pollution may all affect the health of the population.

Although mortality due to diarrhoea is extremely low, it continues to cause significant morbidity among children and adults, indicating inadequate access to safe

water and sanitation. Maldivians traditionally depended on shallow wells to provide access to the islands' freshwater lenses for drinking water. These lenses are susceptible to pollution. As a result of declining quality of water in many islands, high priority has been given to the construction of rainwater tanks and rainwater collection schemes. Now, many people rely on harvested rainwater for drinking purposes.

The national water supply coverage is 83% and sanitation is 59% of the total population[8]. In Malé, 100% of the population has access to an improved source of drinking water. The five wards of Malé have access to desalinated, treated piped water supplied by Malé Water and Sewerage Company. However, it has to be noted that desalinated water is extremely costly and the dependence on imported fuel for desalination is an issue that needs consideration from a sustainability perspective.

In the atolls only two islands have regular access to desalinated water. After the tsunami, an increasing number of desalination plants have been introduced. In future, communities may face the problem of not being able to afford the maintenance cost of these plants, and hence may be deprived of the water despite a plant having been established.

In Malé, all households are connected to a conventional gravity flow system with pumping stations to dispose the untreated sewage in the deep sea. Although the sanitation situation in the atolls has shown a marked improvement over the last 15 years, most households are still dependent on septic tanks. Ground water contamination from leakages caused by improper construction of septic tanks is a significant problem in the atolls.

Vulnerability and disaster preparedness

Being a small island developing nation, Maldives faces special challenges. These include climate change and sea level rise; high dependency on imported oil, food and other essential items; oil pollution of marine life; over-reliance on tourism development for economic growth; and migratory fish stocks and seasonal nature of fisheries.

Maldives is also vulnerable to tsunamis, cyclonic winds and, to some extent, earthquakes[9] as well as disease outbreaks and pandemics. In assessing the risk to individual island populations, physical vulnerability has been treated as a function of exposure concentration. Malé is the island with the highest risk, mainly because of its large population. This makes it especially vulnerable to outbreaks of communicable diseases (i.e., dengue, influenza).

The United Nations Development Programme (UNDP) has launched a Disaster Risk Management (DRM) Programme in Maldives following the tsunami for reducing future disaster risks and ensuring sustainable development. The programme aims to establish an institutional framework for disaster management. It is based on developing

multi-hazard preparedness and response plans at different levels and enhancing the relevant skills of disaster managers at different levels. The programme has a community-based approach to boost the local capacity to manage disasters effectively through identification and reduction of disaster risks.

Addressing climate change and sea level increase, protecting the coral reefs and preserving biological diversity are challenges of global significance. At the national level, supplying safe drinking water and meeting the reported shortages, providing adequate sanitation facilities to protect groundwater, management of solid wastes and mitigating the environmental impacts from coastal zone development remain key issues.

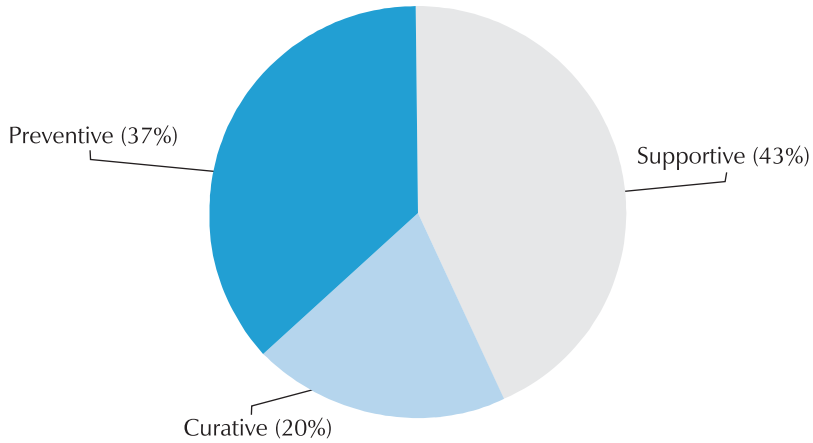
Health policies and financing

The government recognizes health as a human right and is committed to ensuring access to safe and effective primary health care to all citizens in an equitable manner at an affordable price. Government also recognizes that protection and promotion of health is central to the health and well-being of the population and action for health falls beyond the health sector. Thus, the government is committed to address the social determinants of health that facilitate an enabling environment that protects and promotes health and safety through action in all sectors and through legislation, including implementation of international agreements and Conventions such as the International Health Regulations 2005 and the Framework Convention on Tobacco Control.

The government's policy on health services has remained steady for the past decade, as reflected by the expenditure on health as a percentage of the national budget, which was 11.26% in 1996 and 9% in 2005 (provisional data). Health expenditures increased from Rf 221 million (US$ 17.3 million) in 1999 to 390 million (US$ 30.6 million) in 2004. The per capita health expenditure increased from 975 rufiyaa (US$ 76) in 1999 to 1731.1 rufiyaa (US$ 135.80) in 2005. Health expenditures have been roughly classified, functionally, as shown in Figure 2.4. It reveals that the largest share was for supportive services (administrative and logistic costs). Curative care consumed 20% while preventive services consumed 37%. These figures should be interpreted with caution since some of the support services and public health expenditure may still be classified into curative and vice versa.

Maldives is in a period of transition in health-care financing. At present, the main mode of financing is fee-for-service with out-of-pocket payments, which is considered an extremely regressive form of financing health-care. The government has mandated the Ministry of Higher Education, Employment and Social Security to formulate a scheme for government employees and their dependants (which started in the beginning of 2007), and to develop strategies to expand the scheme to include the general public in future.

Figure 2.4: Health expenditures in Maldives, by health service functions, 2004



Total health expenditure (Rufiyaa 390 million)

Sources: 1. Maldives, Health Report 2004.
2. Data obtained from MoH through WR Office.

The government already gives out medical allowances and has a provident fund that allows collection for medical purposes. Furthermore, a number of public and private companies have schemes that could easily be integrated to a national scheme of financing. In addition, the current government welfare scheme and the military medical provisions also provide great scope for such a scheme. During 2005, 3639 people of both sexes received welfare assistance for medical treatment within Maldives and 1488 for medical treatment abroad.

Health system

The major challenge for the Ministry of Health is the provision of services on an equitable basis to populations that are scattered over many islands. The reorganization of the health system with the introduction of atoll hospitals and placement of doctors at health centres has enabled increased access to curative services for the island communities. However, this has led to a shift in health services from preventive and public health services to curative services. The logistical problems associated with this provision of services include infrequent (and very costly) transport links and high operational costs. The provision of curative services at island levels has almost doubled the cost of health service delivery.

In 2006, the Ministry of Health formulated its second Health Master Plan (HMP), for the period 2006-2015. It sets out the following nine policy goals:

(1) To ensure people have the appropriate knowledge and practices to protect and promote their health.

(2) To ensure that safe and supportive environments are in place to promote and protect the health and well-being of the people.

(3) To prevent and reduce the burden of disease and disabilities.

(4) To reduce the disparities in the quality of life and disease burden.

(5) To ensure all citizens have equitable and equal access to health care.

(6) To ensure public confidence in the national health system.

(7) To build partnerships in health services.

(8) To ensure adequate and appropriate human resources for health service provision.

(9) To ensure the health system is financed by a sustainable and fair mechanism.

Based on these policy goals, the HMP highlights priority areas as follows:

- Health promotion and healthy environments
- Human Resources for Health
- Access to health services and medicines
- Nutritional disorders
- Noncommunicable and chronic diseases including mental health
- Quality of health care and services
- Communicable diseases of public concern
- Reproductive and maternal health
- Child and adolescent health
- Disaster and emergency preparedness and response
- Health information and research
- "Dhivehibeys" (Maldivian traditional medicine) and alternative forms of traditional medicine

Decentralization remains a major issue. In the HMP 2006-2015, the government is committed to provide a defined package of services for each level of the health system, utilizing the primary health care approach decentralized to the atoll level. To do this, there will be a need to develop policies and regulatory mechanisms for enabling the development of partnerships with NGOs and international institutions working in the country to ensure that the public and private sectors provide services that complement each other and are of good quality.

Finally, access to medicines remains a concern as pharmaceutical services in the country operate on a fully corporate basis by the private sector. Due to the small size and remoteness of the islands, the operation of private pharmacies at island level is not viable. These constraints have led to a decline in satisfaction of the community with the health services.

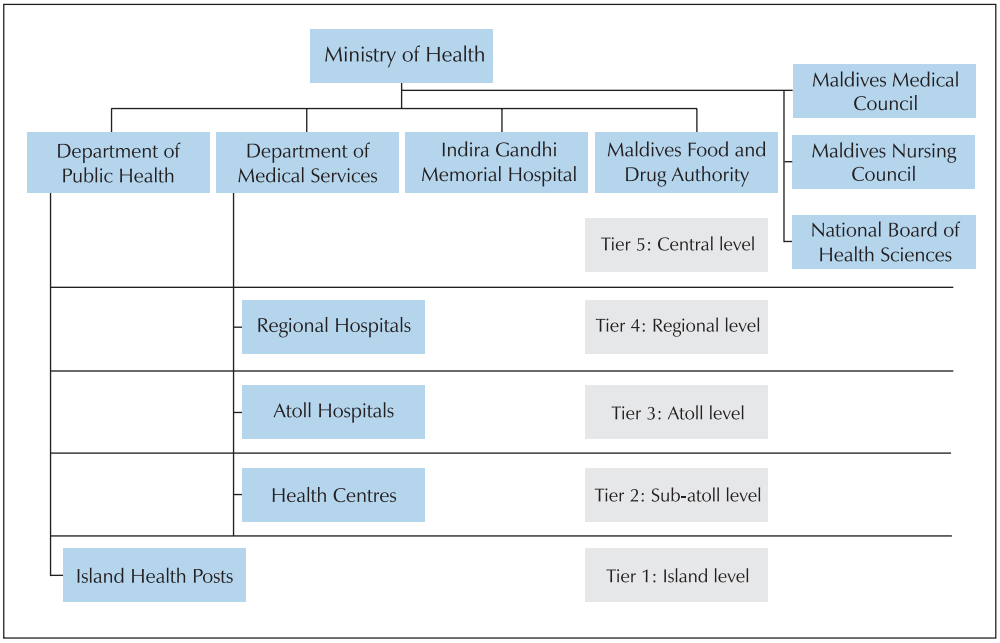
The health services are now structurally organized into a five-tier system. In a reorganization of the system in 2006, all curative facilities were brought under the purview of the newly created Department of Medical Services (IGMH being the lone exception). With this change, currently the Department of Public Health (DPH) is responsible for development and monitoring of all preventive health programmes and administratively responsible only for the health posts/family health sections in the islands. In a similar move, the curative services hitherto provided by the clinics in Malé under DPH which managed tuberculosis, malaria, filarial and leprosy cases, have been integrated into services of IGMH.

Central institutions functioning under the Ministry of Health include the DPH, the Department of Medical Services, the Maldives Food and Drugs Authority (MFDA) and IGMH. The National Thalassemia Centre (NTC) functions under the Department of Medical Services and the National Health Laboratory functions under MFDA. The Maldives Water and Sanitation Authority (MWSA), hitherto under the Ministry of Health, has been shifted to the Ministry of Environment Energy and Water.

Figure 2.5 shows the five tiers that form the structure of the health system in Maldives: The fifth level (Central Level) is the Ministry of Health, which is responsible for formulating overall health policy and health development plans and for monitoring and evaluating the health situation. The Department of Public Health is responsible for delivering preventive health programmes for the prevention and control of communicable diseases and for the promotion of health and well-being. It is also responsible for delivering basic health care (preventive, promotive, curative and rehabilitative) to the first level of the health system. The Department of Medical Services is responsible for organizing and delivering curative services to the regions, atolls and islands. IGMH delivers tertiary curative care, serving as the central referral hospital for the whole country. The MFDA is responsible for regulating and setting standards for pharmacies and laboratories. It also supervises the work of the National Health Laboratory.

At the fourth level are the regional hospitals. The six regional hospitals, each cater to a geographical region of two to five atolls, providing outreach services. They provide secondary-level curative services and, through public health units, also implement preventive health programmes. Curative services include major specialties including surgery, internal medicine, orthopaedics and paediatrics, supported by X-ray, laboratory, and ultrasound scanning facilities. The regional hospitals supervise the third- and second-

Figure 2.5: Organization of the health system



level health services. Public health units have dual control with administrative support coming from the hospital and technical support from DPH.

At the third level is the atoll hospital. The 13 hospitals (data as of December 2006) serve the population of the atolls where no regional hospital is available. Atoll hospitals represent a relatively recent addition to the hierarchy, upgraded from pre-existing health centres, with the aim of handling obstetric emergencies.

At the second level is the atoll health centre. Each atoll has one to six health centres. Their staff includes doctors for curative services and community health workers (CHWs) for preventive services. Upgraded with wards and labour rooms, many of them now offer a wide range of secondary care.

At the first level is the island health post. Staffed with family health workers (FHWs) and *foolhumaas* or traditional birth attendants (TBAs), they provide simple, curative and preventive services at the island level. Some HPs have one doctor.

All public health facilities have been graded based on the population utilizing the facility. The services (including clinical, laboratory and public health), infrastructure and staffing for each facility is defined.

A key challenge is the fact that implementation of preventive programmes has been weakened in the past ten years. This is mainly due to the human capacity

Table 2.1: *Health service outlets in the public sector**

Type	Number	Services
Tertiary referral hospital	1	Specialty and super-specialty services. Advanced imaging including CT scan, Automated laboratory services.
Regional hospitals	6	Major specialties. Basic imaging services. Automated laboratory services.
Atoll hospitals	13	Obstetric services including labor room and operation theater. Basic laboratory services.
Health centers	87	General consultation; basic laboratory services.
Health posts	29	Simple curative and preventive services.

*As of December 2006.
Source: Ministry of Health.

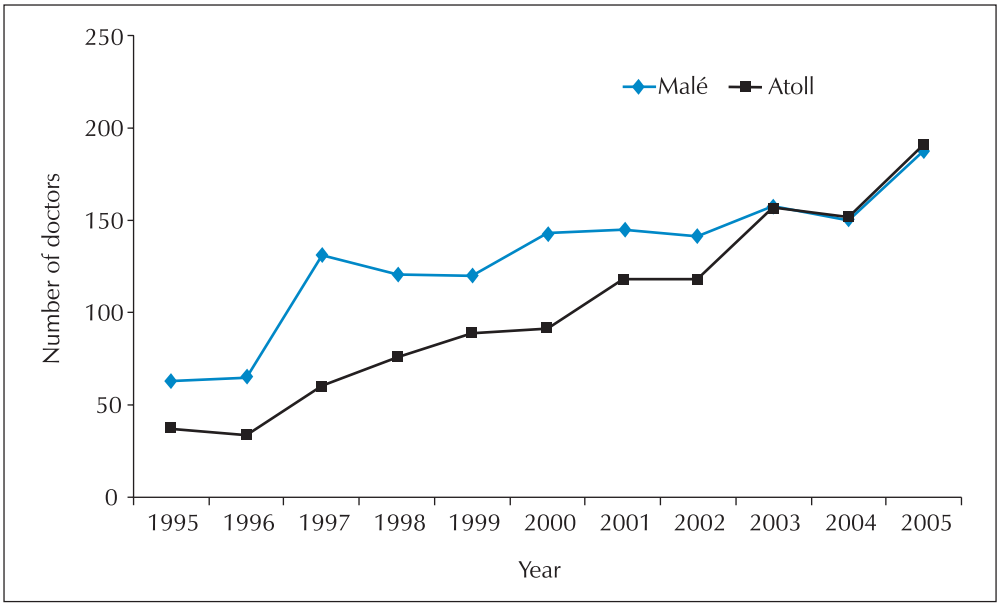
constraints in the public health fields. Vigorous efforts are needed to ensure that capacity is built, both at central and peripheral levels, in the area of prevention in order to sustain the implementation of proposed strategies to control communicable and noncommunicable diseases. The issue of underutilization of the atoll and regional health facilities also needs to be addressed.

Health workforce

Maldives has seen, in the last 10 years, a rapid expansion of medical services, which resulted in a sharp increase in medical personnel. The establishment of IGMH in 1995, the expansion of regional and atoll hospitals and the recruitment of doctors for health centres led to an influx of expatriate medical personnel rising by almost 56% between 1994 and 1999. In 2005 there were 379 medical doctors with a ratio of 1:775 practicing doctors per population. The number of nurses reached 974 with a ratio of 1 nurse per 302 population. The nurse-to-doctor ratio was about three nurses per doctor. The health workforce also included 454 paramedics, 119 community health workers, 333 family health workers and 409 traditional birth attendants.

Due to high dependence on expatriates (77% of the practicing doctors are expatriates), there is frequent discontinuation of services and differences in the provision of quality services between the different health facilities among the atolls and islands. There is a need to develop standard protocols and to strengthen the expatriate orientation and induction programme and include all doctors employed by the MoH in the in-service training as well. Another issue is the placement of local doctors at the atoll level outside the capital. Of the 85 local doctors (Maldivians) practicing in the country, only 14 are working outside Malé.

Figure 2.6: Number of doctors (public and private) working in Maldives, 1995-2005



Source: Maldives, Ministry of Health, 2006.

The local training of health personnel has been given major emphasis by the health sector and there is a need to continue to do that in order to address the issue of availability of the required health manpower, with proper skill mix. The Faculty of

Table 2.2: *Number of doctors and nurses in public and private sectors**

	Public sector				Private sector		Total
	Malé		Atolls				
	Expat.	Local	Expat.	Local	Expat.	Local	
All doctors	**89**	**71**	**176**	**14**	**27**	**2**	**379**
Doctors (MBBS)	49	31	124	12	15	1	232
Doctors (Specialist)	40	40	52	2	12	1	147
All nurses	**181**	**224**	**196**	**312**	**41**	**20**	**974**
Staff nurses	179	156	153	69	41	7	605
Nurse aides	2	68	43	243	0	13	369

*As of December 2005.
Source: Ministry of Health.

Health Science has played a major role in producing nurses, midwives and allied health personnel, which enable the health system to contribute to the remarkable improvement in the health of the people. The FHS was under the MoH till 2001, when it was moved to the College of Higher Education, which is currently under the Ministry of Higher Education. WHO support has been provided to revise some of the course curricula and there will be more support to upgrade the teaching capacity of teachers and to design and run long-term and short-term courses, in collaboration with MoH. Both the MoH and the Faculty of Health Science (FHS) expressed the need to get WHO support in organizing long and short courses for health managers.

Table 2.3: *Health workers trained by Faculty of Health Science, Malé, 2001-2005*

	2001	2003	2004	2005
All types	**67**	**203**	**175**	**183**
Diploma in Nursing and Midwifery	5	16	37	24
Diploma in Primary Health Care	0	6	11	14
Diploma in Medical Laboratory Technology	8	8	5	15
Community health worker	0	0	21	27
Auxiliary nurse midwife	0	0	0	0
Nurse aid	31	83	48	50
Pharmacy assistant	12	19	13	20
Family health worker	0	27	0	0
Foolhumaas (TBA)	0	0	0	0
Others	11	44	40	33

Source: Faculty Health Sciences (Statistical Yearbook of Maldives, 2006).

To ensure adequate and appropriate human resources for health, the HMP 2006-2015 identified targets and strategic actions to achieve this as Policy Goal 8. Strengthening training capacity of FHS, improving administration of health facilities by training managers and ensuring proper functioning of the Medical Council, Nursing Council and Health Science Board are some of the strategies for which WHO support has been requested by MoH.

3

Development assistance and partnerships: aid flows, instruments and coordination

Development AID

During 2005, Maldives received a total of Rf 673.4 million (US$ 52.8 million) as development assistance. This formed about 13.5% of the total government budget. Of this, RF 640.8 million (US$ 50.3 million) was received as soft loans, while RF 32.6 million (US$ 2.5 million) was received as grants. Of the loans received RF 58.8 million (US$ 4.6 million) was for projects in the health sector (one was shared with the education sector) as shown in Table 3.1. Details of disbursement of the grants are not available.

Table 3.1: *Loan assistance to the health sector in Maldives, 2005*

	Rf (Million)
Health and education project	34.6
Institute of Health Sciences*	15.7
Atolls water and sewerage*	8.5
Total	**58.8**

Source: MPND.
(*) Not directly under the health sector.

WHO Partnership with other agencies

WHO's role as the longest-standing partner in the national health development of Maldives is well recognized.

By promoting and maintaining the technical leadership role of the Organization in the overall national health development and management, WHO continues providing Maldives with much-needed technical support with better understanding and coordination between all the ministries, sectors, agencies, donors and NGOs.

The United Nations Population Fund's (UNFPA) Third Country Programme has been in place from 2003 to 2007, with financing of US$1.5 million to US$2.0 million. The priority areas are based on issues identified in the Country Population Assessment and the United Nations Development Assistance Framework (UNDAF); likewise, they are aligned with national priorities and the Millennium Development Goals. UNFPA is focusing its efforts on reproductive health, population and development, and gender. The programme emphasizes capacity-building and partnerships, comprising two sub-programmes, one of which, Reproductive Health (RH), is in partnership with the Department of Public Health/MoH as the executing partner of this project. The project

has contributed to the formalization of a National Reproductive Health Strategy (2005–2007) and also built the evidence base through national surveys on the RH situation. Also, under the RH project, a number of capacity building trainings in counseling skills for service providers have been conducted, in addition to the development of quality information, education and communication/behaviour change communication (IEC/BCC) materials on maternal health and family planning methods. Monitoring and evaluation has been strengthened in "focus" atolls and regular maternal death audits are being undertaken.

The other major UN partner in health is the United Nations Children's Fund (UNICEF). For 2006, UNICEF has allocated US$ 2.5 million, and is working with the Department of Public Health/MoH in implementing its Health and Nutrition Programme. Three main projects are under this programme, each one of them covering different areas:

(1) Policy Development, Planning and Capacity Building: Provides assistance to establish a functional Nutrition and Child Health Surveillance System at all levels for better planning and monitoring, supports surveys and studies for maternal and child health and nutrition, activities related to "capacity development" for policy and plan formulation and advocacy or review activities related to health and nutrition policies including the National Nutrition Strategic Plan (NNSP).

(2) Community-Based Health and Nutrition Intervention: Supports the DPH in the implementation of micronutrient programmes and immunization activities; it also supports integrated community-based activities related to health and nutrition and emergency obstetric care and newborn care activities. Another activity is to improve infrastructure for health and nutrition, for example reconstruction of health facilities, support early childhood development corners and provision of boats for outreach services.

(3) Prevention and Control of HIV/AIDS among mothers and children is basically supporting HIV/AIDS activities through prevention of mother to child transmission & voluntary counselling and testing (PMTC & VCT) and situation analysis.

(a) Intersectoral coordination

To enhance partnerships in health, several attempts have been made towards strengthening inter-sectoral coordination including the formulation and review of a National Nutrition Plan; the formulation of the Health Sector Plan for Emergency Preparedness and Response as part of the National Plan; technical assistance to develop Health Care Waste Management Plans as part of the National Waste Care Management; ensuring quality of water; technical assistance to the implementation of the National Survey on Domestic Violence;

conducting a risk assessment for avian influenza, and support to the School Health Programme.

All these activities have contributed to establishing better links between the health sector and other sectors.

(b) Collaboration with NGOs and civil society

The government recognises that community organizations and NGOs are useful partners in the development of the country and desires to work with them. With assistance of the UN system, there is an initiative to enhance coordination of NGO activities and to facilitate their collaboration with the government. Utilization of NGOs and community organizations would seem to have great potential for social mobilization in Maldives if an efficient, collaborative mechanism could be established to harness their potential. The community organizations existing at various levels with varying functions include Ward Committees, Atoll Development Committees (ADC), Island Women's Development Committees (IWC) and Island Development Committees (IDC). These comprise elected members and are engaged in social, health and economic development activities.

There are several NGOs registered countrywide under the designation of "clubs" or "associations". Among others, well-recognized local NGOs with a proactive role in health include the Society for Health Education (SHE), concentrating on health and family welfare issues; the Foundation for Advancement of Self-help in Attaining Needs (FASHAN – although not very active now) focussing on improving the living conditions of islanders and especially women, youth and children; and more recently the Care Society and Diabetic and Cancer Society, as well as the Manfaa Centre on Ageing. However, lack of coordination has resulted in duplication or blurring of roles and activities between NGOs and the government.

(c) Collaboration with other international organizations and agencies

UN Inter-Agency Group meetings have been organized regularly, to maximize the utilization of available resources and to avoid duplication and unnecessary competition among various agencies. Collaboration on HIV/AIDS-related activities has been an interagency initiative under the UN Theme Group on HIV/AIDS which WHO chairs. WHO and UNICEF have implemented many joint activities, such as international EPI reviews, field testing of the new Child Growth Monitoring Charts, developing the IYCF workplan and training of health staff, training on essential newborn care, workshop on child rights, and the baby-friendly hospital initiative. With UNICEF also, WHO is supporting the MoH in

strengthening the health information system (HIS) and participating actively in the new Integrated Community Development Project, as well as coordinating and providing support in the introduction of new vaccines, essential drugs and assisting government in the area of food safety and water and sanitation programmes.

The *National Guidelines and Minimum Medical Standards for Family Planning Services* developed in 1997, were updated with the technical and financial assistance of WHO and UNFPA in 2005; this included a chapter on emergency contraception to keep in line with the Reproductive Health Strategy 2005–2007. WHO and UNFPA also collaborated in supporting the Ministry of Gender and Family in the training of enumerators participating in the first-ever national survey to assess the problem of domestic violence.

Through a joint WHO-UNDP initiative, MoH received technical and financial support to conduct a "Malé Clean Up Campaign and Dengue Week" in 2006, and within the United Nations Country Team (UNCT), WHO has been coordinating different activities related to preparation of the Avian Influenza and Human Influenza Pandemic Preparedness Plan in support of the MoH and Ministry of Agriculture, Fisheries and Marine Resources (MoAFMR).

Finally, in collaboration with UNICEF and UNAIDS, WHO supported DPH/MoH in conducting an HIVAIDS risk assessment and will provide technical assistance for the development of the second HIV/AIDS National Strategic Plan 2007–2011.

4

Current WHO cooperation

Historical background

The World Health Organization was the first UN agency to establish a country office in Maldives. WHO was also the first UN agency to conduct health programmes in the country. The first mission by WHO was in 1951, when a filaria survey team visited the country at the request of the United Kingdom to review the disease situation in the southern atolls. For a long time, malaria has been the major cause of morbidity and mortality and it is only since 1984 that no indigenous case has been registered. Maldives is the first country in the South-East Asia Region to eradicate malaria and WHO was the major partner in this achievement.

Communicable diseases were the major problems till the mid-1990s when effective programmes on prevention and control of communicable diseases and improved sanitary situation led to a significant change. Mortality due to diarrhoea and acute respiratory infections disappeared. Other communicable diseases, such as leprosy, have been almost eliminated and tuberculosis has been controlled. As a consequence of the high prevalence of malaria, there are many thalassemia carriers and this genetic disorder became the most important and life-threatening disease in children. Vaccine-preventable diseases are also all under control. With WHO's support, the country has introduced viral hepatitis vaccine for all newborns and pregnant women.

During these first decades, WHO dealt with a wide range of problems from health polices on drugs, water and sanitation, hospital management, noncommunicable diseases to training and development of curricula for all categories of health workers. Many of the doctors and health staff were trained abroad with WHO support. These are only a few of the successes in health development where WHO has been a major partner.

The work of WHO during the first CCS period (2002-2006)

WHO's collaboration with Maldives during the current and past bienniums has embraced a broad-based approach for meeting the country's national health development needs. WHO has divided its resources over many areas in order to support the large number of health programmes in the country. Currently, WHO's biennium collaborative programme 2006-2007 covers 26 projects (up from 15 in 2000-2001).

WHO country programmes have been generally successful in supplementing the national programmes and meeting country needs and priorities.

Incorporating the basic concepts of the consecutive National Development Plans and the first Health Master Plan (HMP) 1996-2005, addressing the equity concerns as well as specific health and public health problems and integrating health and human development concerns into public policies, the collaborative programmes focussed on and supported sustainable national health development. Following WHO's policy orientation, the main thrusts of the programmes have been on the following areas:

- Assisting the Ministry of Health in developing the Health Master Plan (HMP), health policies, strategies, management capacity and technical cooperation;
- Strengthening the health systems by improving efficiency, quality and equity of health services;
- Supporting the development of technically competent health personnel and their management;
- Enhancing community participation, intersectoral and interagency collaboration;
- Supporting the development and implementation of national health promotion plan/strategies, and needed interventions for communicable/ noncommunicable diseases, reproductive health, nutrition, food safety and environmental health, including safe water supply and sanitation.

Overall, the WHO country programmes have been effective in meeting the health development needs of the country. WHO has supported visits of several health officials to other countries to exchange experiences and enhance the management of health sector development. It facilitated bilateral cooperation among Maldives and those countries, particularly in increasing training opportunities and placements for Maldivians in health institutions abroad.

WHO has provided extensive technical support to the Ministry of Health and other relevant sectors in the overall health development activities to achieve the Health Master Plan (1996-2005) objectives. It has been collaborating closely with the relevant ministries, UN agencies, donors, NGOs and programme managers on the effective implementation of the WHO collaborative programmes at the country level.

When the tsunami struck Maldives in December 2004, WHO, working with other UN agencies and major donors, responded quickly to prevent adverse consequences for the health of the people. This included restoration of health services and key interventions in disease surveillance, ensuring quality of drinking water and mental health. In the post-tsunami situation, WHO has been continuing its technical support to the government in carrying out rehabilitation and recovery in the tsunami- affected areas and strengthening the overall preparedness and response of the MoH to respond

to future emergencies, including outbreaks. It supported the mobilization of funds from bilateral, multilateral donors and UN agencies.

Overall, WHO has provided assistance valued at about US$12 million during the period of the first CCS (2002–2006), as shown in Table 4.1. Most of this support has been from the regular budget that has been around $2 million per biennium, although the RB was increased substantially from the 2006–2007 biennium. Voluntary contributions have been low, except during the period of the tsunami relief efforts when many donors made substantial donations.

Table 4.1: *WHO assistance to Maldives (US$)*

	2000/01	2002/03	2004/05	2006/07
Reguar Budget programmes	1 961 000	1 968 700	1 953 000	2 623 000
Voluntary contributions	209 031	61 300	5 200 000*	2 023 600
Total	**2 170 031**	**2 030 000**	**6 153 000**	**4 643 600**

(*) Tsunami Project.

During the period 2002–2006, WHO's work focused on addressing the following key issues identified in WHO's Country Cooperation Strategy 2002:

(1) **Human Resources for Health –** WHO's cooperation has emphasized the area of HRH. Generally, more than 35% of WHO's budget has been used to support programmes in this critical area. WHO provided technical assistance to MoH for developing and reviewing its human resources rolling plan. Most WHO resources have been used to contribute to human resource development by sending fellows for long-term pre-service education outside the country in various areas of health and medical care. The Faculty of Health Sciences has been assisted to revise and update the training curriculum and enhance access to up-to-date health related knowledge and information.

Increased public demands on health service delivery – WHO has worked to strengthen public health laboratories by conducting training and providing key laboratory equipment. Work has been done to promote the rational use of drugs and, recently, to help the MoH develop national drug regulatory mechanisms. WHO has supported strengthening of the health information system and medical records, and provided technical support on the use of e-health systems in the country. As part of the tsunami project, WHO supported the development of logistics management systems, where a WHO consultant prepared a concept paper for developing the Medical Supply Management Information System (MSMIS), training workshops on warehouse and storeroom management, promoting the Central Medical Store (CMS) and introduction and training on Logistics Support System (LSS).

(2) **High maternal mortality rates -** With the success in lowering MMR during the period, much of WHO's efforts have concentrated on sustaining efforts to support maternal health care and to increase emphasis on newborn care. The skilled birth attendance rate is very high compared to most other SEAR countries. However, the competency of the "skilled" birth attendant and continuous quality improvement programmes at institutional levels would be essential to further reduce the MMR and neonatal deaths. In collaboration with UNFPA, WHO provided technical assistance to DPH/MoH for revising the national family planning guidelines. Six orientation meetings on the revised guidelines were organized, which were attended by 200 health personnel working at different levels.

(3) **Environmental health –** Most of WHO's efforts in this area have concentrated on water and sanitation, especially on water quality. National water and sanitation policies have been reviewed and new strategies developed. In addition, training has been provided for testing and monitoring water quality in various atolls. WHO has also been active in developing and implementing systems for management of medical waste, from both hospital and health clinics.

(4) **Nutrition –** WHO's efforts have concentrated on implementing the infant and young child feeding strategies in the country. The new child growth standards are also being introduced.

(5) **Food safety –** WHO, in collaboration with UNICEF, the World Food Programme (WFP) and the World Bank, supported the Food Safety Need Assessment with the assistance of a food safety expert, which was undertaken to assess the FOS situation in the aftermath of the tsunami disaster in Maldives. An assessment of the Food Borne Disease (FBD) surveillance was also carried out with WHO assistance. Work is also underway to assist the food safety authority and its stakeholders in carrying out integrated food safety programmes based on the risk analysis approach and recommended strategies for strengthening FBD surveillance.

(6) **Increased burden of disease –** In the area of communicable diseases, WHO has traditionally been strong, providing the MoH with a wide range of support on key communicable diseases in the country. Although there has been notable success in eliminating or controlling malaria, filaria and tuberculosis, efforts are continuing to ensure that these diseases do not re-emerge. Working with other partners, WHO has supported the immunization programme, assisting with the routine immunization programme, the introduction of new vaccines (especially measles rubella) and the regulation and control mechanisms to ensure vaccine quality. Although there are only a few cases of HIV/AIDS, WHO has been working with partners to prevent any increase. Special attention is being placed on treatment of STIs (sexually transmitted

infections) and health promotion activities. As with other countries in the Region, Maldives still has outbreaks of dengue and support is being provided for the prevention and treatment of dengue. After SARS and avian influenza affected many countries in the Region, WHO has increased support to strengthen the disease surveillance systems to ensure that the country is prepared for any new outbreaks. WHO's work regarding noncommunicable diseases has concentrated on prevention. Surveillance activities have attempted to identify the major risk factors for noncommunicable diseases. Maldives has signed and ratified the Framework Convention on Tobacco Control and WHO is working to implement this treaty, reducing the risks associated with tobacco in the country. Regarding injuries, WHO has supported injury surveillance and increased awareness of injuries in the workplace. Efforts are being made to strengthen the mental health programme, especially after the tsunami, when increased attention was paid to the issues of mental health. WHO supported emergency preparedness and response (EPR) even before the tsunami by assisting with the development of an EPR plan. WHO technical assistance has also been provided for upgrading the IGMH emergency department, as well as in implementing the hospital preparedness plan for mass casualties.

(7) **Health promotion** – WHO has supported the development of capacity in health promotion, especially through activities in school health and the healthy atoll project. Related to enhancing access of adolescents to healthcare, WHO supported the establishment of an adolescent friendly clinic in IGMH that will offer, in addition to general medical services, reproductive and sexual health counselling services and awareness activities.

Health sector reform – WHO has provided active support in developing the second Health Master Plan. In addition, it has supported the Macroeconomics and Health Commission to increase spending on health, as well as the involvement of other sectors in health. Health financing support has included work on the national health accounts, as well as advice on the establishment of a national health insurance system. WHO has emphasized the need for regulatory mechanisms and work is underway to support medical and nursing councils in the country.

5

WHO policy framework: global and regional directions

Global challenges in health

The General Programme of Work (GPW) is the main policy document of WHO. The Eleventh GPW (2006–2015) sets out the direction for international public health for the period 2006 through 2015. The document notes that there have been substantial improvements in health over the last 50 years. However, significant challenges remain. The following are four gaps:

Gaps in social justice: Clearly, poverty is a key factor that impedes access to quality health services. In some countries the life expectancy of the poor is 20 years lower than other, privileged members of society. Poor health and poverty form a vicious cycle. Other factors that reduce access to services are discrimination by ethnicity or gender. Often, women's health is not adequately addressed.

Gaps in responsibility: Health problems today are no longer merely the responsibility of the health sector, but require positive action by those outside the health sector as well. International conflicts and national crises often lead to the disruption of social services which include health care. Globalization and decisions made regarding international trade have a direct impact on health, especially in the area of pharmaceuticals and the movement of health professionals. In many countries, ministries of health often do not have the capacity to adequately influence important causes of ill-health outside the health sector.

Gaps in implementation: Very often the technology to implement cost-effective interventions to improve health is available. But these are not implemented because of shortage of funds, lack of human resources or the absence of an effective health system. Available resources may often be allocated to high-cost curative services and favour urban areas, leaving inexpensive and effective interventions in rural and remote areas neglected.

Gaps in knowledge: Global advances in science and technology have improved the effectiveness and efficiency of medical services and the prevention and treatment of diseases. However, information about these advances is often not available in many countries. Also, the lack of information about health conditions, and existing rigidities in many countries have, in turn, made it difficult to formulate and manage effective

health policies and interventions. Even operational research for those most in need of health services is generally not done, thereby reducing the efficiency of key programmes.

Global health agenda

In order to reduce these gaps over the coming ten years, the Eleventh GPW outlines a global health agenda consisting of seven priority areas:

- Investing in health to reduce poverty
- Building individual and global health security
- Promoting universal coverage, gender equality and health-related human rights
- Tackling the determinants of health
- Strengthening health systems and equitable access
- Harnessing knowledge, science and technology
- Strengthening governance, leadership and accountability

The global health agenda is meant for everyone working in the field of health development. WHO will contribute to this agenda by concentrating on its core functions, which have been built on the comparative advantages of the Organization. In accordance with the global health agenda and WHO's core functions, the Organization has set the following priorities:

(1) Providing support to countries in moving to universal coverage with effective public health interventions

(2) Strengthening global health security

(3) Generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health

(4) Increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health

(5) Strengthening WHO's leadership at global and regional levels and supporting the work of governments at the country level

WHO will pursue these priorities through its Medium-term Strategic Plan (2008–2013) and the biennium budget of the Organization. The WHO Director-General has clearly put a major focus on the work of the Organization at the country level. The Regional Offices and Headquarters have been directed to emphasize support for country work and implement these priorities in Member States, especially where the health needs are the greatest.

WHO's core functions
• Providing leadership on matters critical to health and engaging in partnerships where joint action is needed; • Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge; • Setting norms and standards, and promoting and monitoring their implementation; • Articulating ethical and evidence-based policy options; • Providing technical support, catalysing change, and building sustainable institutional capacity; • Monitoring the health situation and assessing health trends.

Regional policy framework

The South-East Asia Region (SEAR) has the second-highest population among the six WHO regions and carries the greatest burden of disease. While there has been great economic development in this Region in recent years, the problems of poverty and poor health remain significant. Many countries have faced health emergencies in the last decade and the threat of disease outbreaks is ever-present. At the same time, noncommunicable diseases have become an increasingly important cause of morbidity and mortality in the Region. Therefore, the global policy framework of WHO is appropriate for the Region, with special attention being given to strengthening the capacity of Member States to support public health interventions.

The South-East Asia Region has always placed a strong emphasis on its work in Member States. Of the total budget provided to the Region, 75% is allocated for countries, the highest among all WHO regions. The WHO Regional Director has recently increased the delegation of authority to country offices to enable them to plan and implement programmes with a higher degree of independence and to be more accountable for their work. At the same time, he has emphasized that the Regional Office staff should give the highest priority to support the work in these countries.

6

Strategic agenda: priorities jointly agreed for WHO cooperation in and with the country

The main priorities of the Ministry of Health are described in the draft Health Master Plan 2006-2015. This and other policy priorities in the Vision 2020 offer WHO a potential role to support policies relevant to its four strategic directions and six core functions, and promote appropriate technologies to implement health sector reforms in the country.

The proposed priority areas and strategies for the WHO Country Cooperation Strategy for the period 2006 to 2011 was as discussed and agreed to in principle during the Eleventh Global Programme of Work presentation by the WHO Representative to MoH.

During the period of the CCS, WHO will assist the MoH in various health programmes as needed. However, major assistance will be provided in the following priority areas:

1. Strengthening health systems

(a) Assist the MoH in monitoring the implementation of the Health Master Plan and in development of strategic plans in communicable and noncommunicable disease control as well as periodic updating of the health workforce plan.

(b) Organize training for managers of health services and programme on effective management, with special focus on atoll hospital and health centre levels.

(c) Assist MoH in introducing necessary health-related legislation and quality assurance mechanisms, based on management protocols and standard operating procedures for improving quality and ensuring patient safety.

(d) Support the human resources development management at central and atoll levels.

(e) Assist HRH regulatory bodies (Medical Council, Nursing Council and Board of Health Sciences, Alternative Medical Care), in updating their legislation, regulations and tools for ensuring quality of HRH education and ethical practice.

(f) Support the Faculty of Health Science in undertaking periodic review of courses and curricula and organizing need-based, short in-service training for service providers in collaboration with MoH.

(g) Support the health services development for prevention and handling gender-based violence.

(h) Provide assistance to strengthen the medical supplies logistical system.

(i) Support the Food and Drug Authority in formulating national drug policy and regulations.

(j) Advocate and support MoH in sensitizing and advocating with policy-makers in international agreements and negotiations that have a health impact.

2. Integrated communicable diseases surveillance and control

Provide support and assistance to:

(a) Implement the Action Plan for integrated disease surveillance.

(b) Support the implementation of the International Health Regulations 2005 and develop necessary core capacities at the ports of entry.

(c) Continue supporting the building up of country capacity in surveillance, response and management of endemic and/or emerging communicable diseases (e.g. chikungunya and scrub typhus).

(d) Strengthen prevention, surveillance, diagnosis, care and management of HIV/AIDS/STI including expansion of VCT services throughout the country in order to sustain the low level of HIV/STI incidence in the context of the second national HIV/AIDS Strategic Plan 2006-2011.

(e) Support sustainability of programmes targeting communicable diseases (EPI,TB, leprosy, filariasis).

(f) Strengthen management of programme implementation including supervision to overcome the major challenge in sustaining its achievement.

(g) Strengthen capacity for research in communicable diseases.

3. Noncommunicable diseases, mental health and health promotion

Provide support and assistance to:

(a) Strengthen surveillance and analysis of the disease burden for noncommunicable diseases and mental health, including key risk factors.

(b) Implement, assess and update strategies and action plans for prevention and control of NCDs.

(c) Develop, implement and assess intersectoral interventions for injury prevention and occupational health.

(d) Formulate behavioural change communication strategies and actions to improve and promote healthy lifestyles.

(e) Support development of print and audiovisual material to support health promotion campaigns.

(f) Implement the Framework Convention on Tobacco Control (FCTC).

(g) Plan and implement healthy settings practices especially for island/atolls communities, schools, markets and hospitals.

(h) Develop, plan and implement appropriate community mental health programmes.

(i) Prevention of substance abuse.

4. Newborn health

Provide support and assistance for:

(a) Training of skilled birth attendants (doctors, nurses).

(b) In collaboration with UNICEF, support DPH/DMS in conducting essential newborn care training at all levels of the health system through the formation of a core group of trainers at the central, regional and atoll levels.

(c) Technical assistance for developing health promotion programmes and campaigns focusing on priority areas including maternal and newborn health.

(d) Training and developing human resources for maternal and newborn health.

(e) Training abroad of a neonatologist in newborn care at the central level.

(f) Introduction of the "baby-Kangaroo" package in collaboration with All India Institute of Medical Sciences (AIIMS), a WHO Collaborating Centre in Newborn Health.

5. Emergency preparedness and response

Provide support and assistance to:

(a) The MoH to develop the health sectoral component of the National Disaster Preparedness and Response Plan.

(b) Build country capacity by training health professionals in triage, mass casualty management, first aid, management, administration etc.

(c) Support training in the areas of logistics management (SUMA or the Humanitarian Supply Management System), damage assessment and coordination at central and peripheral levels.

(d) Train public health staff in epidemic alert and response during disasters.

(e) Build the capacity to provide psychosocial support at the community level; train doctors, nurses and community health workers in mental health and in social support.

(f) Support development of infrastructure to stockpile materials for outbreak surveillance and response and to provide health care for displaced persons.

6. Food safety

Provide support and assistance to:

(a) Assess food safety risks and develop appropriate strategies to reduce the risks, emphasizing intersectoral collaboration.

(b) Review and revise food safety standards, regulations and legislation.

(c) Develop procedures and training materials for food inspectors to enforce food safety regulations.

(d) Develop training programmes and advocacy materials for food handlers.

(e) Strengthen the capacity of the National Health Laboratory to detect food contaminants and quality of food products.

7. Environmental health

Provide support and assistance to:

(a) Develop a water and sanitation master plan for the country.

(b) Advocate access to safe water at all islands and provide technical support and equipment for water quality management through water safety plans and household water treatment and safe storage.

(c) Advocate access to sanitation through proper health and hygiene education and provide technical support in developing sustainable latrine options.

(d) Improve technical capacity of Ministry of Environment, Energy and Water, Maldives Water and Sanitation Authority and MoH staff for more effective programme coordination, management and implementation through training and participation in international forums.

(e) Emphasize and support environmental and hygiene awareness programmes targeting school children, and improve the capacity of family health workers and teachers in the atolls.

(f) Assist in the implementation of strategies for health-care waste management in the context of the national waste management programme.

(g) Support MoH in establishing networks to promote integrated vector control with communities and intersectoral partnerships.

(h) Assist health sector to assess the vulnerability to climate change, prepare and implement mitigation and adaptation plans.

8. Information and research

Provide support and assistance to:

(a) Support institutionalizing health system and public health research, including the development of ethical guidelines for research.

(b) Develop training materials and support training for potential researchers in conducting health system and public health related research.

(c) Support research activities to obtain baselines data and monitor progress on disease burden and the impact of public health interventions.

(d) Support development and implementation of internet and intranet-based health information systems linking central and atoll levels.

(e) Strengthen the health management information system, including the hospital medical records system to ensure effective collection, analysis, dissemination and utilization of information in decision-making.

(f) Provide technical assistance and software/hardware to strengthen e-health and telemedicine services at the central and atoll levels.

Other priority areas for WHO technical support where other agencies are also providing good support include:

- Immunization (Government of Maldives, UNICEF)
- Nutrition (UNICEF)
- Reproductive and maternal health (UNFPA)
- Adolescent Health (UNFPA)
- Thalassemia (Government of Maldives)

7

Implementing the strategic agenda: Implications for WHO Secretariat, follow-up and next steps at each level

The proposed agenda for the WCO-CCS, Maldives, is based on the situation analysis of the health situation in the country, on WHO's collaborative activities during the past three bienniums and discussions held between members of the CCS-Mission that visited Maldives from 29 October to 2 November 2006. This mission met with WHO country office staff, Ministry of Health officials, UN partners and other stakeholders.

This CCS will serve as an Organization-wide reference for WHO's cooperation with the Government of Maldives for the next five years. Some changes are needed in order to make the WHO country cooperation more efficient and to focus country work on the eight selected priority areas. Thus, this means that there will be a need for adjustments in terms of the country office profile, support from other levels of the Organization and resource mobilization to support the implementation of the strategic agenda.

Country Office

Given the small size of the country programme in Maldives, WHO's country presence will be limited. Based on the CCS Strategic Agenda, it is foreseen that there will be three professional positions supported by the Regular Budget:

WHO Representative (WR) – The WR is responsible for the overall management of the WHO collaborative programmes, managing the country office and undertaking a wide range of functions to support the Ministry of Health in the country. Because of the limited number of staff, the WR may be involved in direct technical support for parts of the WHO collaborative programmes.

Medical Officer (Public Health) – The CCS outline supports a wide range of programmes as reflected in the Strategic Agenda. Therefore, it is felt that a Medical Officer in the area of Public Health is needed to provide adequate technical support for the implementation of these priority areas. In addition, he or she will also be responsible for key programme management issues such as programme planning, technical monitoring and evaluation and assessments of WHO's work. This is a change

from the existing post of Medical Officer-Management. It is expected that about 70% of the activities of this post will involve direct technical support to WHO collaborative activities.

Administrative Officer (National Professional Officer, NPO) - In order to support the work of the WR and international staff, there will be a need to have strong administrative and financial support, including financial monitoring of the WHO programme. In addition to the present staff working in these areas, there will be a need to revise the terms of reference of the NPO to shift its present responsibilities as "liaison" officer with different programmes in the MoH, to assume more managerial responsibilities to support the local staff in the daily running of the office to make WHO collaboration more efficient and effective.

Additional, long-term technical staff – Additional, long-term technical staff may be added using Voluntary Contributions if specific donor-funded projects are negotiated to support the priority areas of the CCS. This may be either international staff or NPOs, depending on the availability of technical skills. International technical staff might also be recruited through the APO (Associate Professional Officer) or be seconded from some other organization to be assigned to the country office. In some cases, SSA (Special Service Agreements) may be tried to recruit national staff to work with MoH to support implementation of key priority areas.

Bilateral agreements with training or research institutions - There may be possibilities of direct technical support from research institutions in other countries willing to support the priority areas of the CCS. These could be negotiated directly between the institution, WHO and the government.

Short-term consultants – Because of the limited technical staff available in the country office, it is expected that short-term professionals will be recruited for limited periods of one to six months to provide technical support in priority areas.

Support from the Regional Office

The WHO Regional Office for South-East Asia (SEARO), has been providing effective technical assistance during the period of the current CCS. This should be revised to reflect the priorities outlined in the new CCS. Regional Advisers are needed for the following functions to support country operations:

(a) Assess the current status of national implementation of key priority areas outlined in the CCS and WHO programme implementation, with special attention on identifying key constraints and possible solutions.

(b) Provide the latest technical guidelines.

(c) Help develop workplans for future work in these areas.

(d) Develop terms of reference for short-term professionals and assist in identifying appropriate consultants, as well as staff from other WHO offices.

(e) Assist with the development of proposals for resource mobilization and to help identify possible donors to fund these proposals.

(f) Assist in training of national staff.

Finally, the WR will need to ensure that the level and skill mix of the national administrative staff are appropriate. Thus, there is a need to develop/strengthen these skills through specific training which should be supported by the Regional Office.

Collaboration with other WHO Offices in the Region

In the current CCS period, the Maldives Country Office has benefited from the support of other WHO country offices, especially from Bangladesh, India, Nepal and Sri Lanka. This support should continue as it has been beneficial. Because of the short distance to Sri Lanka and good communications, it is likely that the Sri Lanka country office will be best suited to support Maldives when immediate assistance is required.

Support from Headquarters and other Regions

WHO/HQ should provide more complementary technical support and back-up in areas of work that cannot be provided by the Regional Office. By developing regional and global public health policies/agreements or treaties such as on tobacco, WHO/HQ, through the Regional Office, should help strengthen national policies and their implementation as well as broker support/funds from donors for Maldives.

In particular, Headquarters should continue providing support by compiling and disseminating information in printed form or electronically that can be used to support the advocacy role of the country office.

One of the key roles of WHO/HQ would be to develop evidence-based norms, standards, tools and guidelines that address the special needs and solutions for small island states, and promote meetings among them in order to exchange experiences and foster collaboration. Since Maldives is a small island state, there is a need to interact and exchange experiences with other countries with similar geographical and demographic features.

The countries of the South Pacific in the WHO Western Pacific Region (WPR) and the WHO African Region (AFR) provide opportunities for this kind of exchange. In addition, the Small Island Developing States (SIDS), under the United Nations, is another international group that would help further the exchange of experience among countries

similar to Maldives. WHO Headquarters should work with country and regional offices to facilitate these exchanges.

Resource Mobilization

In most countries, a large part of WHO's work is supported by Voluntary Contributions. However, because Maldives does not have many bilateral agencies, Voluntary Contributions to health have been limited. This will limit the ability of WHO to implement the CCS in the country. WHO should play a more active role in resource mobilization by helping to prepare specific proposals for Voluntary Contributions in the CCS priority areas. As was noted above, it is expected that the Regional Office will help prepare these proposals. In addition, these proposals should be circulated in donor forms at the country, regional and Headquarters levels to ensure that there are adequate financial resources to fully implement the Country Cooperation Strategy.

Annex 1

Current Assessment of Millennium Development Goals in Maldives from the United Nations Common Country Assessment

Millennium Development Goals[10]	Draft 7th National Development Plan[11]
Goal 1: Eradicate Extreme Poverty and Hunger **Status: Fully Achieved**	**Guiding Principle:** "All policies, strategies and targets in the 7th National Development Plan (7th NDP) must improve the quality of life for the people living in the Maldives, particularly the poor, the disadvantaged and the vulnerable groups. The policies should lead to equitable opportunity and fairer distribution of income and wealth. The Government and its international development partners feel the need for a comprehensive development agenda that addresses poverty reduction in the Maldives. "The 7th NDP provides the agenda for poverty reduction in the Maldives and specifies the country's macroeconomic framework, the structural and social policies and programmes over the five-year horizon to promote broad-based growth and reduce poverty. Furthermore, the Plan was developed and finalized through a consultative participatory process involving civil society and development partners. It identifies both the internal and external financing needs; major sources of financing and the framework for monitoring and assessment. In this sense, the 7th NDP serves as the Government's Poverty Reduction Strategy Paper (PRSP)."
Goal 2: Achieve Universal Primary Education **Status: Fully Achieved**	"The Maldives has established a national system of public education with a common national curriculum. Universal primary education has been achieved with high enrolment rates for boys and girls. A net enrolment ratio of 100 percent has been achieved for both girls and boys in the Maldives. (MDG Report) However, access to secondary education is not universal and more needs to be done to improve access to secondary schooling in the atolls and islands. Also, special emphasis must be placed on improving access to and the quality of early childhood development programmes."
Goal 3: Promote Gender Equality and Empower Women **Status: Partially Achieved**	**Guiding Principle:** "Specific intervention to address gender equality is an integral part of the 7th NDP. Special attention would be given for the empowerment of

Millennium Development Goals[10]	Draft 7th National Development Plan[11]
	vulnerable groups by expanding their capabilities and opportunities and all policies shall support gender equality in the development process. The Plan addresses the protection of sexual and reproductive health; rights to information and family planning services; equal access to economic assets such as land and housing; increasing opportunities to pursue vocational and tertiary education; equal labour market opportunities; freedom from violence; and increased representation at all levels of governance."
Goal 4: Reduce Child Mortality **Status: Fully Achieved**	"When applied to the Maldives, the MDG target 5 is to reduce the under five mortality rate to 16 per 1000 live births by 2015. This rate stood at 16 per 1000 live births in 2005. In order to achieve the MDG target and even go beyond that goal in the Maldives, it is essential to address the significant gap between the rates of reduction between Malé and the atolls; as well as reduce the number of new born deaths. Further improvements in the latter area represent an important challenge as they require much more advanced facilities as well as better and faster access to them, especially from the islands."
Goal 5: Improve Maternal Health **Status: Achieved**	"The MDG target 6 to reduce maternal mortality appears to have been achieved in 1999, 2000 and 2003 with rates lower than the target of 125 per 100,000 live births, but these lower figures need to be recorded consistently for a few years before it can be considered that the target has been fully achieved. Improvements have been observed over the past few years in the areas of nutrition and health of women, delayed age at first birth, child-spacing and accessibility to obstetric care. However, despite efforts made to facilitate the delivery of high-risk mothers and the fact that 60% of deliveries are attended today by skilled professionals, maternal mortality is still relatively high in the Maldives. In this area, the inaccessibility to transport in case of emergency remains a major concern."
Goal 6: Combat HIV/AIDS, Malaria and other Diseases **Status: Fully Achieved**	"The MDG targets 7 and 8 regarding combating HIV/AIDS, malaria and other diseases have also been practically achieved. Maldives is a low prevalence country for HIV/AIDS and malaria has been eradicated since 1984. However, the prevention and treatment of emerging and re-emerging communicable diseases remains a national priority in the Maldives. The challenge is to maintain the

Millennium Development Goals[10]	Draft 7th National Development Plan[11]
	low prevalence of HIV/AIDS by further strengthening awareness programmes and surveillance systems, especially for high risk groups such as resort workers, expatriate workers, sailors and adolescents. Also, although malaria has been eradicated and tuberculosis prevalence has been significantly reduced, policy attention needs to be maintained to ensure that these achievements are sustained, especially in Malé where overcrowding represents a major risk for the spread of diseases such as tuberculosis. Furthermore, other epidemic-prone diseases such as diarrhoea, acute respiratory infections, dengue and other emerging diseases such as scrub typhus pose a major threat to public health and need to be closely monitored."
Goal 7: Ensure Environmental Sustainability **Status: Challenging to Achieved**	Chapter 16 of the 7th NDP is entirely dedicated to environmental issues. It notes the country's vulnerable environment, identifies waste management, more specifically solid waste management, climate change and sea level rise as major issues faced by the country."Traditionally, the groundwater aquifers of the islands have been the major source of fresh water for the Maldivians. However, the aquifers have been increasingly subject to depletion and deterioration from sea water intrusion and pollution, particularly due to the absence of environmentally-sound sewerage disposal systems. Saltwater intrusion from the 2004 tsunami has further depleted the quality of the aquifers."

Annex 2

List of Acronyms

ADC	Atoll Development Committee
BCC	Behaviour Change Communication
CAP	Consolidated Appeal Process
CAT	Convention against Torture
CCA/UNDAF	Common Country Assessment / United Nations Development Assistance Framework
CCM	Country Coordinating Mechanism
CCS	WHO Country Cooperation Strategy
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHW	Community Health Worker
CMS	Central Medical Store
CRC	Convention on the Rights of the Child
DPH	Department of Public Health
DRM	Disaster Risk Management
ECD	Early Childhood Development
EPI	Expanded Programme on Immunization
FASHAN	Foundation for Advancement of Self-help in Attaining Needs
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GPW	General Programme of Work
HIV/AIDS	Human immunodeficiency virus/ Acquired immunodeficiency syndrome
HMP	Health Master Plan
IDC	Island Development Committee
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
IEC	Information, Education and Communication

IGMH	Indira Gandhi Memorial Hospital
IMR	Infant mortality rate
IYCF	Infant and Young Child Feeding
LDC	Least Developed Country
LSS	Logistics Support System
MDG	Millennium Development Goals
MFDA	Maldives Food and Drugs Authority
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
MOSS	Minimum Operating Security Standard
MSMIS	Medical Supply Management Information System
NDP	National Development Plan
NNSP	National Nutrition Strategic Plan
NTC	National Thalassemia Centre
PMTC	Prevention of Mother to Child Transmission
PRSP	Poverty Reduction Strategy Paper
SHE	Society for Health Education
SARS	Severe Acute Respiratory Syndrome
STEPs Survey	STEPwise approach to surveillance
SWAP	Sector-Wide Approach
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UN-RAS	United Nations Rapid Assessment Substance Abuse
VCT	Voluntary Counselling and Testing
VPA	Vulnerability and Poverty Assessment
WFP	World Food Programme
WHO	World Health Organization

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