

# WHO Country Cooperation Strategy Republic of Maldives 2013–2017



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Republic of Maldives  
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## Message from the Minister of Health

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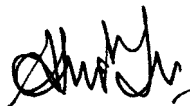
The World Health Organization has been a trusted partner for Maldives contributing to the country's achievements in health. The new WHO country cooperation strategy outlines the medium-term vision for the World Health Organization's collaboration with the Republic of Maldives in support of its national health strategies and policies.

Being a small island nation, Maldives is highly vulnerable to the impacts of political, social, economical transformations and environmental challenges of the Twenty-first Century. The new Constitution of 2008 lays out the basis for democratic development of the nation providing for separation of powers; a fully elected parliament, the People's *Majlis*, presidential elections, an independent judiciary and independent institutions. The country made significant progress in its health status and development indicators over the past decades. The main challenge now is to sustain this progress as well as the achievements made by the country in improving the health and nutrition of the Maldivian population, by ensuring universal access to quality preventive and curative services and medical technologies through strengthened health systems.

The Government's Health Master Plan 2006–2015 and the Health Sector Roadmap 2012–2013 depict these concerns, and identify 10 policy goals, with emphasis on health protection and promotion, safe and supportive environment, access to health services and their quality including health care financing and emergencies, building a competent workforce, and improving evidence-based decision-making within the health system. The strategic priorities identified in the 2013–2017 WHO Country Cooperation Strategy have been aligned with national health priorities and with the government's efforts in addressing these areas, while harmonizing with the work of other United Nations organizations, agencies and development partners. The extensive consultative process has resulted in a country strategy that aims for a true and equal partnership. It took into consideration health situation and trends, achievements and constraints in our national health development and the ongoing context of decentralization and health sector reforms.

The core of this document identified four strategic priorities: (i) strengthening the health system towards universal health coverage, based on the primary health care approach; (ii) preventing and controlling diseases and disabilities; (iii) enhancing public health interventions at national and subnational levels to sustain achievements in health-related Millennium Development Goals and beyond; and (iv) promoting all-inclusive health governance and maintaining WHO's coordinating role and country presence to support health reforms and national health priorities.

The Ministry of Health recognizes the need to focus strategically on selected collaborative programme areas that require more attention in the coming years. The Ministry welcomes WHO's new country cooperation strategy, which will contribute to improving the health of the Maldivian population and thus sustain national health development.



Dr Ahmed Jamsheed Mohamed  
Minister of Health, Republic of Maldives

## Preface

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WHO country cooperation strategies are a key instrument of the World Health Organization's work in and with countries. They provide a medium-term vision for technical cooperation in support of national health plans. The World Health Organization has been working hand in hand for many years with the Member States of the WHO South-East Asia Region to improve the health of their people. In fact, the Region was the first to promote WHO country cooperation strategies, which guide WHO on how best to support national health development according to the challenges, strengths and strategic priorities of the country. In the case of Maldives, WHO began working with the country in 1951, pre-dating even the country's independence in 1965.

The previous cycle of WHO country cooperation strategy for the Republic of Maldives covered the period 2007–2011. The country has been experiencing significant transitions since, including in health. WHO, too, is undergoing reform. As such, it is the right time to develop a new country cooperation strategy, for the period 2013–2017, to address the changes and chart the way ahead, guided by the strategic vision of the Organization for the six-year period commencing 2014 elaborated in the Twelfth General Programme of Work of WHO.

The process of development of the new country cooperation strategy 2013–2017 took more than one year. It involved the Ministry of Health and a whole range of stakeholders working in and for health, including development partners, United Nations agencies, nongovernmental organizations and civil society. This is important since all stakeholders have a part to play in complementing the efforts spearheaded by the Ministry of Health to address emerging health needs and priorities of the country. This comprehensive consultative process ensured that WHO's corporate inputs would effectively supplement and support sustainable development of health in the country.

I would like to take this opportunity to thank all those who have been involved in the development of this country cooperation strategy, which has the full support of the WHO Regional Office for South-East Asia. Over the next five years, we shall work together towards public health gains for the people of Maldives. I am confident that with our joint efforts, we shall be able to contribute to the country's vision – to build a healthier nation in which better health contributes to economic, social, mental and spiritual development of all citizens.

A handwritten signature in black ink that reads "Samlee Plianbangchang". The signature is fluid and cursive.

Dr Samlee Plianbangchang  
Regional Director

## Foreword

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The World Health Organization and the Government of Maldives share a long history of working together to protect health and prevent the public from diseases and disability through the implementation of primary health care principles. Collaboration has led to a number of historic achievements in public and international health: sustained control of communicable diseases including eradication of malaria, reduction in transmission of and disability from lymphatic filariasis; control of poliomyelitis and other vaccine-preventable diseases. More recent achievements are related to health-related Millennium Development Goals (MDGs) demonstrated by considerable declines in infant and maternal mortality rates since 1990.

The WHO country cooperation strategy provides a strong foundation for this collaboration, highlighting an in-depth analysis of key challenges and opportunities for advancing health and development in the country.

The current country cooperation strategy is the third generation of this document. It articulates WHO's corporate strategy and collaboration with the Republic of Maldives for the period of 2013–2017. In line with the Organization's mandate in promoting global health, the strategic priorities for the next five years articulated in the WHO country cooperation strategy take into consideration the Government's agenda for promotion of health equity within a nation and universal health coverage as a major objective. The country cooperation strategy recognizes the uniqueness of the Maldives as a small island nation, its vulnerabilities and risks related to environment and climate change, new opportunities due to the rapid increase in travel, trade and communication, and the challenges the speed of global interconnectedness brings to sustaining the achievements in health.

This country cooperation strategy is purposely presented at this juncture taking into account the national challenges on the one hand and the ongoing WHO reform process on the other. It represents a consensus of several multisectoral consultations with national and international stakeholders and health partners in the Maldives. The objective of the current country cooperation strategy is to reflect WHO's corporate medium-term vision for its cooperation in the Republic of Maldives and to outline the strategic framework for such cooperation. In order to optimize its contribution to national development and health, the country cooperation strategy attempts to strike a balance between evidence-based country priorities and WHO's mandate in global health. Specifically, WHO's role in health governance and in positioning and promoting health in national policies, processes and plans has been highlighted.

I am pleased to present the third WHO country cooperation strategy for the Republic of Maldives. I trust it will help ensure closer cooperation in health and development by the national and international partners – and that health and well-being of the people of Maldives and those around the globe be enhanced and sustained as a result of collaborative efforts.

A handwritten signature in black ink, appearing to read 'Akjemal Magtymova', with a stylized, cursive script.

Dr Akjemal Magtymova  
WHO Representative to the Republic of Maldives

## Acronyms

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AC	assessed contribution (by Member States)
ADB	Asian Development Bank
ARI	acute respiratory infections
BMI	body mass index
CAS	Country Assistance Strategy
CCS	Country Cooperation Strategy
COPD	chronic obstructive pulmonary diseases
DALYs	disability-adjusted life years
EB	Executive Board
EPI	Expanded Programme on Immunization
EU	European Union
FAO	Food and Agriculture Organization of the United Nations
FCTC	WHO Framework Convention on Tobacco Control
GDP	gross domestic product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNI	gross national income
GPN	global private network
GPW	General Programme of Work (of WHO)
GYTS	Global Youth Tobacco Survey
HIB	haemophilus influenzae type B
HIS	health information system
HPA	Health Protection Agency
IDA	International Development Association
IEC	information, education, communication
IFAD	International Fund for Agricultural Development
IFC	International Finance Corporation
IFIs	International Financial Institutions
IGMH	Indira Gandhi Memorial Hospital
IHR	International Health Regulations
ILO	International Labour Organization
IMR	infant mortality rate
IsDB	Islamic Development Bank

LECReD	Low Emission Climate Resilient Development Programme
LGA	Local Government Authority
MDGs	Millennium Development Goals
MDHS	Maldives Demographic and Health Survey
MDR-TB	multidrug-resistant tuberculosis
MFDA	Maldives Food and Drug Authority
MMR	maternal mortality ratio
MoH	Ministry of Health
MPF	Maldives Partnership Forum
MRF	Maldivian <i>Rufiyaa</i>
MTSP	Medium-term Strategic Plan
NCD	noncommunicable diseases
NGO	nongovernmental organization
NHA	National Health Accounts
ODA	Official Development Assistance
OECD	Organisation for Economic Cooperation and Development
PLHA	people living with HIV/AIDS
SAARC	South Asian Association for Regional Cooperation
SAP	Strategic Action Plan
SIDAS	WHO Regional Office for South-East Asia Integrated Data Analysis System
SOs	strategic objectives
STI	sexually transmitted infections
TB	tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNICEF	United Nations Children’s Fund
UNFPA	United Nations Population Fund
UNDP	United Nations Development Programme
UNOPS	United Nations Office for Project Services
UNESCO	United Nations Educational, Social and Cultural Organization
UNODC	United Nations Office on Drugs and Crime
VC	voluntary contribution(s)
WHO	World Health Organization
XDR-TB	extensively drug-resistant tuberculosis



## Executive summary

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The health status of the people of Maldives has improved in the past few decades. In 1977, the life expectancy at birth was 46.5 years as compared with about 74 years in 2011. In 1990, 34 live-born babies in every 1000 live births in Maldives died before reaching the age of one year. In 2011, the comparative infant mortality rate figure was 9, with the majority of infant deaths occurring in the neonatal period. The maternal mortality ratio declined from about 500 per 100 000 live births in 1990 to 56 per 100 000 live births in 2011. Notable achievements have been made in the control of communicable diseases; however, some challenges persist. Dengue, scrub typhus and toxoplasmosis have surfaced due to environmental and climate changes. Diarrhoea and acute respiratory infections (ARI) continue to cause significant morbidity among children and adults. Tuberculosis, although controlled, has a high risk of spreading in Malé due to overcrowding and poor housing conditions. Noncommunicable diseases (NCDs) accounted for more than 70% of all deaths and disease burden. Lifestyle risk factors are prevalent in the country. The disparity between the atolls and Malé has increased over the past 10 years.

Maldives is undergoing socioeconomic and political transition. In this transition, the country is facing extraordinary challenges in consolidating its initial progress within its decentralization programme. Building capacity and strengthening the newly formed institutions, professionalizing the civil service, ensuring equity, and establishing and promoting good governance – all remain key challenges for the country. With the newly formed local government structure in place, the government's agenda on decentralization requires local communities, spearheaded by the councils, to undertake a number of new roles and responsibilities. Considering this transformation, it is imperative to lay out the framework for smooth and efficient functioning of the local government system.

Within the reform context, the Health Master Plan 2006–2015 was reviewed in 2012. The review redirected the policies and strategies of the plan, based on national development priorities, the emerging needs and the lessons learnt. It formulated four principles of the government's health policy, particularly addressing health as a human right, equitable access to quality health-care services, solidarity for health in all national policies and policy development based on facts and scientific evidence. A focus on the Millennium Development Goals (MDGs) was kept throughout the process as the timeline for the Health Master Plan is congruent with that of the MDGs. In addition, the Health Sector Roadmap 2012–2013, addressing current challenges and indicating strategic approaches related to the building blocks of the health system, has been drafted.

There are 10 National Health Policy Goals articulated in the Health Master Plan 2006–2015:

- (1) To ensure that 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, and to improve the quality of life.
- (4) To ensure that all citizens have equitable access to comprehensive primary health care.
- (5) To establish and enforce appropriate quality assurance and regulatory framework for patient and provider safety.
- (6) To build public–private partnership in health.
- (7) To build a competent and professional health workforce.
- (8) To ensure that the health system is financed by a sustainable and fair mechanism.
- (9) To enhance the response of the health system in emergencies.
- (10) To build a culture of evidence-based decision-making within the health system.

Maldives has been collaborating with the World Health Organization (WHO) since 1951. WHO was the first United Nations (UN) agency to support health programmes in the country. WHO's support has been evolving over time, starting with an assessment of the lymphatic filariasis situation and malaria eradication activities. Later, support was provided for other communicable diseases prevention and control and implementation of International Health Regulations 2005 (IHR 2005), policies on drugs, water and sanitation, hospital management, NCDs prevention and management, emergency preparedness and response, and disaster management. WHO also supported training and development of curricula for all categories of health workers. As a result, WHO is considered a major partner in Maldives' health development.

The current country cooperation strategy (CCS) development process was guided by the WHO CCS Guide 2010, and involved documentary reviews, situation analysis and extensive consultation with key national and international stakeholders in health, including UN agencies within Maldives, the WHO Regional Office for South-East Asia and WHO headquarters. Important documents such as the Health Master Plan 2006–2015 (reviewed), the contributions by the WHO country programme to WHO's biennial programme budget performance assessment, WHO's Eleventh and Twelfth General Programmes of Work, WHO's Medium-term Strategic Plan (MTSP), the former (2008–2010) and the current United Nations Development Assistance Framework

(UNDAF) 2011–2015, and other documents were reviewed and used as the basis to identify priorities for WHO collaborative work in Maldives.

Among the principal outcomes of these activities are: identification of the strategic agenda for WHO collaboration in Maldives; agreement on strategic priorities, main focus areas and strategic approaches; consensus among key public health bodies in Maldives, WHO and partners in health regarding modalities of cooperation; and a renewed CCS.

The guiding principles defining the strategic agenda for WHO's cooperation in Maldives over 2013–2017 are:

- (1) recognition of decentralization as an important national policy;
- (2) health systems are in transition and are being redesigned to improve accessibility and quality of health services towards the goal of universal health coverage;
- (3) WHO's focus is to enhance public health, and address public health challenges by fostering partnerships at national as well as subnational levels;
- (4) WHO's role in health governance, particularly in completing the work on the health-related MDGs and in consultation on the post-2015 development agenda, in the area of NCDs, universal health coverage, and in capacity-building for implementation of international legal instruments.

The strategic priorities and the main focus areas for the WHO country cooperation strategy Maldives 2013–2017 are summarized below.

**1. Strategic priority: Strengthening the health system towards universal health coverage based on the primary health care approach.**

- 1.1 Support the strengthening of health systems policy, legislation and health-care delivery for universal coverage.
- 1.2 Promote efforts to improve access to medicines and health-care technologies based on primary health care.
- 1.3 Support the strengthening of health financing towards universal health coverage.
- 1.4 Support strengthening of health information systems (HIS).
- 1.5 Advocacy and technical support in monitoring and evaluation.
- 1.6 Provide technical support to strengthen health research.

**2. Strategic priority: Preventing and controlling diseases and disabilities.**

- 2.1 Provide technical support to strengthen national capacity in prevention and control of communicable diseases.
- 2.2 Provide policy and technical support to prevent and reduce disease, disability and premature death from chronic NCDs, lifestyle risk factors, mental disorders, injuries and visual impairment, and to orchestrate a

coherent response across societies to address interrelated social, economic and environmental determinants.

**3. Strategic priority: Enhancing public health interventions at national and subnational levels to sustain achievements in health-related UN MDGs and beyond.**

**3.1** Strengthening public health programmes related to the life-cycle.

**3.2** Strengthening food safety, water and sanitation and occupational health.

**4. Strategic priority: Promoting all-inclusive health governance and maintaining WHO's coordinating role and country presence to support health reforms and national health priorities.**

**4.1** Fostering partnership with UN partners, other government sectors and civil society at national and subnational levels.

**4.2** Policy advice for public health management, emergency preparedness and response.

**4.3** Mobilizing resources for sustainable development of health.

WHO will undertake technical and brokering roles. It is expected that further priority-setting and implementation will be a dynamic process wherein some collaborative programmes will be ended on completion of targets and replaced with new priorities during the course of the CCS cycle.

The four strategic priorities constitute the main focus for WHO. However, other important collaborative programme areas will not be neglected. They include normative functions and public health challenges. The CCS is aligned with the national Health Master Plan 2006–2015 and harmonized with the UN's Republic of Maldives agenda described in the UNDAF 2011–2015.

For effective implementation of the CCS, the WHO Country Office will be strengthened through re-profiling of individual staff functions and through mobilizing technical assistance from the Regional Office for South-East Asia, WHO headquarters, horizontal collaboration and external professional assistance on a task and time-bound basis. Technical support needs for health policy development, information management, disease surveillance, especially in building national capacity for the implementation of IHR, development of human resources for health and other critical areas have been highlighted.

The new WHO Country Cooperation Strategy for Maldives 2013–2017 is a dynamic strategic tool for future collaboration between the Republic of Maldives and WHO, in the spirit of harmonized and aligned country-led multisectoral partnership.

# 1 — Introduction

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The World Health Organization's Country Cooperation Strategy (CCS) is an Organization-wide reference for country work, which guides planning, budgeting, resource allocation and partnership. The CCS reflects the overarching values of the United Nations that underpin WHO's Constitution and contribute to improving global health, health-related human rights, equity and gender equality. The key principles guiding WHO cooperation in countries and on which the CCS is based are:

- ownership of the development process by the country;
- alignment with national priorities and strengthening national systems in support of the national health strategies or plans;
- harmonization with the work of sister UN agencies and other partners in the country for better aid effectiveness; and
- cooperation as a two-way process that fosters Member States' contributions to the global health agenda.

The CCS is a medium-term vision for WHO's technical cooperation with Maldives, in support of the country's national health policies, strategies and plans. It is the main instrument for harmonizing WHO cooperation in Maldives with government plans and those of other UN agencies and development partners.

The work of WHO as the world's health agency is directed by the General Programme of Work (GPW). The general programme of work also describes the WHO core functions, which reflect the comparative advantages of the Organization (Annex 1).

The Eleventh GPW identified the agenda for international public health for the period 2006–2015, linked to the UN Millennium Development Goals (MDGs).

The Eleventh GPW noted substantial improvements in health over the past 50 years. However, significant challenges remain, as described in the following four gaps: (i) gaps in social justice; (ii) gaps in responsibility; (iii) gaps in implementation; and (iv) gaps in knowledge.

In order to reduce these gaps over the coming six years, the Twelfth GPW of WHO, discussed by the WHO Executive Board in January 2013, identified eight high-level strategic priorities (Box 1).

**Box 1:** Strategic priorities of WHO's work for the period 2014–2019

- (1) Health-related Millennium Development Goals: unfinished and future challenges
- (2) Addressing the challenge of noncommunicable diseases and mental health
- (3) Advancing universal health coverage
- (4) Implementing the provisions of the International Health Regulations (2005)
- (5) Increasing access to essential, high-quality, effective and affordable medical products
- (6) Addressing the social, economic and environmental determinants of health as a means of reducing health inequities within and between countries
- (7) Strengthening WHO's governance role
- (8) Reforming management policies, systems, and practices.

**Source:** World Health Organization Executive Board, 132 session, January 2013. Document EB132/26 dated 21 December 2012.

The strategic priorities for the period 2014–2019 gave directions for WHO reform, which reflect new realities, and the need for both continuity and change. The Twelfth GPW of WHO agreed on six categories, which will define the structure for successive programme budgets from 2014 (Box 2).

**Box 2:** Categories for priority-setting

- (1) Communicable diseases
- (2) Noncommunicable diseases
- (3) Promoting health through the life-course
- (4) Health systems
- (5) Preparedness, surveillance and response
- (6) Corporate services and enabling functions.

**Source:** World Health Organization Executive Board, 132 session, January 2013. Document EB132/26 dated 21 December 2012.

The South-East Asia Region of WHO has the second-highest population among the six WHO regions, the greatest burden of disease and the largest share of poverty. While economic development in the Region has been remarkable in recent years, the problems of poverty and poor health remain significant and substantial. Many countries faced health emergencies in the past decade, and the threat of disease outbreaks is ever-present. At the same time, noncommunicable diseases (NCDs) have become an

increasingly important cause of morbidity and mortality in South-East Asia. The global policy framework of WHO is, therefore, appropriate for the countries of the Region, with special attention given to strengthening the capacity of Member States to support cost-effective public health interventions.

The first generation WHO CCS in Maldives covered the period 2002–2006, followed by the second generation CCS for 2007–2011. In 2012, the mid-term review of the Health Master Plan 2006–2015<sup>1</sup> showed the need to redirect policies and strategies based on national development policies and priorities, emerging needs and the lessons learnt nationally and globally.

Maldives has embarked on a new constitution (ratified in 2008) that paves the way for a modern democracy with an elected president, parliament and new government. At the same time, a decentralization and privatization policy is being addressed to ensure equitable access to quality health care for all. In this environment, the development of the new WHO CCS for Maldives started in a very timely manner, taking into consideration the targets for achieving MDGs 2015 and developing the agenda for the post-2015 period.

The current CCS development process (Annex 2) guided by the new WHO CCS Guide 2010 involved documentary reviews, situation analysis and extensive consultation with key national and international stakeholders in health, including UN agencies within Maldives, WHO Regional office for South East Asia and WHO headquarters. Important documents, such as the reviewed Health Master Plan 2006–2015, the Health Sector Road Map 2012–2013, the contributions by the WHO country programme to WHO's biennial programme budget performance assessment, the WHO GPWs, the WHO Medium-term Strategic Plan 2008–2013, the former (2008–2010) and the current UNDAF 2011–2015, and other documents were reviewed and used as the basis for identifying priorities for WHO's work in Maldives.

An extensive consultation process involving stakeholders and high-level decision-makers was undertaken to formulate the priorities and the working modalities reflected in the current CCS. Among the principal outcomes of these consultations are: identification of the strategic agenda for WHO collaboration in Maldives; agreement on strategic priorities, main focus areas and strategic approaches; consensus among key public health bodies in Maldives, WHO and partners in health regarding modalities of cooperation; and a new CCS.

## 2 — Health and development challenges

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### 2.1 Macroeconomic, political and social contexts

Maldives has a narrow economic base relying on two key sectors: tourism and fisheries. Despite this, the economy has been growing steadily and is in rapid transition. Maldives graduated from least developed country status in 2011, to one with the highest per capita income in South Asia.<sup>2</sup> In 2011, the gross national income (GNI) per capita was US\$ 5800<sup>3</sup> and the gross domestic product (GDP) per capita was US\$ 6488<sup>4</sup>. However,



in the light of the food and fuel price hikes, the global recession and climate change, social protection systems – both formal and informal, have come under increasing pressure. Unfortunately, these same events led to significant erosion in resources and fiscal space available to the government, as indicated in the Health Master Plan. In addition, the people of Maldives remain vulnerable both environmentally and geophysically.

The *Population and Housing Census of Maldives 2006* indicated that the population of Maldives was 298 968 with a predicted annual average population growth rate (2008–2010) of 1.6%.<sup>5</sup>

The general shape of the population pyramid indicates that the age and sex composition of the population is similar to other developing countries, with relatively smaller proportion in the older age categories and larger proportion of the population in the less-than-20-years-of-age categories (Figure 1). Thirty per cent of the population comprises women in the reproductive age group (15–49 years), a fact that may have an impact on the population growth.<sup>6</sup> Furthermore, 36% of the population were between 10 and 24 years. It is also projected that the size of the population above 75 years will almost double between 2006 and 2015.

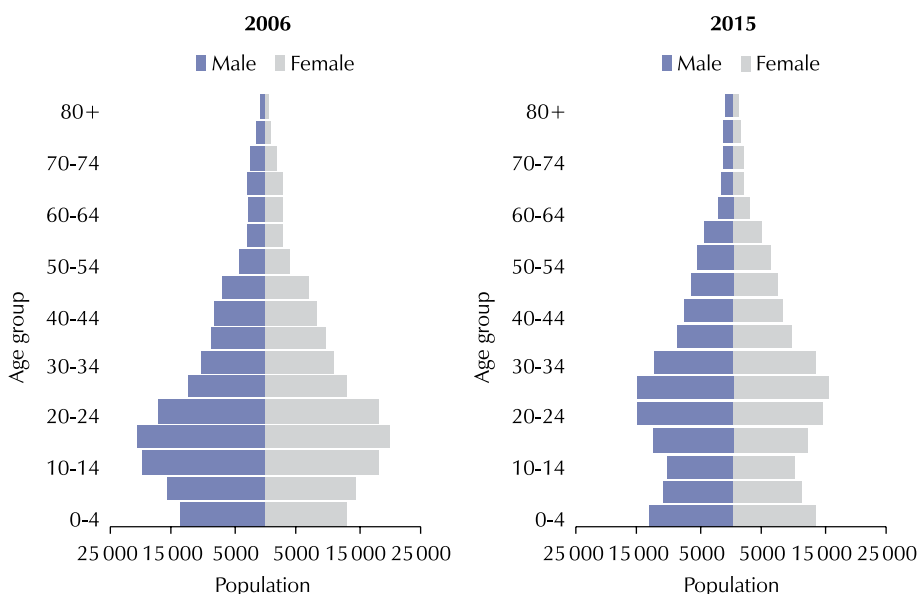
**Table 1:** Population trends from 1995 to 2015 (projected)

	1995	2000	2006	2010	2015
Population	244 814	270 101	298 968	319 466	347 552
Numerical increase	31 599	25 287	28 867	20 498	28 096
Average annual growth (%)	2.73	1.96	1.69	1.6	1.76

Source: Analytical Report of Census, Maldives, 2006; Statistical Yearbook of Maldives 2010.

The life expectancy at birth increased from 70.0 to 73 years in males and from 70.1 to 75 years in females, from 2000 to 2011.<sup>7</sup> Improved accessibility to health services, better diagnostic and quality health services and greater awareness among the population about their health are considered to be the contributing factors in the increase in life expectancy.

**Figure 1:** Population pyramids, 2006 and 2015  
(projection based on 2006 census)



Source: Republic of Maldives. Maldives Statistical Yearbook 2012, Department of National Planning.

A number of important social changes have resulted from the economic growth. Rapid and unplanned urbanization of the capital city, Malé, has seen one of the world's smallest capitals double its population in the past 16 years, from 55 000 inhabitants in 1990 to 152 000 in 2006,<sup>8</sup> making it by far the most densely populated island in the country, with one of the highest population densities among the world's capitals. Much of this has resulted from inward migration from other atolls, due to the availability of

better education, social services and job opportunities in Malé. The Republic of Maldives consists of 1192 islands, out of which 194 are inhabited.

Economic growth has been accompanied by substantial gains in social development, with significant increases in the educational levels of the Maldivian population. For example, the net enrolment in lower secondary schools increased from 18.9% in 1997 to 64.6% in 2005.<sup>9</sup>

In consolidating initial progress, the national decentralization programme poses extraordinary challenges to the country, and to the health sector in particular (see also sections 2.4 and 2.5 of this document). Capacity development, strengthening of the newly formed institutions, professionalizing the civil service, ensuring equity, and establishing and promoting good governance continue to be key challenges for the country.<sup>10</sup> With the newly formed local government structure in place, the government's agenda on decentralization requires local communities, spearheaded by the councils, to undertake a number of new roles and responsibilities. The elected councils are to assume responsibility broadly for all aspects of local development. Considering this transformation, it is imperative to lay out the framework for smooth and efficient functioning of the local government system.

The Ministry of Health is the lead agency for the health sector. It is responsible for developing the national health policy of the country, public health protection, health service delivery as well as regulation and quality assurance of health services (the organizational structure of the Ministry of Health is shown in Annex 4). There are regulatory bodies (Maldives Medical Council, Maldives Nursing Council, Maldives Health Services Board) responsible for regulating the practice and conduct of professionals in relevant fields. Furthermore, Maldives Food and Drug Authority is responsible for quality and safety of medicines and food products and services, and the Health Protection Agency (formerly Centre for Community Health and Disease Control) is responsible for regulating public health provision and protection. During the period 2009–2012, public sector health facilities were corporatized, and assets and health service delivery mandate transferred to state-owned enterprises. As such, Health Services Corporations were established in eight regions, and public hospitals and health centres were transferred. However, in 2012, it was decided by the cabinet to reverse the change and to transfer the assets and health services delivery back to the Ministry of Health (Health Master Plan 2006–2015, reviewed 2012). The changes in the health sector have not always been accompanied by a solid dissemination and enforcement strategy with institutions and staff at times are being left disoriented and unclear on their roles and reporting channels. Health system managers, stakeholders and development partners are aware of this challenge.<sup>11</sup> There is also concern that a rapid response action mechanism to address public health emergencies may not be in place as yet.

Numerous external organizations contribute and support the development of the health sector. Some key contributors are the United Nations Children's Fund (UNICEF),

the United Nations Population Fund (UNFPA), the United Nations Development Programme (UNDP), the Joint United Nations Programme on HIV/AIDS (UNAIDS), The World Bank, International Federation of Red Cross and Red Crescent Societies (IFRC), Asian Development Bank (ADB), Kuwait Fund, Commonwealth and other regional health-care institutions and organizations, other donor agencies, and international NGOs focused on the area of health.

Some health-related national legal instruments, such as the Social Health Insurance Act and Health Protection Act, have passed through the parliament and are being enforced. A number of other legal instruments, such as the Health Professionals Bill and Medicines Bill, the Health Services Bill and the Medical Negligence Bill are either being developed or are awaiting the parliament's approval. Maldives ratified the WHO Framework Convention on Tobacco Control in 2004. The Tobacco Control Act was passed in August 2010. Under the Act, a national advisory body, the Tobacco Control Board, has been constituted and the first piece of regulations under the Tobacco Control Act, the Ban of Smoking in Public Places, has been implemented from January 2013. Furthermore, the IHR 2005 are being implemented. However, advocacy for adherence, legal backing in the country, and continued core capacity-building are crucial challenges ahead.

## 2.2 Other major determinants of health

Along with economic growth, *living standards* in Maldives have increased substantially in the past two decades. Since 1997–1998, the average household income per capita in the atolls has increased by over 50%, and within Malé, it has almost doubled. However, there is a substantial discrepancy between the income levels of Malé and the atolls, with the median per capita household income of Malé being 2.3 times higher.<sup>12</sup>

Today, *poverty* in Maldives is determined largely by geography and the imbalance in access to services, with remote islands far from Malé being particularly deprived. The MDG target on poverty (eradicate extreme poverty and hunger) had been achieved at the national level. It is clear that rapid economic growth hides wide and increasing income disparities across areas within the country, representing an increasing cause for serious concern. Indeed, income poverty in Maldives has strong geographical and rural dimensions.<sup>13</sup> There is a high incidence of transient income poverty, with individuals moving in and out of poverty status, rather than moving permanently out of poverty.<sup>14</sup>

Almost all children in Maldives receive primary *education*, and almost everyone is literate. But the quality of education is still quite low, and children have few opportunities to participate actively in their learning and to develop more enquiring minds. This is largely due to the fact that the national curriculum is not based on participatory learning methods. Over 30% of teachers in Maldives are untrained, with many islands having up to 100 pupils per trained primary teacher. There are many barriers to

training, transport being the primary among them. Up to 80% of staff training costs are transport-related.<sup>15</sup>

The population **demographics** of the country as per the 2006 census indicated that 37% of the population were between 10 and 24 years old. Hence health issues and specific needs of this population segment, such as adolescent sexual and reproductive health and nutrition, psychological status, education, employment and socioeconomic problems leading to tobacco and drug use, are a priority. At the same time, the size of the elderly population increased from 3.8% in 2000 to 5.3% of the total population in 2006, indicating the need for developing targeted programmes for healthy ageing. The decline of population growth between the intercensus periods, with corresponding lower levels of fertility, together with increased internal migration of reproductive-age male population from the atolls to Malé has an implication for provision of family planning and reproductive health services to the population in the atolls and to the overcrowding population of Malé.

**Gender-responsive policies and programmes** are important for the country. Violence against women and girls persists with 1 in 3 women aged 15–49 years experiencing some form of physical or sexual violence during their lifetime. This affects the overall mental, psychological and physical health of women survivors as well as that of their children and families, thus requiring focused action in the health sector to enable their participation in society and development.<sup>16</sup> There is also a concern that some interpretations of cultural, religious, and/or traditional beliefs might create certain barriers to the right-based access to maternal and child health care (e.g. reproductive health, antenatal care, immunization).

**Malnutrition** in children under 5 years was reduced from 43% in 1994 to 27% in 2004. The demographic health survey 2009 showed that the situation of undernutrition is improving with the prevalence of underweight in children below 5 years further decreasing to 17%, stunting to 19% and wasting to 11%, a rather high figure when considering the Maldivian per capita income. The micronutrient survey of 2007 observed that only 50% infants were being exclusively



Health education session for mothers and children during nutrition campaign at Laamu Atoll.

breastfed, and that the weaning and feeding practices of infants and children were the major factors for the continued problem of malnutrition. The study also showed

that micronutrient deficiencies, especially deficiencies of iron, vitamin A and zinc are nutrition issues that need to be addressed in children and in women of reproductive age.

The increasing prevalence of **drug abuse** among young people is of great concern to public health.<sup>17</sup> In 2006, results of an assessment showed that the age of first use had declined to 12–16 years with isolated incidents being reported of children as young as 9 years using drugs. Of respondents, 28% reported having injected drugs. The main findings of the National Drug Use Survey (age group 15–64 years) revealed that the estimated number of drug users in Malé was 4342 and the estimated number of drug users in the atolls was 3154. The estimated prevalence for Malé and atolls were 6.64% and 2.02%, respectively. The majority of respondents who had ever used drugs belonged to the age group of 15–19 years. The age of onset for consuming drugs was 15 and 16 years in Malé and atolls, respectively. An overwhelming majority of drug users were males; drug use in Maldives was predominantly a male phenomenon that needs to be taken into consideration while designing intervention programmes.<sup>18</sup>

The deteriorating quality of the **environment** and its impact on health are emerging as areas of concern. Outdoor air pollution from dust, smoke, and fumes from motor vehicles is rising in Malé and some of the industrial islands.<sup>19</sup> Noise pollution is also a growing problem in these islands. Indoor air pollution from wood-burning stoves is a serious problem in the rural islands. Most island communities lack a comprehensive, environmentally sound system for collection and disposal of solid waste. The capital island and some of the islands with a sewage system have the discharge pipes out of the lagoon. Sewage is treated before discharge into the sea in the capital and in some islands.

**Air pollution** is an emerging issue in Maldives and is confined largely to the densely populated island of Malé. Local air quality in Malé is poor, largely due to pollution from vehicle emissions and is exacerbated by a very congested population of above 100 000. Although the link between respiratory diseases and ambient air quality in Malé has not been formally studied, in recent years there has been an increase in the reported cases of respiratory diseases.

**Food safety** is receiving attention. Under Article 12 of Act number 1/96 (Consumer Protection Act), all food items manufactured or imported to Maldives for purpose of trade should contain on the packaging in Dhivehi or English the type of food item, ingredients, weight or measurements, manufactured country and date, duration within which it should be used or the expiry date, and instructions on usage if it should be used in a particular way.<sup>20</sup> The main issue in Maldives within the agriculture sector is to develop better linkages to the tourism industry for the marketing of agriculture produce in order to enhance the livelihoods of farmers and ensure their food security. The biggest danger facing farmers is depletion of the freshwater aquifers used for irrigation as well as drinking purposes. Overall **food security** is satisfactory.<sup>21</sup>

The uneven population distribution within the archipelago gives rise to a range of **housing and shelter** problems. Malé, the capital island, is barely 1 km wide and 2 km long but has a density of 58 500 persons per km<sup>2</sup> (one of the highest in the world) and, with 14 107 households, has an average household size of 7.4 persons. Severe overcrowding is not confined to Malé. Three other islands have even higher population densities while lacking much of Malé's infrastructure and services. The extreme level of overcrowding places people at great risk of infections from communicable diseases. In order to address the problem of very high population density and the environmental impact in the capital island Malé, a land reclamation project has been launched in a lagoon near the capital.<sup>22</sup>

According to the national target of 4 litres per capita a day, the urban population (Malé) has achieved 100% access to safe **drinking-water** through desalination. Ninety seven per cent of households have access to improved sources of water. Rural households are slightly less likely to have access to improved water sources than urban households, at 97% and 99%, respectively. Rainwater is a more important source of drinking-water in rural areas (95%) than in urban areas (5%). Fifty two per cent of urban households have piped water in their premises, but it is not the main source of water for drinking. Overall, 13% of households use bottled water for cooking and washing (41% in urban areas and 1% in rural areas). Of households, 94% have the water source on the premises (99% in urban and 91% in rural areas). In urban areas, most households use water from desalinated plants. More than half of households (57%) do not treat water prior to drinking (81% in urban areas and 46% in rural areas). Among households that treat their drinking-water, 39% use an appropriate method (19% in urban areas and 48% in rural areas). Straining through cloth (27%) and boiling (10%) are the most common methods used to treat water.<sup>23</sup>

The coverage pattern is similar for **sanitary** facilities. Rural households are somewhat less likely to have a non-improved toilet facility than urban households (7% and 3%, respectively). Flush toilets are the most common type of toilets in Maldives. Households in urban areas use 97% flush toilets with a piped system. The most common type of toilets in rural areas is the flush toilet facility with a pit latrine. Only 2% of households have no toilet facility.

**Solid waste management** is also emerging as a key issue that threatens the ecosystem and health: the estimated quantity of waste was expected to jump by more than 30% between 2007 and 2012 alone, from 248 000 tons to 324 000 tons, with much being domestic waste.<sup>24</sup> A little less than half of all waste is generated from Malé; on average, between 2002 and 2008, the Malé municipality transferred nearly 110 000 tons of waste to Thilafushi island every year for burning. In 83% of other islands, households collect and transfer waste to a designated area in the island. Although island-level waste disposal sites exist, these are rarely used because of their remoteness from homes and because of the low level of environmental awareness.

Random disposal of waste is quite common, nearly 25% households throw waste into the bushes or burn it in their living areas. Solid and hazardous waste management is recognized as a critical environmental issue.

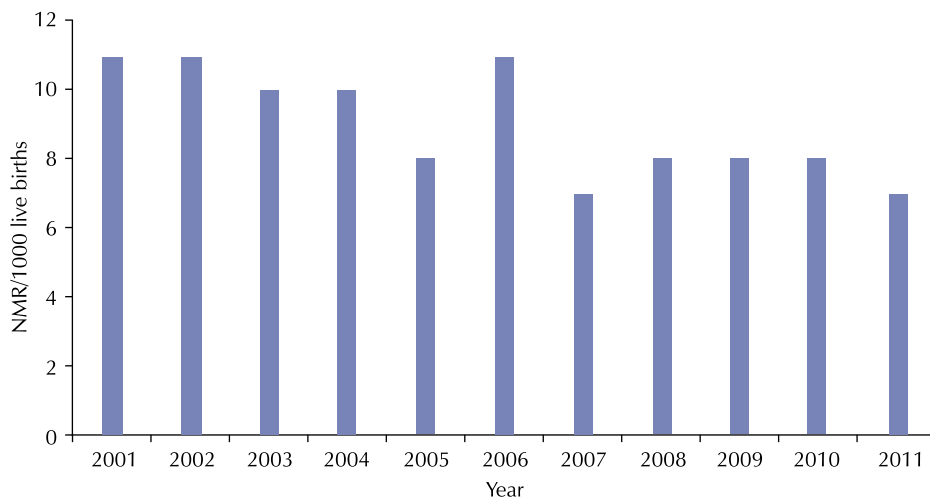
Rapid growth in economic sectors such as construction industry, fisheries, boat building, transportation, tourism and agriculture underscores the need for **occupational health and safety measures**. The International Labour Organization's (ILO's) report *Decent work – safe work, 2005*<sup>24</sup> estimated that in Maldives, there were, in one year, more than a dozen work-related fatal accidents, nearly 12 000 nonfatal work-related accidents, and over 40 deaths due to work-related diseases and 11 deaths caused by dangerous substances. Mental health and occupational health are “MDG plus” issues.

Prior to the December 2004 tsunami, the **vulnerability of Maldives to natural disasters** was thought to be moderate. Although the country had to deal often with storm surges and localized flooding, there had been no history of destructive hazards on a major scale. The tsunami exposed the extensive vulnerability of Maldives to natural disasters. In 2006, UNDP undertook the first disaster risk assessment in the country: *Developing disaster risk profile for Maldives*,<sup>25</sup> according to which Maldives faces multiple hazards including storm surges, tsunamis, heavy rains and flooding, tidal waves, earthquakes, and dry spells. These threats are expected to intensify and become more frequent due to climate change. Given the country's fragile ecological profile and the heavy economic dependence on tourism, fisheries and foreign imports, Maldives is among the most vulnerable countries to natural hazards. This is evidenced by the loss of 62% of GDP (compared with less than 2% in Indonesia and Thailand) as a result of the tsunami.

### 2.3 Health status of the population

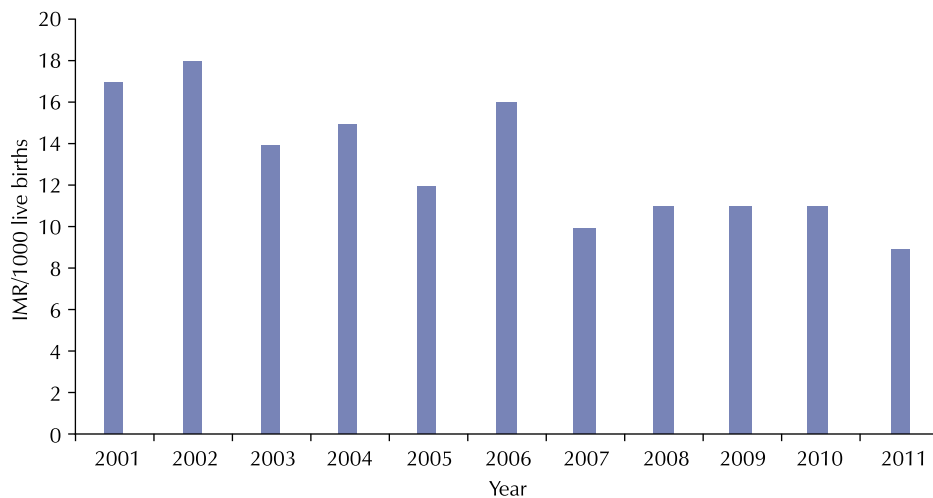
The health status of the people of Maldives has improved in the past few decades. In 1977, the life expectancy at birth was 46.5 years. In 2011, it was 73 years for males and 75 years for females. In 1990, 34 live-born babies in every 1000 live births in Maldives died before reaching the age of one. In 2011, the comparative infant mortality rate (IMR) figure was 9, with the majority of infant deaths occurring in the neonatal period. The maternal mortality ratio (MMR) declined from about 500 per 100 000 live births in 1990 to 56 per 100 000 live births in 2011.<sup>26</sup> Although MDGs 4 and 5 related to maternal and child mortality have been achieved, a trend in infant and maternal deaths for the past few years (Figures 2–4) might indicate that sustaining this success would require revitalizing the public health interventions and primary health care approach in health-service delivery. Selected socioeconomic and health indicators, including achievements in MDGs, are indicated in Annex 3.

**Figure 2: Neonatal mortality rate per 1000 live births, 2001–2011**



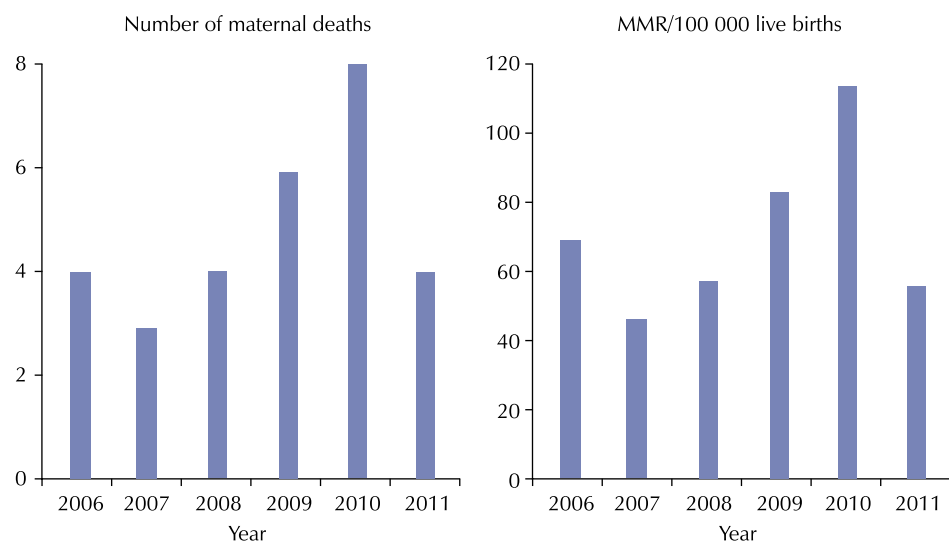
**Source:** Republic of Maldives, Ministry of Health. *Maldives health statistics 2012. in press.*

**Figure 3: Infant mortality rate per 1000 live births, 2001–2011**



**Source:** Republic of Maldives, Ministry of Health. *Maldives health statistics 2012. in press.*

**Figure 4:** Maternal mortality: trends in the number of maternal deaths and in the maternal mortality ratio (MMR per 100 000 live births), 2006–2011.



**Source:** Health Information and Research Section, Policy and Planning Division, Ministry of Health, Maldives, 2012.

### (i) Burden of communicable diseases

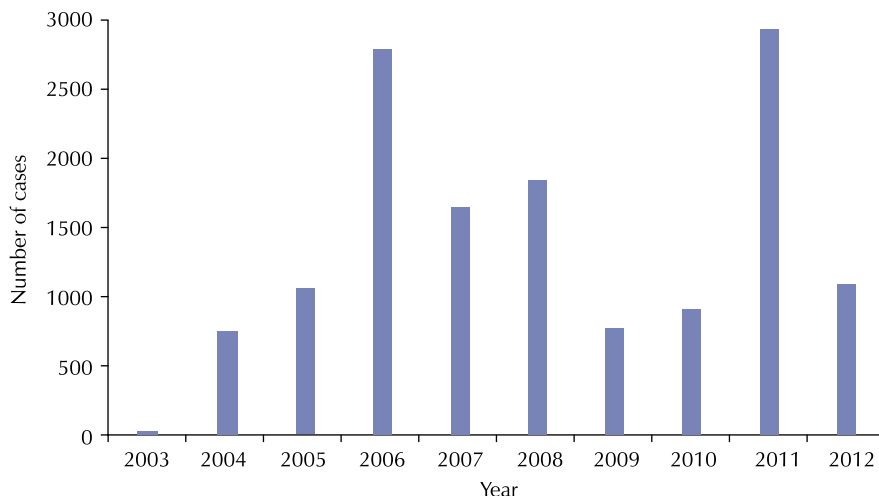
Notable achievements have been made in the control of communicable diseases. Maldives has been malaria-free since 1984. Vaccine-preventable diseases have been controlled to such an extent that diseases such as polio, neonatal tetanus, pertussis and diphtheria are nonexistent. Control measures regarding lymphatic filariasis and leprosy are progressing towards the WHO regional elimination targets. The country is on track to achieve MDG 6.

However, dengue, scrub typhus and toxoplasmosis surfaced due to environmental and climate changes (Figure 5). Diarrhoea and acute respiratory infections (ARI) continue to cause significant morbidity among children and adults. In 2011 and 2012, ARI and diarrhoea cases accounted for approximately 57% and 9%, respectively, of all reported communicable diseases cases.



*Immunization session at Malé health centre, Malé.*

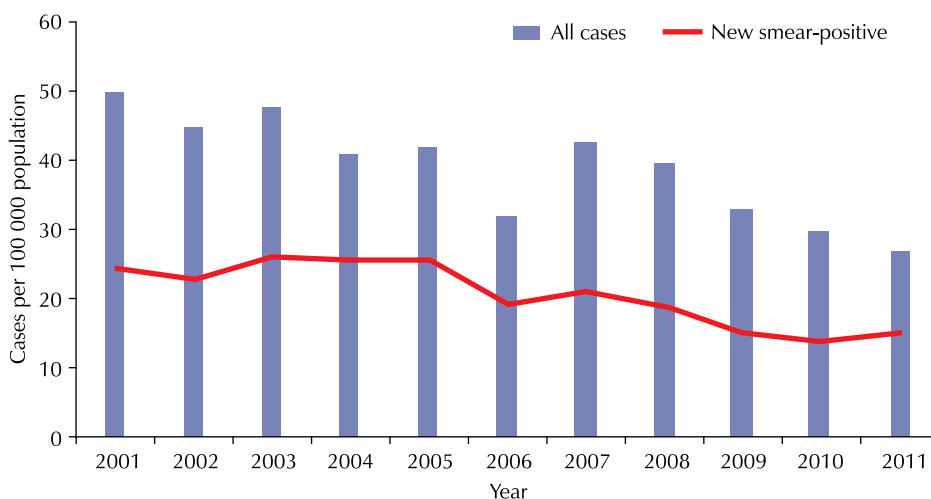
**Figure 5: Dengue: trend in number of reported cases, 2003–2012**



**Source:** Health Protection Agency, Ministry of Health, Maldives, February 2013.

In 2011, the notification rates for all forms of tuberculosis (TB) and new smear-positive cases were, respectively, 27 and 15, showing a steady decrease, particularly for all cases (Figure 6). The TB epidemiology in Maldives seems to be shifting from an epidemic phase to a low-endemic phase. However, efforts towards TB control should continue to be strengthened, as estimated incidence is still above 20 cases per 100 000 population (threshold for low-incidence country) and the shift of infection to older age groups is still not patent. The recording and reporting systems for TB should be strengthened in order to reliably monitor further progress in TB control on time and with accuracy.<sup>27</sup>

**Figure 6: Tuberculosis: trends in case notifications, 2001–2011**



**Source:** Republic of Maldives, Ministry of Health. Maldives health statistics 2012. in press.

While Maldives has been able to maintain the low-level HIV epidemic until now, there is an indication that the monitoring system and linkages across services (number of patients with sexually transmitted infections (STI) versus HIV testing and counselling) may not be satisfactory. The 2008 biological and behavioural survey of at-risk population groups suggested increased HIV risks and STIs due to the practice of unprotected sex among sex workers and young people as well as needle-sharing among intravenous drug users. Although about 65–80% of respondents were aware of the ways to prevent HIV transmission, condom use was low. Most respondents preferred self-medication or did nothing about symptoms of STIs.

**Table 2:** Twenty leading causes of deaths, number and per cent of total number of deaths, 2011

ICD	Cause	Number	Per cent
I30-I52	Other forms of heart disease	130	11.4
I20-I25	Ischaemic heart diseases	113	9.9
I60-I69	Cerebrovascular diseases	108	9.5
I10-I15	Hypertensive diseases	79	6.9
I26-I28	Pulmonary heart disease and diseases of pulmonary circulation	14	1.2
J40-J47	Chronic lower respiratory diseases	80	7.0
J95-J99	Other diseases of the respiratory system	17	1.5
J80-J84	Other respiratory diseases principally affecting the interstitium	15	1.3
C00-C75	Malignant neoplasms	78	6.9
C76-C80	Malignant neoplasms of ill-defined, secondary and unspecified sites	16	1.4
E10-E14	Diabetes mellitus	36	3.2
W00-X59	Other external causes of accidental injury	37	3.3
R95-R99	Ill-defined and unknown causes of mortality	120	10.6
R50-R69	General symptoms and signs	24	2.1
R00-R09	Symptoms and signs involving the circulatory and respiratory systems	18	1.6
A30-A49	Other bacterial diseases	12	1.1
A90-A99	Arthropod-borne viral fevers and viral haemorrhagic fevers	11	1.0
N17-N19	Renal failure	28	2.5
P20-P29	Respiratory and cardiovascular disorders specific to the perinatal period	19	1.7
K90-K93	Other diseases of the digestive system	12	1.1
<b>Total deaths (all ages)</b>		<b>1 137</b>	

Source: Republic of Maldives, Ministry of Health. *Maldives health statistics 2012*. in press.

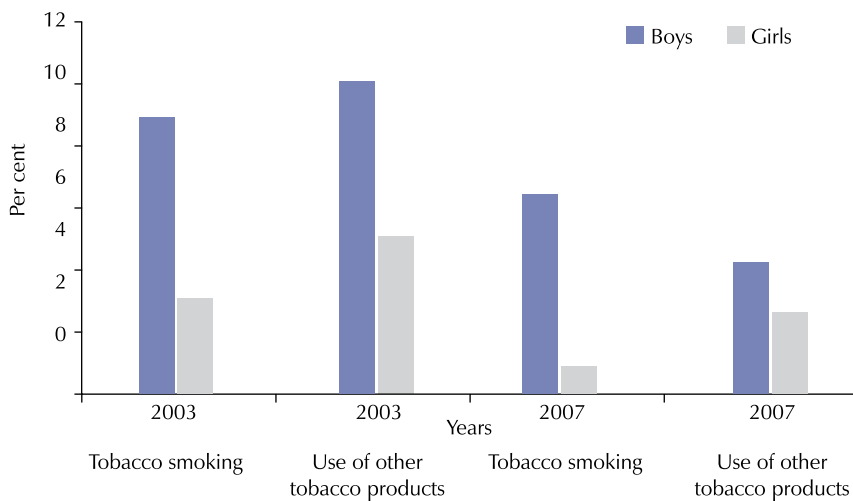
## (ii) Burden of chronic noncommunicable diseases, risk factors, injuries and mental disorders

Noncommunicable diseases (NCDs) account for up to 70% of all deaths in Maldives.<sup>28</sup> Cardiovascular diseases caused 38.9% of all deaths, chronic lower respiratory diseases 7.0%, cancers 6.9% and diabetes 3.2% of all deaths in the country (Table 2).

Besides the major NCDs, Maldives has the highest prevalence of thalassaemia in the world with a carrier rate of 18% of the population.<sup>29</sup> The National Thalassaemia Centre of Maldives screens all persons seeking marriage in Malé. Medical termination of pregnancy is offered when a thalassaemia major child is diagnosed prenatally where both partners are carriers. Prevalence continues to be high. The Maldives National Thalassaemia Programme includes thalassaemia in the school curriculum; the legal requirement for screening prior to marriage; legalization of prenatal diagnosis and medical termination of pregnancy; and the commencement of prenatal diagnostic services.<sup>30</sup> Neuropsychiatric conditions (disease burden or disability-adjusted life years (DALYs)<sup>31</sup> lost due to these conditions) were highest in Maldives among the countries of the South-East Asia Region, i.e. 3938 per 100 000 population as per 2008 estimates. This therefore represents a serious public health problem in Maldives.<sup>32</sup>

The WHO STEPwise approach to Surveillance (STEPS) survey 2004 conducted in Malé (urban area) indicated that 24.1% of the adult population (aged over 25 years) were current daily smokers. It also indicated that 40% of males and 10% of females were current daily smokers, one of the highest rates among countries in the Region. A national survey – Global Youth Tobacco Survey in students aged 13–15 years – found the prevalence of tobacco use in boys between 5–10% (Figure 7).

**Figure 7:** Change in tobacco use in youths (aged 13–15 years), 2003–2007



**Source:** *Report on the global tobacco epidemic*, World Health Organization, Geneva, 2009.

The Maldives Demographic and Health Survey (MDHS) 2009<sup>33</sup> showed that 45% women of reproductive age (15–49 years) are overweight (body mass index (BMI) >25) and that 13% are obese (BMI >30). The MDHS 2006 showed that prevalence of overweight and obesity was higher in urban (Malé) than in rural areas (atolls). The STEPs survey 2004 showed that the mean BMI for men and women in Malé was 24.5 and 25.7, respectively. The STEPS survey reported abdominal obesity in 24% of men and 54% of women. In both males and females, the prevalence of both overweight and obesity was the highest among countries in the South-East Asia Region.

Maldives has acknowledged NCDs as a top health priority. The country's Health Master Plan 2006–2015 stated that, among NCDs, cardiovascular diseases, diabetes, renal diseases, chronic obstructive pulmonary diseases, and selected cancers would be given the main focus. Thalassaemia and mental health also receive priority attention. Services for the prevention and rehabilitation of physical and mental disabilities would be developed in partnership



*Monitoring risk factors for noncommunicable diseases at the physician's office, Indira Gandhi Memorial Hospital, Malé.*

with social services and the private sector. In addition, Maldives has developed the Noncommunicable Diseases Strategic Plan 2008–2010. The plan intended to combine private and public sector efforts in the management and care of priority NCDs.

Maldives is making progress on tobacco control. It ratified the WHO Framework Convention on Tobacco Control in 2004. The enabling national legislation, the Tobacco Control Act, was passed and ratified in August 2010. As per the stipulations of the Act, a national advisory body (Tobacco Control Board) has been formed and is currently formulating tobacco control regulations, of which the first one – the Ban of Smoking in Public Places, has been implemented from 1 January 2013. An effective implementation and enforcement of such regulations is a challenge. In parallel, the Health Protection Agency, in collaboration with national stakeholders, is conducting awareness and advocacy activities targeted at the general population and at policy-makers. Despite these recent efforts, Maldives has one of the highest prevalence rates of tobacco use in South Asia. Tobacco products are widely available and comparatively low priced. Also, progress towards effective policy (e.g. taxation, supply control) is hindered by the strong lobbying from the tobacco industry.<sup>34</sup> However, in 2012, removal of tobacco products from the list of items enjoying waiver of import duty at regional ports, coupled with the

increase in import duty of tobacco products by 200% resulted in a marked increase in their retail prices; a proposal for further increase is being considered.<sup>35</sup>

### **(iii) Health over the life-cycle**

With the total fertility rate of 1.8 per woman in 2012,<sup>36</sup> IMR of 9 per 1000 live births and MMR of 56 per 100 000 live births in 2011 and life expectancy at birth of about 74 years in 2011, Maldives is well ahead of many of the South Asian countries and has entered the era of “*demographic dividend*”.<sup>37</sup> Maldives claims to have already achieved the MDGs for universal primary education, IMR and MMR and is on track to achieve other MDGs, except the goal on environment, which is difficult to attain given the geographical constraints. Improvements in health care delivery and referral services also resulted in significant reduction of maternal deaths. In spite of a decline in MMR from about 500 per 100 000 live births in 1990 to 56 per 100 000 live births in 2011, there was an increase in the number of maternal deaths from 3 maternal deaths in 2007 to 8 maternal deaths in 2010. The main causes of maternal deaths were complications of pregnancy and childbirth: haemorrhage, eclampsia and infection. These are all preventable causes of maternal mortality.

Due to demographic transition, the adolescent youth population of Maldives has bulged. Studies have documented evidence that adolescents and youth in Maldives are sexually active and indulge in risky behaviour including drug abuse and unsafe sex. Access to reproductive health services including contraceptives to unmarried adolescent youth is not officially promoted. As a result, adolescents find it difficult to access condoms and other reproductive health services.<sup>38</sup> Attempts by NGOs to provide services to adolescents and youth have been less than satisfactory.

Although child survival has improved over the years, two issues threaten progress: increasing disparity and undernutrition rates. The MDHS 2009 indicated that rural children are more often stunted (20%) than urban children (16%). Regional variation in nutritional status of children is substantial, with stunting being highest in the North Central Region (23%) and lowest in Malé and the North (16%). The North Central Region reports the highest level of wasting (15%) and Malé reports the lowest level (7%). With regard to children under the age of 5, 17% are underweight for their age. There are substantial geographical variations. The proportion of children who are underweight is higher in rural than in urban areas. At the regional level, children in Malé are the least likely (11%) to be underweight, while children in the North Central and South Central regions are the most likely (24% and 20%, respectively). Reduction in undernutrition has not been commensurate with health developments. Among countries with comparable rates of under-five mortality, Maldives shows persistent levels of undernutrition in respect of all three indicators of the nutrition status. Many factors are responsible for the high levels of undernutrition in the country. These include dietary habits and preferences for staple foods like rice and fish; inadequate access to health care; poor infant feeding, child care, and hygiene practices; and the high incidence of certain infections. The

significant proportion of imported food, high in cost and irregularly supplied, restricts the consumption of vitamin- and mineral-rich foods. Among all the fruits and vegetables imported into Maldives, the largest proportion goes to tourist resorts and the second largest to Malé. Very few, if any, imported fresh foods arrive at the islands.

Despite gains in mortality rates, the disparity between the atolls and Malé has actually increased over the last 10 years, with atolls enduring an under-five mortality rate of 30 compared with 11 in Malé.

The government has set up strategies for the improvement of elderly health care. Home care for the aged who have no relatives, particularly the chronically ill and widowed, has been established at Guraidhoo. The strategies include strengthening health care institutions by providing training programmes for health-care providers. Facilities and special equipment for treatment of the elderly would be provided. Home care for the elderly, and community care and health education would be strengthened by training health-care providers. Counselling and early detection procedures would be reinforced in the community. Moreover, outreach programmes, particularly for the bedridden, in collaboration with NGOs and the private sector would be developed. Furthermore, the government has also developed a strategy to provide special facilities for the assistance of the elderly in leading independent lives such as hearing aids, prescription glasses, wheelchairs and walking sticks.

#### **(iv) Health of vulnerable population groups and hard-to-reach communities**

Overall, the extensive provision of health-care services by the government has reduced disparities in access to services, although they continue to exist. It has also ensured a high degree of protection against the financial risks associated with medical treatment. Maldives compares credibly with most other developing Asian countries in the degree of financial risk protection it offers. Health service provision by the government is largely pro-poor. An outreach health service system for populations in small rural islands has been established. In 2012, a social health insurance system “*Aasandha*” was introduced, with free universal access to the scheme for the entire population, subject to annual individual financial limits. Maldives has not only had a high per capita expenditure on pharmaceuticals (US\$ 95), almost all drugs are trade name products that are imported into the country.<sup>39</sup> Travel costs may play a significant burden of out-of-pocket expenditures for people (in 2011, the out-of pocket expenditure as per cent of total health expenditure was 49.4%).

## **2.4 National response to overcome health challenges**

Within the reform context, the Health Master Plan 2006–2015 was reviewed in 2012. The review redirected the policies and strategies of the plan, based on national development priorities, the emerging needs and the lessons learnt. A focus on the MDGs was kept throughout the process as the timeline for the Health Master Plan is

congruent with that of the MDGs. In addition, the Health Sector Roadmap 2012–2013, addressing current challenges and indicating strategic approaches related to the building blocks of the health system, has been drafted.

The following are the 10 ***national health policy goals*** as formulated in the Health Master Plan 2006–2015:

- (1) to ensure that 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, and to improve the quality of life;
- (4) to ensure that all citizens have equitable access to comprehensive primary health care;
- (5) to establish and enforce appropriate quality assurance and regulatory framework for patient and provider safety;
- (6) to build public–private partnership in health;
- (7) to build a competent and professional health workforce;
- (8) to ensure that the health system is financed by a sustainable and fair mechanism;
- (9) to enhance the response of the health system in emergencies;
- (10) to build a culture of evidence-based decision-making within the health system;

The Health Master Plan serves as the principal planning document of the government in the delivery of its health programmes.

The mission of the government as outlined in the Health Master Plan 2006–2015 is to protect and promote the health of the population with enabling policies and healthy environment; provide social health insurance, develop an efficient sustainable health system and provide need-based, affordable and quality health services in partnership with the private sector and community.

The right of every citizen to access good quality health services in Maldives is protected by the Constitution of the Republic of Maldives,<sup>40</sup> which directs the government to ensure that this right is realized for all. In execution of its constitutional mandate, the government’s health policy is based on four principles:

- (1) recognizing health as a human right and its universality;

- (2) ensuring equitable access to affordable, quality health services based on the primary health care approach;
- (3) harnessing solidarity for health in all national policies; and
- (4) ensuring policy development based on facts and scientific evidence.

As per the national Health Master Plan, in the area of health care financing, public spending shall be maintained at 7–8% of GDP and shall be reoriented to greater investment in prevention, protecting and improving the population's overall health, including human resource development for primary health care. Out-of-pocket payments by the households (particularly catastrophic and impoverishing) are to be kept to the minimum. The social health insurance scheme shall be based on the population's capacity to pay and on the principle of solidarity of the society in financial and health risk-pooling to achieve equitable access to essential health services, medicines and commodities. The private sector is expected to contribute human resources, capital and operational cost of service delivery, provision of medicines, medical devices and technology for health care.

To protect health, the government recognizes that the country's health is not an issue for health policy alone. Other national policies of environment, education, food and agriculture, social protection, housing, transport, labour and employment, as well as taxation, trade and import policies play a key role in health and well-being. The government has instituted a policy coordination mechanism through the President's office to ensure synergies of all national development policies, plans and projects with health and the social determinants of health, and to facilitate health and safety in all sectors.

The government is committed to empower people and local communities to exercise their right to health, reduce inequities in health, improve the nutrition status of populations in different socioeconomic strata, to reduce the inequities between the urban and rural populations, and improve the health of the poor and the vulnerable.

Based on the demographic and epidemiological transition, and guided by the primary health care approach, the government aims to implement age and gender appropriate programmes targeted at newborn, reproductive-age population and ageing populations, and persons with disabilities. It would address NCDs and conditions including mental health, together with food safety and control of emerging and re-emerging communicable diseases of national and international concern. Environmental health programmes, including human health effects of climate change would be the focus area for programme implementation by the government. Specific policies and strategic plans on these public health programme areas would be developed.

Maldives is vulnerable to natural hazards including floods, storms, tsunamis, and also epidemics. The National Disaster Management Centre coordinates national emergencies and supports health services in public health emergencies. Maldives

Police Force enforces social distancing measures in public health emergencies. Maldives National Defense Force coordinates with health services in fire and rescue operations, while Maldives Red Crescent provides humanitarian services related to emergencies and disasters.

The government is committed to implement commitments of the State in relation to international conventions and other such agreements, to achieve MDGs and other multilateral and regional targets. Maldives is obliged to comply with the IHR. The port assessment was conducted in December 2008 as part of the preparedness for the implementation of IHR and the assessment of IHR core capacities was made in March 2012 with WHO's technical assistance. There is a need to train front-line health-care workers including laboratory personnel, port health workers, medical staff and public health officers in field epidemiology, outbreak investigation and response, and infection control. Upgrading of laboratories and stocking of laboratory equipment in the atolls for timely specimen collection and transport for investigation are required. Establishing of quarantine and medical screening facilities at ports is a necessity in addition to maintaining antiviral and personal protective equipment stocks in the atolls. Also, appropriate legislations for IHR implementation including a port health act, a quarantine act and relevant regulations are required.

The Health Sector Roadmap 2012–2013 was drafted to solicit sectoral actions to address immediate challenges in the health sector. It focuses on strategic approaches and actions related to coordination at national and subnational levels, health care financing, health workforce, health service delivery, health information management system and medical products and technology.

## **2.5 Health systems and services, and response of other sectors**

There has been a rapid expansion of medical services in the last ten years. In 2005 there were 379 medical doctors with a doctor-to-population ratio of 1:775, while in 2010 there were 525 doctors with a doctor-to-population ratio of 1:609. In 2005, the number of nurses was 974 with a nurse-to-population ratio of 1:302, whereas in 2010, with the total number of nurses being 1868, the nurse-to-population ratio was 1:171. The nurse-to-doctor ratio was about 4:1. Mainly an expatriate workforce provides medical services (Table 3). This holds true for both doctors and nurses, and leads to some difficulties such as patient–doctor communication problems and a high turnover of staff, especially in the outlying islands. Compounding the existing shortage of local skilled health-care personnel, there are also skills-to-job mismatches of trained personnel in the health systems suggesting the need to build capacity for health system management.

The Ministry of Health provides comprehensive public health services; primary, preventive and curative care services through its facilities. The Ministry of Health highly subsidizes health-care services for the entire population. These are funded by

general tax revenues and donations. Almost 90% inpatients', and 70% outpatients' services were provided by the public sector health facilities in 2011. This coverage is independent of the income and asset status of the individual. In addition, the Ministry with the help of its donor partners also covers the cost of all preventive services and immunization. There are 260 licensed health facilities in the country, out of which 80 are in Malé (Box 3).

**Table 3: Health workforce by locals and expatriates, 2010**

	Public sector				Total public sector		Total private sector*		Grand total
	Malé		Atolls		Expats	Local	Expats	Local	
	Expats	Local	Expats	Local					
General practitioners	58	39	218	6	276	45	4	5	<b>330</b>
Doctors (specialists)	44	45	82	0	126	45	22	2	<b>195</b>
Nurses	342	264	639	569	981	833	44	10	<b>1 868</b>
Lab. technicians**	28	109	94	41	122	150	3	1	<b>276</b>
Physiotherapists	11	0	8	0	19	0	3	0	<b>22</b>
Radiographers	14	9	21	0	35	9	6	2	<b>52</b>
Dentists ***	1	18	4	1	5	19	1	7	<b>32</b>
Pharmacists/ pharm. asst.	0	0	0	0	0	0	177	70	<b>247</b>
Community health workers	0	2	0	276	0	278	NA	NA	<b>278</b>
Family health workers	0	0	0	313	0	313	NA	NA	<b>313</b>
Traditional birth attendants (Foolhuma)	0	0	0	214	0	214	NA	NA	<b>214</b>
<b>Total</b>	<b>498</b>	<b>486</b>	<b>1 066</b>	<b>1 420</b>	<b>1 563</b>	<b>1 906</b>	<b>260</b>	<b>97</b>	<b>3 827</b>

\*The private sector includes only the ADK Hospital and AMDC Clinic, Malé

\*\*includes laboratory technicians, laboratory assistants, food technologists and microbiologists

\*\*\*dentists, dental mechanics and dental hygienists

**Source:** Republic of Maldives, Ministry of Health. *Maldives health statistics 2012*. in press.

The ADK hospital is the only private tertiary facility located in Malé while others are smaller clinics. Except for the pharmacy operated by the State Trading Organization, all pharmacies in the country are in the private sector. Owing to remote and small populations in many islands, and the need to ensure access to drugs, the government supports women or youth committees or community-based organizations to establish community pharmacies.

### Box 3: Providers of health services and facilities, 2011

- 1 main referral general public hospital (IGMH)
- 6 regional public general hospitals,
- 13 atoll hospitals
- 132 health-care centres
- 108 health aid posts

**Source:** Maldives National Health Accounts for 2011, 2013.  
<http://www.searo.who.int/maldives/documents/executivesummarynhareport.pdf>, 7 April 2013.

The NGOs actively working in health are limited in number and are mostly concentrated in Malé. The Society for Health Education delivers awareness programmes and provides thalassaemia screening services and adolescent health and family planning services. The Diabetes and Cancer Society of Maldives conducts screening, awareness and group education programmes. The Manfaa Institute on Ageing provides empowerment and awareness programmes for the elderly and their caregivers. The Care Society conducts community-based programmes for persons with disabilities and conducts awareness and advocacy for the rights of persons with disabilities. The Maldives Autism Association is focusing on increasing awareness on autism, and on training teachers and running classes for autistic children.

The government provides community-based public health protection and enforcement functions through its Health Protection Agency (under the Health Protection Act), regulates professional practitioners through other regulatory bodies, and monitors the quality of health services and compliance with national health policy. Responsiveness of the health system has been tracked through the Ministry of Health's Quality Assurance and Improvement Division.

Maldives' National Health Accounts for 2011 indicated that the total national health expenditures amounted to Maldivian *Rufiyaa* (MRF) 2766 million (US\$ 179 million), with per capita spending of MRF 8646 (US\$ 561). Health spending as a share of the GDP worked out to 9.2%. This represented a high range for low- and middle-income countries. Almost 44% of the total funds originate from public sources, whereas 53% are apportioned private funds and the remaining 3% are contributed by international donors. The total expenditure on health as a percentage of total government expenditure in 2011 was 21.6%. The household out-of-pocket spending represents 49% of the total health expenditure. Almost 23% of the total health expenditure is spent on inpatient curative services, 19% on outpatient basic services, 12% on health administration and 3.5% on other health-related functions. Only 2% of the total health expenditure was incurred on preventive and primary care in 2011. Expenditure on drugs in Maldives is expected to be higher than most neighbouring countries and within its income group. Pharmaceuticals accounted for 17% of the total expenditure on health-care services in 2011. All pharmacies are private, except those operated by the State Trading

Organization with 17% of private ownership<sup>41</sup>). There is a capped scheme for social insurance-approved drugs.<sup>42</sup>

While health insurance is of relatively recent origin in Maldives, the universal social health insurance scheme, *Aasandha* (a public–private partnership), has attained sizable coverage of the country’s population. In 2012, *Aasandha* was introduced, with free universal access to the scheme for the entire population and with annual individual financial limits. A number of issues may impact the financial viability of the universal health insurance, such as above-average usage of most outpatient services, irrational use of medicines and supplier-induced demand for specialized interventions. It is estimated that drugs account for around 20% of total insurance cost.

The dispersed nature of the country’s topography means that distance and travel are significant barriers to reaching health services, especially in the case of higher-level services. Steps to expand public transport services would make health services in Maldives more accessible to those who live outside Malé and in major islands.

## Decentralization

With local elections held in the country in February 2011, 188 island councils, 19 atoll councils and 2 city councils were formed; 1084 councillors were elected. According to the Republic of Maldives Constitution, the country has a unitary government and the councils are part of the executive branch. The Decentralization Act, ratified on 18 May 2010, stipulates that councils have their own budget, appropriated to them through revenue and resource-sharing measures for which the councils will be held accountable. The councils have to prepare development and management plans with the participation of the community, NGOs and other relevant stakeholders, and include projects to utilize these funds and other resources. The oversight body for the elected councils is the Local Government Authority (LGA), another newly formed body at national level, which standardizes and harmonizes the operations of local councils.

Structurally, the Ministry of Health, being the regulatory agency and also with responsibility for health service provision, would work towards the technical players in the system through its monitoring role carried out by the Health Protection Agency (established under the Health Protection Act, formerly Centre for Community Health and Disease Control), the Maldives Food and Drug



*Typical island scenery in Maldives, Faafu Atoll.*

Authority (MFDA) and its other organs. As stipulated in the Health Master Plan 2006–2015, there is a direction to move towards a decentralized health-care management model. In May 2012, the cabinet took a decision to reverse the corporatization of health-care services and to transfer the assets and health services delivery back to the Ministry of Health (Health Master Plan 2006–2015 reviewed, 2012). The Health Protection Act passed in December 2012 empowers the Minister of Health to direct and oversee measures for protecting and maintaining public health and increasing the awareness of citizens of Maldives.

A number of other sectors and stakeholders address the other determinants of health in collaboration with the Ministry of Health (Health Master Plan 2006–2015), such as: Ministry of Economic Development; Ministry of Finance and Treasury; Department of National Planning; Ministry of Human Resources; Youth and Sports; Ministry of Education; Ministry of Home Affairs; Ministry of Housing and Environment; Ministry of Fisheries and Agriculture; Ministry of Tourism, Arts and Culture; Maldives Police Service; Department of Penitentiary and Rehabilitation; Maldives National Defense Force; National Disaster Management Centre; Ministry of Transport and Communication; Maldivian Red Crescent; National Centre for Information Technology; Maldives Ports Company Ltd; Maldives Customs Services; higher education academic institutions (state and private); telecom providers; and media (state and private).

## **2.6 Key health achievements, opportunities and challenges**

### **Achievements and opportunities**

- A middle-income country has taken significant strides in human development.
- Achievements in political development and socioeconomic contexts.
- High government priority placed on health with transformational changes implemented in health systems for universal coverage and promotion of healthy public policies.
- Decentralization affords an opportunity to improve the provision of health services to the Maldivian population with a high level of access to medical facilities.
- Experiences from achievements related to prevention and control of communicable and vaccine-preventable diseases as well as with child and maternal health.
- Agreement on the implementation of the UNDAF 2011–2015 and WHO CCS 2013–2017.

## Challenges

- The country is in political transition. Health sector reform is underway, which requires time for implementation and understanding new roles and responsibilities at atoll, island and city councils on the scope of public health; understanding that health is everybody's responsibility, beyond the health sector.
- Emphasis on the development of curative care and less focus on public health interventions led to deterioration of primary health care delivery.
- Shortage of national health professionals at all levels of the health system due to the absence of a well-defined human resource plan and limited training opportunities in the country.
- New skills at central level (Ministry of Health) are needed, to enhance the capacity for regulation and management, and to ensure supportive supervision and quality of service delivery.
- Gaps in a legal framework to protect the patients and providers.
- Limited capacity for research and evaluation of emerging health needs, and monitoring the quality of health services provision and health system management.

## 3 — Development cooperation and partnership

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### 3.1 The aid environment in the country

The Annual Maldives Partnership Forum (MPF), initiated in 2007, was established as a platform for dialogue between the Government of Maldives and development partners, especially in the international community, on partnerships to support achieving the country's development priorities, objectives and the MDGs. In 2010, the government decided to hold a donor conference instead to address the significant shortfall in finance identified by the government in five priority areas, including health. The donor conference yielded a commitment of about US\$ 350 million. It is, however, unknown how much of this commitment has actually been received by the government or when it will be received, how much and how it was utilized. Unofficial reports state that only 10% of the pledged amount was actually realized.

In 2010, a UN mission was undertaken to support the government to develop strategies for resource mobilization and partnerships. Several recommendations were presented to the government:<sup>43</sup>

- An International Cooperation Strategy was formulated to complement the government's development policy as articulated in the Health Master Plan, as well as its national budget process, indicating how international cooperation will be used to effectively complement domestic resources and support national policy objectives. The strategy is a statement of the government's leadership on international partnerships and its intention to play an active role as both a recipient of assistance and a capable actor in the international arena. The development of the strategy marks a new milestone in the progressive international partnership that the Government of Maldives and the international community have built together.
- The Paris Declaration on Aid Effectiveness should be signed to signal the government's intention to play its role in the international policy process. In addition, the Paris Declaration methodology should be used to review the quality of its current aid partnerships. It will also send a strong signal to work with other like-minded partners in the Asia-Pacific region and globally; specifically, shaping the international agenda for the provision of external assistance in the context of climate change; and helping establish clear parameters for the role

of Official Development Assistance (ODA) in the context of Middle Income Countries and Small Island Developing States. A number of other countries are interested in this agenda and collaborative work in these areas should be pursued. The government signed the Paris Declaration on Aid Effectiveness and informed the Organisation for Economic Cooperation and Development (OECD) of its endorsement.

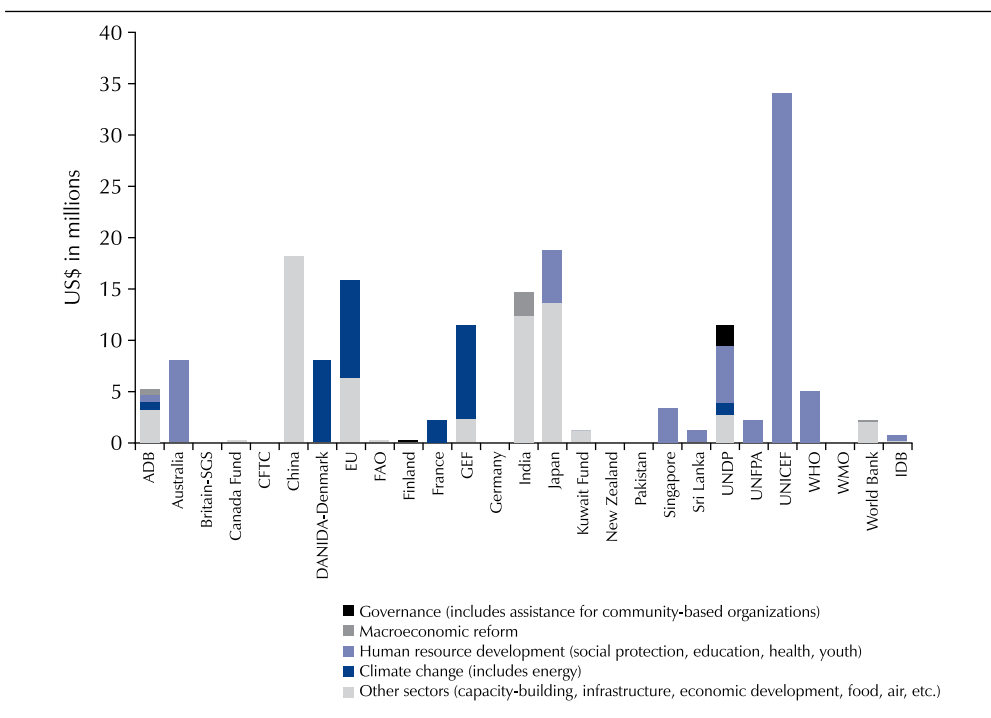
- The government should continue to work with its closest bilateral and regional partners including China, India, Japan, Kuwait, and the Islamic Development Bank (IsDB), alongside international agencies such as the UN Agencies and the International Financial Institutions (IFIs) to strengthen the complementarities of all development resources – both financial and technical.
- Maldives should strengthen the coordination of its partners through regular communications and dialogue and by working with partners based in the country, to communicate with those located outside the country in Colombo, Sri Lanka, and elsewhere. This has worked well before, too. In 1995, a thematic donors’ meeting “Towards sustainable development of health”, organized by the Maldives government for its health sector,<sup>44</sup> was held in Colombo with technical support of the World Health Organization.<sup>45</sup>
- To further facilitate coordination, the government should work to strengthen its own internal coordination to provide a clear process and procedure for interested donors wishing to provide support to the national development effort.
- The government and the UN agencies should strengthen communication and engagement with international development partners through the UNDAF implementation/monitoring process.

During 2010, Maldives received a total of US\$ 24.7 million as a grant in aid.<sup>46</sup> The total grant in aid commitments for the period 2005–2009 were US\$ 166.6 million. Social protection, education, health and youth are the dominant sectors receiving the grant in aid (Figure 8). During 2005–2009, loans of US\$ 96.7 million were disbursed, particularly for infrastructure, water and sewerage, economic development, social protection and coastal protection.

### **3.2 Stakeholder analysis**

There are 7 UN agencies with “resident” presence in the country, and 11 non-resident agencies, comprising the United Nations Country Team, namely United Nations Children’s Fund (UNICEF), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), World Health Organization (WHO), Food and Agriculture Organization (FAO), the International Fund for Agricultural Development (IFAD), International Labour Organization (ILO), Joint United Nations Programme on

**Figure 8: Grant in aid commitments (US\$ in millions) by agency and sectors, 2005–2009**



Source: Ministry of Finance and Treasury, Republic of Maldives, February 2010.

HIV/AIDS (UNAIDS), United Nations Educational, Social and Cultural Organization (UNESCO), United Nations Industrial Development Organization (UNIDO), United Nations Entity for Gender Equality and the Empowerment of Women (UN Women), United Nations Office on Drugs and Crime (UNODC), United Nations Office for Project Services (UNOPS), United Nations Economic and Social Commission for Asia and the Pacific (UN ESCAP), United Nations International Strategy for Disaster Reduction (UN ISDR), United Nations Human Rights Office of the High Commissioner for Human Rights (UN OHCHR), United Nations Conference on Trade and Development (UNCTAD), and the United Nations Environment Programme (UNEP). The International Organization on Migration is the newest addition to the team. The World Bank has field presence, although programmes are managed from Colombo. The International Monetary Fund (IMF), International Finance Corporation (IFC) and the Asian Development Bank (ADB) have programmes in the country. Bilateral institutions undertake programmes in the country as well.

The other key health partners for Maldives include: the Global Fund (GFATM), the South Asian Association for Regional Cooperation (SAARC) and its health institutions that provide technical and financial support to health development. The World Bank, the IsDB and the ADB provide support to government in financing selected health

development projects. Health and academic institutions of other countries provide support in exchange of experiences, technical expertise and training opportunities and collaborative programmes.

UNICEF in Maldives is working in the following areas related to health: (i) young child survival and development (health and nutrition – supply and training in health centres, support to national nutrition strategy, nutrition and child health surveillance system to immediately identify children in need of attention; mobilizing family health workers and the community and provide knowledge on five integrated early child development (IECD) caring practices); (ii) child protection (government policy-makers and service providers have access to information for responding to cases of abuse, violence, exploitation and substance abuse; an improved legislative and policy framework for the prevention and protection of victims and offenders; multisectoral, coordinated protection services for child victims and offenders in Malé and two atolls; and (iii) HIV/AIDS is an area where UNICEF has made a core contribution to promoting public discussion and mobilizing political commitment around prevention.

UNFPA country programme contributes to the UNDAF priority areas of social and economic equity and governance. The programme has two components: (i) reproductive health, population and development; and (ii) gender. The overall goal is “to contribute to the national goal of improving the quality of life of the Maldivian people through improved reproductive health status and empowerment of women”.

The United Nations Development Programme (UNDP) is addressing challenges in democratic governance, poverty reduction, disaster risk management, energy and environment, and HIV/AIDS (as a GFATM principal recipient).

The new World Bank Group Country Assistance Strategy (CAS) for the Republic of Maldives envisages lending around US\$ 45 million in highly concessional funds from the International Development Association (IDA) over the next five years to support the country’s development programmes. The strategy was prepared jointly by the World Bank and the IFC, aiming to improve the standard of living for all Maldivians, serving the country’s Poverty Reduction Strategy, and supporting projects on pension subsidies and health insurance.

The ADB focuses on capacity-building in public sector financial management, and on providing support for transport, power, and small- and medium-sized enterprises.

UNODC supports the project *Strengthening the national response to prevent drug abuse in Maldives*, which is being implemented by the Government of Maldives. The project is funded by the European Union (EU).

The United Nations Office for Project Services (UNOPS) in Maldives focuses on the sewage treatment project and waste disposal technology, and more recently, on issues related to procurement and the supply chain of pharmaceuticals.

### 3.3 Coordination and effectiveness of aid in the country

#### Joint programming

Different UN agencies are planning and designing programmes to optimize resources, enhance the developmental impact and increase programme effectiveness. Through these programmes, UN entities would jointly carry out problem assessments and design interventions — consisting of shared objectives, actions, timeframes and resource requirements — while delineating responsibilities at the same time.

The “One UN Fund” is one of several funding modalities that is available for donors to support the un/under-funded portions of the UNDAF and UNDAF Action Plan. This will enhance flexibility and responsiveness of the UN system through the UNDAF and UNDAF Action Plan to adapt to national priorities and emerging needs. The UNDAF and UNDAF Action Plan budgetary framework, which will be the basis of fund allocation and disbursement, will assist in aid coordination, effectiveness and increased accountability. The Fund will start as soon as donor funds or commitments have been received, and is scheduled to end on 31 December 2015, i.e. at the end of the UNDAF 2011–2015 implementation period.<sup>47</sup>

A joint programme on Strengthening of the Human Rights Commission was signed in 2006 by UNDP, UNICEF, UNFPA and WHO to contribute to the mission of the Human Rights Commission of Maldives – “to lead the promotion and protection of human rights under the Constitution of Maldives, Islamic *Shariah* and regional and international human rights”. Phase two of the programme was initiated in 2010 (up to 2013). WHO has agreed to provide technical assistance to the programme.

From July 2007 to March 2009, the UN country team implemented a joint programme under the Action 2 global programme entitled “Enhance United Nations country team capacity to create human rights culture in the Maldives”. This programme aimed to strengthen the capacity of the UN and government to mainstream a human rights-based approach in programme development and implementation.

An added joint programme 2009–2010 was the Joint UN Programme on Strengthening Response to Prevention and Elimination of Gender-based Violence Against Women and Children in Maldives, led by UNFPA and participated in by UNDP, UNICEF and WHO. It focused on three areas: (i) prevention, advocacy and awareness-raising and legal literacy; (ii) protection: capacity-building, strengthening existing services and institutional collaboration; and (iii) creating an enabling environment.

The government is a successful recipient of the GFATM, to support the national strategic plan for HIV/AIDS. Through the interagency HIV/AIDS Theme Group, the UN system provides technical support to the Country Coordinating Mechanism of the Global Fund-supported programme on HIV/AIDS. The recent upgrading of Maldives from the

category of low-income to the category of middle-income countries will make future GFATM support for Maldives much more challenging due to the eligibility criteria.

To help address climate change, the Maldives Low Emission Climate Resilient Development Programme (LECReD) was initiated and developed in Laamu atoll in 2013. It aims to demonstrate the material difference in making one area of the country less vulnerable to climate change and energy-related challenges. It could be replicated and scaled up for climate change and energy projects with a view to attract major donor and investment funds to Maldives. The programme is also an important initiative in terms of its health and environment component, with WHO involvement, reaching into 2014 and beyond.

### Joint initiatives

Although not formalized as joint programmes, several joint initiatives were undertaken by UN agencies in Maldives as described below.

The **MaldivInfo** is a database with mapping capabilities that provides policy-makers, media and the general public with up-to-date information on key social indicators used to track the country's progress towards the MDGs. In partnership with the Department of National Planning, Ministry of Finance and Treasury, the DevInfo was customized and adapted to the Maldives context resulting in MaldivInfo, launched nationally in June 2007. It captures the available MDG data for the country, with calculated indicators from censuses for island-level data, covering the past 17 years. The initiative is supported by UNDP, UNICEF, UNFPA and WHO.<sup>48</sup>

The **MDG progress report** shows the country's progress in achieving the UN MDGs. The first report was released in 2005, while the second report was published in 2010. These were developed by the government in consultation with relevant staff of the UN system.

The **development assistance database**, kept and updated by the Ministry of Finance and Treasury with inputs from the UN agencies, is being used to track the progress of development aid. Furthermore, a number of key studies were undertaken jointly by UN agencies, including WHO. These included, importantly, the Demographic Health Survey 2009, and a study on violence against women entitled Women's Health and Life Experiences 2007.

## 3.4 UN reform status and UNDAF process

For the UNDAF 2011–2015 in Maldives, four priority areas were identified: (i) social and economic equity; (ii) environment, climate change adaptation and disaster risk reduction, (iii) good governance; and (iv) gender equality and women's empowerment. These contain 15 UNDAF outcomes broadly grouped in four clusters: (i) social equity, which includes health, education, social protection, social security, and substance

abuse and HIV prevention; (ii) economic development and environment, which includes economic sector, decent work, environment management and water and sanitation, climate change and disaster risk reduction; (iii) good governance, which includes transparency and accountability, access to justice and strengthened rule of law, promotion of human rights and judicial independence, civil society empowerment, and evidence-based development planning and administration; and (iv) gender equality and women's empowerment.

WHO is an active participant in the UNDAF, serving as the lead agency for several outcomes, with access to UN multi-trust funds from 2013. The UNDAF programme strategies are: (i) provision of upstream support; (ii) advocacy and communications; (iii) institutional capacity-building; (iv) civil society empowerment; and (v) mainstreaming human rights, gender and social inclusion. The UNDAF action plan is to be used as a management tool with a results framework and targets to be achieved.

Maldives is a self-starter of the Expanded Delivering as One Window for Achievement of the Millennium Development Goals,<sup>49</sup> which formulated an UNDAF Action Plan 2011–2015.

## UN interagency coordination mechanisms

In line with the UN General Assembly resolutions, the Resident Coordinator System is operational in Maldives. Under this system, the UN country team, under the leadership of the UN Resident Coordinator, is the principal mechanism for coordination of UN activities at the country level. The UN country team uses the platform to exchange ideas and make decisions on policies, plans and strategies for the UN system in Maldives. The Resident Coordinator System aims for efficiency and effectiveness of operational activities for development at country level, with a coordinated multidisciplinary response to country needs and priorities.<sup>50</sup> It is supported by the UN Resident Coordinator's office. UNDP, UNICEF, UNFPA, UNODC and UN Women supported the operations of the Resident Coordinator System in the past. However, due to resource constraints, only UNDP and UN Women provided funding support for 2011. Modalities of support by other UN agencies are being examined. Furthermore, the following UN interagency or UNDAF thematic groups are operating in 2013:

- **Social equity** (chaired by UNICEF, co-chaired by WHO)
- **Health** (chaired by WHO)
- **Environment and economic development ICCP team and disaster management support group** (chaired by UNDP and co-chaired by WHO)
- **Governance and civil society** (chaired by UNDP)
- **Gender** (rotational chairmanship, in 2013 chaired by UNICEF)

- **Monitoring and evaluation working group** (chaired by UNICEF)
- **Communications group** (chaired by the UN Resident Coordinator’s Office)
- **Social cohesion group** (chaired by UNDP)
- **Joint UN team on HIV/AIDS** (chaired by WHO)
- **Operations management team** (rotational chair, in 2013 chaired by UNICEF, alternates are UNDP, UNFPA and UNODC).

### 3.5 Opportunities and challenges related to partnership, coordination and aid effectiveness in the country

There is a need for placing greater focus on health in the thematic groups. Coordination and collaboration, between the government and the UN; within the government agencies; and among UN agencies, also have room for improvement. Mutual understanding and timely exchange of information on health activities within the UN system and also between and among the Ministry of Health, WHO and external donors could also be improved. The Ministry of Health needs to provide a clear guidance to the UN and other development partners on their priorities and needs, and should coordinate efforts to avoid duplication and overlaps.

To facilitate aid coordination and aid effectiveness in the country, a UN thematic group platform could be used with a health subgroup operating as a full-fledged Health Thematic Group and expanding its membership to donors and the government.

WHO has been advised by stakeholders to play a key role to help transform the health sector at national level, and to shift the emphasis to also provide support at the subnational level. WHO should play a positive role in harmonization of partners’ efforts, establishing transparency of all stakeholders to avoid duplication, and in focusing on the comparative advantages enjoyed by the partners in health in the country. Support in public health functions, building management capacity in health service delivery, and health information and monitoring, should be included in the list of priorities for WHO for the next CCS cycle.



*Development of telemedicine as an example for partners in health efforts, Alif Alif Atoll.*

## 4 — Review of past WHO cooperation: the 2007–2011 CCS cycle

The Government of Maldives has been collaborating with WHO since 1951. WHO was the first UN agency to support health programmes in the country. It is also considered a major partner in health development in Maldives. WHO's cooperation over the past CCS cycle 2007–2011 has been extensively discussed with stakeholders. Furthermore, relevant documents have been reviewed. Senior officials of the Ministry of Health, other relevant sectors, UN agencies and NGOs, have been consulted. The review has involved key WHO staff at country and regional levels.

### 4.1 Consistency in the 2007–2011 priorities over the CCS cycle

The previous CCS addressed eight priority areas: (i) strengthening health systems; (ii) integrated communicable disease surveillance and control; (iii) noncommunicable diseases, mental health and health promotion; (iv) newborn health; (v) emergency preparedness and response; (vi) food safety; (vii) environmental health; and (viii) information and research.

The CCS priorities are consistent with the national priorities of the Health Master Plan 2006–2015 and the WHO country collaborative programmes 2008–2009 and 2010–2011. The CCS priorities covered most strategic objectives (SOs) of the Medium-term Strategic Plan (MTSP). Table 4 shows the linkage between the eight priorities in the CCS and the MTSP.

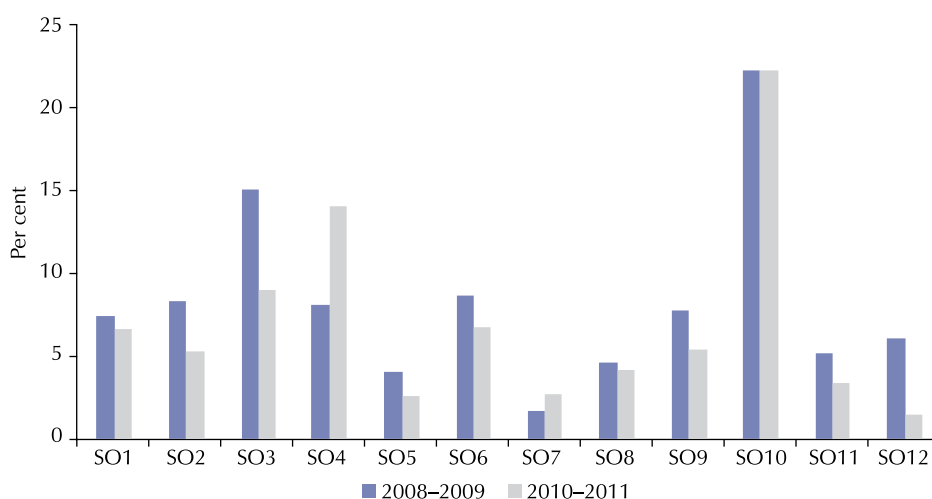
**Table 4:** Linkages between strategic priorities of the previous CCS cycle 2007–2011 and strategic objectives

CCS priorities 2007–2011	Strategic objectives (SO) 2008–2013
Health systems	SO 10, SO 11
Communicable diseases	SO 1, SO 2
Noncommunicable diseases	SO 3, SO 6
Newborn health	SO 4
Emergency preparedness and response	SO 5
Food safety	SO 9
Health and environment	SO 8
Information and research	SO 10

The 2008–2009 collaborative workplans had 97 products and the 2010–2011 collaborative workplans had 67 products spanning all technical strategic objectives. The budget for activities was US\$ 1.3 million for the 2008–2009 biennium and US\$ 1.5 million for the 2010–2011 biennium. Figure 9 shows the degree of focus per strategic objective for the biennia 2008–2009 and 2010–2011, respectively, as far as the budget allocation is concerned. Clearly, strategic objective 10 – “improving health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research” – has had the highest degree of focus of the work of the WHO country office, with an allocation of 22% of the total budget, followed by “prevention and control of communicable diseases” (strategic objectives 1 and 2), “noncommunicable diseases” (strategic objective 3) and “health during the life course” (strategic objective 4).

Some voluntary contribution was also available, amounting to 12.5% of the total available resources in the 2010–2011 biennium.

**Figure 9:** Mapping the WHO CCS Maldives 2007–2011 to the strategic objectives (SOs)\* of the MTSP, workplans 2008–2009 and 2010–2011 – percentage of total budget for activities allocated to strategic objectives 1–12.



**Source:** WHO Maldives country office, 2012

\* SO1 = communicable diseases; SO2 = HIV/AIDS, malaria, TB; SO3 = NCDs; SO4 = health during life-cycle; SO5 = emergency preparedness and response; SO6 = risk factors; SO7 = socioeconomic determinants; SO8 = primary prevention and environment; SO9 = nutrition and food safety; SO10 = health systems; SO11 = access to medical products and technologies; SO12 = partnerships–leadership–governance.

There has been consistency between the CCS priorities over the 2007–2011 period and between the three health-related outcomes of the UNDAF 2008–2010: addressing better health status and social protection of vulnerable and marginalized sections of the society; access to environmental services; and protecting the environment and governance.

## 4.2 Resources for WHO collaborative programmes

The WHO country office in Maldives has a small team. Currently, there are 2 international professional staff, 2 national professional officers and 10 national support staff in the office (Annex 5).

Since November 2010, the Ministry of Health has provided free office space for the WHO country office. It is equipped with tele- and videoconference facilities. Since the beginning of 2010, the country office has switched over from the Activity Management System to the Global Management System as the main administrative platform. This has facilitated monitoring of implementation and other administrative processes. WHO's global private network (GPN) connection has also been established.

Technical support of the WHO country office is further augmented through frequent visits of technical staff from the Regional Office and through a number of consultancies. During the 2010–2011 biennium, there were 63 contractual agreements (40 from assessed contributions and 23 from voluntary contributions), and the products were duly delivered. Two temporary international professionals were recruited. The country office's technical assistance role has been enhanced through horizontal collaboration by using the existing expertise of other WHO country offices in the Region.

Although voluntary contribution funds were planned in the past biennial programmes, only a small percentage of planned funds were mobilized. There are several causal factors for this, including paucity of donor organizations in the country.

## 4.3 Implementation and achievements of strategic priorities

### (i) Strengthening health systems

WHO provided support in strengthening the building blocks of the health system, in normative areas, as well as in capacity-building/training in planning and management, health-care financing and quality of health-care delivery.

Activities aimed at strengthening the health systems included guidelines and regulations on traditional and herbal medicines, national drug index, review and update of the health workforce plan, training and development of standards and protocols to deliver quality health services, training on health policy planning and development of health legislation, technically supporting review of health insurance system, National Health Accounts, and training on health-care financing issues, as well as dissemination of hand hygiene guidelines and surgical safety checklist. Health system support in decentralization processes has been addressed in relevant activities, particularly in the new WHO CCS and in the comprehensive proposal for health system strengthening.

## **(ii) Integrated communicable diseases surveillance and control**

WHO supported areas of disease surveillance and response, monitoring, case detection and management, research in communicable diseases, IHR implementation, development of guidelines, service delivery for prevention and treatment, community awareness programme, safe injection practices, immunization guidelines and procedures, laboratory surveillance, national blood policy and waste management.

The achievements included, among others, initiation of the process of certification of lymphatic filariasis elimination, developing of disability care manual (for leprosy) for homes and health-care institutions, reviewing and improving leprosy reporting procedure and forms, strengthening capacity for detection and management of common zoonotic diseases, improvement of communicable diseases surveillance including the SIDAS system, development of IHR plans for seaports and airports, training for health-care providers on management of dengue, chikungunya, diarrhoeal diseases and acute respiratory infections, development of provincial preparedness plan for major epidemics and pandemics, adaptation of guidelines for psychological services for people living with HIV/AIDS, development and printing of information, education and communication materials to promote voluntary counselling and testing services and procurement of high-quality drugs for HIV and STI, training on integrated vector management and control, development of information package for schools on transmission of TB and adaptation of guidelines on treatment MDR-TB as national guidelines, supporting evaluation of the National AIDS Programme, conducting a “burden” study for HIB vaccine introduction, and developing laboratory surveillance guidelines for vaccine-preventable diseases.

## **(iii) Noncommunicable diseases, mental health and health promotion**

For this strategic priority, WHO supported the strengthening of NCD surveillance, implementation of Vision 2020, implementing chronic NCDs programmes, injury prevention and mental health programmes, health promotion plan and addressing the NCD risk factors.

Surveillance and information systems for NCDs, and mental health and injuries were established. The mapping of eye care resources in the country was finalized and health-care workers trained on early detection of hearing and visual impairment. The national action plan for prevention of blindness was finalized. An extensive training of community



*Promotion of physical activity for prevention and control of non-communicable diseases, Malé.*

health workers on community-based intervention for NCDs and risk factors, awareness campaign related to traffic accidents and conducting awareness programmes on adolescent mental health promotion and suicide prevention were supported. A multisectoral health promotion action plan was also finalized. Awareness programmes on health lifestyles, nutrition and physical activity were conducted at national and subnational levels.

#### **(iv) Newborn health**

The work of WHO consisted of supporting universal access to health services for maternal, newborn, child and adolescent health, particularly delivery of maternal and newborn services, maternal and perinatal audits, child health programme, expansion of adolescent-friendly health services, and guidelines and tools for STIs and family planning.

Achievements in this strategic priority included analysis, compilation and dissemination of data from Demographic and Health Surveys on key newborn, maternal and adolescent health issues; assessment on national policies and laws on adolescent health in relation to conventions on Rights of the Child; reviewing and updating human resource plans for maternal and newborn health and reproductive health; training of skilled birth attendance and conducting awareness campaign for families and communities on maternal and newborn care; training on maternal and perinatal audits and on implementation of national guidelines on antenatal, delivery and postnatal care; reviewing child health programme; multisectoral participation in creating awareness about adolescent, sexual and reproductive health including training on adolescent-friendly health services at provincial level; and enhancement of capacity of health-care providers on implementation of guidelines and decision-making tools for family planning.

#### **(v) Emergency preparedness and response**

Support provided by WHO in this area focused on emergency preparedness and response planning, capacity-building, communication and information management, response operations and recovery activities, and capacity-building to reduce environmental hazards to health.

The national emergency preparedness plan was revised in line with emergency preparedness and response benchmarks, and standard operating procedures for health sector response to disasters and emergencies, and emergency standard operating procedures for IGMH and regional hospitals were developed. The capacity for emergency preparedness and response was built through training (i) on community-based disaster risk management; (ii) on emergency preparedness at schools, and (iii) of trainers on emergency first aid and triage. The Ministry of Health, WHO country office, and media were trained on effective risk communication and information management.

Emergency field assessment of response operations was conducted, gaps found and corrective actions implemented. Emergency preparedness and response needs in all public health programmes for recovery activities were identified and disseminated. Training for government and other partners to carry out interventions and recovery activities was conducted. This area would require further attention in the CCS cycle 2013–2017.

#### **(vi) Food safety**

WHO provided support to develop guidelines and standards and built capacity of the national nutrition programme and of the MDFA.

The achievements included development of food composition tables, food-based dietary guidelines and drafting food standards. A *total diet study* in the Maldives was also conducted. Awareness and advocacy programmes on nutrition promotion and good nutrition practices in schools were conducted. National-level training on food safety, food inspection and developing standards within the risk analysis framework was also provided. The capacity of MFDA and other stakeholders on *Codex Alimentarius*<sup>51</sup> and on awareness on the Food Act was built.

#### **(vii) Health and environment**

Most activities implemented were intended to build capacity to reduce environmental hazards to health, delivery of occupational health programmes and services, and addressing public health problems resulting from climate change.

WHO provided support for the establishment of an air quality monitoring system. Guidelines on rainwater harvesting were disseminated and materials for creating awareness on rainwater harvesting developed. Water, sanitation and hygiene education guidelines for schools were pilot-tested. Capacity at island level for groundwater quality monitoring was built. Awareness materials related to occupational health and safety were developed. Climate change has been addressed by identification of preventive measures to minimize the impacts of climate change on islands, and through awareness programmes on preventing public health problems resulting from climate change. Capacity at island level on waste management, including health care waste management, remains an important area to be addressed.

#### **(viii) Information and research**

WHO provided support for capacity-building and training in monitoring, recording, analysing and reporting, and in conducting health research. Activities included support for monitoring and reporting on progress in achieving MDGs, support in conducting assessment of the vital registration system, training on the use of International Classification of Diseases, developing policy and standards to establish medical records system, and development of guidelines and protocols on health research and ethics.

## 4.4 Experience gained, lessons learnt from the CCS 2006–2011 cycle

There have been constructive contacts with government counterparts at programme manager's and policy levels throughout the planning and implementation of activities. A transparent dialogue and open collaboration with stakeholders at country level during the CCS period and workplan development facilitated the programme implementation. The WHO Regional Office for South-East Asia played an important role in technical, programmatic and administrative assistance. WHO's work in the country has been highly recognized by a wide spectrum of national and international actors, community, civil society and the government.

Rapid and frequent turnovers of national counterparts, programme managers and policy-makers and limited managerial capacities of newly appointed staff at the national level have sometimes affected the quality of products and timely completion of activities. The availability of information on reforms and on directions for change has been inadequate among stakeholders, including lack of coordination between various agencies and stakeholders in the decentralized system. Another challenge was flexibility of funding and lack of voluntary contribution.

High-level engagement of the government is necessary to prioritize the government–WHO collaboration. WHO's work in Maldives may need to be prioritized into fewer areas based on a transition period, partnership with the government and collaboration with health stakeholders including UN agencies.

Taking into consideration the transformation of the health sector, WHO's support might be required at national and subnational levels. In addition, working with other government sectors through established and revised mechanisms of aid coordination may facilitate greater efficiency and impact of WHO's work.

Communications and working with new actors in health – island and atoll councils – would be needed to maintain coordination and information exchange between various levels, which should lead to an adequate response to change. Many health challenges related to decentralization require intersectoral action. WHO may facilitate in bringing different sectors and actors together.

# 5 — The strategic agenda for WHO cooperation

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## 5.1 Prioritizing to define the strategic agenda

During 2011 and 2012, extensive discussions were held with the government and all stakeholders, partners in health, and the WHO Secretariat, to analyse WHO's collaboration and support during the past CCS cycle, and define the priorities for collaboration between WHO and the government as the basis for the next CCS. During these extensive discussions and meetings, information on WHO's contribution to, for example, stewardship by the Ministry of Health, or on WHO's alignment with national health priorities and contributions to the achievement of MDGs relevant to CCS, on areas where WHO's contribution was more needed, on collaboration with UN agencies, and on areas to which WHO should shift its focus during the next CCS cycle, were obtained and elaborated. In addition, internal consultations were held among WHO country team members and existing documents were reviewed.

**The guiding principles in defining the WHO strategic agenda 2013–2017 in Maldives are:**

- recognition of decentralization as an important national priority;
- health systems are in transition and being re-designed to improve accessibility and quality of health services towards the goal of universal health coverage;
- WHO's focus is to enhance public health, address public health challenges, and foster partnerships at national as well as subnational levels;
- WHO's role in health governance, particularly in completing work on the health-related MDGs and in consultation on the post-2015 development agenda, in the area of NCDs, universal health coverage, and on capacity-building for implementation of international instruments (e.g. IHR 2005, access to quality medical products, intellectual property rights and public health).

The major change in WHO's approach in this cycle is that WHO's collaboration will be strategically focused on a limited number of public health challenges. Technical assistance would be extended to working with relevant stakeholders at central level and with decentralized structures, to build local capacity to help attain universal coverage for delivery of health services. The proposed strategic priorities for 2013–2017 have been developed, with consensus obtained during the high-level stakeholder's meeting

held in October 2011, and concluded in February 2013. Some public health challenges, which may not fall within the strategic priorities and may arise during the period 2013–2017, would be considered or planned in biennial collaborative workplans, based on agreement between WHO and the national authorities in accordance with WHO's mandate. At the same time, the CCS can be amended as necessary during mid-term review, based on emerging issues or special public health needs for Maldives' sustainable development.

## 5.2 The strategic agenda

The strategic agenda for WHO's cooperation is at the heart of the Maldives CCS. It defines not only the strategic priorities, but also the main focus areas and strategic approaches for their implementation.

The strategic priorities for the WHO CCS Maldives 2013–2017 have been developed as follows:

- (1) *strengthening the health system towards universal health coverage based on the primary health care approach;*
- (2) *preventing and controlling diseases and disabilities;*
- (3) *enhancing public health interventions at national and subnational levels to sustain achievements in health-related UN MDGs and beyond;*
- (4) *promoting all-inclusive health governance and maintaining WHO's coordinating role and country presence to support health reforms and national health priorities.*

The strategic priorities and main focus areas have been validated with the national health policies and strategies, with UNDAF 2011–2015, WHO MTSP and with the Twelfth GPW 2014–2019 (Annex 6).

The strategic priorities, main focus areas and strategic approaches are denoted with one, two and three digits, respectively.

**1. Strategic priority:** Strengthening the health system towards universal health coverage based on the primary health care approach.

**1.1 Main focus area:** *Support strengthening of health systems policy, legislation and health-care delivery for universal coverage.*

**1.1.1** Provide technical support to develop necessary health-related gender- and family-responsive policies and programmes, legislation, quality assurance mechanisms and regulations, such as (i) management protocols; (ii) standard operating procedures for patient safety; (iii) public–private partnerships; (iv) accreditation of

health services; and (v) mechanisms for effective monitoring and evaluation of health service collaborative programmes.

**1.1.2** Provide technical support to strengthen capacity of human resources for health regulatory bodies in medico-legal issues and to help ensure quality of human resources for health education and ethical practice.

**1.1.3** Provide technical support to strengthen capacity of managers of health services and programmes at all levels (including private sector) for effective management, delivery and evaluation of health services, to build capacity in health component of disaster preparedness and response, and to advocate enhancement of national emergency medical services.

**1.2** ***Main focus area:** Promote improving access to medicines and health-care technologies based on primary health care.*

**1.2.1** Provide technical support to define standard operating procedures, including quality standards.

**1.2.2** Provide technical support for revision of existing legislation (Medicines Act) and its adaptation to a decentralized environment as appropriate.

**1.3** ***Main focus area:** Support strengthening of health financing towards universal coverage.*

**1.3.1** Advocate and provide technical support to strengthen national capacity in health economics and financing.

**1.3.2** Advocate and provide technical support in building national capacity for national health accounts.

**1.3.3** Provide technical support to explore different options for health-care financing, including social health insurance.

**1.4** ***Main focus area:** Support strengthening of health information systems.*

**1.4.1** Provide technical support to the development of health information systems policy, regulations, standards and strategic plan to strengthen health information systems to ensure effective collection, analysis, dissemination and utilization of information for decision-making.

**1.4.2** Advocate and provide support for collaboration of all involved sectors in data collection, analysis, presentation and dissemination.

**1.4.3** Provide support in implementation of health information systems appropriate to national and local health system contexts, particularly in coordination with hospitals, health centres and clinics.

**1.5** *Main focus area: Advocacy and technical support in monitoring and evaluation.*

**1.5.1** Provide technical support to strengthen monitoring, evaluation and auditing capacity of public health programmes and monitoring of health system performance at national and subnational levels.

**1.5.2** Facilitate support for international (regional and global) reporting purposes.

**1.6** *Main focus area: Provide technical support to strengthen health research.*

**1.6.1** Provide technical support to strengthen capacity to define and develop prioritized health research agendas.

**1.6.2** Provide technical support to conduct research with focus to generate added evidence for policy-making and programme management to strengthen public health interventions.

**2. Strategic priority:** Preventing and controlling diseases and disabilities.

**2.1** *Main focus area: Provide technical support for strengthening national capacity in prevention and control of communicable diseases.*

**2.1.1** Provide support to strengthen capacities in prevention, detection, surveillance, diagnosis, care, management and outbreak response of endemic and emerging diseases of public health concern, including vaccine-preventable diseases programme and its evaluation, and address public health problems resulting from climate change and disasters.

**2.1.2** Provide support for strengthening capacities in prevention, surveillance, diagnosis, care and management of HIV/AIDS, sexually transmitted infections, MDR-TB and extensively drug-resistant TB (XDR-TB) and TB/HIV co-infection.

**2.1.3** Provide advocacy and technical support to ensure implementation of legally binding commitments related to prevention and control of communicable diseases (e.g. IHR 2005).

**2.2** *Main focus area: Provide policy and technical support to prevent and reduce disease, disability and premature death from chronic NCDs, lifestyle risk factors, mental disorders, injuries and visual impairment, and*

*to orchestrate a coherent response across societies to address interrelated social, economic and environmental determinants.*

- 2.2.1** Provide technical support to integrate essential interventions to prevent and manage NCDs, mental health and neurological disorders, injuries and disabilities into health system strengthening initiatives.
- 2.2.2** Provide advocacy and technical support for the development and implementation of collaborative programmes to promote healthy behaviour by settings-based approaches (schools, communities, health facilities, islands), to reduce risk factors for health conditions associated with tobacco use, alcohol, drugs and psychoactive substances (harm reduction and rehabilitation), unhealthy diets, physical inactivity and unsafe sex.
- 2.2.3** Provide advocacy and technical support to help ensure implementation of legally-binding commitments related to prevention and control of NCDs, including lifestyle risk factors (e.g. WHO Framework Convention on Tobacco Control).
- 2.2.4** Support capacity-building of the newly reformed Health Protection Agency of the Ministry of Health.
- 2.2.5** Provide technical support to strengthen implementation of the national plan of action to address social determinants of health and strengthen capacity to conduct health impact assessment of relevant projects or programmes.
- 2.2.6** Provide advocacy and technical support to adopt primary prevention interventions to reduce environmental hazards, including health-care waste management, at national and subnational levels.
- 2.2.7** Provide advice and technical support for healthy public policies and help mitigate public health impact of climate change.

**3. Strategic priority:** Enhancing public health interventions at national and subnational levels to sustain achievements in health-related UN MDGs and beyond.

**3.1 Main focus area:** *Strengthening public health programmes related to the lifecycle.*

- 3.1.1** Provide support for strengthening capacity, at national and subnational levels and with particular attention to community health workers and nurses, in reproductive, maternal, newborn, child and adolescent health, such as (i) essential newborn care; (ii) emergency obstetric care; (iii) early childhood development

including nutrition and young child feeding; (iv) adolescent health needs; and (v) harm reduction and rehabilitation.

**3.1.2** Provide support to strengthen capacity in management of common problems of the elderly and people with disabilities.

**3.2** *Main focus area: Strengthening food safety, water and sanitation and occupational health.*

**3.2.1** Provide technical and policy support in food safety (norms, regulations, standards, testing, food inspection).

**3.2.2** Advocate and support capacity-building to implement water and sanitation master plan and occupational health programmes.

**4. Strategic priority:** Promoting all-inclusive health governance and maintaining WHO's coordinating role and country presence to support health reforms and national health priorities.

**4.1** *Main focus area: Fostering partnership with UN and other international partners, government sectors and civil society at national and subnational levels.*

**4.1.1** Advocate public health and primary prevention to other sectors and help broker stakeholder consultations at national and community levels.

**4.1.2** Coordinate UN partners on health issues through mechanisms established under UNDAF through regular consultations for health partnerships, to prioritize assistance for joint programmes or joint reviews.

**4.1.3** Advise on and support coordination mechanisms at regional and subregional levels of health-care services and public health interventions.

**4.2** *Main focus area: Policy advice for public health management, emergency preparedness and response.*

**4.2.1** Policy advice on health management and health financing towards universal coverage.

**4.2.2** Policy advice on public health interventions and emergency preparedness and response, including coordination of health cluster in the UN context.

**4.3** *Main focus area: Mobilizing resources for sustainable development of health.*

**4.3.1** Facilitate joint efforts with UN partners to mobilize additional resources for sustainable development of health in the country.

#### **4.3.2 Mobilize resources for public health to help implement the strategic agenda of the CCS in partnership with WHO Regional Office for South-East Asia and WHO headquarters.**

WHO will undertake technical and brokering roles. It is expected that further priority-setting and implementation will be a dynamic process wherein some collaborative programmes will be ended on completion of targets and replaced with new priorities during the course of the CCS cycle.

### **5.3 Normative functions**

WHO will continue to perform its normative functions as part of its core area of support. Norms, standards and guidelines will be shared in a timely way with key stakeholders. Expertise will be provided to support application of standards and guidelines. Their use will be promoted and their implementation monitored. Programme reviews of specific areas, involving international experts, continue to be a programmatic part of WHO country cooperation.

Knowledge management will be strengthened in the country office with support from WHO Regional Office for South-East Asia. The purpose is to provide timely, reliable and comprehensive information and knowledge services to health institutions and individuals in Maldives and WHO staff members to help strengthen the health system. The aim is to achieve this in two ways:

- (1) by supporting the transfer of knowledge and technology in identification and management of national information and knowledge assets;
- (2) by creating an environment for sharing and effectively using knowledge.

# 6 — Implementing the strategic agenda

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## 6.1 The role of WHO

The proposed shift in the strategic agenda may have implications for the functions in the WHO country office and the support needed from other levels of the Organization. The normative functions will be strengthened and efforts will be made to mobilize additional funding, particularly for health systems strengthening, health information system, health-care financing and implementation of IHR, and to address various issues that have arisen due to the structural changes in the country. WHO's leadership and engagement in partnership in matters critical to health will be provided, along with technical support, thereby catalysing change and building sustainable institutional capacity. An extensive support will be provided to monitoring and evaluation of health system performance, monitoring of the health situation and assessing health trends.

The strategic priorities in this CCS cover a range of technical expertise available at the WHO Regional Office for South-East Asia and WHO headquarters. A close working relationship between the country office and relevant technical units at WHO Regional Office for South-East Asia and WHO headquarters will add value to the work of WHO in Maldives. In addition, valuable technical assistance of WHO experts from other country offices through horizontal collaboration would greatly contribute to quality implementation of WHO collaborative activities in Maldives.

## 6.2 Implications on WHO country office staffing

The WHO Maldives country office is currently staffed with 2 national professional officers, 1 international medical/technical officer and 10 national support staff. It is headed by the WHO Representative. The WHO Maldives country office will be strengthened from the re-profiling of individual staff functions. While funding and budgetary constraints provide only limited room to enhance the country office staffing pattern, the main strategy to implement this CCS and WHO biennial collaborative programmes successfully will be based on the ability of the WHO country office to mobilize external professional technical assistance for focused technical areas on a task- and time-bound basis. The requirements for technical assistance and high-level expertise could be met through WHO Regional Office for South-East Asia and WHO headquarters support, as well as through short-term consultancies. The ability of WHO to offer focused technical assistance on information management, disease surveillance and control and other critical areas will be of paramount importance and in demand, given the current health reform context and rapid ongoing changes in the health system.

Furthermore, the government has expressed the need for provision of national-level support for health policy.

### **6.3 Using the new country cooperation strategy**

The WHO Maldives country office intends to:

- (i) widely disseminate the CCS document to the government and other partners working in and with the country;
- (ii) apply CCS priorities, main focus areas and strategic approaches to guide future collaborative workplans;
- (iii) use the content of the CCS to coordinate the health component of UNDAF and other partnership platforms, keeping in mind partners' contributions; and
- (iv) use the CCS for advocacy and resource mobilization for health.

WHO Regional Office for South-East Asia and WHO headquarters intend to:

- (i) widely disseminate the CCS document and CCS brief to WHO departments and divisions, and to other relevant partners and stakeholders, including through the use of innovative approaches such as “country days”, the “official launch” of the CCS, lunch-time seminars and the use of intranet and Internet sites;
- (ii) help ensure that technical interactions with the country office and government are consistent and based on the CCS priorities;
- (iii) promote CCS priorities to be used as the basis for the preparation of strategic and operational plans, including budgets and resource allocation; and
- (iv) use the CCS for advocacy and resource mobilization for WHO's contribution to sustainable development of health in the Maldives.

### **6.4 Monitoring and evaluation of the country cooperation strategy**

WHO will monitor programme implementation using established procedures. Efforts will be made to align the monitoring of priority programmes with the agreed-upon processes for their oversight and accountability.

These procedures will include a mid-term review and end-of-biennium review of collaborative programmes. These also contribute to WHO's biennial programme budget performance assessment. The mid-term review may consider curtailing or phasing out some programmes, while identifying and initiating activities in new priority areas, in which case WHO will adjust collaborative activities accordingly.

WHO will undertake a mid-term review of the CCS cycle 2013–2017, in order to ensure that collaborative workplans and activities are in line with the strategic priorities and with any emerging needs, allowing for lessons learnt during implementation and for making required adjustments in future programming.



## **Annexes**

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## Annex 1

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### WHO core functions<sup>52</sup>

- (1) Providing **leadership** on matters critical to health and engaging in partnership where joint action is needed.
- (2) Shaping the **research** agenda and stimulating the generation, translation and dissemination of valuable knowledge.
- (3) Setting **norms and standards**, and promoting and monitoring their implementation.
- (4) Articulating ethical and evidence-based **policy options**.
- (5) Providing **technical support**, catalysing change, and building sustainable institutional capacity.
- (6) **Monitoring** the health situation and assessing health trends.

WHO core functions in crisis or emergency situations<sup>53</sup>:

- measurement of ill-health and needs assessment
- coordination of joint action for health
- filling critical gaps in the health response
- building health system capacity.

## Annex 2

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### **Process of developing WHO country cooperation strategy, Republic of Maldives, 2013–2017**

- Country team led by the WHO Representative to Maldives. Process of formulation is participatory, evidence-based, consultative
- Inception in late 2010. Action Plan of the United Nations Development Assistance Framework 2011–2015
- Mid-term Review of Health Master Plan 2006–2015, during early 2011
- Consultations and strategic dialogue with the Ministry of Health, Republic of Maldives, national stakeholders and development partners, April 2011–February 2013
- Review of WHO cooperation over the past cycle 2007–2011 (August–October 2011)
- Field visits, consultations and discussions with Gaume Idhaaraas, health corporations, atoll councils, civil society (5–20 October 2011)
- Situation analysis – health and development challenges and opportunities (current, anticipated), current response, health status, national policies and strategies, development cooperation (September 2011–February 2013)
- Identification of Strategic Agenda – strategic priorities for 2013–2017 (October 2011–February 2013)
- Alignment, harmonization with the Health Master Plan 2006–2015, the United Nations Development Assistance Framework and the WHO Medium-term Strategic Plan (October–November 2011)
- Strategic priorities jointly agreed with national authorities (10–30 October 2011)
- Strategic priorities shared and consulted with key stakeholders (October–November 2011)
- Draft document shared with WHO Regional Office for South-East Asia and WHO headquarters (November 2011)
- WHO Regional Office for South-East Asia circulated the draft for comments (December 2011–January 2012)
- Further work at regional and country levels. Alignment with WHO reform, as well as with national events (February 2012–February 2013)
- CCS mission to finalize the strategic agenda (February 2013)
- Finalization of the entire document (March–April 2013)

## Annex 3

### Selected demographic, socioeconomic and health indicators for Maldives, denoting progress towards achieving the UN Millennium Development Goals and beyond

Total population (projected mid-year population 2013)	(i)	336 848
Population under 15 years of age (%)	(i)	26.3
Life expectancy at birth (in years), 2011	(i)	73 (males), 75 (females)
Population living in urban areas (%), 2010	(iii)	40.0
Adult literacy (%) 2005–2010	(iii)	98.0
Total fertility rate (per woman) 2010	(iii)	1.8
% GDP on health (2011)	(iv)	9.2
Gross national income (per capita in international dollars) 2010	(iii)	8 110
Out-of-pocket expenditure as % of total health expenditure (2011)	(iii)	49.4
Human Development Index Rank, out of 177 countries, 2012	(v)	104
Number of doctors per 10 000 population (2005–2010)	(iii)	16.0
Number of nurses per 10 000 population (2005–2010)	(iii)	44.5
Infant mortality rate (per 1000 live births) (2011)	(ii)	9
Under-5 mortality rate (per 1000 live births) 2011	(ii)	10
Maternal mortality ratio (per 100 000 live births) 2011	(ii)	56
Population using an improved drinking water source (2009)	(vi)	97.7
Population with improved access to sanitation (2009)	(vi)	94.5

#### Sources:

- (i) Republic of Maldives, Department of National Planning. *Statistical yearbook of Maldives, 2012*. Malé: DNP, 2012.
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**MDG 1:** Eradicate extreme poverty and hunger – achieved

**MDG 2:** Achieve universal primary education – achieved

**MDG 3:** Promote gender equality and empower women – on track

**MDG 4:** Reduce child mortality – achieved

**MDG 5:** Improve maternal health – achieved

**MDG 6:** Combat HIV/AIDS, malaria and other diseases – achieved

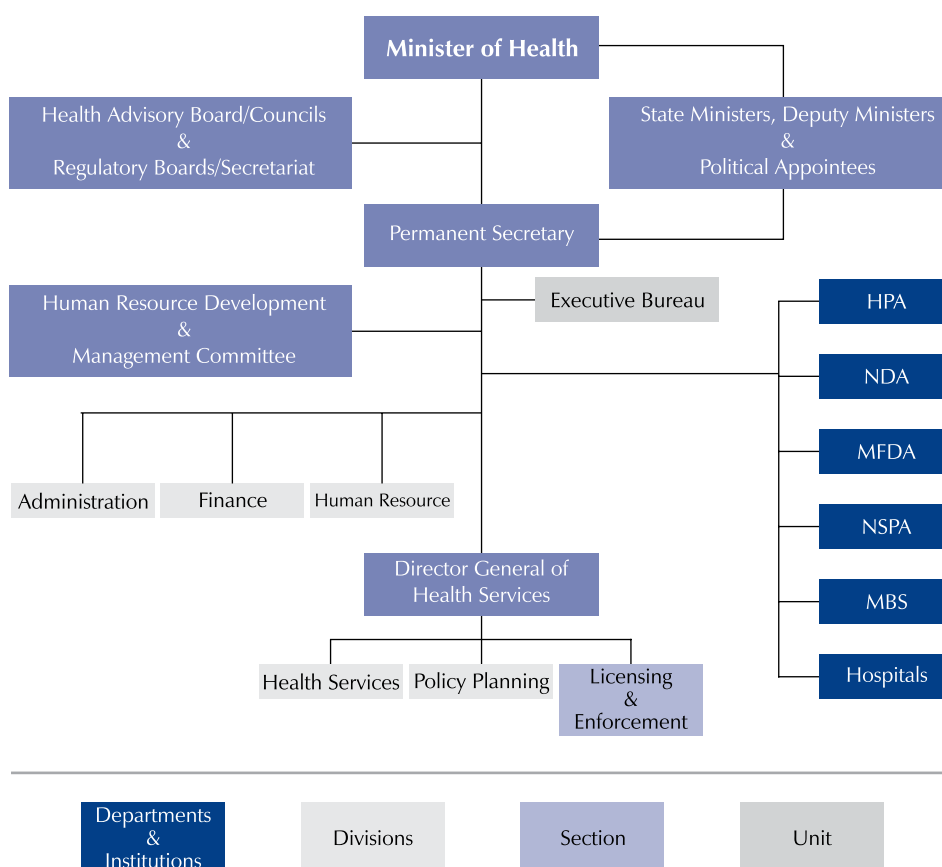
**MDG 7:** Ensure environmental sustainability – on track

**MDG 8:** Develop a global partnership for development – on track

**Source:** Republic of Maldives, Ministry of Finance and Treasury. Millennium development goals: Maldives country report 2010. Malé: Department of National Planning, 2010.

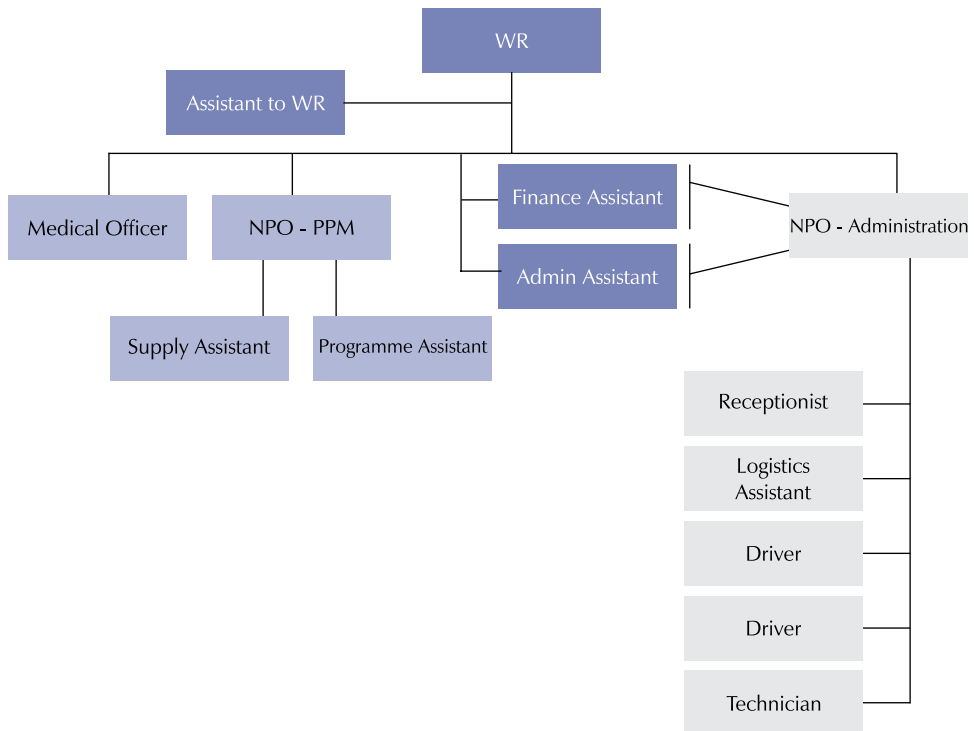
## Annex 4

### Organizational structure of the Ministry of Health, Republic of Maldives (May 2013)



## Annex 5

### Organizational structure of the Office of the WHO Representative to Republic of Maldives (May 2013)



## Annex 6

### Validation of strategic priorities with the national health policies and strategies, with UNDAF 2011–2015, with WHO MTSP and with the Twelfth GPW 2014–2019.

#### Validation of the CCS strategic agenda with the national Health Master Plan 2006–2015

	<i>CCS strategic priorities</i>	<i>Policy goals in the national Health Master Plan 2006–2015</i>
<b>1</b>	<i>Strengthening the health system towards universal health coverage based on the primary health care approach.</i>	<p>4. Ensure all citizens have equitable access to comprehensive primary health care.</p> <p>5. Establish and enforce appropriate quality assurance and regulatory framework for patient and provider safety.</p> <p>7. Build a competent and professional health workforce.</p> <p>8. Ensure the health system is financed by a sustainable and fair mechanism.</p> <p>9. Enhance the response of health system in emergencies.</p> <p>10. Build a culture of evidence-based decision-making within the health system.</p>
<b>2</b>	<i>Preventing and controlling diseases and disabilities.</i>	<p>1. Ensure people have the appropriate knowledge and practices to protect and promote their health.</p> <p>3. Prevent and reduce the burden of disease and disabilities, and improve the quality of life.</p>
<b>3</b>	<i>Enhancing public health interventions at national and subnational levels to sustain achievements in health-related UN MDGs and beyond.</i>	<p>2. Ensure that safe and supportive environments are in place to promote and protect the health and well-being of the people.</p>
<b>4</b>	<i>Promoting all-inclusive health governance and maintaining WHO's coordinating role and country presence to support health reforms and national health priorities.</i>	<p>Overall: the national Health Master Plan identified the need for collective action with other government agencies, civil society and private sector, to attain identified priorities.</p>

## Validation of CCS strategic agenda 2013–2017 with UNDAF 2011–2015 outcomes and outputs

### *Strategic priority 1: Strengthening the health system towards universal health coverage based on the primary health care approach.*

CCS strategic approaches	UNDAF outcomes	UNDAF outputs
1.1.1: Provide technical support to develop necessary health-related gender- and family-responsive policies and programmes, legislation, quality assurance mechanisms and regulations, such as: (a) management protocols; (b) standard operating procedures for patient safety; (c) public–private partnerships; (d) accreditation of health services; (e) mechanisms for effective monitoring and evaluation of health service collaborative programmes	15: Improved individual, institutional and systemic capacities to promote gender equality and non-discrimination, and to empower women and girls to enjoy their rights in all spheres of life in line with national commitments by 2015 (UNFPA, UNIFEM, ILO, UNDP, UNICEF, WHO, UNESCO)	15.1: Capacities of government bodies strengthened to make operational national gender architecture (UNFPA, UNIFEM, UNICEF, UNESCO)  15.3: Strengthened advocacy capacity of parliamentarians, religious institutions, civil society, private sector and media to promote gender equality, women's rights and empowerment and action, including men and boys, and to prevent violence against women (UNFPA, UNIFEM, UNICEF, UNDP, ILO, UNESCO)
1.1.2: Provide technical support to strengthen capacity of human resources for health regulatory bodies in medico–legal issues and to help ensure quality of human resources for health' education and ethical practice	12: Culture of respect for human rights advocated, fulfilled, protected and fostered at all levels (UNDP, UNICEF, UNFPA, ILO, WHO, UNESCO, OHCHR)	12. 1: Human rights related policies and legislation in place (UNDP, UNICEF, UNFPA, ILO, WHO, UNESCO)
1.1.3: Provide technical support to strengthen capacity of managers of health services and programmes at all levels (including private sector) for effective management, delivery and evaluation of health services, to build capacity in health component of disaster preparedness and response and to advocate enhancement of national emergency medical services	1: Targeted groups have equitable access to preventive and essential health care services and nutrition (WHO, UNICEF, UNFPA, UNOPS)	1.4: Capacity of health system strengthened to address health and nutrition during emergencies (WHO, UNICEF, UNFPA, UNOPS)
1.5.1: Provide technical support to strengthen monitoring, evaluation and auditing capacity of public health programmes and monitoring of health system performance at national and subnational levels	14: Institutional capacity strengthened and framework in place to coordinate and plan national development at local and national levels (UNDP, UNICEF, UNFPA, UNOPS, WHO, UNESCO, ONODC)	14.2: Institutional and technical capacity for monitoring and evaluation strengthened (UNICEF, UNDP, UNFPA, UNODC, WHO, UNOPS, UNESCO)

**Strategic priority 2: Preventing and controlling diseases and disabilities.**

CCS strategic approaches	UNDAF outcomes	UNDAF outputs
<p>2.1.1: Provide support to strengthen capacities in prevention, detection, surveillance, diagnosis, care, management and outbreak response of endemic and emerging diseases of public health concern, including vaccine-preventable diseases programme and its evaluation, and address public health problems resulting from climate change and disasters</p>	<p>9: Enhanced capacities at national and local levels to support low carbon lifestyles, climate change adaptation, and disaster risk reduction (UNDP, UNEP, WHO, ISDR, ESCAP, UNOPS, UNICEF, UNESCO, UNFPA, UNIDO)</p>	<p>9.2: National institutional capacity for climate change adaptation and disaster risk reduction established involving all stakeholders (UNDP, ISDR, WHO, UNEP, GEF, ESCAP, UNOPS, UNESCO)</p>
<p>2.1.2: Provide support for strengthening capacities in prevention, surveillance, diagnosis, care and management of HIV/AIDS, sexually transmitted infections, MDR-TB and extensively drug-resistant TB (XDR-TB) and TB/HIV co-infection</p>	<p>5: Most-at-risk and vulnerable populations have equitable access to drug and HIV prevention, treatment, care and support services (UNDP, WHO, UNICEF, UNODC, UNFPA, ILO, UNAIDS, UNESCO)</p>	<p>5.1: Access to effective HIV prevention services increased for most-at-risk and vulnerable populations (UNICEF, UNODC, UNFPA, UNDP, WHO, ILO, UNAIDS)</p> <p>5.2: Most-at-risk populations and youth have access to harm reduction interventions and rehabilitation services (UNODC, UNICEF, UNDP, WHO, UNOPS)</p> <p>5.3: Service providers have enhanced capacities to deliver comprehensive packages for HIV prevention (UNODC, UNFPA, UNDP, WHO, UNICEF)</p> <p>5.4: Legal barriers to effective HIV and drug abuse prevention identified and addressed (UNICEF, UNODC, UNAIDS, UNDP, WHO)</p> <p>5.5: Monitoring and evaluation capacity of Government and key stakeholders strengthened (UNICEF, UNODC, UNAIDS, UNDP, WHO)</p>

CCS strategic approaches	UNDAF outcomes	UNDAF outputs
<p>2.2.2: Provide advocacy and technical support for the development and implementation of collaborative programmes to promote healthy behaviour by settings-based approaches (schools, communities, health facilities, islands), to reduce risk factors for health conditions associated with tobacco use, alcohol, drugs and psychoactive substances (harm reduction and rehabilitation), unhealthy diets, physical inactivity and unsafe sex</p>	<p>1: Targeted groups have equitable access to preventive and essential health care services and nutrition (WHO, UNICEF, UNFPA, UNOPS)</p>	<p>1.1: Communities empowered to promote and practice healthy behaviours (UNICEF, UNFPA, WHO)</p>
<p>2.2.5: Provide technical support to strengthen implementation of the national plan of action to address social determinants of health and strengthen capacity to conduct health impact assessment of relevant projects or programmes</p>	<p>12: Culture of respect for human rights advocated, fulfilled protected and fostered at all levels (UNDP, UNICEF, UNFPA, ILO, WHO, UNESCO, OHCHR)</p>	<p>12. 2: Relevant institutions have enhanced capacities to promote and protect human rights (UNDP, UNICEF, UNFPA, WHO, ILO, UNESCO, OHCHR)</p>
<p>2.2.6: Provide advocacy and technical support to adopt primary prevention interventions to reduce environmental hazards, including health care waste management, at national and subnational levels</p>	<p>8: Communities have access to safe drinking-water and adequate sanitation and sustainably manage the natural environment to enhance their livelihoods (UNDP, UNEP, WHO, FAO, UNICEF, ILO, UNOPS)</p>	<p>8.3: Communities have access to waste management systems, including health care waste (UNICEF, WHO, UNDP, UNOPS, WHO, UNEP)</p>
<p>2.2.7: Provide advice and technical support for healthy public policy and help mitigate public health impact of climate change</p>	<p>9: Enhanced capacities at national and local levels to support low carbon life-styles, climate change adaptation, and disaster risk reduction (UNDP, UNEP, WHO, ISDR, ESCAP, UNOPS, UNICEF, UNESCO, UNFPA, UNIDO)</p>	<p>9.2: National institutional capacity for climate change adaptation and disaster risk reduction established involving all stakeholders (UNDP, ISDR, WHO, UNEP, GEF, ESCAP, UNOPS, UNESCO)</p>

**Strategic priority 3: Enhancing public health interventions at national and subnational levels to sustain achievements in health-related UN MDGs and beyond.**

CCS strategic approaches	UNDAF outcomes	UNDAF outputs
3.1.1: Provide support for strengthening capacity, at national and sub-national levels and with particular attention to community health workers and nurses, in reproductive, maternal, newborn, child and adolescent health, such as a) essential newborn care, b) emergency obstetric care, c) early childhood development including nutrition and young child feeding, d) adolescent health needs, e) harm reduction and rehabilitation	1: Targeted groups have equitable access to preventive and essential health care services and nutrition (WHO, UNICEF, UNFPA, UNOPS) 2: Children including those with special needs and vulnerable youth are engaged in quality, gender-responsive, and relevant educational programmes (UNICEF, UNFPA, WHO, ILO, UNESCO)	1.2: Children, youth and women have equitable access to nutrition and related health services (UNICEF, WHO) 1.3: Enhanced equitable access of men, women and young people to reproductive health services (UNFPA, WHO) 2.1: Children enjoy learning in a comprehensive child-friendly environment (UNICEF, UNESCO) 2.2: An inclusive education policy and strategy, including for children with special needs, is in place (UNESCO, UNICEF)
3.2.1: Provide technical and policy support in food safety (norms, regulations, standards, testing, food inspection)	7: Creation of opportunities for decent work and labour markets better governed and regulated in line with ILO principles/standards (ILO, UNDP, WHO)	7.4: Capacities strengthened to deliver occupational health and safety services (ILO, WHO)
3.2.2: Advocate and support capacity-building to implement water and sanitation master plan and occupational health programmes	8: Communities have access to safe drinking water and adequate sanitation and sustainably manage the natural environment to enhance their livelihoods (UNDP, UNEP, WHO, FAO, UNICEF, ILO, UNOPS)	8.1: Communities have access to safe drinking water and have sufficient quantities of water to support agriculture (UNICEF, UNDP, UNOPS, WHO, FAO) 8.2: Communities have access to improved sanitation facilities (UNICEF, WHO, UNDP, UNEP)

**Strategic priority 4: Promoting all-inclusive health governance and maintaining WHO's coordinating role and country presence to support health reforms and national health priorities.**

Strategic approaches	UNDAF outcomes	UNDAF outputs
4.1.1: Advocate public health and primary prevention to other sectors and help broker stakeholder consultations at national and community levels	12: Culture of respect for human rights advocated, fulfilled protected and fostered at all levels (UNDP, UNICEF, UNFPA, ILO, WHO, UNESCO, OHCHR)	12.3: Public awareness of human rights increased and ability to exercise rights enhanced (UNDP, UNICEF, WHO, ILO)

**Validation of CCS strategic agenda 2013–2017 with WHO's Medium-term Strategic Plan 2008–2013 and WHO's Twelfth General Programme of Work 2014–2019**

The four strategic priorities of this WHO CCS fall under the 13 strategic objectives of WHO's Medium-term Strategic Plan 2008–2013 and the 6 categories of WHO's Twelfth General Programme of Work 2014–2019, respectively, as follows:

	Strategic priorities of WHO CCS, Maldives 2013–2017	WHO Medium-term Strategic Plan 2008–2013	Twelfth General Programme of Work of WHO 2014–2019
1	Strengthening the health system towards universal health coverage based on primary health care approach.	Strategic objectives 7, 10 and 11	Category 4
2	Preventing and controlling diseases and disabilities.	Strategic objectives 1, 2, 3, 6 and 8	Categories 1, 2 and 5
3	Enhancing public health interventions at national and subnational levels to sustain achievements in health-related UN MDGs and beyond.	Strategic objectives 4, 5, 7, 8 and 9	Category 3
4	Promoting all-inclusive health governance and maintaining WHO's coordinating role and country presence to support health reforms and national health priorities.	Strategic objectives 5, 12 and 13	Categories 5 and 6

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This *WHO country cooperation strategy, Republic of Maldives, 2013–2017* is a strategic document that provides a medium-term vision for technical cooperation in support of national health plans. The strategic agenda reflects and envisages the health agenda of the government and is aligned with the mandate for collaboration in health with WHO.

The development process of this WHO country cooperation strategy involved documentary reviews, situation analysis and extensive consultation with key national and international stakeholders in health, including UN agencies within Maldives, the WHO Regional Office for South-East Asia and WHO headquarters. Important documents, for example, the Health Master Plan 2006–2015, WHO's Eleventh and Twelfth General Programmes of Work, WHO's Medium-term Strategic Plan (MTSP), the current and former United Nations Development Assistance Frameworks, were reviewed and used as a basis to identify priorities for WHO collaborative work in the Maldives.

At the heart of the country cooperation strategy is its strategic agenda. Four areas of work have been identified as **strategic priorities** for the coming five years of cooperation:

- strengthening the health system towards universal health coverage based on the primary health care approach;
- preventing and controlling diseases and disabilities;
- enhancing public health interventions at national and subnational levels to sustain achievements in health-related UN Millennium Development Goals and beyond;
- promoting all-inclusive health governance and maintaining WHO's coordinating role and country presence to support health reforms and national health priorities.

*The strategic agenda for WHO cooperation defines also the main focus areas and strategic approaches for their implementation.*

Some public health challenges, which may not fall within the strategic priorities and may arise during the period 2013–2017, would be considered or planned in biennial collaborative programmes, based on agreement between WHO and the national authorities. At the same time, the strategy can be amended as necessary during mid-term review, based on emerging issues or special public health needs for Maldives' sustainable development.

This new *WHO country cooperation strategy, Republic of Maldives 2013–2017* is a dynamic tool for future collaboration between the country and WHO, in the spirit of harmonized and aligned country-led partnership.