

# **WHO Country Cooperation Strategy, Maldives**

**(Report of the First Mission, 28 May 2000 -1 June 2000)**



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## **EXECUTIVE SUMMARY**

A mission was launched to evaluate the WHO collaborative programme with Maldives and identify key national priority issues in which WHO has a comparative advantage of fulfilling its normative core functions under its new strategic directions. The team was headed by Dr Imam Mochny, Director, Social Change and Noncommunicable Diseases, WHO SEARO, and composed of: Dr M Khalilullah, Programme Development Officer, WHO SEARO; Dr D Caussy, Regional Epidemiologist, WHO SEARO; Dr Ei Kubota, WHO Representative, Dr S Puri, Medical Officer (Management), and Ms. Laila Ali, National Programme Officer, all from the WHO Country Office, Maldives.

The mission jointly identified nine areas of priorities in which a window of opportunity exists for WHO to exercise its new corporate strategies consisting of four strategic directions and six core functions. The nine areas identified included: increased public health demands on health delivery, high maternal mortality rate, environmental health, nutrition, food safety, increased burden of diseases, health promotion, and development of health sector reforms.

The WHO Office in Maldives in collaboration with the Government of Maldives/ Ministry of Health had taken a step in the right direction by adopting and adapting the WHO Corporate Strategy as their basic working concept for country programming. They identified nine main issues based on the last five years' development of the country health programmes and anticipated challenges in the 21<sup>st</sup> century. The Maldives Country Cooperation Strategy Team from WHO, in collaboration with the Government of Maldives, tried to harmonize the country programme elements (and their issues) with the four strategic directions and six core functions. The activities related to these issues are associated with the potential 11 WHO priorities. In general, all of the country programmes are very much within the framework of the 35 WHO work programme areas.

The results of the WHO Country Cooperation Strategy (WHO-CCS) Team's analysis are congruent with most of the strategies stated in the country Master Health Plan and National Development Plan for the years 2000-2005. With necessary modifications, the WHO Mission Team believes that the results of present Country Cooperation Strategy may be used for planning and implementing the incoming Country-WHO Programme Budget proposals for the years 2002-2003 in the context of "One WHO". However, further review is needed for the elaboration of the Health Sector Reforms strategy and the harmonization of country priorities with the WHO priorities.

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## 1. INTRODUCTION

Following the guidance of the WHO Corporate Strategy as presented by the Director-General to the 105<sup>th</sup> Session of the WHO Executive Board, a series of WHO missions have been initiated to the countries of WHO South East-Asia Region. The goal is to prepare and formulate WHO Country Cooperation Strategies (WHO-CCS), within the overall framework of WHO Corporate Strategy.

The WHO Corporate Strategy is a framework for the WHO secretariat in response to a changing global environment. It is designed to meet the challenges posed by significant changes in international health since the past decade. It is a process of organizational development and forms a policy framework for the work of WHO for the period 2002-2005. It will give rise to a number of different products including the next WHO General Programme of Work, Proposed Programme Budget and Work-plans 2002-2003 and 2004-2005, etc.

The WHO Corporate Strategy has *four main strategic directions*: i) reducing excess mortality, morbidity, and disability, especially in poor and marginalized populations; ii) promoting healthy lifestyles and reducing factors of risk to human health that arise from environmental, economic, social and behavioural causes; iii) developing health systems that equitably improve health outcomes, respond to people's legitimate demands and are financially fair; and iv) developing an enabling policy and institutional environment in the health sector, and promoting an effective health dimension to social, economic, environmental and development policy. To carry out these strategic directions, WHO will undertake the main *six core functions* in the areas of i) policy and advocacy; ii) information, research and development; iii) technical and policy support; iv) partnerships; v) norms and standards; and vi) technologies, tools and guidelines.

The WHO Country Cooperation Strategy (WHO-CCS) is a strategic framework focussing on WHO's collaborative work in the Republic of Maldives and intends to define WHO's comparative advantage and added value in the country.

### (a) Purpose of mission

- (1) To review the existing health system for health policy and health care delivery;
- (2) To prioritize national health issues that need to be adapted;
- (3) To identify areas in which WHO has a comparative advantage to provide support, and

- (4) To formulate a common WHO-Country Cooperation Strategy for collaboration of WHO with the government of Maldives during 2002-2005.

**(b) Methods of Assessment**

The formulation of WHO CCS for Maldives involved two main steps consisting of extensive consultation and preparation at both WHO country and regional offices.

Prior to the country visit, both the regional and country level teams prepared and exchanged two different preliminary country analytical reports based on the information available at both levels. The evaluation of WHO collaborative programmes of Maldives carried out in 1998 and reports of WHO consultants/staff were helpful in identifying the strengths and weaknesses of WHO collaboration to date. The available country information through the latest Government documents was utilized to the extent possible in preparing the country analytical report. The report by the country level team was prepared in close consultation with the nationals.

The list of participants and agencies involved in the work of the mission is at *Annex 1*. The working schedule of the CCS mission is in *Annex 2*.

During the country visit, meetings and discussions were conducted with policy and decision-makers as well as technical persons, chiefly from the Ministry of Health, Maldives and principal development partners. Daily sessions were conducted with the full CCS team and the national authorities to review the preliminary situational analysis of the country in terms of priority, to identify pertinent national policy and to harmonize the country priority with WHO's strategic directions. A summary of the issues identified is given in *Annex 3*. The CCS team then conducted a functional analysis to synchronize the country's priorities in line with the four strategic directions and six core functions of WHO to formulate a matrix. These were discussed daily with the nationals for refining the issues and the mutually agreed version was presented in a plenary session to relevant ministries and development partners from Maldives. The discussions on concerned issues are summarized in *Annex 4*.

## **2. NATIONAL HEALTH SITUATION**

### **2.1 Overall National Health Situation**

Maldives is an archipelagic state, sharing a common language, religion and history with an estimated population in 1999 of over 277 000<sup>1</sup> and a growth rate in 1995 of 2.7%<sup>1</sup> per year. The country consists of nearly 1 200 small coral islands, of which about 200 are

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<sup>1</sup> Statistical Year Book of Maldives 1999

inhabited and grouped into 20 administrative atolls (26 natural atolls). These form a narrow chain of 820 km in length and 130 km at its widest point, set in an area of about 90 000 sq. km of the Indian Ocean. The widely dispersed population and the distances separating the small islands give rise to severe diseconomies of scale in transport and provision of a social and physical infrastructure for health. Maldives' economy continues to be largely dependent on tourism and fishery exports. Despite the severity of constraints, the country has made impressive progress in health development. With a per capita GDP of US\$920<sup>2</sup> and over 98% adult literacy rate, less than 50% of people have access to safe drinking water and 40% to sanitation facilities.

There was a considerable reduction in infant mortality rate (IMR) between 1990 and 1998 from 34 to 20, maternal mortality rate (MMR) from 200 to 141 per 100 000 live births and under-five mortality from 48 to 27 per 1 000 live births. The life expectancy for women became higher at 71 than 70 for men. Information was derived from the Health Master Plan of Maldives (1996-2006). These statistics are as of 1995 and have not been adjusted for over- or under-reporting. The following *Table 1* shows the selected health indicators of Maldives as of 1998 at a glance.

Table 1: ***Selected health indicators, Maldives, 1998***

Indicator	Rate
Infant Mortality Rate <sup>1</sup>	20
Under-five Mortality Rate <sup>1</sup>	27
Life Expectancy at Birth in Years <sup>2</sup>	71.12
Population Growth Rate <sup>3</sup>	2.7
Crude Birth Rate <sup>2</sup>	21
Crude Death Rate <sup>2</sup>	4
Maternal Mortality Rate <sup>2</sup>	141
Contraceptive User Rate <sup>1</sup>	18.5
Functional Literacy Rate <sup>2</sup>	98
Percentage with Access to Safe Drinking Water <sup>4</sup>	90
Percentage with Sanitation Facilities <sup>4</sup>	40

**Sources:** 1. *Maldives Health Report 1999*  
 2. *Statistical Yearbook of Maldives 1999*  
 3. 1995 figures in *Statistical Yearbook of Maldives 1999*  
 4. *Fifth National Development Plan 1997-2000*

<sup>2</sup> Statistical Year Book of Maldives 1999

The most common prevailing diseases are intestinal parasitic diseases; acute respiratory infections; malnutrition; tuberculosis; dengue fever/dengue haemorrhagic fever; sexually transmitted diseases; noncommunicable diseases such as cancer, diabetes, cardiovascular diseases and thalassaemia. *Table 2* on out-patients' visits reflects that fever (PUO), injury, common cold and skin diseases are at the top of the list, followed by worms and bronchitis/asthma.

**Table 2: *Out-patient visits to Atoll health centres and regional hospitals by selected diseases, 1996–1997***

<b>Selected Diseases:</b>	<b>1996</b>	<b>1997</b>
Bronchitis/Asthma	2 741	2 446
Worms	6 378	2 758
Injury	16 278	8 623
Skin diseases	8 447	8 994
Pregnancy and child birth	1 212	2 142
Common cold	14 124	10 688
Fever	18 635	8 770
Others	65 779	82 585
<b>Total</b>	<b>133 594</b>	<b>127 026</b>

**Source:** *Statistical Yearbook of Maldives 1997 and 1999*

In 1998-1999, most of the cases reported countrywide were: 42 malaria, all imported; 10 filariasis, classified as four imported and six indigenous; 1 826 Dengue Fever (DF) and 57 Dengue Haemorrhagic Fever (DHF) with one death; 22 meningitis with four deaths; two encephalitis with one death; 58 leprosy with 50 new and eight as skin smear positive; 330 TB with 179 sputum positive, 151 sputum negative and 13 deaths, six from positives and seven from negatives; 29 372 influenza; and 83 new cases of thalassaemia. Since the first HIV case diagnosed in 1991, 77 more were found bringing the cumulative total to 78 (10 nationals and 68 foreigners) of which six nationals have since developed AIDS and died. A more rapid increase in the number of HIV cases is being observed compared to the earlier years, i.e., during 1998 the total number of HIV cases reported was 13, whereas, during 1999 alone, it was 22. The National Thalassaemia Centre reported a registered cumulative total of 387 (male 191 and female 196) cases with 77 deaths by the end of 1999. It is estimated that this number of registered cases is only a quarter of all the cases and that about 18% of the population are with beta thalassaemia major.

A decreasing trend was observed in death rates caused by diseases of the respiratory and circulatory systems and parasitic infections, but an increase in death rates

was also found in relation to diseases of the nervous system, mental disorders, gastrourinary system, and neoplasm.

Malnutrition among children below five years of age is extremely high with the national figures of 1996 (Maldives Multiple Indicator Cluster Survey Report) indicating 22.36% stunted, 14.5% wasted and 37.5% undernourished. There is a high prevalence of anaemia and also iodine deficiency disorders. Vitamin A deficiency is considered to be a public health problem; however, a full assessment using biochemical analysis is needed to establish the definitive situation.

There has been an improvement in distribution of the health resources. From 1997 to 1998, even though there was 0.90% reduction in the health expenditure of the national budget, an increase was observed in the per capita expenditure on health out of the national budget. Table 3 below shows the distribution of health resources in 1997 and 1998:

Table 3: ***Distribution of Health Resources, 1997 & 1998***

	<b>1997</b>	<b>1998</b>
Total Number of hospital beds	367	391
IGMH, Malé	184	200
ADK Hospital, Malé	40	50
Regional hospitals	127	157
Population / hospital bed	705	684
Nurse / bed	1	1
Population / practising staff nurse	1 369	1 372
Population / practising doctor	1 354	1 358
Doctor / 10 000 population	7.4	7.4
Community health workers / 10 000 population	2.6	2.4
Family health workers / 10 000 population	10	10
Health expenditure as % of national budget	10.94	10.04
Per capita health expenditure out of the national budget in MRf	819.55	832.61
in US\$	69.92	71.04

**Source:** *Statistical Yearbook of Maldives 1999*

## **2.2 Major Health Problems and Key Issues in Health**

The major health problems and key issues are to be derived from a set of functional factors including the geographical characteristics of Maldives, diseconomies of scale due to

the scattered population and relatively high population growth rate coupled with rising life expectancy. Acute scarcity of skilled health personnel is a major constraint for sustainable health development. Mostly expatriates staff the health institutions at different levels. Most of the available local doctors prefer to stay at central level institutions. Only local nurses outnumber expatriates. The highest priority is, therefore, accorded to HRH development, realizing that capacity building – vital for self-reliance - takes time. The implications of these factors are:

- Shortages of professionally and technically skilled national health manpower in almost all the areas and levels of the health sector, necessitating hiring of expatriates resulting in financial burden to the government, emphasize the need for appropriate HRH development and management.
- Considering the difficulties in transportation between small widely dispersed islands due to the lack of an established transport system hindering the usual flow of progress, accessibility and equity of health services delivery, there is a strong need for adequate management of the transport system.
- High population growth rate, maternal and perinatal disorders emphasize the need to ensure an effective reproductive health programme all over the country.
- Burden of diseases, including vector-borne diseases influenced by environment, emphasizes the need for improved environmental health including access to safe drinking water and sanitary disposal of excreta, especially at the island level.
- Malnutrition among children below five years of age with a high degree of stunting, wasting, and under-nourishment requires that emphasis be placed on effective management of the national nutrition, food security and food safety programme.
- Burden of emerging/re-emerging, preventable communicable/non-communicable diseases stresses the need on improving the operational efficiency of ongoing intervention programmes.
- Interventions aimed at improving healthy behaviour inculcating healthy lifestyles and enhancement of community awareness through effective information, education and communication (IEC) strategies, including those on advocacy for disease prevention, environmental health and intersectoral coordination, need to be addressed adequately.

The issues adversely affecting the ability of the government as well as organizations to operate and manage the health sector in relation to the above, include the following:

- Planning, financial, information, human resources management, use of logistics, and consideration of long-term benefits during project planning and implementation continue to be weaker than required.
- Monitoring of sector performance (availability, accessibility, affordability, acceptability of services and equity) remains insufficient.
- Staff motivation, deployment and retention are limited, due to frequent changes of the persons responsible for programme/project implementation.
- Decentralization and delegation of authority are being exercised sub-optimally.
- Less community involvement in planning, implementation and supervision of the services delivery.
- More government expenditure on secondary and tertiary levels of care, which contradicts the emphasis of the national health policy on preventive health and promotion of healthy lifestyles.
- Strategy for intersectoral collaboration still remains weak.
- Regulatory mechanism and framework remain inadequate for proper financing including alternative health care financing, and availability, accessibility and equitable provision of services.
- Inadequate coordination among development partners, leading to duplication or gaps in needed support.

### **2.3 National Health Policy, Strategy and Programmes**

The country vision 2020 on health states: “By 2020, Maldives will be a more urbanized country providing satisfactory living conditions to all. The people will have greater awareness of and commitment to healthy lifestyles. Good quality medical care will be available to all citizens in the area in which they live, and will have easy access to a health insurance scheme that will enable them to meet their medical expenses”.

Maldives has made a firm commitment to achieve the HFA goals with PHC as the key approach. To provide tools, to address equity concerns as well as specific health

problems, integrating the health and human development concerns into public policies, the Government finalized in early 1997, a Health Master Plan (HMP) covering the period 1996-2005. It is envisaged that by 2005, all Maldivians will have the knowledge and skills required to protect themselves from ill health and access to effective and affordable health care that enhances their quality of life and enables them to lead healthy productive lives. Accordingly, the national health policy emphasizes that primary health care (PHC) is the most appropriate approach for attaining the goal of health for all (HFA). Emphasis is, therefore, laid on the following:

1. Preventive health and promotion of healthy lifestyles;
2. Reducing the burden of diseases in the community;
3. Early detection of preventable diseases, health problems and complications;
4. Equitable access and affordability of health care services, and
5. Health of women and other vulnerable groups.

Attainment of the highest possible level of self-sufficiency in tertiary medical care within the available resources is also given priority. Based on the priorities laid down in the HMP, the Ministry of Health emphasized the following priority programme areas for intensification and collaboration:

1. Human resources development for health;
2. Specific/integrated disease prevention and control programmes;
3. Population issues, including maternal and child health;
4. Environmental health, and
5. Health education and health promotion.

The Government will strategically strengthen national capacities in management and development of the health system to achieve maximum self-reliance. To implement these policies and programmes, high priority has been given to ensuring the availability of essential health services at the atoll and island levels with expansion of the health facilities and strengthening of the referral system. A wide, four-tiered network of health care facilities throughout the country is being established to make basic health services available and accessible to the majority of the population. It includes Indira Gandhi Memorial Hospital - IGMH (Central level) at Malé; five Regional hospitals (Regional level) in five different parts of the country; 31 Atoll health centres (Atoll level) and 34 Health posts (Island level). At the island level, Family Health Workers (FHWs) and Traditional Birth Attendants (TBAs) provide basic health services. With the development of inpatient and labour room facilities, since 1994, doctors in addition to Community Health Workers (CHWs) have staffed most health

centres. Public health units established in all regional hospitals are intended to provide comprehensive preventive and promotive health care. Participation of NGOs, private sector and the community will be encouraged and mobilized. Alternative financing mechanisms, i.e., health insurance schemes will be introduced in support of the public financing.

## **2.4 Partnership in Health Development**

WHO's role as the longest standing partner in the national health development of Maldives is well recognized. It is clearly reflected in the message of His Excellency President Maumoon Abdul Gayoom to the special forum of the Fifty-first World Health Assembly on WHO's 50<sup>th</sup> Anniversary, 14 May 1998: *"The partnership between WHO and Maldives has been an eminently successful one. Given the constrained circumstances of a resource-poor, widely dispersed and developing archipelagic state, the relationship is indeed an indispensable one in order to ensure affordability of health care services to all and to increase national capacity to address health threats. The Government and people of Maldives, therefore, remain firmly committed to working with WHO, in ensuring the highest attainable standard of health for all Maldivians for now and in the time to come"*. Obviously, this speaks of the need and usefulness of the continued partnership of WHO at country level for jointly tackling health challenges as they arise.

Promoting and maintaining the technical leadership role of the organization in the overall national health development and management, WHO has been providing Maldives with much-needed technical support with better understanding and coordination between all the ministries, sectors, agencies, donors and NGOs. The Government and its principal development partners in health have begun to move in the direction of exchanging information on planning and programming, as an initial step towards an integrated development of the national health system.

### **(a) Intersectoral Coordination**

To enhance partnerships in health, several attempts have been made towards strengthening intersectoral coordination including formulation of a National Nutrition Plan, National Plan for Health and Environment and implementation of the School Health Programme, which established better links with the health sector. Developing health awareness among the general public with active involvement of concerned ministries and sectors is a good example of intersectoral coordination. However, these efforts need a more cohesive approach with clearer directives to get better multi-dimensional results.

**(b) Collaboration with NGOs and Civil Society**

The Government espouses the view that community organizations and NGOs are useful partners in the development of the country and desires to work with them. However, no initiative has yet been taken to enhance coordination of NGO activities or to facilitate their collaboration with the Government. Utilization of NGOs and community organizations would seem to have great potential for social mobilization in Maldives if an efficient, collaborative mechanism could be established to harness their potential. The community organizations existing at various levels with varying functions include Ward Committees, Atoll Development Committees (ADC), Island Women's Development Committees (IWC) and Island Development Committee (IDC). These comprise elected members and are engaged in activities of social, health and economic development.

There are several NGOs registered countrywide under the designation of "clubs" or "associations". Among others, well recognized local NGOs with a proactive role in health include the Society for Health Education (SHE) concentrating on health and family welfare issues, the Foundation for Advancement of Self-help in Attaining Needs (FASHAN) focussing on improving the living conditions of islanders especially women, youth and children, Kanduholhudhoo Island Development Society (KIDS) active in agricultural production for better nutrition and also involved in advocacy on Reproductive Health (RH), and Writers on Environment (WE) influencing media by producing newsletters, leaflets and posters on environment. However, absence of official guidance and coordination has resulted in duplication or blurring of roles and activities between NGOs themselves and the Government. Instances of such duplication are drug counselling by both SHE and FASHAN, training on health awareness and radio programmes by SHE and the Institute of Health Sciences (IHS).

**(c) Collaboration with other International Organization and Agencies**

To address the issue of mobilization of resources for health, the Ministry of Health and WHO organized the first International Health Sector Donors' Meeting in May 1995 at Colombo with the theme of "Towards Sustainable Development in Health". On WHO initiatives, more donors came forward to provide financial support to Maldives in different priority health programmes. Overseas Development Assistance (ODA), Japan supports basic human needs in health, sanitation and education. Australia supports Institute of Health Sciences and Human Resources for Health development. Additional supports have been generated in areas of HRH development, control of communicable/noncommunicable

diseases, health information system (HIS), essential drugs, district health systems, and strengthening of reproductive health.

Following the initiative of the WHO Representative in Maldives, UN Inter-Agency Group meetings have been organized regularly since 1999, to maximize the utilization of available resources and to avoid duplication and unnecessary competition among various agencies. Collaboration on HIV/AIDS related activities has been an Inter-Agency initiative under the UN Theme Group on HIV/AIDS. UNDP with UNICEF supported a series of community nutrition workshops with multisectoral participation of concerned ministries/institutions. The UNRC funds supplemented activities related to HIV/AIDS and community nutrition. WHO and UNICEF have implemented many joint activities, such as international EPI reviews, a nutrition survey and baby-friendly hospital initiative. UNFPA with UNICEF supports strengthening of health information system (HIS). UNICEF provides essential drugs and nutrition, and assists in food safety, and water and sanitation programmes. Through joint WHO UNFPA country support, Home Based Maternity Record Card (HBMRC) has been introduced countrywide to facilitate the RH programme. With WHO initiative, UNDCP supported the country in prevention and rehabilitation of drug abuse and UNDP supports the environment programme.

**(d) Flow of funds, inputs from International Agencies**

For Maldives, the GDP per capita in 1998 was US\$ 920 compared to US\$ 872 in 1997 and US\$ 823 in 1996. Economic growth has moved Maldives in the UNDP Human Development Index (HDI) ranking to 93 in 1999 from 95 in 1998 and 111 in 1997. This progression has an implication for 'graduation' from a least developed to developing nation, which reflects a gradual decline in donor assistance. However, while the index rating is an indicator to phase-out from a lower category to a higher level, Maldives is still in need of continued donor assistance to sustain and further advance towards social and economic development. It requires a phase-out plan to meet the challenges. The Sixth Round Table Meeting of International Organizations and Agencies for Maldives, organized by UNDP in Geneva on 11 May 1999, unanimously agreed to continue supporting Maldives as a special case in its socioeconomic goals and aspirations even if it was considered to have "graduated" from Least Developed Country (LDC) status, so that the momentum of positive changes would not be impeded<sup>3</sup>.

The total Overseas Development Assistance (ODA) for 1999 from multilateral and bilateral loans and grants was US\$ 41 782 000 excluding the United Nations ODA of

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<sup>3</sup> Report of the Sixth Round Table Meeting for Maldives by UNDP in Geneva on 11 May 1999

US\$ 3 186 000. The UN contributions are from UNDP, UNICEF, WHO, UNFPA, FAO and IFAD. The grant assistance dropped by US\$ 1 739 130 in 1999, compared to US\$4 925 130 in 1998<sup>4</sup>. The resource flow from donors to the health sector has also been reduced. Table 4 below indicates contributions from agencies and donors to the health sector during the years 1997, 1998 and 1999. Additionally, these agencies have also supported the participation of Maldivians in several intercountry training, meetings, seminars and workshops.

Table 4: **Contributions to health sector, 1997-1999 (in MRf.)**

<b>Agencies/Donors</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>
UNFPA <sup>1</sup>	7 428 136	3 480 770	3 404 707
UNDP <sup>2</sup>	175 500	425 073	NA
UNICEF <sup>3</sup>	425 000	425 000	548 000
WHO <sup>4</sup>	10 919 524	11 972 917	13 559 102
UNRC <sup>5</sup>	132 202	512 340	123 060
Bilateral Donors <sup>3</sup>	9 596 313	804 154	2 419 980
IPPF <sup>3</sup>	479 827	486 679	645 063
<b>Total</b>	<b>29 156 502</b>	<b>18 106 933</b>	<b>20 699 912</b>

**Sources** 1. UNFPA Country Office, Malé  
 2. Budget Speech of HEP, 29-12-1999  
 3. Information Unit, MOH, Malé  
 4. WHO Country Office, Malé  
 5. UNDP, Malé

Up-to-date and reliable information on overall health expenditure is difficult to get as depending on the nature of the development partners' agreement with the Government, funds are managed either by the Ministry of Health, its units or other ministries, international or local NGOs or other development partners themselves. However, there has been a steady increase in the Government expenditure on health during the past decade.

- Between 1990 and 1997, the Government health expenditure including grants and loans increased from MRf. 114.1 million (US\$ 12.2 million) to MRf. 212.0 million (US\$ 18.1 million). It has again increased with the provisional expenditure of MRf. 222.7 million (US\$ 19 million) in 1998 and budget estimate of MRf. 239.8 million (US\$ 20.5 million) in 1999<sup>5</sup>.

<sup>4</sup> Annual Report of the Resident Coordinator in Maldives, 1998 and 1999

<sup>5</sup> *Statistical Yearbook of Maldives 1992, 1997 and 1999*. The US Dollar exchange rates in 1989, 1990 and October 1994 onwards were MRf. 9.04, MRf. 9.35 and MRf. 11.72, respectively.

- Although there was a steep increase in the health expenditure as percentage of the national budget, from 6.73% in 1989 to 15.47% in 1990, it decreased gradually to 10.04% in 1998<sup>5</sup>.
- The per capita health expenditure as part of the national budget increased from MRf. 190.0 (US\$ 20.32) in 1990 to MRf. 832.61 (US\$ 71) in 1998<sup>6</sup>.
- Among all the health expenditures during 1998, the Department of Public Health (DPH) responsible for communicable diseases control and Maldives Water and Sewerage Authority (MWSA) accountable for water and sanitation programmes got 25.7% and 0.74% respectively, whereas, IGMH (central level hospital) and the regional hospitals shared with 48.7% and 10.8% respectively, totalling 59.5% of the total health expenditure<sup>6</sup>.

In addition, there are several bilateral donors supporting the health development of Maldives but the financial figures of their assistance are not available. Health activities in Maldives sponsored by Australia, Bangladesh, Bhutan, Canada, India, Japan, Nepal, New Zealand, Pakistan, Republic of Korea, Sri Lanka, and United Kingdom, among others, include mainly the training of health manpower by providing support as well as placements in their academic institutions, development and strengthening of health training institutions in the country, such as Institute of Health Sciences. The Voluntary Service Organization (VSO), Australian Service Organization (AVA), and Japanese Overseas Cooperation Volunteers (JOCV) have been assisting in compensating for the shortage of experts by fielding technically qualified manpower as volunteers. The United Nations Volunteers (UNV) have also been actively working in areas of sustainable human development and capacity building for management of development programmes, in particular to grass-roots development interventions. Financial assistance from development banks for health sector development include aid from the World Bank for HRH development, the Asian Development Bank for technical assistance to water and sanitation related activities, and the Islamic Development Bank for infrastructure development of hospitals and Institute of Health Sciences.

### **3. ASSESSMENT OF WHO COLLABORATIVE PROGRAMMES FOR THE LAST THREE BIENNIA**

WHO's collaboration with Maldives over the current and past biennia has embraced a broad-based approach for meeting the country's national health development needs. A general tendency among nationals is to spread WHO resources thinly over several areas in

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<sup>6</sup> Percentages are drawn from the *Maldives Health Report 1999*

order to get continued WHO technical support. However, for better utilization of WHO resources and focussing on the national health priorities, the number of Plans of Action had been reduced to 15 in 2000-2001 from 22 in 1998-1999 and 24 in 1996-1997. WHO country programmes have been generally successful in supplementing the national programmes and meeting country needs and priorities.

**(a) Achievements of the WHO Collaborative Programmes**

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

- Assisting the Ministry of Health in developing Health Master Plan, health policies, strategies, management capacity and Technical Cooperation among Developing Countries (TCDC);
- Strengthening the district health systems by improving efficiency, quality and equitable health services;
- Ensuring the development of technically competent health personnel and their management;
- Enhancing community participation, intersectoral and interagency collaboration;
- Collaborating in the development of the national drug policy, regulatory and quality assurance capacity, rational drug use and national drug supply strategies, and
- Supporting the development and implementation of national health promotion plan/strategies, and needed interventions for communicable/noncommunicable diseases, reproductive health, nutrition, food safety, and environmental health including safe water supply and sanitation.

Overall, the WHO country programmes have been generally effective in meeting the health development needs of Maldives. Under **National Health Policies and Programme Development and Management** to improve technical cooperation among countries, WHO supported visits of several health officials to other countries to exchange experiences and enhance the management of health sector development. It facilitated bilateral cooperation

among Maldives and those countries, particularly in the area of getting more training opportunities and placements for Maldivians in health institutions abroad. The HMP developed with WHO support, envisaging plans, strategies and programmes for the period 1996-2005 has been providing directions to improve health planning, management and resource mobilization.

In the area of **Biomedical and Health Information and Trends** with WHO support, the country health information system has been strengthened by the development of a methodology on conducting survey to validate birth/death registration database for improving data communication, processing and analysis between health departments and regional hospitals.

Under **Organization of Health Systems Based on PHC**, to improve the preventive, promotive and curative health services at all levels of health institutions including hospitals, health centres, along with their performance and quality assurance, WHO supported training of health manpower and strengthening the training institutions. The Public Health Units (PHU) in regional hospitals have been facilitated with adequate equipment, trained CHWs staffing these units and reviewing its functions for much needed improvement. Likewise, for providing PHC services through locally trained health personnel, WHO support has also been instrumental in strengthening IHS, the only training institution in the country. In addition to in-service training, IHS now offers training in several health categories, including diploma in PHC, nursing and medical laboratory technology (MLT).

Considering the top priority given by the Government to the development of **Human Resources for Health**, WHO support has benefited the country considerably over the past biennia and continues to do so. Adaptation of the economical WHO Contractual Services Agreement (CSA) mechanism under bilateral arrangements to train the health personnel has been a major achievement in meeting the HRH requirements. A nursing/midwifery council has been established with related regulatory mechanism. The present trend of WHO support and that of other agencies to HRH development was analyzed and it was recommended to streamline future WHO support in line with the HRH Master Plan to be developed in the near future.

WHO support has ensured the effective management of supplies, rational use, quality control and regular provision of **Essential Drugs**. A recently introduced computerized drug registration system has facilitated the process. In **Quality of Care and Health Technology**, public health laboratory services were improved through training of health personnel and provision of essential equipment and chemicals.

In the area of **Reproductive, Family and Community Health and Population Issues**, the successful pilot testing of Home Based Maternal Record Card (HBMRC) with WHO support during 1996-1997 led in 1998-1999 to its nationwide expansion through joint WHO/UNFPA country support. It illustrates the catalytic effect of WHO generating larger resources required for programme scaling. To improve the existing reproductive health programme, training of community health workers, traditional birth attendants and health workers of islands was supported to implement HBMRC.

In the area of **Healthy Behaviour and Mental Health**, activities related to health promotion were integrated into all public health programmes in order to create awareness. WHO supported the preparation of the national health promotion plan with its strategies targeting the general masses. The School Health Programme, in collaboration with Ministries of Health and Education, contributed to educating school children, parents and teachers in the areas of nutrition, communicable and noncommunicable disease control, personal hygiene and sanitation.

On WHO initiative and with UNDP support, a national mechanism comprising national sectors, agencies and donors was established to promote the programme on **nutrition, food security and safety**. WHO assisted in modifying food safety regulations and training of personnel involved in preparation and handling of food and inspection of tourist resorts and hotels.

In **Environmental Health**, concerted efforts were underway with the ultimate aim of improving the quality and quantity of safe water supply and sanitation provision throughout the country. The sewage system in Malé was restored with technical support of WHO. A "National Action Plan on Health and Environment" was developed with the integrated efforts of the concerned ministries, sectors and WHO. Five islands are under development as "Healthy Islands", adopting WHO's Health and Environment Initiative on "Healthy City" concept and incorporating the health concerns into environmental management.

With regard to the **Integrated Control of Diseases**, Maldives has sustained the immunization coverage at above 90% for all the antigens. Indigenous polio, neonatal tetanus, pertussis and diphtheria are close to being eradicated, while measles is no longer a significant cause of morbidity or mortality. Contact tracing, case management and monitoring activities of leprosy continued in an integrated manner with other WHO supported disease control programmes. However, ongoing Acute Flaccid Paralysis (AFP) surveillance must be strengthened and maintained to avoid reintroduction of diseases and to meet the WHO criteria for certification. The National Immunization Days are being regularly and successfully

conducted on SAARC polio days with WHO/UNICEF support, on 18 January and 7 December every year, with over 90% coverage of the children under five.

The main thrust of WHO support for the **National Tuberculosis Programme** was geared towards intensifying the control and prevention activities to strengthen the quality of services in terms of active case finding, follow-up treatment and management of diagnosed cases using Directly Observed Treatment Short-Course (DOTS) as a standard protocol with diagnostic facilities at regional and atoll levels. Although Maldives had achieved the year 2000 targets for Tuberculosis (TB) control in 1996, and the mortality rate from TB has decreased, morbidity still remains high.

Due to the sudden withdrawal of UNAIDS input to Maldives from 1998, extra WHO/HQ support was added to strengthen the **national HIV/AIDS/STD programme**. On initiatives taken by the WHO Representative, and agreed by all the UN agencies present in Maldives, the UN Theme Group on HIV/AIDS was incorporated as a sub-group of the existing National AIDS Council/Committee to facilitate the overall management of the programme. It considerably strengthened the national coordination mechanism on HIV/AIDS by providing the Government of Maldives the ownership and liberty to call on other agencies/donors/NGOs for participation and assistance, as and when required.

With global increase in **emerging/re-emerging diseases** and the necessity for strict vigilance and surveillance, quarantine and health control measures for incoming passengers from abroad has been supported. Enforcement of the international health regulations at the airports, seaports and cargoes has improved through training of selected health personnel and provision of essential equipment. Despite the successful control of malaria, the mosquito-borne diseases, including filaria and dengue fever, remain public health problems. Filariasis has been brought under control to a point where no case reached an advanced stage, but dengue remains endemic. To get Maldives certified as a malaria-free state, WHO recommended further strengthening of the present epidemiological and entomological surveillance system and staff development with early diagnosis and prompt treatment (EDPT) to prevent reintroduction of malaria and to reduce the incidence of filaria, DF and DHF.

Under **Integrated NCD Activities**, management of cardiovascular, cancer and nephrotic diseases were supported. WHO also supported the overall programme management of the National Thalassaemia Centre facilitating screening services and preventive programmes. An amount of US\$ 20 000 granted by the Regional Director, WHO

Regional Office for South-East Asia from his development fund to the Society for Health Education (SHE) has improved its diagnostic facilities related to Thalassaemia.

**(b) Lessons learnt**

- Assessing the overall performance of WHO collaborative programmes, the most significant advances beyond those achieved in specific programme areas have occurred in the areas of policy dialogue between the Government and WHO, leveraging of WHO resources and coordination activities. It was stimulated and enhanced by technical contributions of WHO staff from the HQ, regional and country offices through frequent contacts, regular, ad hoc, individual and group meetings with concerned ministries, sectors, and programme managers. The momentum of ongoing improvements has to be sustained.
- The periodic meetings of the Government of Maldives and WHO Joint Coordination Mechanism, with its two tiers of the Advisory and Working Committees, effectively generated a conducive working environment, direct communication and improved participatory approach between the Government of Maldives and WHO. Better implementation of collaborative programmes has been observed with increased number of technically sound proposals submitted, activity implementation completed and documentation submitted. However, to achieve the complete and timely utilization of WHO resources, strict application of the procedure is still needed with continued follow-up by both WHO and the nationals.
- The school-health programme has shown a better performance, through the Ministry of Education in the Working Committee meetings. Likewise, as and when the need arises, the Government of Maldives/WHO Joint Coordination Mechanism could be used to further improve intersectoral collaboration in order to support the health areas.
- The quality of planning and management of WHO collaboration needs further improvement by incorporating national and WHO programme priorities, including the feasibility and complementarity of WHO programme activities with that of other agencies. Even though the products of WHO collaborative programmes have been relevant and complementary to the national priorities, the achievement of national health targets requires much broader partnerships, involving efforts and inputs of national and international agencies.

- There is a need to organize further orientation for the nationals on WHO managerial reform, so that WHO Programme Budget would not reflect the entire national health targets. It should rather reflect those that strategically contribute to achieving the national health targets.
- In order to sustain the achievements made in the areas of integrated control of communicable diseases through WHO collaborative programmes, there is a further need of support to improve the epidemiological surveillance and control.

#### **4. PRIORITY AREAS IN HEALTH FOR THE PERIOD 2002-2005**

##### **Current Country Needs, Challenges and Opportunities for WHO, Identified by the CCS mission**

After careful review and deliberations, the CCS mission team identified nine issues that were ranked as being priority areas for collaboration with WHO. These are:

1. Inadequate Human Resources for Health
2. Increased Public Demands on Health Service Delivery
3. High Maternal Mortality Rate
4. Insufficient Environmental Health Activities
5. Incomplete Nutrition Programmes
6. Weak Food Safety Programmes
7. Increased Burden of Diseases
8. Insufficient Health Promotion
9. Need for Development of Health Sector Reforms

To better define the functions of WHO, each of these issues was categorized by a matrix table under the four WHO strategic directions and six core functions. The results are shown in *Annex 4*.

**Inadequate Human Resources for Health:** The country's priority in developing adequate human resources for health offers WHO a window of opportunity to collaborate in areas of support on implementation and follow-up of HRH master plan, including research on HRH policy, auditing, staff development training programmes in appropriate technology with standard curriculum development for health vision 2020.

**Increased Public Demands on Health Service Delivery:** The country's priority in adequate Health Service Delivery for All affords an opportunity to WHO to collaborate in areas of

support to national policy development on health care delivery, including production of equity guidelines, and defining indicators for monitoring and evaluation.

**High Maternal Mortality Rate:** WHO can take advantage of the country's priority in strengthening and expansion of comprehensive maternal health services to collaborate in the collection of evidence-based data on safe pregnancy, evaluation of health workers, and development of guidelines for risk reduction of maternal mortality rate.

**Environmental Health:** WHO could collaborate in the surveillance for health impacts due to environmental hazards in all settings; integrated vector controls; research on environmental risk factors, promulgate guidelines and standards on safe drinking water and waste disposal in line with the country's priority to Promote Environmental Health Awareness and Environmental Health Monitoring.

**Nutrition:** The country's priorities in food security, breastfeeding, health of pregnant mothers; use of iodized salts; deworming; and micronutrients harmonize well with WHO's normative role to support the updating of national policy on nutrition, survey of malnutrition, monitor growth charts, and develop and promulgate indicators for malnutrition.

**Food Safety:** WHO could assist the country in the survey of food safety; support formulation of food legislation; facilitate development of national standards and quality assurance (QA); and train staff in food safety practice and monitoring in order to implement the country's priorities in maintenance of safety of food; development of food legislation; development of food standards; infrastructure and capacity building.

**Increased Burden of Diseases:** The country's priorities in intensified epidemiological and entomological surveillance to reduce morbidity and mortality and efforts in IEC and community participation in disease control fits with the WHO strategic directions of reduction of disease morbidity and mortality. WHO can extend its core function in assisting the country in formulation of policy on emerging/re-emerging diseases; support integrated control of priority diseases; train nationals in standard case definition and indicators for disease surveillance, and render assistance in surveillance of risk factors for diseases.

**Health Promotion:** WHO has a potential role to support planned activities based on the Jakarta and Mexico Declarations; promote sustainable development of health programmes through advocacy and research on Knowledge Attitude and Behaviour Practice (KABP) survey in view of the country's priority for including health promotion in all health programmes in different settings and targeting decision/policy-makers and professional groups.

**Development of Health Sector Reform:** WHO has a potential role in the country's priority in health vision 2020 concept; health care financing; health insurance; review of management and administration offers to support policy relevant to four strategic directions and six core functions and promote appropriate technologies to implement health sector reform in the country.

## **5. CONCLUSIONS**

Population growth, malnutrition, communicable/noncommunicable diseases, and environmental degradation including soil conservation are indeed daunting challenges towards the goal of sustainable health development of Maldives. Still, the high literacy rate, increase in life expectancy, reduction in infant mortality, eminent prospect of eradication of polio and neonatal tetanus and elimination of leprosy gives hope that together, much can be achieved by utilizing the available resources properly.

The WHO CCS mission found that most of the strategies of the country Master Health Plan match with the WHO Corporate Strategy of four strategic directions and six core functions. In this respect, the relationship between Maldives and WHO is truly one of cooperation. This report may be used for planning and implementing the upcoming country –WHO Programme Budget Proposal. This report may also serve as a blueprint for galvanizing donor and partner support.

## List of Participants and Agencies Involved in Preparing Country Analytical Report

### National Health Officials

- Dr Abdullah Waheed,  
Director-General, Health Services, Ministry of Health, Maldives
- Mr Ahmed Salih,  
Deputy Director, Ministry of Health, Maldives
- Mr Abdul Bari Abdullah,  
Under-secretary, Ministry of Health, Maldives

### WHO Country Office Team

- Dr Ei Kubota,  
WHO Representative to Maldives
- Dr S Puri,  
Medical Officer (Management), WHO, Maldives
- Ms Laila Ali,  
National Programme Officer, WHO, Maldives

### WHO Regional Office Team

- Dr Imam Mochny,  
Director, Social Change and Noncommunicable Diseases, WHO SEARO
- Dr M Khalilullah,  
Programme Development Officer, WHO SEARO
- Dr H Caussy,  
Regional Epidemiologist, WHO SEARO

### Development Partners Contacted in Malé

- Mr Sjaak Bavelaar, Resident Representative, UNDP
- Ms Aishath Mohamed Didi, Officer In-charge, UNICEF
- Ms Dunya Maumoon, National Programme Officer, UNFPA
- Ms Coumba Ceesay-Marenah, UNV Programme Officer, UNDP

### Additional Government Officials who participated in the concluding session

- |  |          |
|--|----------|
| • Ms Fathimath Moosa, DG-Nursing                     | MoH      |
| • Mr Hassan Moosa, Director                          | MoH      |
| • Ms Shehenaz Fahmy, Assistant Director              | MoH      |
| • Ms Aminath Nasheeda, Planning Officer              | MoH      |
| • Ms Hawwa Zahira, Secretary                         | MoH      |
| • Ms Zakiyya Hassan, Programme Coordinator           | DPH      |
| • Dr Abdul Azeez Yoosuf, Director Medical Services   | IGMH     |
| • Ms Ihusana Ahmed, Director Nursing                 | IGMH     |
| • Mr Mohamed Ismail Fulhu, Director                  | IGMH     |
| • Mr Abdul Ghafoor, PM/NCD                           | NTC      |
| • Mr Abdullah Abdul Fathah, Director                 | MWSA     |
| • Ms Shaheeda Adam Ibrahim, Deputy Director          | MWSA     |
| • Mr Ahmed Latheef, Director                         | MoFA/DER |
| • Mr Mohamed Shahdhee, Desk Officer                  | MoFA/DER |
| • Mr Mohamed Abdul Azeez, Assistant Director General | MoWASS   |
| • Mr Mohamed Inaz, Senior Environment Analyst        | MoHAH&E  |

### Working Schedule

27 May 2000	Arrival of the mission in Maldives.
28 May 2000	Meeting the country team in WHO Office Meeting of members with H E the Minister of Health, Hon Mr Ahmed Abdullah Meeting of members with Representatives of UN Joint Working Session
29 May 2000	Joint working session
30 May 2000	Joint working session
31 May 2000	Joint working session
1 June 2000	Private meeting with H E the Minister of Health, Hon Mr Ahmed Abdullah, followed by concluding session
0900-0940 hrs -	<b>Concluding Session</b>
0900-0905 hrs -	Introduction by Dr Abdullah Waheed, Director-General of Health Services, Ministry of Health
0905-0920 hrs -	Brief on CCS by Dr Imam Mochny, Director, Social Change and Noncommunicable Diseases, WHO/SEARO
0920-0925 hrs	Remarks by Dr Ei Kubota, WR Maldives
0925-0935 hrs -	Address by Hon Ahmed Abdullah, Minister of Health, Maldives
1000-1230 hrs -	<b>Plenary Session</b>
	Moderator Dr M. Khalilullah, Programme Development Officer, WHO/SEARO
1000-1030 hrs -	Presentation of draft CCS, Dr H D Caussy, Regional Epidemiologist, WHO/SEARO
1030-1230 hrs -	Plenary/discussions
1330-1500 hrs -	Discussion among members of WHO CCS Mission

## Major Issues Identified During Daily Working Sessions with National Staff

Situation/Issues	Country Status			WHO Strategic Directions*				Remarks
	National Policy	National Management	Collaborative/ Technical	1	2	3	4	
(1) HRH: limited quantity and quality	HMP: self reliance	- Training of Managerial staff - Training of professional staff	< 2005 ~ 50% of the need should be filled  TCDCS			x		- RA-HRH, SEARO – 2000 - Training on health financing & management - WHO - 12 postgraduate trained (1998-2000)
- Shortage of local staff								
- Inadequate incentive								High attrition rate
- Unclear future career development								
- No HRH master plan - Limited Institutes / facilities for education								Only one Health Institute with limited capacity
(2) Increased public demands on - Health service delivery - transport - quality assurance - essential drugs	- Decentralization through 4- tier system - Availability & accessibility of essential drugs mostly through private sectors	- Public and private sectors - Lack of an organized public transport network	- Technical and regulatory mechanism - Limited Inter agency advocacy	x		x		- Outreach services from regional hospital & health centers - inadequate medical services on some islands from Central/ Regional Hospital up to the periphery
Scattered population	- dhoani mechanism of transport							+ 40% of WHO budget for transport activities

Situation/Issues	Country Status			WHO Strategic Directions*				Remarks
	National Policy	National Management	Collaborative/ Technical	1	2	3	4	
<p>(3) High MMR</p> <ul style="list-style-type: none"> <li>- Unsafe pregnancy</li> <li>- Inadequate services in remote areas</li> </ul>	<ul style="list-style-type: none"> <li>-High priority for improving quality of life through expansion of reproductive and family planning services.</li> <li>-Services for the protection and promotion of maternal health</li> </ul>	<p>Inadequate management of referral services</p>	<ul style="list-style-type: none"> <li>- IHS training for mid level health workers</li> <li>- Replacement of foolhuma by better trained CHW/HA</li> <li>- 90% for non Foolhumaas training abroad by WHO training</li> <li>- WHO/UNICEF UNFPA/ NGO'S</li> </ul>	x		x		<p>MMR – 158/100,000</p> <ul style="list-style-type: none"> <li>- Low family planning acceptance</li> <li>- Inadequate foolhuma referral activities</li> </ul>
<p>(4) Environment health</p> <ul style="list-style-type: none"> <li>- &lt; 50% safe drinking water (as of 1995/6)</li> <li>- 26% water &amp; sanitation facilities</li> </ul>	<ul style="list-style-type: none"> <li>- No specific environmental health legislation</li> <li>- National Plan of Action</li> <li>- Environmental health plan of action</li> </ul>	<ul style="list-style-type: none"> <li>- Revolving fund for providing safe water tanks</li> <li>- Privatization of Malé water and sewage</li> <li>- Small bore sewage system for islands</li> </ul>	<ul style="list-style-type: none"> <li>- Training / surveillance/ monitoring inadequate</li> <li>- Collaboration with UNICEF, Ministries of Atolls Administration, Construction &amp; Public Works Home Affairs, Housing &amp; Environment, Malé Municipality, related ministries and agencies</li> </ul>		x		x	<ul style="list-style-type: none"> <li>- Diarrhoeal Disease is high</li> <li>- DF/DHF/increased (Domestic malaria has been controlled)</li> <li>- Surveillance for imported Malaria must be maintained</li> <li>- Industrial/ household sewage disposal</li> <li>- Inadequate chemical safety draft regulation</li> <li>-Draft occupational health &amp; safety</li> <li>- Drafts of drinking water and sea water for domestic &amp; industrial use quality national standards) and Hospital Waste Management</li> </ul>

Situation/Issues	Country Status			WHO Strategic Directions*				Remarks
	National Policy	National Management	Collaborative/ Technical	1	2	3	4	
<p>(5) Nutrition</p> <ul style="list-style-type: none"> <li>- Food security</li> <li>- Food safety</li> <li>- IEC</li> <li>- Promoting Breast feeding</li> <li>- Pregnant mothers</li> <li>- Mass De-worming campaign</li> <li>- Hospital diet</li> <li>- Consumer protection</li> <li>- Availability of Iodized salt</li> <li>- Vulnerable Groups</li> </ul>	<ul style="list-style-type: none"> <li>- food security</li> <li>- balanced diet</li> <li>- nutritional health promotion</li> <li>- Enact and enforce food act</li> <li>- Implement National nutrition plan of action</li> </ul>	<ul style="list-style-type: none"> <li>-Eliminate sever and moderate malnutrition</li> <li>-availability of iodized salts</li> </ul>	<p>Establishment of National Advisory Committee (NAC) and development of intersectoral collaboration on nutrition</p>		x		x	<ul style="list-style-type: none"> <li>- Wide spread anaemia and growth stunting, however no severe mal nutrition, only moderate and mild forms in some remote areas</li> <li>- Anemia contributes to MMR</li> <li>- Goiter rate mostly of grade 1</li> <li>- Limited fruits and vegetables compared with abundance of fish eating</li> <li>- Worm infestations</li> </ul>
<p>(6) Food safety</p> <ul style="list-style-type: none"> <li>- Unclear mechanism of national control on incoming food</li> <li>- Inadequate export and import quality control</li> <li>- Inadequate monitoring of food establishment</li> <li>- Weak laboratory services</li> <li>- Inadequate consumer protection</li> </ul>	<ul style="list-style-type: none"> <li>- limited legislation aspect of national policy</li> <li>- export quality control is a high priority of GOM</li> </ul>	<ul style="list-style-type: none"> <li>- DPH/PHS</li> <li>- PHL</li> </ul>	<ul style="list-style-type: none"> <li>- Ministries of trade &amp; Industries, fisheries &amp; Agriculture, MIFCO, MWSA, MWSC, IHCS</li> <li>-WHO collaboration in strengthening water and sanitation, food safety &amp; public health laboratory</li> </ul>	x	x		x	<ul style="list-style-type: none"> <li>- Lack of coordination with the concerned parties on food safety</li> </ul>
<p>(7) Increase burden of diseases such as:</p> <ul style="list-style-type: none"> <li>- Communicable diseases                             <ul style="list-style-type: none"> <li>VBD (DF/DHF)</li> <li>HIV/AIDS/STDs</li> <li>Meningitis/encephalitis</li> </ul> </li> <li>- Noncommunicable diseases</li> <li>- Mental health</li> <li>- Tobacco use, Drug abuse, CVD, Cancer, renal diseases</li> <li>- Other Diseases - TB, etc.</li> <li>- Weak surveillance</li> </ul>	<ul style="list-style-type: none"> <li>- Emphasis on epidemic control</li> <li>- Noncommunicable diseases</li> <li>-Thalassaemia</li> <li>- Maintain malaria free status</li> <li>- Tobacco control</li> </ul>	<ul style="list-style-type: none"> <li>- Vertical programmes for disease control</li> <li>- Promoting healthy lifestyle</li> <li>- Surveillance of epidemic disease</li> </ul>	<p>WHO UNICEF NGOs</p>	x	x			<ul style="list-style-type: none"> <li>- Diarrhoeal Disease</li> <li>- ARI</li> <li>- Mental Health – depression increasing,</li> <li>-Tobacco use and drug abuse,</li> </ul>

Situation/Issues	Country Status			WHO Strategic Directions*				Remarks
	National Policy	National Management	Collaborative/ Technical	1	2	3	4	
(8) Health Promotion (HP) <ul style="list-style-type: none"> <li>- Good media coverage</li> <li>- Strengthening school health program</li> </ul>	<ul style="list-style-type: none"> <li>- National health promotion plan developed as:</li> <li>- Safe motherhood</li> <li>- Child survival</li> <li>- Thalassaemia and other NCDs</li> <li>- HIV/STD</li> <li>- FP &amp; RH</li> <li>- Tobacco, drugs/ alcohol abuse</li> <li>- Healthy Diet &amp; Exercise</li> </ul>	<ul style="list-style-type: none"> <li>- DPH</li> <li>- MoH</li> <li>- School Health Programme/MoE</li> <li>- Healthy settings/atolls</li> </ul>	<ul style="list-style-type: none"> <li>- WHO Training/MHP</li> <li>- UNICEF/UNFPA/ NGO</li> <li>- Ministries of Education, Fisheries &amp; Agriculture, Information, Arts &amp; Culture, Women's Affairs &amp; Soc. Security, IHS</li> </ul>		X		X	<ul style="list-style-type: none"> <li>- "Inculcating healthy behavior, leading to healthy lifestyles..."</li> <li>- included in all health programs</li> <li>- 98% functional literacy rate</li> </ul>
(9) The need for Health Sector Reforms <ul style="list-style-type: none"> <li>- Health care financing</li> <li>- Management &amp; administration</li> <li>- Equity</li> <li>- Decentralization</li> <li>- Privatization</li> <li>- Resource mobilization</li> </ul>	<ul style="list-style-type: none"> <li>- Health vision 2020</li> </ul>	Formulation of new management tools.	<ul style="list-style-type: none"> <li>- technical assistance and facilitation from WHO</li> </ul>			x	x	<ul style="list-style-type: none"> <li>- Health care finance use office introduced at central level</li> <li>- Health insurance under development</li> <li>- Cross subsidization in water &amp; sanitation service</li> <li>- Transport network to be established</li> <li>- Possible Review of HMP</li> <li>- CCA</li> <li>- UNDAF</li> <li>- intersectoral approach</li> <li>- inter agency partnership</li> <li>- TCDC/Resource mobilization</li> <li>- M.I.S</li> <li>- IHS Collaborative Management</li> </ul>

**\* Note:** WHO STRATEGIC DIRECTIONS:

1. Reduction of excessive mortality, morbidity, and disability;
2. Promoting healthy lifestyle and reducing risk factors to human health;
3. Developing equitable health system to improve health outcomes;
4. Developing and enabling policy and institutional environment in the health sectors

## WHO Country Cooperation Strategy for Maldives, 2002-2005

Country Strategic Direction	*WHO Strategic Direction	WHO Core Functions						Remarks
		Policy and Advocacy	Information Management	Technical and Policy Support	Partnerships	Norms and Standards	Technologies, Tools and Guidelines	
<b>Issue No.1 : Inadequate Human Resources For Health</b>								
<ul style="list-style-type: none"> <li>- Develop - implementing the HRH master plan for training health personnel within the country and abroad</li> <li>- Strengthening of IHS institutional capacity.</li> <li>- Enhancing career development</li> <li>- Revising incentive scheme</li> </ul>	3	<ul style="list-style-type: none"> <li>Technical support for HRH master plan implementation and follow-up</li> <li>Strengthen TCDC</li> </ul>	<ul style="list-style-type: none"> <li>Research on HRH policy</li> <li>Human resource auditing</li> </ul>	<ul style="list-style-type: none"> <li>Technical support for capacity building including staff development training programmes</li> </ul>	<ul style="list-style-type: none"> <li>Collaboration and advocacy with partners including bilateral, UNDP, UNFPA, UNICEF, ISDB for training resources</li> </ul>	<ul style="list-style-type: none"> <li>Standard training curriculum development</li> </ul>	<ul style="list-style-type: none"> <li>Training in appropriate technology for health vision 2020</li> </ul>	<ul style="list-style-type: none"> <li>- SEARO/HRH – 2000</li> <li>- Training on health financing &amp; management</li> <li>- WHO - at least 12 postgraduate trained (1998-2000)</li> <li>- High attrition review</li> <li>- Review of managers etc</li> </ul>
<b>Issue No.2 : Increased Public Demands On Health Service Delivery</b>								
<ul style="list-style-type: none"> <li>- Adequate health service delivery covering for all</li> <li>- Essential drugs</li> </ul>	1 & 3	<ul style="list-style-type: none"> <li>- Equity policy</li> <li>- Exchange of experiences among countries</li> <li>- Support monitoring and evaluation of the national drug policy</li> </ul>	<ul style="list-style-type: none"> <li>Support to exchange information with HIMS</li> </ul>	<ul style="list-style-type: none"> <li>- Supporting government in formulating national policy on health care delivery</li> <li>- Support of essential drugs, QA &amp; emergency evacuation</li> </ul>	<ul style="list-style-type: none"> <li>Intra &amp; intersectoral collaboration: CCA</li> </ul>	<ul style="list-style-type: none"> <li>Indicators &amp; milestones for monitoring &amp; evaluation</li> <li>- SOP</li> <li>- QAQC</li> </ul>	<ul style="list-style-type: none"> <li>Equity guidelines</li> </ul>	<ul style="list-style-type: none"> <li>- Outreach services from regional hospital and health centers.</li> <li>- inadequate medical services on some islands from Central/ Regional Hospital up to the periphery</li> <li>- ± 40% of WHO budget for transport activities for scattered population</li> </ul>
<b>Issue No.3 : High Maternal Mortality Rate (Mmr)</b>								
<ul style="list-style-type: none"> <li>- Strengthening and expansion of maternal health services including emergency obstetric care</li> <li>- Strengthening of</li> </ul>	1 & 3	<ul style="list-style-type: none"> <li>Evidence-based data on safe pregnancy</li> </ul>	<ul style="list-style-type: none"> <li>- Evaluation of the utility/ effectiveness of HWs including Foolhumaas</li> </ul>	<ul style="list-style-type: none"> <li>- Increase capacity of CHW &amp; HA in emergency obstetric care</li> </ul>	<ul style="list-style-type: none"> <li>Ministries of Women's Affairs &amp; Social Security; Education; Atolls Administration, UNDP, UNFPA</li> </ul>	<ul style="list-style-type: none"> <li>Milestones and indicators setting to monitor and evaluate.</li> </ul>	<ul style="list-style-type: none"> <li>Continue support for safe motherhood guideline and risk reduction for</li> </ul>	<ul style="list-style-type: none"> <li>- MMR – 141/100,000</li> <li>- Low family planning acceptance</li> <li>- Inadequate foolhuma referral activities</li> </ul>

Country Strategic Direction	*WHO Strategic Direction	WHO Core Functions						Remarks
		Policy and Advocacy	Information Management	Technical and Policy Support	Partnerships	Norms and Standards	Technologies, Tools and Guidelines	
community health nursing			- Support MHP	- Country wide use of HBMRC	UNICEF, NGO etc.		maternal mortality	- Common database with UNDP
<b>Issue No.4 : Environmental Health</b>								
<ul style="list-style-type: none"> <li>- Installation of desalination plants &amp; harvesting rain water</li> <li>- Developing environmental health awareness by use of IEC</li> <li>- Monitoring of environmental and occupational health</li> <li>- Promoting healthy settings</li> <li>- Ensuring adequate sewage disposal</li> <li>- Formulating policy on waste disposal</li> </ul>	2 & 4	Support government to formulate legislation	<ul style="list-style-type: none"> <li>- Support surveillance system for environmental monitoring &amp; research on environmental risk factors</li> <li>- Protocol for water resource data base</li> <li>- Protocol for environmental health impact assessment</li> </ul>	<ul style="list-style-type: none"> <li>- Support for implementation of National Action Plan on Health &amp; Environment (NAPHE)</li> <li>- Support formulation of policy on Integrated vector control</li> </ul>	Collaboration for implementing NAPHE: MWSA Ministries of Transport, Industry, Const- ruction & Public Works, Home Affairs, Housing & Environment, Tourism, Atolls Administration, DPH/ Port health Authority, and UNDP,UNICEF, bilateral etc.	Promote use of WHO standards in safe drinking water quality, Indoor air pollution and waste management	<ul style="list-style-type: none"> <li>- Guidelines on policy for implementation of environmental protection activities</li> <li>- Guideline on integrated control &amp; monitoring of environmentally-linked diseases (vector &amp; water borne)</li> </ul>	<ul style="list-style-type: none"> <li>- high prevalence of CDD&amp; VBD</li> <li>- prevalence of respiratory and allergy disorders</li> <li>-threat of imported malaria</li> <li>-inadequate industrial &amp; household sewage disposal</li> <li>- &lt;50% population have access to safe drinking water</li> <li>- 40 % population covered by sanitation facilities</li> <li>- absence of drinking water quality standards</li> <li>- limited intersectoral coordination</li> <li>- existence of pollution from boats, vehicles &amp; coral dust</li> </ul>
<b>Issue No.5 : Nutrition</b>								
<ul style="list-style-type: none"> <li>- Food security</li> <li>- Food safety</li> <li>- IEC</li> <li>- Breastfeeding</li> <li>- Pregnant mothers</li> <li>- Deworming</li> <li>- Hospital diet</li> <li>- Consumer protection</li> <li>I- Iodized salt</li> <li>- Vulnerable Groups</li> </ul>	2 & 4	Support the policy on adequate quantity and quality of food and micro nutrients	<ul style="list-style-type: none"> <li>-Support nutrition survey especially on possible malnutrition due to: worm, deficiency of iodine, anaemia</li> <li>- Research on balanced diet (of locally available food)</li> </ul>	Support to update national policy facing challenges of 21 <sup>st</sup> century namely among vulnerable groups, and influence multi national enterprises on exclusive breastfeeding	<ul style="list-style-type: none"> <li>- Collaboration with UNICEF, UNFPA, UNDP, Ministry of Fisheries, Agriculture, bilateral agencies interested parties communities, etc</li> <li>- Need of high political commitment implement national nutrition</li> </ul>	<ul style="list-style-type: none"> <li>-Support to lab controls, technical guidelines on qualified nutrition</li> <li>- Standard growth monitoring charts</li> <li>- Sea water quality testing for home/food production</li> </ul>	Recent global and regional guidelines on specific components of nutritional improvement	<ul style="list-style-type: none"> <li>-Wide spread anaemia and growth stunting, however no severe mal nutrition, only moderate and mild forms in some remote areas</li> <li>-Anaemia contributes to MMR</li> <li>-Goitre rate mostly of grade 1</li> <li>-Limited fruits and vegetables compared with abundance of fish eating</li> <li>-Worm infestations</li> </ul>

Country Strategic Direction	*WHO Strategic Direction	WHO Core Functions						Remarks
		Policy and Advocacy	Information Management	Technical and Policy Support	Partnerships	Norms and Standards	Technologies, Tools and Guidelines	
					policy			
<b>Issue No.6 : Food Safety</b>								
Maintenance of quality & safety of food through development of food legislation by setting national food standards & specifications including infrastructure & capacity building	1, 2 & 4	Support establishing food safety policy, implementation of IHR & Codex Alimentarius, & developing food safety law	Support food safety survey	WHO support – training of hotel/ resort staff & Port health staff  - Support for public health lab & QA	Bilateral collaboration with interested Government including DPH and Port Health Authority & WHO HQ and FAO	- Facilitate the establishment of the standards for food safety	Provide surveillance guidelines and computer software	- Lack of intersectoral coordination  - Unclear mechanism of national control on incoming food -- NUT/mal nutrition, IDD  - At present no legislation  - In collaboration with Customs
<b>Issue No.7 : Increased Burden Of Diseases</b>								
- Ensure availability of essential drugs & vaccine  - Conduct intensified epidemiological, entomological and laboratory surveillance of diseases  - Increase IEC and community participation in disease control  - Maintain malaria free status	1, 2 & 4	- Support Health Master Plan on community based approach  - Support formulation of national policy on emerging issues, incl. blood safety  - Support for integrated control of priority diseases	-Strengthening of surveillance system for risk & burden of diseases including emerging & re-emerging diseases  -Regular information exchange on risk factors and disease prevalence  -Strengthening of reporting at regional level	Support policy on sustainable development pertaining to burden of disease	Collaboration with UNICEF, UNFPA, UNDP, NGOs and other agencies in developing indicators for disease surveillance and monitoring - media	- Formulating standard case definition and indicators for disease surveillance and reduction of risk factors  - Promulgating WHO Quality Assurance in blood safety	Produce guidelines on integrated control of diseases (ICD)	<b>Communicable Diseases:</b> - Diarrhoeal diseases - ARI - Dengue/DHF - Filariasis - HIV/STD & Hepatitis B - Meningitis/Encephalitis - TB - No indigenous malaria  <b>Noncommunicable Diseases:</b> - Thalassaemia - Mental Health/depression - Tobacco and drug abuse - CVD, Cancer, Diabetes

Country Strategic Direction	*WHO Strategic Direction	WHO Core Functions						Remarks
		Policy and Advocacy	Information Management	Technical and Policy Support	Partnerships	Norms and Standards	Technologies, Tools and Guidelines	
<b>Issue No.8 : Health Promotion</b>								
<ul style="list-style-type: none"> <li>- Targets: policy decision makers, public figures, professional groups, service provider</li> <li>- Evidence based information on impact of health promotion</li> <li>- School health &amp; Disadvantaged groups</li> <li>- Inclusion of health promotional activities in all health programs (reinforced by HE President's guidance)</li> <li>- Advocacy of health in the context of country development as a whole</li> </ul>	1 to 4	Support HP Plan of activities following Jakarta & Mexico declarations	<ul style="list-style-type: none"> <li>- Promote research on health equity in the area of health promotion</li> <li>- Promote research on KABP</li> </ul>	<ul style="list-style-type: none"> <li>- Support training/HMP</li> <li>- Promote sustainable development of health programs through advocacy</li> <li>- TV/radio/posters/other media and community feed back from peripherals</li> </ul>	DPH UNDP/UNICEF/UNFPA/NGOs - MoH- Ministries of Education, Information, Arts & Culture	Support Health Promotion Indicators for schools, hospitals, work place and other settings (including islands & atolls committees)	<ul style="list-style-type: none"> <li>- Support development of health promotional materials &amp; Maldives specific health promotional tools &amp; guidelines to implement the National health promotion plan</li> </ul>	<ul style="list-style-type: none"> <li>- 98% literacy rate, however effectiveness of the health messages should be reviewed</li> <li>- health promotion strategy should be promoted/ strengthened based on the previous experiences of health education approach</li> <li>- "Inculcating healthy behavior, leading to healthy lifestyles..." (HE Minister of Health)</li> </ul>

Country Strategic Direction	*WHO Strategic Direction	WHO Core Functions						Remarks
		Policy and Advocacy	Information Management	Technical and Policy Support	Partnerships	Norms and Standards	Technologies, Tools and Guidelines	
<b>Issue No.9 : Development Of Health Sector Reforms</b>								
No specific country strategy on this item; however there is an advocacy for reforms: - Health vision 2020 concept - Health care financing - Health insurance - Review of management and administration - Equity - Decentralization - Privatization - Resource mobilization - Indigenous systems of medicine	4	Policy on cooperate strategy/four strategic direction/six core functions	- Health system performance proposal - Operational research on health care access and utilization of health care in the context of the country health vision-2020.	- Sustainable health in the context of country development - Health care financing/ health insurance	- Intersectoral coordination UNDP, UNCEF, UNFPA, Bilaterals WB, ADB IDB,etc	Benchmark, milestones, indicators, expected result, goals etc to assess development of health sector reforms (being proposed)	Appropriate technologies suitable for Maldives for the implementation of health sector reform	- Health care financing is introduced at central level - Health insurance under development - Cross subsidization in water & sanitation service - Transport network to be established - Possible Review of HMP - Country Common Assessment (CCA) by UN - United Nations Development of Administrative Framework (UNDAF) - Possible World Bank Common Country framework (CCF) - Intersectoral approach - Inter agency partnership - TCDC/SAARC - Resource mobilization - M.I.S - IHS Collaborative Management

**\* Note:** WHO STRATEGIC DIRECTIONS:

1. Reduction of excessive mortality, morbidity, and disability;
2. Promoting healthy lifestyle and reducing risk factors to human health;
3. Developing equitable health system to improve health outcomes;
4. Developing and enabling policy and institutional environment in the health sectors

**List of Acronyms**

ADC	Atoll Development Committees
ADK	Abdul Rahman Don Kaleyfaan
AFP	Acute Flaccid Paralysis
AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infections
AVA	Australian Service Organization
CCA	Common Country Assessment
CDD	Control of Diarrheal Diseases
CHW	Community Health Worker
CSA	Contractual Services Agreement
CVD	Cardio Vascular Diseases
DF	Dengue Fever
DHF	Dengue Haemorrhagic Fever
DOTS	Directly Observed Treatment Schedule
DPH	Department of Public Health
EDPT	Early Diagnosis and Prompt Treatment
FAO	Food and Agricultural Organization
FASHAN	Foundation for Advancement of Self Help in Attaining Needs
FHW	Family health Worker
GDP	Gross Domestic Product
HA	Health Assistant
HBMRC	Home Based Maternal Record Card
HDI	Human Development Index
HE	His Excellency
HFA	Health for All
HIS	Health Information Support System
HIV	Human Immuno-deficiency Virus
HMP	Health Master Plan
HQ	Head Quarters
HRH	Human Resources for Health
HW	Health Worker
ICD	Integrated Control of Diseases
IDC	Island Development Committee
IDD	Iodine Deficiency Disorders
IEC	Information Education Communication
IFAD	International Fund for Agricultural Development
IGMH	Indira Gandhi Memorial Hospital
IHR	International Health Regulation
IHS	Institute of Health Sciences
IMR	Infant Mortality Rate
IsDB	Islamic Development Bank
IWDC	Island Women's Development Committee
JOCV	Japanese Overseas Cooperation Volunteers

KABP	Knowledge Attitude Behaviour Practice
KIDS	Kanduholhudhoo Island Development Society
LDC	Least Developed Country
MDT	Multi Drug Therapy
MIS	Management Information Support
MLT	Medical Laboratory Technology
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MWSA	Maldives Water and Sanitation Authority
MWSC	Maldives Water and Sewerage Company
NAPHE	National Action Plan on Health and Environment
NCD	Noncommunicable Diseases
NGO	Nongovernmental Organization
NUT	Nutrition
ODA	Overseas Development Assistance
PDM	Programme Development and Management
PHC	Primary Health Care
PHL	Public Health Laboratory
PHU	Public Health units
PUO	Pyrexia of Unknown Origin
QA	Quality Assurance
QC	Quality Control
RD	Regional Director
RH	Reproductive Health
SAARC	South Asian Association for Regional Cooperation
SHE	Society for Health Education
SOP	Standard Operating Procedure
TB	Tuberculosis
TBA	Traditional Birth Attendant
TCDC	Technical Cooperation among Developing Countries
UN	United Nations
UNDAF	United Nations Development Assistant Framework
UNDCP	United Nations Drug Control Programme
UNDP	United Nations Development Programme
UNFPA	United Nations Family Planning Agency
UNRC	United Nations
UNICEF	United Nations Children Education Fund
UNV	United Nations Volunteer
VBD	Vector-Borne Diseases Control
VSO	Voluntary Services Overseas
WE	Writers on Environment

**Documents Consulted**

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- (b) Maldives Health Report 1999
- (c) 1995 figures in Statistical Yearbook of Maldives 1999
- (d) Fifth National Development Plan 1997-2000
- (e) Statistical Yearbook of Maldives 1997
- (f) Information Unit, MOH
- (g) Budget Speech of HE President on 29 December 1999
- (h) WHO Country Office
- (i) Report of the Sixth Round Table Meeting for Maldives by UNDP in Geneva on 11 May 1999.
- (j) Annual Report of the Resident Coordinator in Maldives, 1998 and 1999
- (k) Statistical Yearbook of Maldives 1992, 1997 and 1999.
- (l) Towards Sustainable Development of Health – Final Report of the Consultations held in Colombo on 25 May 1995.
- (m) Report on Comprehensive WHO Country Programme Review for Maldives
- (n) The Maldives – Country Context and Health Sector Analysis, 1995 : Briefing Notes for Consultants, Experts and Visitors to the Republic of Maldives
- (o) Health and Environment Initiatives – Report of a Regional Consultation, Bandos Island, Maldives, 13-15 October 1997
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- (r) Towards Sustainable Development of Health – Consultations in Colombo between the Government of the Republic of Maldives and the Nation's Development Partners, 1995
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- (z) Food Safety in the Republic of Maldives – 2-12 October 1999 – Draft Report by Dr Peter Wareing, WHO STC

- (aa) National Quality Assurance System for Clinical Chemistry, Maldives – 6-22 August 1997 – by WHO STC Dr D M Browning
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- (cc) Strengthening of HIV/AIDS and STD Surveillance System, Maldives – 8-17 December 1997 – by WHO STC Dr S R Salunke
- (dd) Evaluation of Leprosy Situation in Maldives – 15 July – 13 August 1997 – by WHO STC Dr Kyaw Lwin
- (ee) Drug Policy and Development in Maldives – 28 December 1995 – 7 December 1996 – by WHO STC Dr B B Gaitonde'
- (ff) Report on Implementation of Collaborative Programmes for the Period 1 January 1996 to 30 June 1997 – Maldives
- (gg) Report on Implementation of WHO Collaborative Programmes – 1 January 1998 – 31 December 1999
- (hh) WHO Estimates of Health Personnel
- (ii) Report of the Study of Efficiency of WRO Maldives, 1998