Maldives

HEALTH SITUATION

The 2014 census estimates the total Maldivian population at 341,256 and confirms rapid urbanization. The health status of the people of Maldives has improved in the past few decades. Life expectancy at birth has increased from 46.5 years (in 1977) to 78 years (in 2013). Child and maternal mortality and morbidity has reduced, malaria has been eradicated, polio eliminated and communicable diseases such as tuberculosis and lymphatic filariasis controlled. Vaccine preventable diseases have been controlled to such an extent that diseases like poliomyelitis, neonatal tetanus, pertussis and diphtheria are non-existent in the country. Despite these achievements Maldives is facing a changing disease epidemiology with noncommunicable diseases (NCDs) estimated to cause 81% of all deaths. Life style risk factors such as tobacco use, imbalance nutrition, obesity and lack of exercise are of the highest prevalence in the Region. Thalassemia and mental health also receive priority attention. Some of the major determinants of health are living standards, nutrition, drug abuse and environmental factors. Dengue, scrub typhus and toxoplasmosis have re-surfaced as an effect of environmental changes. Diarrhoea and acute respiratory infections continue to cause significant morbidity among children and adults.

Maldives has achieved 5 out of 8 Millennium Development Goals, ahead of the 2015 deadline, making it MDG+ country. Progress towards equitable healthcare was successfully established through universal immunization, high per capita health spending and service expansion. The government is committed to implementing international commitments, including the progress towards meeting IHR core capacities the deadline for which was extended until June 2016.

Maldives is facing resilience to environment and climate change challenges. There is increasing threats of tsunami, sea level rise and routine heavy rain fall resulting in acute disruption of infrastructure, clean water supply and sanitation in islands. Rapid urbanization, development and urban construction, increase in travel, traffic, migration carry significant risks to human health.

HEALTH POLICIES AND SYSTEMS

The decentralized public health services in 2009-2011 were reversed ng in 2012 because of the lack of institutional anchoring and neglect of legislative reforms which caused confusion during the decentralization process. The primary health care has been the cornerstone of the Maldives’ health sector successes for the past decades but is now disintegrating as a curative approach is dominating the sector. The health system faces major human resources challenges.

The Health Master Plan (HMP) 2006-2015 outlines the mandate of the Government 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 services in partnership with the private sector and communities. The new Government formed in March 2014 brought a number of health reforms in 2014 such as the introduction of General Practitioner services; delegation of the management of the only tertiary hospital (Indira Gandhi Memorial Hospital) to a Board independent of the Ministry of Health; and entering into partnership with the State Trade Organization to outsource medical supply.

In February 2014, health insurance Aasandha was re-launched as Unlimited Aasandha (Husnava Aasandha) to expand the service coverage and remove annual cap, escalating costs from MRF 70 million in 2013 to an estimated MRF 1.3 billion in 2014. Growing proportion of aging population and high prevalence of NCDs are putting further financial burden on the national health system.

In the second half of 2014, the implementation of the 2006-2015 HMP was reviewed and a multi-stakeholder dialogue to build a consensus on the next 2016-2025 Health Master Plan was held. The overall goal articulated in the next HMP is to “Enhance health and wellbeing of the population”. The HMP outlines the strategies to be achieved within the next ten years to: (I) build trust in the national health system, (II) reduce disease and disability among the population, and (III) reduce inequities in access to health care services and medicines.

Some health-related national legal instruments, such as the Social Protection Act and Public Health Protection Act have passed through the parliament and are being enforced. Maldives ratified the WHO Framework Convention on Tobacco Control in 2004 and passed the Tobacco Control Act in August 2010. Furthermore, the IHR 2005 are being implemented.

COOPERATION FOR HEALTH

Maldives has long-standing collaboration with UN agencies involved in health, and WHO’S role as the longest partner in the national health development of the country is well recognized. The other key partners are South Asian Association for Regional Cooperation (SAARC) and its health institutions, the World Bank, Islamic Development Bank and Asian Development Bank. The GFATM grant on HIV/AIDS was closed in 2012 and currently work is on-going to develop a new proposal for funding. Health issues are incorporated in the UN Development Assistance Framework (UNDAF). WHO serves as the lead agency for several outcomes of UNDAF, with access to UN multi-trust funds from 2013. Furthermore, several joint initiatives are undertaken by UN agencies in Maldives including, Strengthening of the Human Rights Commission, Maldives Low Emission Climate Resilient Development Programme etc.

Maldives also has strong bilateral relationships with China, India, Japan, Kuwait and the Islamic Development Bank, alongside international agencies such as the UN Agencies and the International Financial Institutions.
### WHO COUNTRY COOPERATION STRATEGIC AGENDA (2013–2017)

#### Strategic Priorities

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<th>Strategic Priority</th>
<th>Country Cooperation Strategy Focus Areas</th>
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| **STRATEGIC PRIORITY 1:** Strengthening the health system towards universal health coverage based on the primary health care approach. | • Support strengthening of health systems policy, legislation and health care delivery for universal coverage  
• Promote improving access to medicines and health care technologies based on primary health care  
• Support strengthening of health financing towards universal coverage  
• Support strengthening of health information systems  
• Advocacy and technical support in monitoring and evaluation  
• Provide technical support to strengthen health research |
| **STRATEGIC PRIORITY 2:** Preventing and controlling diseases and disabilities. | • Provide technical support for strengthening national capacity in prevention and control of communicable diseases  
• 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 |
| **STRATEGIC PRIORITY 3:** Enhancing public health interventions at national and subnational levels to sustain achievements in health-related UN MDGs and beyond. | • Strengthening public health programmes related to the lifecycle  
• Strengthening food safety, water and sanitation and occupational health |
| **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. | • Fostering partnership with UN and other international partners, government sectors and civil society at national and subnational levels  
• Policy advice for public health management, emergency preparedness and response  
• Mobilizing resources for sustainable development of health |

Mid-Term Review of the Maldives CCS 2013-2017 is scheduled in May-June 2015. It coincides with UNDAF 2016-2020 formulation and will help to steer future WHO cooperation and guide 2016-2017 PB.