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Message
from the Minister of Health

The Maldives have made significant progress in its health status and development indicators over the past decades with sustained high investments in Health and ensuring universal health coverage for its population. In recent years Maldives achieved several public health milestones such as elimination of Malaria, Filariasis, and Measles to add to elimination of Polio and Maternal and Neonatal Tetanus. The main challenge now is to sustain these achievements and be prepared for emerging challenges. Being a small island nation; country is vulnerable to the impacts of social, economic transformation and environmental challenges.

Ministry of Health with collaborative and consultative effort with multi-stakeholders developed the ‘Health Master Plan 2016-2025’ that outlines strategic directions and guidance to all partners in health and other sectors for further improvement in health of the population.

I am pleased to note that Country Cooperation Strategy (CCS) 2018-2022 recognizes emerging health needs and challenges. The strategic priorities of Country Cooperation Strategy 2018-2022 complement the national policies and strategies and are aligned with Sustainable Development Goals, the 13th Global Program of Work of WHO and regional flagships.

Ministry of Health welcomes new WHO Country Cooperation Strategy that provides a framework for the partnership between the World Health Organization and the Ministry
of Health and other partners, to support and focus strategically on selected collaborative programme areas that require more attention in the coming years.

I acknowledge the participatory and consultative process involving multiple stakeholders, from the Ministry of Health and other related ministries, as well as other UN and international agencies, academia, the private sector and civil society that resulted into 4th Country Cooperation Strategy. The Ministry of Health welcomes this strategy as guiding framework for WHO’s technical cooperation in Maldives, which will contribute towards implementation of Health Master Plan 2016-2025 and achievement of Sustainable Development Goals.

Abdulla Nazim Ibrahim
Minister of Health
Republic of Maldives
Good planning backed by sound strategy and firm commitment are key to achieving public health outcomes that change lives, strengthen communities and advance the health and wellbeing of whole countries. Where multiple partners are involved, developing and implementing detailed cooperation strategies that increase efficiency and reinforce strong and effective partnerships are vital.

To that end, this fourth Country Cooperation Strategy (CCS) 2018–2022 will map how the World Health Organization (WHO) will work at the country, regional and global levels to support the Government of Maldives (GoM) pursue key national health initiatives, in line with the challenges, strengths, strategic objectives and priorities defined in the GoM’s National Health Master Plan (2016–2025).

Our ongoing journey is sure to be rewarding. Over the years Maldives has made remarkable progress, with more than 9% of its gross domestic product spent on the health sector, reflecting high-level commitment to achieving universal health coverage and with it the Sustainable Development Goal targets.

Notably, that spending is paying off. In recent years life expectancy across the country has increased, while maternal, newborn and child mortality has markedly declined. Maldives has meanwhile had immense success in tackling a series of diseases countries across the world –
regardless of income – continue to grapple with: in 2015 Maldives was certified malaria-free; in 2016 it was validated to have eliminated lymphatic filariasis as a public health problem; and in 2017 it was verified as having interrupted and eliminated endemic measles transmission.

Nevertheless, new challenges are emerging, including the rising tide of noncommunicable diseases, the health and wellbeing of migrants and the country’s vulnerability to the impacts of climate change. Increasing the quality of health services across the country while making the health sector less dependent on expatriate health professionals are likewise of pressing need.

In formulating the following CCS extensive consultations were held with different stakeholders – from the GoM, sister UN agencies and donors to academia and nongovernmental organizations – to ensure it draws on and reflects a variety of perspectives.

I very much appreciate the valuable contributions made and the effort to ensure the CCS’ four strategic priorities complement the GoM’s National Health Master Plan (2016–2025) and are aligned with WHO’s Thirteenth General Programme of Work (2019–2023), the Regional Flagship Priorities and the 2030 Agenda for Sustainable Development.

Importantly, the following pages renew and reinforce WHO’s ongoing cooperation with and support of Maldives’ vision to achieve “excellence in health as a nation”. We look forward to strengthening our partnership with the GoM; building on the country’s successes, including by fostering multisectoral engagement; and reaffirm our close collaboration with all stakeholders to continue to improve the health and wellbeing of the people of Maldives.

Dr. Poonam Khetrapal Singh
Regional Director
WHO South-East Asia Region
The World Health Organization has been working closely with the Government of Maldives to strengthen the health sector and improve the health status of its population since decades. This Country Cooperation Strategy 2018–2022 is the fourth strategic collaboration between WHO and the Government of Maldives which describes WHO’s medium-term strategic vision to guide its work in Maldives.

The four Strategic Priorities address some of the critical public health challenges facing Maldives in its unique context: a high-income small island developing state that ensures universal health coverage for its population and is committed to make quality health services available in each of its inhabited islands, but is increasingly faced with new challenges such as the growing menace of noncommunicable diseases, vulnerability to climate change, and continuing dependence on an expatriate health workforce, among others.

This Country Cooperation Strategy is based on the lessons learned from previous such strategies, best practices and partnership experiences with the government and other stakeholders. A year-long, extensive consultative and iterative process has been followed to develop the document involving different stakeholders including the government, UN agencies, development partners, academia, nongovernmental organizations and civil society. It identifies strategic priorities, focus areas and deliverables to optimize on WHO’s comparative advantages and expertise.
The priority areas of the CCS are: (i) transforming health systems with a focus on universal health coverage and fostering multisectoral engagement to go beyond the health sector; (ii) promoting well-being with a focus on tackling noncommunicable diseases and their determinants; (iii) readiness to respond, especially in promoting resilience in the face of health threats and fast-tracking disease eliminations; and (iv) protecting what matters the most with a thrust on sustaining gains along with a firm focus on climate change and young people.

These strategic priorities are inextricably linked to the National Health Master Plan 2016–2025, which aims to ensure better health and well-being of the population. The CCS is guided and aligned with WHO’s Thirteenth General Programme of Work (2019–2023) and the WHO Regional Flagship Priorities, builds on the United Nations Development Framework (UNDAF), and is overall anchored in the Sustainable Development Goals Agenda. This CCS will serve as an instrument to foster multisectoral engagement and integrated approaches to achieve the health-related SDGs.

On behalf of the WHO Country Office team, I express sincere gratitude to all stakeholders, especially the Ministry of Health and other ministries, academia, professional associations, civil society organizations, development partners and UN agencies, for their invaluable contributions to the development of this document. The CCS Working Group at the Country Office deserves a special mention for their tireless efforts. I also thank the WHO Regional Office for South-East Asia and WHO headquarters for providing valuable feedback.

I strongly believe that the Country Cooperation Strategy 2018–2022 will further strengthen the partnership between the Government of Maldives and WHO and will continue to contribute to improving the health and well-being of all people of Maldives.

Dr. Arvind Mathur
WHO Representative to the Republic of Maldives
### Acronyms & Abbreviations

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<th>Description</th>
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<td>AMR</td>
<td>antimicrobial resistance</td>
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<td>ASDs</td>
<td>Autism Spectrum of Diseases</td>
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<td>CCS</td>
<td>Country Cooperation Strategy</td>
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<tr>
<td>CHD</td>
<td>congenital heart disease</td>
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<td>COPD</td>
<td>chronic obstructive pulmonary disease</td>
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<td>CPR</td>
<td>contraceptive prevalence rate</td>
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<td>CVD</td>
<td>cardiovascular disease</td>
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<td>ENAP</td>
<td>Every Newborn Action Plan</td>
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<td>EPI</td>
<td>Expanded Programme on Immunization</td>
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<td>FCTC</td>
<td>WHO Framework Convention on Tobacco Control</td>
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<td>FENSA</td>
<td>Framework of Engagement with Non-State Actors</td>
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<td>FHS</td>
<td>Faculty of Health Sciences</td>
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<td>GDD</td>
<td>Global Developmental Delay</td>
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<td>GDP</td>
<td>gross domestic product</td>
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<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>GNI</td>
<td>gross national income</td>
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<tr>
<td>GP</td>
<td>general practice</td>
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<td>GPN</td>
<td>Global Private Network</td>
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<td>GPW</td>
<td>General Programme of Work (of WHO)</td>
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<td>GYTS</td>
<td>Global Youth Tobacco Survey</td>
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<td>HDI</td>
<td>human development index</td>
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<td>HIV</td>
<td>human immunodeficiency virus</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<td>HPA</td>
<td>Health Protection Agency</td>
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<td>HRH</td>
<td>human resources for health</td>
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<td>IDA</td>
<td>International Development Association</td>
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<td>IEC</td>
<td>information, education, communication</td>
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<td>IGMH</td>
<td>Indira Gandhi Memorial Hospital</td>
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<td>IHR</td>
<td>International Health Regulations</td>
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<td>IMR</td>
<td>infant mortality rate</td>
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<td>INFOSAN</td>
<td>International Authorities Network</td>
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<td>IOM</td>
<td>International Organization of Migration</td>
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<td>JEE</td>
<td>Joint External Evaluation</td>
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<td>LECReD</td>
<td>Low Emission Climate Resilient Development Programme</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>MDHS</td>
<td>Maldives Demographic and Health Survey</td>
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<td>MDR-TB</td>
<td>Multidrug-resistant tuberculosis</td>
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<td>MFDA</td>
<td>Maldives Food and Drug Authority MMR</td>
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<td>MMR</td>
<td>maternal mortality ratio</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>MPDSR</td>
<td>Maternal and Perinatal Death Surveillance and Response</td>
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<td>MSM</td>
<td>men who have sex with men</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<td>MVR</td>
<td>Maldivian Rupee</td>
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<td>NBS</td>
<td>National Bureau of Statistics</td>
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<td>NCD</td>
<td>noncommunicable disease</td>
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<td>NGO</td>
<td>nongovernmental organization</td>
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<td>NHA</td>
<td>National Health Accounts</td>
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<td>NHRP</td>
<td>National Health Research Policy</td>
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<td>NSPA</td>
<td>National Social Protection Agency</td>
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<td>OOP</td>
<td>out-of-pocket</td>
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<td>PHC</td>
<td>primary health care</td>
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<td>QARD</td>
<td>Quality Assurance and Regulations Division</td>
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<tr>
<td>RFW</td>
<td>Result Framework</td>
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<td>RHS</td>
<td>Reproductive Health Survey</td>
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<td>SDGs</td>
<td>Sustainable Development Goals</td>
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<tr>
<td>SDL</td>
<td>Staff Development and Learning</td>
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<tr>
<td>SOP</td>
<td>standard operating procedure</td>
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<tr>
<td>STEPS</td>
<td>STEPwise approach to surveillance</td>
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<tr>
<td>STI</td>
<td>sexually transmitted infection</td>
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<td>STO</td>
<td>State Trading Organization</td>
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<tr>
<td>TB</td>
<td>tuberculosis</td>
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<tr>
<td>TFR</td>
<td>total fertility rate</td>
</tr>
<tr>
<td>THE</td>
<td>total health expenditure</td>
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<tr>
<td>UHC</td>
<td>universal health coverage</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNFCCC</td>
<td>United Nations Framework Convention on Climate Change</td>
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<tr>
<td>UNESCO</td>
<td>United Nations Educational, Social and Cultural Organization</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>VRS</td>
<td>Vital Registration System</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Executive Summary

Maldives has made remarkable socioeconomic progress during the past two decades and is now an upper middle-income country with per capita gross domestic product (GDP) of US$ 7177 (World Bank, 2014). Notable achievements have also been made in the health sector, particularly the increase in life expectancy, improvement of infant, child and maternal health, control of communicable diseases including elimination of diseases such as malaria, measles and lymphatic filariasis, and high rates of immunization coverage. Despite these achievements, the country is facing newer challenges such as growing rates of noncommunicable diseases (NCDs), accounting for more than 80% of total deaths, demand for better quality services, and heavy reliance on expatriate health professionals, limited health access for the increasing migrant population and being an island nation vulnerability to the impact of climate change.

To address the new health challenges and empower people to lead healthy lives, the Government of Maldives has set an overall national long-term goal to “Enhance health and well-being of the population” in alignment with the global Sustainable Development Goals (SDGs), which has been reflected clearly in its recently developed National Health Master Plan: 2016–2025. The government anticipates to achieve the goal in close collaboration with the health partners focusing on three specific outcomes: (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. Priority has been given to develop a people-oriented and accessible health system focusing on good governance and ensuring increased multi-stakeholder participation for disease prevention and quality health service delivery.

The Country Cooperation Strategy (CCS) is the basis for WHO’s mid-term strategic collaborative work with the Government of Maldives. It provides strategic directions and policy support to national health development initiatives of the government to address the challenges and priorities of the country. This CCS for 2018–2022 is the fourth strategic collaboration with the Government of Maldives, which focuses on mainstreaming of the SDGs including providing an opportunity to address cross-cutting and intersectoral challenges on environmental and social determinants of health.

The four Strategic Priorities and 14 Focused Areas of the CCS (as shown below) have been identified through documentary reviews, situation analysis and extensive consultations with different national stakeholders and development partners. The strategic agendas are guided by the National Health Master Plan (2016–2025), the WHO priorities outlined in the Thirteenth WHO General Programme of Work (GPW) (2019–2023), Global and Regional Priorities of WHO including its transformational changes, the Flagship Programmes and overall, the SDGs. The CCS complements the United Nations Development Assistance Framework (UNDAF: 2016–2020) for Maldives.
## Country Cooperation Strategy 2018-2022

### 1. Transforming Health Systems: Ensuring universal health coverage (UHC) and towards achieving the health related Sustainable Development Goals (SDGs).
- Health beyond health sector
- Strengthen governance and local stewardship
- Workforce excellence, evidence-based decision making and knowledge management:
  - Financial protection

### 2. Promote wellbeing: Empower people to lead healthy lives and enjoy responsive health services.
- NCD prevention and management
- Mental Health
- Migrant health
- Road Safety

### 3. Ready to respond: Addressing the emergencies and accelerate efforts to eliminate priority diseases and promote surveillance.
- Emergency preparedness
- Antimicrobial resistance (AMR), International Health Regulations (IHR), and food safety
- Enabling advocacy platforms for disease elimination

### 4. Protecting what matters the most: Create an enabling environment for safe and healthy living and address specific health issues of children, adolescents and women during reproductive age and beyond.
- Climate Resilience
- Health of young people
- Reproductive, maternal and newborn health
Chapter 1
Introduction: Working for a common goal
Introduction: Working for a common goal

The World Health Organization (WHO) has been providing technical assistance to the Government of Republic of Maldives to strengthen country’s public health system since 1965. In this fourth Country Cooperation Strategy (CCS 2018–2022), the strategic priorities and the focus areas were designed for WHO’s engagement to complement the health system development efforts of the government and provide demand-driven policy and technical support. The WHO country cooperation will support mainstreaming of the SDGs into the national plans and enhance their implementation process to address the new health challenges including environmental and social determinants of health. This CCS has been developed based on the lessons learnt from the previous CCS and extensive consultations with the government and other stakeholders. The CCS is guided by the National Health Master Plan (2016–2025), the Thirteenth WHO General Programme of Work (GPW 2019–2023), Regional Flagship Programmes and it complements the United Nations Development Assistance Framework (UNDAF) for Maldives (2016–2020).

The formulation of the CCS has been guided by the following principles:

- transformation of the health system to address future challenges and ownership of the development process by the country;
- alignment with national priorities, systems and procedures;
- evidence-based, results-focused and equitable approaches;
- inclusive development partnerships for sustainable development involving civil society, media, the private sector and academia, among others;
- harmonization of work among various United Nations agencies and partners in countries.

To address the emerging needs of the Member States, WHO is undergoing a reform process and adopting new working approaches. The strategic shifts adopted in the new WHO Thirteenth GPW are directed towards a result-oriented “differentiated approach based on capacity and vulnerability” for every country (Fig. 1). Considering the new transformative role of WHO, emphasis will be given on the leadership role, quality of technical support and health communication including knowledge management, advocacy and partnership, throughout the CCS implementation process.
The WHO Regional Office and headquarters will continue to provide technical support to build capacity of the country office as well as generate international best practices and provide guidance on global policies, directives and standards. To mobilize resources for effective implementation of the CCS, funding opportunities will be explored both internally and externally. A highly competent country office team will be in place to implement the CCS. The CCS will be monitored regularly throughout its implementation cycle including the mid-term review at the mid-point and the final evaluation towards the end of the CCS cycle.

For the next five years, the WHO Country Office in Maldives and the Government of Maldives are committed to work more closely for the well-being of the Maldivian people.
Health and Development Situation

2.1. Political, demographic and macroeconomic context

The Maldives is a Presidential Representative Democratic Republic, where the President is the Head of Government. The Maldives has gone through a number of political changes since the new constitution has been ratified in 2008. In 2014, the health system has been reorganized as a central system again from the previously decentralized system.

Maldives became a “developing country” from the status of a “least developed country” in January 2011 by the UN system and is now considered a “middle human development country” with a human development index (HDI) of 0.688 (in 2012) with a per capita GDP of US$ 7177 (World Bank, 2014). The poverty level in the country has declined from 31% in 2003 to 24% in 2010 (World Bank, 2014). But the poverty gap continues to exist and has shown an increasing trend in Male. The unemployment rate decreased at the national level from 5.5% to 5.2% from 2006 to 2014 (Population and Housing Census, 2014).

According to Census 2014, the total population of Maldives is 402,071 of which the Maldivians represent 84% while 16% are the migrant population. The male-to-female ratio is 103:100 and the annual population growth rate is 1.65% (Population and Housing Census, 2014). Male, the capital, is one of the most densely populated capitals in the world.

The life expectancy at birth has increased from 70.0 to 73.1 years for males while it has increased from 70.1 to 74.8 years for females from year 2000 to 2014, respectively (NBS, 2014). The population of Maldives is relatively young as depicted by its wide-based population pyramid (Fig. 2). Young people aged under 25 years represent the majority (40% of Maldivians; 43% of the total population including expatriates) of the Maldivian population (National Bureau of Statistics, 2016). The dependent population (<5 years and 65+ years) has increased as a high percentage of young people are entering the reproductive age and life expectancy for males and females has increased.

Figure - 2 Maldives Population Pyramid [Census 2006 & 2014]

Source: 2014 Censuses
2.2. Other major determinants of health

Maldives has achieved the goal of the universal primary education (MDG-2) and maintained a high literacy rate for several years. The present literacy rate is 97.4% for males and 98% for female (Census, 2014). However, challenges exist, it has been found that secondary-level achievement rates stand at only 47%, with major disparities between Male (58%) and the atolls (30%) (World Bank, Human Capital for a Modern society: General Education in the Maldives, 2012). In addition, out-of-school children and children with disabilities are having limited opportunities to avail inclusive education.

Maldives ratified the Convention on the Elimination of All forms of Discrimination against Women (CEDAW) in 1993 and gender equality and promoting women’s rights are well recognized and articulated in the national policies. But gender-based violence in Maldives is quite widespread. It has been reported that one in three women aged 15–49 experience physical and/or sexual violence at some point in her life (Ministry of Gender and Family, Maldives Study on Women’s Health and Life Experiences, 2007). Many people appear to accept domestic violence as a norm in women’s lives.

In Maldives, the numbers of migrant population (documented and undocumented) are increasing. Health of the migrant emerged as an important challenge as many belong to neighbouring countries, which have a high prevalence of communicable diseases such as TB, HIV, malaria and therefore expose the local population to risk of these diseases.

Solid waste management and water security are of huge concerns for Maldives. The current medical health-care waste management system in facilities is yet to be standardized. Major shortcomings include: (i) infectious waste including pharmaceutical waste are disposed of without appropriate treatment; (ii) chemical liquid waste is drained and routed to the sea; and (iii) inadequate technical capacity of the persons involved in health-care waste management. The National Policy and the Strategy on Health Care Waste Management (2016–2021) have been developed through a collaborative approach with the Ministry of Environment and Energy and technical assistance from development partners particularly WHO.

Use of improved and safe drinking water in Maldives is very high: 100% (urban) and 98% (rural) (GHO, April 2015). However, water security is an urgent issue as Maldives has no surface storage and it relies on groundwater resources for daily use in the islands which face constant challenges of contamination from improper waste management practices including the use of pesticides for agriculture and from flooding.
Maldives is highly vulnerable to the projected adverse effects of climate change. Rise of sea level by one metre could mean that most of the republic’s islands would require to be abandoned (WHO UNFCCC in Climate and Health Country Profile Maldives). Due to increase in the sea surface temperature and ocean acidification process, biodiversity and livelihoods are seriously threatened. Moreover, heavy rainfall and storm surges are expected to be aggravated because rise of sea level and climate change effects cause change in weather patterns. Climate change seriously affects social and environmental determinants of health such as clean air, safe drinking water, sufficient food and secure shelter. The key health threats include heat stress and the spread of vector-borne diseases. In recent years, diseases such as dengue, scrub typhus and toxoplasmosis have re-emerged due to the effect of climate change. In addition to deaths from drowning, flooding causes extensive indirect health effects such as impact on food production, water provision and contamination, damage of the health-care logistics and disruption of the ecosystem. Large-scale population displacement could happen as longer-term effects of flooding. It is estimated that Maldives may face an annual loss of up to a 2.3% of GDP by 2050 due to costs related to adverse climate change effects and adaptation (Asian Development Bank).

Building on partnerships and through a collaborative approach, WHO has worked extensively with the ministries and local authorities to implement the Low Emission Climate Resilience Development (LECReD) programme in Laamu atoll. This demonstrative project is a step forward in building resilience to climate change impacts on human health in Maldives. A multisectoral approach for making greater alliance both

Road traffic accidents are reported to be growing in Maldives particularly in cities, which have a high number of two-wheelers. To assess the real magnitude of this growing problem and ensure road safety, a multisectoral nationwide Road Safety Campaign was launched in 2016. Besides building awareness, the campaign included developing an injury surveillance system across the country and improving trauma care skills of service providers at different levels.
at the national and international level to address climate change vulnerabilities and building resilience of the communities through effective adaptation mechanisms will be the most priority need in future for Maldives.

Air pollution became an emerging public health issue in Maldives, particularly for the city of Male which is densely populated, with a population of 174,666 (Census 2014). The air quality of Male is poor due to pollution from vehicle emissions and congestion caused by the large population. In rural areas, it is estimated that approximately 9% of the population uses primarily solid fuels for cooking (WHO, 2013), which increases the risk of chronic obstructive pulmonary disease (COPD), ischaemic heart disease, etc.

Maldives has adopted a number of CODEX guidelines and established network with the International Food Safety Authorities Network (INFOSAN), and the National Food Safety Policy 2017–2026 has been endorsed. However, there is lack of an adequate food safety and security system in the country including regulation and registration of food items. There is an urgent need to develop an effective food control mechanism for imported foods at different stages, such as pre-border controls, border controls, which include permits, admissibility and inspection procedures and post-border or in-country controls. The quality of food distributed at different outlets needs to be ascertained. The country also imports packaged meat or animal products, which expose people to various pathogens of animal origin. The Joint External Evaluation (JEE) of IHR Implementation held recently in Maldives recommended adopting a “One Health” approach for greater collaboration among different ministries and units of the HoM including the Maldives Food and Drug Authority (MFDA). To address antimicrobial resistance (AMR) as one of the key priority activities, the National Action Plan on Antimicrobial Resistance: 2017–2022 has also been developed through multisectoral and multi-stakeholders’ consultative process including technical assistance from WHO. It is worth mentioning that the MFDA has been designated as the focal agency for AMR in Maldives.

2.3. Health status (burden of disease)

Maldives has achieved five out of eight Millennium Development Goals (MDGs), ahead of the 2015 deadline. A strong foundation has been created towards achieving the global Sustainable Development Goals (SDGs). However, considering the unfinished tasks during the MDG period, the socioeconomic and environmental transitional situation of the country poses new challenges in terms of accesses to health services, changing lifestyles, diseases pattern and preventive measures.
2.3.1. Burden of communicable diseases

Notable achievements have been made in controlling communicable diseases, e.g. the country has been certified to being free of malaria; and vaccine-preventable diseases including polio, neonatal tetanus, whooping cough and diphtheria are non-existent. Measles has been eliminated. Maldives received the malaria and filaria free status certification in 2016.

Although tuberculosis (TB) is of low prevalence, it continues to persist with high risk of transmission. To assess the disease burden of TB in Maldives, an indirect estimation method involving modelling, was adopted in 2015, with technical support from WHO. The review revealed the new raised estimates of TB incidence rate by 56% (from the 2014 WHO estimate of 41 per 100 000 population to 64 per 100 000 population (C.I. of 57–74) in 2015), indicating situations of under-reporting and missing cases. The main causes for persistent TB cases include: (i) overcrowding and poor housing conditions in Male, the capital city with majority of inhabitants; (ii) case-detection activities are not adequate; (iii) screening processes of the migrant population, particularly from countries with high TB prevalence, are not rigorous; and (iv) there is continued stigma associated with TB among the local population. Due to poor case management, the treatment success rate became low causing emergence of multidrug resistance (MDR)-TB in the country. Moreover, there is lack of effective TB surveillance and data management process in place. Under-reporting and missing cases result due to inadequate capacity of data management and lack of coordination among private and government facilities.

The Government of Maldives has made its commitment to achieve Zero TB by 2020, which is 10 years ahead of the regional target of 2030. Accordingly, the government has decided to update the National Strategic Plan for Tuberculosis (2014–2020) to enhance and accelerate TB-related activities across the country, which include: (i) providing quality TB services in all health facilities; (ii) sustaining higher case-detection rates; (iii) establishing a facility to treat MDR-TB cases; and (iv) screening of the migrant workers, prison inmates and other high-risk groups for TB. For effective diagnosis of TB, including drug-resistant cases, the National Public Health Laboratory has procured the country’s first Gene Xpert with support from WHO.

The prevalence of HIV is very low. However, risks of HIV and sexually transmitted infections (STIs) remain high due to unsafe and harmful practices such as unprotected sex, commercial sex work, men who have sex with men (MSM) and needle-sharing among injecting drug users (BBS: 2008 Behavioral and Biological Survey). The total number of STI cases were 13,395 from 2004-2015. Another communicable disease that has a high risk of transmission, particularly among adults is hepatitis B. Despite maintaining safe blood practice and routine vaccination of hepatitis B under the Expanded Programme on Immunization
(EPI), strengthening surveillance of hepatitis B infection is required. A comprehensive strategy for prevention and control of hepatitis B, with a particular emphasis on women of reproductive age will be a priority need.

Aedes mosquito-borne diseases such as dengue, Zika and chikungunya have established local transmission. Dengue is reported every month and is a serious public health problem. A total of 1890 dengue cases and six deaths were reported in 2015 and 1931 cases including three deaths occurred in 2016. The current serotype of the dengue virus has not been studied recently. Since 2015, a total of six Zika cases transmitted in the country have been identified.

Acute respiratory infections are also common in Maldives as 4000–6000 cases are being reported every week. The country experienced its first influenza outbreak in March 2017. A total of 277 H1N1 cases and six attributed deaths were reported. Diarrhoea is another emerging public health problem. According to the Ministry of Health (MoH) data, at least 270 cases of diarrhoea are reported every week since 2015. The etiology is not known and is an area of future research. During the past decade, more than six leprosy cases per year have been reported, the majority of which are adult cases. The infection is identified at very early stage and no Grade 2 disability has been detected. The disease had been eliminated as a public health problem in 1997; however, pockets of disease transmission exist in the country.

2.3.2. Burden of noncommunicable diseases

Noncommunicable diseases (NCDs) are the leading cause of death in Maldives; they account for 81% of total deaths (Vital Registration Statistics, 2014). In 2012, the reported leading causes of death were cardiovascular diseases (CVDs), ischaemic diseases and hypertensive diseases followed by chronic respiratory diseases and diabetes. Prevalence of hypertension and diabetes continue to remain high – hypertension is 16% in Male (CCHDC and WHO, 2011) and the national estimate of type 2 diabetes is 2–7% in the country (WHO, 2014). The 2011 STEPs survey revealed high rates of overweight and obesity, unhealthy diets, smoking, high blood pressure and low levels of physical activity. The percentage of daily smokers decreased slightly (18.3% in 2011 versus 22.0% in 2004 STEPs), but smokers have started smoking earlier (19.0 years in 2011 versus 21.6 years in 2004), which is alarming.

The Maldives Global School-based Student Health Survey (2014) also found exposure of the teen-aged group students (13–17 years) to tobacco products (12.3% of the 3493, 13–17-year-old students surveyed had used tobacco products). Prevalence of obesity increased from 13.4% in 2004 to 15.6% in 2011. Prevalence of overweight increased from 47.1% in 2004 to 51.5% in 2011. These increases were much greater
among women (60.1% versus 52.2% for overweight, 21.2% versus 17.4% for obesity). Some very positive and bold steps have been taken by the Government of Maldives to control tobacco and the consumption of so-called soft drinks in the country, including the announcement of a 40% increase in taxes on all tobacco products and 20% increase in duty on energy and fizzy (colas and soda) drinks, and the ban on sale of tobacco, energy and fizzy drinks in all schools and health facilities.

Disabilities including mental health and psychosocial well-being continue to be a challenge for Maldives. The national estimate of mental and neurological disorders combined is found to be high at 18.7% (WHO, 2011). Prevalence of mental disorders such as depression, anxiety disorder, bipolar disorder, schizophrenia, substance abuse disorders, obsessive–compulsive disorder with depression and intellectual disabilities is rising (National Mental Health Strategic Plan [draft] Maldives: 2016–2021). But overall representative data are not available for comprehensive planning on mental health issues. Due to limited opportunities to access education or employment, the persons with disabilities including children and women remain at high risk of abuse and neglect.

Maldives has one of the highest carrier rates of the beta-thalassaemias in the world. It is estimated that one in six Maldivians has the carrier trait and 60–70 children are born with the disease every year though only one-sixth of them are diagnosed. Support has been provided from WHO to the Maldives Blood Services to train health service providers on prevention and management of thalassaemia. However, for effective identification, prevention and management of thalassaemia, the National Blood Transfusion Services need further strengthening.

To address the burden of NCDs, a multisectoral national plan of action: “Multisectoral Action Plan for the Prevention and Control of Noncommunicable Diseases in Maldives (2016–2020)” has been developed in August 2015 with greater focus on preventive and promotive health interventions to bring changes in lifestyles and reduce health risks. Initiatives have been taken to roll-out a healthy lifestyle campaign at the regional level.
2.3.3. Health of children, adolescents, mothers and older people

Child health: Maldives has already achieved the MDG target of reducing child mortality. The under-five mortality rate and the infant mortality rate have declined sharply during 2005–2014. As of 2014, the under-five mortality rate was 10 per 1000 live births and the infant mortality rate was 8 per 1000 live births (Vital Registration System, 2014). The neonatal mortality rate also decreased substantially from 11.5 to 5.3 per 1000 live births during 2006–2015 (MoH, 2016a).

The childhood vaccination coverage has been more than 95% for all EPI vaccines during the past decade (Ministry of Health and Family and ICF Macro, 2009). However, increasing trends of disabilities, particularly Autism Spectrum of Diseases (ASDs), Global Developmental Delay (GDD) and congenital heart diseases (CHDs) are emerging, which require serious attention.

Childhood malnutrition is still a problem in Maldives as 17.3% of children being underweight (weight-for-age). Only 48% of infants are exclusively breastfed (for 6 months) and at the time of weaning 53% of infants are given commercial baby food as their first food (MDHS, 2009). Prevalence of obesity among children has also been observed as 5.9% of children under 5 years being overweight (Ministry of Health and Family and ICF Macro, 2009). This double burden of malnutrition offers an important opportunity for integrated action on malnutrition in all its forms. To achieve the SDGs (in particular Goal 2 and Target 3.4), addressing the double burden of malnutrition adequately, should be given a high priority.

Tobacco consumption and prevalence of drug use among adolescents have been found alarming as tobacco use among the 13–15-year age group increased from 10.4 to 11.2 during 2001–2011. A majority of drug users (in both Male and atolls) are in the 15–19-year age group (UNODC, 2013). To increase access to information on healthy lifestyle and empower adolescents with adequate life skills, more emphasis has been given on the school health programme involving various stakeholders from the public and private sectors.

Maternal health: The maternal mortality ratio (MMR) has been reduced significantly over the years. The MMR decreased from 69 to 13 per 100 000 live births during 2006–2012. Prevalence of anaemia among women was found to be 15.1% in 2007. High prevalence of thalassaemia and other haemoglobinopathies are the key factors that cause anaemia. It has been found that 38% of women of reproductive age were iron-deficient and 44% vitamin A-deficient (AGA Khan University, Ministry of Health and Family and UNICEF, 2010).
The majority of births (95% in 2011) occur in a health facility, with 85% in a public facility and 10% in a private health facility. The caesarean section rate is too high at 32% (MDHS, 2009) in Maldives, which varies with the education level of the pregnant woman. For women with no formal education, the rate was 22% and among educated women, it was 27–39% or more.

2.3.4. Fertility and family planning

The total fertility rate (TFR) of Maldives was 2.5 in 2009, with the TFR among urban women being lower than that of rural women (2.1 births compared with 2.8 births per woman). The contraceptive prevalence rate (CPR) in Maldives is low. Use of any modern method by currently married women has decreased from 42% in the 1999 Reproductive Health Survey (RHS) to 27% in the 2009 MDHS. Use of contraceptive pattern is quite different for Maldives from commonly occurring patterns. Likewise, the CPR shows a decline with increasing education as is evident in use of modern methods declining from 36% among women with no education to 21% among women with more than secondary education (MDHS 2009). Teen-age childbearing at age 18 is very limited as only 7% have started at the age of 19 years (Ministry of Health and Family and ICF Macro, 2009). A National Reproductive Health Strategy 2014–2018 has been developed with the aim to address the reproductive health issues in an integrated and comprehensive manner.

2.4. Health system response

2.4.1. Governance and stewardship

The Ministry of Health (MoH) is mainly responsible for developing the national health policies and strategies, delivering health services, provide public health protection and oversee health regulations to provide quality health services. The health-care delivery system of Maldives is organized into a three tier system, the first being at the island level primary health centres, the second at the higher level of health facilities which include specialty care hospitals (at the atoll level), and tertiary care services at the urban level.
Regulatory bodies such as the Maldives Medical Council, Maldives Nursing Council, Maldives Health Services Board are in place and functioning. In addition, there is the Health Protection Agency (HPA), which is responsible for regulating public health provision and protection.

Based on the lessons learnt from previous health planning cycles, future health needs and transitional socioeconomic and political situation, the MoH has developed the National Health Master Plan (NHMP) for the next ten years (2016–2025) with a vision to achieve “Excellence in Health”. This is the third long-term plan for the health sector of Maldives, which is developed in alignment with the global SDGs.

2.4.2. Health service delivery

Although the government is committed to providing primary health-care services for all its citizens including preventive care, there has been a shift in the government’s policy towards curative and hospital-based care. The main challenges for health service delivery at the primary level include: (i) geographical isolation of islands; (ii) inadequate human resources including specialties; (iii) insufficient supplies and equipment; (iv) inadequate quality of care and referral mechanism; and (v) overall very weak management.

A number of reforms have been introduced in the public health service delivery system by the government since the beginning of 2014, which included: (i) piloting of a general practice (GP) service system to develop an effective referral system; (ii) delegation of management of public health facilities in the Male city region (including the national referral hospital, Indira Gandhi Memorial Hospital (IGMH), Villimale’ Hospital, and Hulhumale’ Hospital) to Corporate Management Boards independent of the MoH; (iii) developing partnership with the State Trading Organization (STO) to outsource the supply of medical goods for the public health sector; and (iv) proposed enhancing the level of specialized care at IGMH in cardiac care and treatment of renal diseases, the establishment of a national...
diagnostic centre that can be accessed by all health-care facilities (NHMP: 2016–2022). However, effectiveness and sustainability of these reforms are yet to be assessed.

Although a number of regulations (act and laws), standards protocols and guidelines to improve health care are in place, effective use of those standard procedures is still challenging due to high professional staff turnover and high reliance on expatriate health professionals. In alignment with the government’s Health Services Bill, a Quality of Care Framework has been developed with technical support from WHO in 2016, which requires to be implemented effectively.

The private health sector in Maldives is relatively small but it has establishments across the islands. The ADK, a 58-bedded hospital is the main private hospital located in Male, which provides a wide range of services including specialized medical and surgical services. It has been found that out of a total of 202 institutions, about 50% are located in Male (Ministry of Health, 2016).

A few establishments across the country also provide traditional Maldivian medicine (Dhivehi beys) and alternative medical services such as Acupuncture, Ayurvedic medicine and Chinese medicine. Health services provided by nongovernmental organizations (NGOs) are limited. The key leading NGOs that provided services in a sustained mode during the past decade were the Society for Health Education, Diabetes Society of Maldives, Care Society, Aged Care Maldives and Journey.

### 2.4.3. Human resources for health (HRH)

Due to rapid expansion of curative health services in the country, the doctors/nurses/specialists’ ratios with the population have increased over the years. Presently, per 10 000 population there are 23 doctors, 66 practising nurses, 14 primary health-care workers (2015, HI-MoH records). Per cent of local doctors and local nurses in the health workforce was found 23% and 56%, respectively (2015, HI-MoH records). However, disparity remains high in terms of distribution of different medical personnel (local and expatriate) both in the public and private sectors across the country (Fig. 3).
Some major HRH issues identified in Maldives are: (i) shortage of trained workforce including professionals; (ii) overdependence on expatriate health professionals; (iii) equitable distribution of health workers between Male and atolls; (iv) retaining trained health workforce at the island level, which causes high turnover; (v) lack of career and professional development opportunities; (vi) inadequate quality and continuous education for pre-service, postgraduate and professionals; and (vii) weak leadership and management at all levels (National Health Workforce Strategic Plan: 2014–2018).

Maldives has only one institute to train HRH professionals, which is the Faculty of Health Sciences (FHS), established in 1973. Presently, the FHS is offering a number of long-term and short-term courses such as Diploma, Bachelor’s, Master’s courses in the field of Nursing and Midwifery, Public Health, Laboratory Science and Diploma in Pharmacy. Short-term certificate courses are also being offered regularly through four departments, namely, Nursing, Public
Health, Biochemical Science and Wellness. However, of the numerous challenges being faced by the FHS, the main issue is the reluctance of fresh graduate nurses to go for placement outside the home island. To develop a workforce with enhanced skills, more exposure is needed in clinical practice for nurses and midwives, the faculty development process requires improvement, including more exposure for teachers, development of standardized curricula, and more opportunities for sharing experiences.

It is worth mentioning that currently there is no institute to train medical doctors in the country. High interest exists in establishing a medical school and feasibility studies are being done by overseas experts to establish a medical school. However, factors such as lack of trained faculty, lack of infrastructure, lack of availability of clinical materials and case mix and overall costs have been found to be the main barriers to establish a medical school in the country.

### 2.4.4. Health-care financing

In Maldives, the total health expenditure (THE) in 2011 was 9% of the GDP, which is high when compared to other developing countries of the same category. Due to the shift of the government’s policy towards curative care, the public health resources are spent mainly on curative care. The per capita THE was US$ 561, with the government contribution of US$ 247 per capita (MoH, 2013). From 2011 to 2014, the government spending on health rose by 130% (from 1315 million Maldivian Rupee [MVR] to 2922 million MVR) – making up 68% of the total health spending. At the same time, households’ out-of-pocket (OOP) expenditure declined from 45% to 30% (Fig.– 4). Total spending from all sources has risen by 50% during 2011–2014 to 12 641 MVR per person or US$ 810 – almost double the average of upper middle-income countries (US$ 436).

**Figure 4 : Changes in health spending and financing from 2011 to 2014, Maldives**

![Figure 4: Changes in health spending and financing from 2011 to 2014, Maldives](image)

Source: Maldives National Health Accounts, 2014, MoH, Maldives
Overall, more than 49% of health funds are managed and spent directly by the households, 45% by public financing agents and 3% by donors and NGOs (HMP: 2016–2025). It should be noted that increased OOP in recent years was mainly due to a rise in frequency of seeking treatment abroad.

The financial protection scheme and its management in the public sector seem highly complex in Maldives. The current social health insurance scheme called “Husnuvaa Aasandha” was introduced in 2014 with the aim of protecting the people from catastrophic health expenditure and also covers some of the costs of curative services. Although it started as a contributory scheme, it became a non-contributory scheme with an annual limit of MVR 100 000. The current scheme has no annual individual financial limit. The scheme is administered by a state-owned private company “Asandha Pvt Ltd”, and governed by the National Social Protection Agency (NSPA) while the MoH is the main service provider. The mechanism appears to be very complex with inadequate coordination among different entities. A coherent and efficient model needs to be developed urgently for sustainable health protection system in the country.

2.4.5. Gender, equity and human rights

To address the women’s vulnerability and empowerment issues, the government has developed a number of laws, such as the Domestic Violence Act 2012, Sexual Harassment Prevention Act, Sexual Offences Act 2014 and Prevention of Human Trafficking Act. A number of policies are in the process of development such as the Gender Equality Bill, Gender Advocacy Strategy and Gender Action Plan (UNDAF 2016–2020). A National Reproductive Health Strategy has been developed in 2014 with the aim to ensure effective reproductive health and rights, but there are gaps in the implementation process. The issue of accessing health-care equity has been given a high priority in the newly developed National Health Master Plan: 2016–2025.

2.4.6. Diseases surveillance and response system

Considerable amount of work has been done to strengthen disease surveillance and reporting as Maldives has made good progress towards most of the eight core International Health Regulations, IHR (2005). A national IHR Committee is functioning to coordinate the required activities to achieve IHR core capacities, but it requires further strengthening. The committee’s reporting of recent positive cases of Zika has underlined the need for serious strengthening of the disease surveillance system and vector control interventions. Due to the absence of a national laboratory policy, strategy and plan, there is high dependency on overseas confirmation of the tests. Overall, there is an urgent need to develop laboratory surveillance, surveillance for hospital-acquired infections and AMR, and accordingly develop a quarantine facility.
2.5. Joint programming through United Nations Development Assistance Framework (UNDAF)

The UNDAF is a complementary programming mechanism of the United Nations Country Team. The current UNDAF is the strategic programming partnership between the Government of Maldives and the United Nations for the period 2016–2020, which aims to support national development priorities in alignment with the SDGs. In consultation with the government, four priority focused areas: (i) youth and children; (ii) gender; (iii) governance; and (iv) environment and climate change, have been identified with specific outputs and outcomes which will be achieved through “Delivering as One” approach. There are Outcome and Thematic Groups that are responsible for joint planning, implementation, monitoring and reporting along with national partners. A joint Steering Committee comprising government policy-level representatives is responsible for providing management directions throughout the UNDAF cycle.

To implement the UNDAF, the estimated resource requirement will be US$ 53.79 million. WHO is an active participant of the UNDAF. WHO is contributing through its biennium plans and joint programming with other UN agencies to achieve the targets of UNDAF Action Plan. As part of the joint programming initiative, the notable ones include, WHO’s participation in a large multi-donor funded climate change project in Laamu Atoll, which is managed by the United Nations Development Programme (UNDP) and Joint UN programming (UNFPA, UNICEF and WHO) to support the National Demographic and Health Survey.

2.6. Review of WHO’s cooperation over the past CCS cycle

The Country Cooperation Strategy (CCS): 2013–2017 of WHO was the third one for the Maldives, which was developed through an extensive consultative process with the MoH and other stakeholders, and focused on priority needs of the country. There were four strategic priority areas.
The strategic priorities of the WHO CSS: 2013-2017

i. Strengthening the health system towards universal health coverage based on the primary health care approach;

ii. Preventing and controlling diseases and disabilities;

iii. Enhancing public health interventions at national and subnational levels to sustain achievements in health related MDGs and beyond and

iv. Promoting all-inclusive health governance and maintaining WHO’s coordinating role and country presence to support health reforms and national health priorities.

A comprehensive process was initiated by WHO Maldives County Office to assess WHO’s contribution during the past CCS period. The process included situation analysis through consultation meetings with stakeholders (external and internal), review key national documents, review of performance during the past CCS (biennium achievements), mid-term review of the CCS, UNDAF document, etc. A qualitative study was done to assess the views of external stakeholders about WHO’s contributions and their future recommendations.

2.7. Key contributions of WHO and major lessons learnt during the past CCS period.

During the past CCS period, many positive lessons have been learnt, which contributed to achieving notable progress of the health sector of Maldives. The major lessons were:

(i) high political commitment from the government; (ii) development of a long-term plan for the health sector of Maldives in alignment with the global SDGs; (iii) increased health workforce; (iv) improved infrastructure, logistics supply and quality of care; (v) enhanced social behaviour change communication; (vi) improved health protection mechanism of the public sector to reach the unreached; (vii) organizational reforms and restructuring; (viii) greater multisectoral collaboration; and (ix) socioeconomic progress of the country.

WHO’s support during the past CCS period to develop different national policies, strategies, guidelines, action plans, standard protocols and to build capacity of different levels of health professionals, managers, technicians and service providers has contributed in achieving steady progress of the health sector of Maldives.

WHO has supported the MoH in developing country’s long-term health sector development strategy, the National Health Master Plan (NHMP) for 2016–2025, which emphasizes on governance, public health protection (i.e. diseases and injury protection) and health-care delivery (ensuring high-quality service delivery from primary to tertiary levels). WHO has played a lead role in developing the NHMP, which included an intensive consultative and participatory process involving different stakeholders such as various government ministries, NGOs, academia, international development partners and UN agencies.

With support from WHO, the government has introduced the Maldives Quality of Care Framework in 2016, which aims to assess the quality of service delivery both at public and private facilities across the country. The framework consists of a comprehensive set of 125 standards that are essential to providing quality services including
facility readiness: skilled service providers, adequate physical facilities, equipment, drugs and commodities. To implement the framework, WHO assisted in building capacity of 70 members of the national assessor team.

To address the NCDs, WHO has provided support to develop the National Tobacco Cessation Toolkit and effective implementation of the Multisectoral Action Plan For The Prevention And Control of Noncommunicable Diseases (2016–2020). With WHO support, high-level policy advocacy was done on tobacco control, and innovative health promotion interventions were implemented involving multisectoral stakeholders. Encouraging results were achieved as the government has increased taxes and import duties on cigarettes, energy drinks and fizzy drinks. To provide appropriate counselling and treatment services, specialized NCD clinics have been established in all six regional hospitals.

To address AMR, which is one of the priority activities, a National Action Plan on Antimicrobial Resistance: 2017–2022 has been developed with support from WHO through an extensive multisectoral and multi-stakeholders’ consultative process. To develop a regulations and registration system for food and health supplements, WHO has provided technical support to the MFDA including build capacity of the MFDA officials and importers, establishing a stronger network with INFOSAN and the Codex Alimentarius Committee. WHO became operational at the national hospital and all six regional hospitals.

The Government of Maldives has made its commitment to achieve Zero TB by 2020 and WHO has provided support for effective diagnosis of TB, including drug-resistant cases and helped the National Public Health Laboratory to procure the country’s first Gene Xpert. WHO has been working closely with the government to update the National Strategic Plan for Tuberculosis (2014–2020).
worked closely with the government and other stakeholders to finalize the National Food Safety Policy 2017–2026, which has already been endorsed.

To mitigate climate change effects and increase community’s adaptation capacities, WHO assisted the ministries and local authorities to implement an innovative pilot intervention, namely the Low Emission Climate Resilience Development (LECRed) programme in Lammu atoll. The intervention was found to be an effective resource-efficient model on health adaptation to climate change.

WHO’s support in organizing large-scale national-level campaigns such as the Nationwide Vector Control Campaign, Multisectoral Nationwide Road Safety Campaign and Rubella–Measles Campaign have contributed positively in achieving the national health targets.

Considering lessons learnt during the past CCS, the unfinished MDG agendas and future priority health needs of the country to achieve the SDGs, the following support areas were identified by the national stakeholders where WHO can play a more pro-active role:

- Health system strengthening: Legislation, policy support, essential medicine, medical products, technology including laboratory, AMR interventions, blood bank
- Health information system
- Reduce disease burden: Communicable and non-communicable diseases
- Health service delivery (including quality of care) particularly for the vulnerable community
- Human resource development including nursing and medical education
- Food safety and nutrition (testing food quality)
- Environmental health and vulnerability due to climate change including emergency preparedness, disease surveillance and IHR
- Disability including mental health
- Health of the migrant population
- Knowledge management and evidence-based research
Chapter 3
Setting the Strategic Agenda for WHO cooperation
Setting the Strategic Agenda for WHO Cooperation

3.1. The SDGs, Maldives’ Vision for Health and WHO Mandate

In 2015, the United Nations General Assembly adopted the SDGs with a set of 17 goals, to be achieved by 2030. Emphasis has been given on the need for more integrated and inclusive approaches to development ensuring that “no one is left behind”. The SDGs have vision to end poverty and improve health, education, food security and nutrition and environmental issues among others. Health is centrally placed in the SDGs and closely linked with all three dimensions of sustainable development – economic, social and environmental. The health goal SDG3 aims “to ensure healthy lives and promote well-being for all at all ages”, which is cross-cutting to all other SDGs such as poverty reduction, education, nutrition, gender equality, clean water and sanitation, sustainable energy and environmental protection (Fig. 5). To achieve the SDG3 goals ensuring health for everyone, particularly for the vulnerable, a holistic approach with multisectoral involvement and greater coordination and collaboration among the stakeholders will be crucial.

Figure 5: Health in the SDG era

Maldives is in a transitional phase in terms of socioeconomic, demographic, political and environmental transformations resulting in changes in people’s living standards, behaviour and lifestyle; and epidemiological pattern of diseases and disabilities poses newer vulnerabilities. The Government of Maldives is committed to work towards achieving a vision of “Excellence in health” by empowering people to lead healthy lives. To address the newer challenges of health and empower people to lead healthy lives and with a sustainable, efficient and responsive health system, Maldives has adopted an overall national goal to “Enhance health and well-being of the population” by aligning with the global SDGs. The government anticipates to achieve the goal in close collaboration with the health partners focusing on three specific outcomes: (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.

WHO being the closest health partner of the government will work together to achieve the goal of “Excellence in Health” for the people of Maldives. This CCS (2018–2022) will be implemented in close collaboration with the government and other stakeholders for the next five years and will contribute to building a strong foundation to achieve the SDGs by 2030. WHO will play a transformative role to go beyond the health sector with interconnected strategic priorities to ensure healthy lives and well-being for all at all ages including: (i) achieving universal health coverage (UHC); (ii) addressing health emergencies; and (iii) promoting healthier populations (Thirteenth WHO GPW 2019–2023). WHO will support the government to build a people-centred accountable health system focusing more on policy dialogue, strategic support, technical assistance and service delivery in emergencies (Fig. 6).

**Strategic Priority 1: Transforming Health Systems: Ensuring universal health coverage (UHC) and towards achieving the health related Sustainable Development Goals (SDGs)**

**Focus Areas:**
- Health beyond health sector
- Strengthen governance and local stewardship
- Workforce excellence, evidence-based decision making and knowledge management
- Financial protection

**Key Deliverables:**
- Equitable, evidence-based and gender sensitive policies and procedures developed and implemented
- Multisectoral collaboration including public-private partnership strengthened for primary prevention of diseases and risk factors
- People’s centred integrated health service delivery program including Quality of Care Framework developed and implemented
- Capacity strengthened to implement e-health strategy and establish a functional digital platform for greater accountability
- The HRH plan developed and institutionalized for equitable distribution of the trained health workforce across the country
- Capacity strengthened to document and disseminate best practices and generation of evidence through local research and knowledge dissemination
- Coherent and efficient model for sustainable health protection plan developed and implemented

**Strategic Priority 2: Promote wellbeing: Empower people to lead healthy lives and enjoy responsive health services**

**Focus Areas:**
- NCD prevention and management
- Mental health
- Migrant health
- Road safety

**Key Deliverables:**
- Multi-sectoral plan of action on prevention and control of NCDs implemented and monitored
- Interventions for promoting healthy life-style supported
- Regulations on tobacco control are effectively implemented
- National policies and plans on Mental Health developed and implemented
- Service providers are skilled to prevent and treat mental disorders
- Multisectoral approach to address migrant health issues supported
- Nationwide Road Safety Campaign supported and health service providers are skilled in trauma care

**Strategic Priority 3: Ready to respond: addressing the emergencies and accelerate efforts to eliminate priority diseases and promote surveillance**

**Focus Areas:**
- Emergency preparedness
- AMR, IHF, Food Safety
- Enabling advocacy platforms for disease elimination

**Key Deliverables:**
- Core capacities for health emergency preparedness and the IHF strengthened
- Implementation of the Emergency Response Framework supported and monitored
- Capacity enhanced for effective implementation of national plans on AMR containment, Food Safety
- Surveillance system strengthened to prevent and control emerging and re-emerging diseases and neglected tropical diseases
- Elimination strategy for targeted diseases (TB, Hepatitis, HIV, Rubella and Syphilis ) developed and implementation of key interventions supported

**Strategic Priority 4: Protecting what matters the most: Create an enabling environment for safe and healthy living and address specific health issues of children, adolescents and women during reproductive age and beyond.**

**Focus Areas:**
- Climate Resilience
- Health of young people
- Reproductive, maternal and newborn health

**Key Deliverables:**
- Increased awareness on climate change vulnerabilities particularly the health hazards amongst different stakeholders at national and sub-national levels
- National health adaption plan to improve resilience of health system to climate change implemented and monitored together with relevant stakeholders
- Effective network and multi-sectoral alliances developed at national and international level to reduce climate change vulnerability
- Capacity strengthened to reach the adolescents and youth friendly health services scaled-up
- National strategies and plans on reproductive, maternal and newborn health implemented and quality of care improved both in public and private sector
- Technical assistance provided for introduction of the new vaccines in the country

**Achieving a vision of “Excellence in health” by empowering people to lead healthy lives and protected from emergencies in Maldives**
3.2. **Strategic Priorities**

**Strategic Priorities**

1. Transforming health systems: Ensuring universal health coverage (UHC) and towards achieving the health-related Sustainable Development Goals (SDGs).

2. Promote well-being: Empower people to lead healthy lives and enjoy responsive health services.

3. Ready to respond: Addressing the emergencies and accelerate efforts to eliminate priority diseases and promote surveillance.

4. Protecting what matters the most: Create an enabling environment for safe and healthy living and address specific health issues of children, adolescents and women during reproductive age and beyond.

To develop the strategic agenda, WHO Maldives Country Office followed a roadmap with specific activities, time frame and responsibilities. The roadmap included:

- formation of a CCS Working Group;
- dialogue with MoH and other stakeholders;
- situation analysis through consultative meetings with different stakeholders such as other ministries, development partners including UN agencies, academic institutions, civil society organizations;
- extensive review of different national documents, performances during the past CCS (biennium achievements) including Mid-term Review of the CCS; WHO’s Global Programme of Work, National Health Master Plan, UNDAF document, etc.; and
- conducting a policy dialogue to finalize the “Strategic Agenda”.

The Strategic Agenda for 2022–2018 is guided by the National Health Master Plan (2025–2016), the WHO priorities outlined in the Thirteenth WHO GPW (2023–2019), WHO’s Global and Regional Priorities including Flagship Programmes and overall the SDGs.

### Strategic Priority 1

**Transforming Health Systems: Ensuring universal health coverage (UHC) and towards achieving the health-related Sustainable Development Goals (SDGs)**

Considering the changing socioeconomic, demographic, environmental and epidemiological scenario of the country, “transformation of the health system” is essential as it needs to adopt a public health perspective going beyond the conventional curative cares. A people-centred and accessible health system focusing on good governance with increased engagement of people especially vulnerable population and multi-stakeholder participation in disease prevention and health service delivery is the key. To address the social, economic, commercial and environmental determinants of health, stronger intra- and intersectoral linkages will be required. Policy advocacy for integrating health in all relevant policies, for example, healthy environment, employment, affordable housing, waste management, safe drinking water, early childhood development, healthy diet and discouraging tobacco use, etc. will be given high priority.

With commitment for UHC, the need for further strengthening stewardship and regulatory role of the government and fostering new partnerships between the public and private sectors in ensuring quality health services for all will be the focus. Critical elements such as
effective use of digital platforms for communicating health and evidence-based decision-making through strengthened health management information system (HMIS) and use of innovative knowledge management technologies including for local level capacity development will be among the priorities. Supporting workforce excellence, documenting best practices including building research capacities and supporting upstream work in strengthening a coherent and efficient financial and social protection mechanism are some of the focus areas.

Focus Areas

• **‘Health beyond the health sector’**: Advocate for primary prevention of diseases by providing support to enhance intra-ministerial and the multisectoral collaboration. Strengthen government’s oversight functions to adopt a broader view of different risk factors and diseases related to environmental and social determinants of health.

• **Strengthen governance and local stewardship**: Scaling up capacities of the national regulatory authorities to develop and implement more efficient, equitable, evidence-based and gender-sensitive policies and procedures and ensuring effective delivery of the essential service package and implement the Quality of Care Framework.

• **Workforce excellence, evidence-based decision-making and knowledge management**: Provide support to strengthen skill development processes of different cadres of health professionals especially frontline health workers and strengthen delivery of quality primary health-care services. Strengthen the use of appropriate digital platforms/tools for strengthening HMIS and facilitate informed policy decisions. Support to generate, utilize and disseminate local knowledge using innovative technologies on knowledge management and effective implementation of the National Health Research Policy (NHRP).

• **Financial protection**: Advocate and support strengthening national capacity to develop equitable and efficient social, economic and health protection policies and frameworks.

Deliverables for Strategic Priority 1

• Equitable, evidence-based and gender-sensitive policies and strategies developed and implemented;

• Multisectoral collaboration including public-private partnership strengthened for primary prevention of diseases and risk factors;

• People-centred integrated health service delivery programme including Quality of Care Framework developed and implemented;

• Capacity strengthened to implement e-health strategy and establish a functional digital platform for greater accountability;

• The HRH plan institutionalized for equitable distribution of the skilled health workforce;
• Capacity strengthened to document and disseminate best practices and generation of evidence through local research and knowledge dissemination;
• Coherent and efficient model for sustainable health protection plan implemented.

Strategic Priority 2

Promote well-being - Empower people to lead healthy lives and enjoy responsive health services

As the country’s economy and living standards improve, NCDs are emerging as the main cause of morbidity and mortality in Maldives with NCDs (including injuries) accounting for 78% of the total deaths, and mental disorders also constituting a high proportion. There is lack of availability of mental health services in the country with very limited preventive and promotional efforts in mental health. With a mental health policy, strategic and operational plan in place, it is expected that in coming years a coordinated and planned approach to improve mental health of the people of Maldives will be operationalized.

In Maldives, the numbers of both documented and undocumented migrant population are increasing as Census 2014 indicated that 16% of the total population of 402,071 are migrants. Health of migrant workforce therefore emerged as a big challenge as they come from countries with a high prevalence of communicable diseases with increased probability of exposing the local population and with possible import of diseases. WHO will continue to explore opportunities to collaborate with the International Organization of Migration (IOM) and the Department of Labour, Ministry of Economic Development to address the complex issue of health screening of migrant workers and will support a coordinated effort in addressing migrant health issues both at the individual and institutional levels though a multisectoral approach.

Focus areas:

• **NCD prevention and management:** Reduce burden of NCDs through promotion of lifestyle change interventions, early detection, prevention and effective management through intersectoral collaboration. Provide support and advocate effective implementation of the national “Multisectoral Action Plan for the Prevention and Control of Noncommunicable Diseases (2016–2020)”. Provide support for effective implementation of the Framework Convention on Tobacco Control (FCTC).

• **Mental health:** Strengthen national capacities to scale up mental health services to prevent, diagnose, treat and rehabilitate people with mental health problems and work with partners.

• **Migrant health:** Increase access of migrants to health services and prevent introduction of noble or reintroduction of eliminated disease transmission in the country.

• **Road safety:** Strengthen the nationwide road safety campaign through a multisectoral approach and build capacity on injury surveillance system and trauma care.
Deliverables for Strategic Priority 2

- Multisectoral plan of action on prevention and control of NCDs implemented and monitored
- Interventions for promoting healthy lifestyle supported
- Regulations on tobacco control are effectively implemented
- National policies and plans on mental health implemented
- Service providers are skilled to prevent and treat mental disorders
- Multisectoral approach to address migrant health issues supported
- Nationwide Road Safety Campaign supported and health service providers are skilled in trauma care.

Good lessons have been learnt in building national capacities to develop policies, legislations, standard operating procedures (SOPs), and frameworks including raising technical skills of the different cadres of health officials, etc. The key policies, regulations, action plans/frameworks developed include: Emergency Response Framework, National Action Plan on AMR containment, National Food Safety Policy and National Blood Transfusion Policy. But challenges remain such as limited skilled workforce with technical expertise, financial resources, high staff turnover, lack of monitoring including quality assurance mechanism, suboptimal functioning of the national-level committees, and suboptimal coordination among various sectors and professional bodies. The Joint External Evaluation (JEE) of IHR, held in Maldives recommended adopting “One Health” approach. During this CCS period emphasis will be given on strengthening technical capacities of different categories of staff, bringing new technologies, expand surveillance network, enhance interagency workings and data-sharing, joint monitoring and policy advocacy for greater intersectoral collaboration.

Strategic Priority 3

Ready to respond: Addressing the emergencies and accelerate efforts to eliminate priority diseases and promote surveillance

To address the challenges related to emergency response, IHR (2005) core capacities, strengthening national emergency programme, AMR), food safety, controlling vector-borne diseases and safe blood transfusion system, numerous initiative have been undertaken jointly by WHO and the government during the previous CCS period.
As part of the global mandate as well as regional flagships, enhanced support will be made available for diseases elimination, e.g. accelerate progress towards the elimination of diseases such as TB, hepatitis, HIV and rubella. WHO will provide support in developing such strategies and roadmap, help in building new partnerships and mobilize technical resources, strengthen national capacity for integrated diseases surveillance with enhanced laboratory systems and strengthen advocacy efforts to ensure greater political commitment.

**Focus Areas:**

- **Emergency preparedness:** Support the national and subnational level capacity building process on emergency preparedness by considering that the community will be first responders and implementation of the Emergency Response Framework.
- **AMR, IHR and food safety:** Support implementation of the National Action Plan on AMR: 2017–2022 including advocating for implementation of one health approach. Enhance national capacity to attain and sustain IHR core capacity including effective implementation of recommendations of JEE. Strengthen institutional capacity to implement the National Food Safety Policy: 2017–2026.
- **Enabling advocacy platforms for disease elimination** through accelerating progress towards the targeted elimination of rubella, TB, hepatitis, mother-to-child transmission of HIV and syphilis.

**Deliverables for Strategic Priority 3**

- Core capacities for health emergency preparedness and the IHR strengthened;
- Implementation of the Emergency Response Framework supported and monitored;
- Capacity enhanced for effective implementation of national plans on AMR containment, food safety;
- Surveillance system strengthened to prevent and control emerging and re-emerging diseases and neglected tropical diseases;
- Elimination strategy and plans for targeted diseases (TB, hepatitis, HIV, rubella and syphilis) developed and implementation of key interventions supported.

**Strategic Priority 4**

**Protecting what matters the most:** Create an enabling environment for safe and healthy living and address specific health issues of children, adolescents and women during reproductive age and beyond

Climate change affects social and environmental determinants of health – clean air, safe drinking water, sufficient food and secure shelter. Maldives continues to be vulnerable to the impacts of climate change. Improved social awareness about the risks and effects of climate change on health will increase societal supports in taking actions to reduce greenhouse gas emission. The complex relationships between environmental factors, climate
change and human health, should be seen in a broader public health context and health interventions need to be re-prioritized to achieve the SDGs.

Improved awareness along with technical support will help health sector policymakers to give leadership in developing comprehensive strategies to mitigate climate change effects and increase community’s adaptation capacities. During the next CCS period, major thrusts will be given on developing tools, information and guidance to support awareness and advocacy at the national and regional levels; undertake policy advocacy aiming to bring health at the centre of the climate change mitigation and adaptation agenda of the government. Emphasis will be given in developing innovative and resource-efficient model on health adaptation to climate change. WHO will advocate mobilizing resources both at the country and international levels. Highest effort will be given to develop a resource-efficient, cleaner and environmentally sustainable health protection system, through alliance building with government, private sector, NGOs, international organizations including UN agencies, civil society organizations, academic institutions, professional bodies, etc.

More coordinated efforts are required to increase access to reliable information on healthy lifestyle for adolescents using innovative approaches including the social media. Joint initiatives will be undertaken to empower adolescents with adequate life skills. Best practices in improving adolescent health care will be scaled-up in collaboration with different stakeholders including the ministries of youth, education, telecommunication, sports and private institutions. To improve maternal and newborn health, WHO will provide specific and need-based technical support, such as to build capacity on implementation of MPDSR, ENAP and surveillance of birth defects, their prevention and management. WHO will also provide support for promoting quality sexual and reproductive health services through effective implementation of the National Reproductive Health Strategy.

Introduction of a new vaccine into a national immunization schedule depends upon several factors such as disease burden, cost-effectiveness, safety, availability and suitability of available vaccine products for national programmes. WHO will provide technical support to the government to assess the feasibility of introduction of the new vaccine, monitor implementation process and coverage.

Focus Areas:

- **Climate resilience**: Raise public and policy awareness on the health impacts of climate change across the entire society, and strengthen national capacity in building health systems resilience to climate change. Advocate and initiate greening of the health sector by adopting environment-friendly technologies, and using energy-efficient services;

- **Health of young people**: Increase health awareness, improve health-seeking behaviour and support preconception care and scaling up of adolescent- and youth-friendly health services through a multisectoral approach.
• Reproductive, maternal and newborn health: Advocate and support quality of care through implementation of MPDSR, ENAP and sustaining birth defects surveillance, prevention and management. Enable reproductive choices for all women and men by supporting the implementation of the reproductive health policy and facilitating the provision of appropriate reproductive health services and information. Advocate introducing new vaccines for the well-being of people of Maldives.

• Effective network and multisectoral alliances developed at the national and international level to reduce climate change vulnerability;

• Capacity strengthened to scale up adolescents and youth-friendly health services;

• National strategies and plans on reproductive, maternal and newborn health implemented and quality of care improved both the public and private sector;

• Technical assistance provided for introduction of the new vaccines in the country.

Deliverables for Strategic Priority 4

• Increased awareness on climate change vulnerabilities particularly the health hazards among different stakeholders at the national and subnational levels;

• National health adaption plan to improve resilience of the health system to climate change, implemented and monitored together with relevant stakeholders;
Chapter 4
Implementing the Strategic Agenda
4.1. Implications for the WHO Secretariat

The WHO Country Office will be responsible to provide need-based high-quality technical assistance to the government in addressing the priority and emerging health-related challenges of the country including contribution to the SDGs. Stronger and closer working will take place with the WHO Regional Office and headquarters and engagement with wider health sector stakeholders to mobilize technical and financial resources. Exchange of technology, experience and resources among countries within the Region will be given high priority. The WHO headquarters and the Regional Office will continue to provide support on global policies, directives and standards including changes, transformations and innovations in light of the Thirteenth GPW. As the CCS 2018–2022 is aligned to the National Health Master Plan (2016–2025), as well as United Nations Development Assistance Framework (UNDAF) 2016–2020 it will be utilized by the Country Office as a platform for collaboration, partnership, resource mobilization and joint advocacy.

4.2. Key roles of WHO

To implement the strategic agendas effectively emphasis will be given on leadership role, quality of technical support across all priority areas and health communication including knowledge management, advocacy and partnership:
WHO will have leadership role to support the government in promoting well-being of the people. WHO will be proactive in assisting government in multisectoral engagement with relevant sectors and in utilizing information and appropriate digital platforms in formulating evidence-based policies and strategies. A greater collaboration will be made with different ministries, private institutions, civil society organizations and UN bodies to address the social, economic and environmental determinants of health for achieving the SDGs.

Maldives is one of the highest users of internet and social media in the region. WHO will build upon this and use social media as strong platform for communicating healthy lifestyles. WHO will promote this social connectivity to assimilate information from various segment of population and use them for policy advocacy.

To enhance knowledge and skills of different cadre of health professionals WHO will promote innovative knowledge management process including e-learning. WHO will facilitate cross-learning process by establishing networks with different professional and academic institutions (such as universities, dedicated public health institutes, etc.) within the Region including WHO Collaborating Centres.

Strong policy advocacy will be required to bring transformational changes in the health system. Policy-makers will require greater understanding about impact of different social and environmental factors on health. To promote “health in all policies” as a holistic approach, WHO will continue to support advocacy through structured policy dialogues with the stakeholders including different ministries. WHO will be proactive in collaborating with the SDG Secretariat run by the Ministry of Environment and Energy.

WHO will promote partnerships and “one health” approach to progress to the targets of NHMP 2016–2025 and CCS 2018–2022. In partnership with MoH, its contributions to partners’ policies, plans and targets and thus creating a harmonious approach to move jointly to attain the SDGs.

To mobilize resources, WHO will facilitate exploring funding opportunities from different international financing institutions, mechanisms and donors including alternative sources of funding (such as from the private sector). WHO will explore partnerships with institutions beyond the health sector especially for demonstration projects on building resilience to climate change impacts in alignment with the UNDAF.

WHO Country Office will continue efforts to enhance visibility of their effort to improve the health and well-being of the people of Maldives. This will be achieved through both the traditional and current approaches such as advocacy, communication through mass and social media, or through printed materials.
4.3 Working as “One WHO”

The CCS 2018–2022 for Maldives represents the commitment of three levels of organization and technical expertise will be mobilized throughout the organization in order to implement the CCS effectively over the next five years. The efforts will include support from the headquarters in Geneva, Regional Offices and horizontal collaboration with other country offices and WHO collaborating centres to ensure timely, relevant and optimal support.

Considering the paradigm shift in terms of WHO’s approaches to achieve the SDGs as well as the CCS strategic priorities, an adequate structure with a team of competent and motivated staff will be in place with appropriate backstopping from the Regional Office and headquarters when required. WHO will continue to facilitate regional and country exchange of knowledge, expertise and experience and coordinate activities on public health with other countries.

Staff Development and Learning (SDL) will be given high priority to enhance staff capacity. All staff will have comprehensive SDL components with priority to develop the leadership skills including technical competencies of the team members.

4.4. Using the Country Cooperation Strategy

The CSS document will be widely disseminated to all stakeholders including the government, UN bodies, donors, academic institutions, private and social organizations. A CCS brief will be available in English and Maldivian versions. Both the documents will be posted on the Country Office website and links will be shared with all relevant stakeholders.

High-level policy-makers as well as the operational level managers of different sectors of the government and other stakeholders will be provided with adequate
orientation about WHO’s roles, functions and priority agendas of the CCS and its implementation modalities.

This CCS 2018–2022 will be implemented through two consecutive biennial programme budgets and workplans.

4.5. Managing risks

The current political scenario of Maldives poses some risks that may hamper smooth implementation of the CCS agendas in the future. But WHO has a long-term commitment and presence in the country, and will be able to adapt the situation and maintain optimal relationship with the government. The risk factors related to politics, natural disasters and socioeconomic conditions will be closely monitored by WHO and appropriate risk mitigation strategy will be developed as required.

After Maldives became an upper middle-income country, donor support became very limited. The government is now the main contributor for financing health in the public sector. WHO will work more closely with UN agencies, international organizations and diplomatic missions and explore funding opportunities from different international financing institutions. To enhance partnership with the non-State Actors, the FENSA (Framework of Engagement with Non-State Actors) guideline of WHO will be increasingly used.
Chapter 5
Monitoring and Evaluation
To assess the progress and improve overall performance, the CCS will be monitored regularly throughout its implementation cycle including the mid-term review at the mid-point and the final evaluation towards the end of the CCS cycle. Regular monitoring is an early warning system to alert the WHO Country Office to the need to refocus the biennial workplans and adjust staffing pattern as feasible, or seek additional support from the Regional Office or the headquarters. The progress of CCS implementation will be jointly monitored by the WHO Country Office and the MoH. Besides routine performance review meetings (Biennial Workplans Reviews) with the government, a CCS Monitoring Working Group will be established involving government and other key stakeholders. Annual performance report will be prepared based on the progress of achievements of the CCS deliverables using colour code like a “traffic light system” (Fig. 7).

The CCS Monitoring Working Group will meet yearly to discuss the progress, programmatic challenges and key issues in implementing the CCS and the biennial workplans.
### Deliverables

**Strategic Priority 1:**
Transforming Health Systems: Ensuring universal health coverage (UHC) and towards achieving the health related Sustainable Development Goals (SDGs)

<table>
<thead>
<tr>
<th>Deliverables</th>
<th>Key to progress:</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equitable, evidence-based and gender sensitive policies and strategies developed and implemented</td>
<td>On-track/ achieved</td>
<td>Green</td>
</tr>
<tr>
<td>Multisectoral collaboration including public-private partnership strengthened for primary prevention of diseases and risk factors</td>
<td>Likely to be achieved /challenges</td>
<td>Yellow</td>
</tr>
<tr>
<td>People's centred integrated health service delivery program including Quality of Care Framework developed and implemented</td>
<td>Unlikely/ Off-track</td>
<td>Red</td>
</tr>
<tr>
<td>Capacity strengthened to implement e-health strategy and establish a functional digital platform for greater accountability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The HRH plan institutionalized for equitable distribution of the skilled health workforce</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capacity strengthened to document and disseminate best practices and generation of evidence through local research and knowledge dissemination</td>
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<table>
<thead>
<tr>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
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<tr>
<td>2</td>
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</table>

Sample
Developing Result-based Monitoring Framework:

The CCS outputs and targets are well-linked with the outcomes and targets of the GPW, HMP, SDGs, UNDAF and WHO’s Regional Flagship Priorities (Annex 2: Validation matrix). To monitor the contribution of the CCS in achieving national health targets a result-based monitoring framework with intended outputs, outcomes and impacts will be developed in alignment with the Result Framework (RFW) of HMP (2016–2025), the GPW and UNDAF. The indicators, targets, means of verification and timing will be finalized by the Monitoring Working Group through consultations with the national-level stakeholders (Fig. 8).

Mid-term review

To assess the overall contribution in addressing the health and health-related challenges, a review of the CCS at the mid-point will be conducted in consultation with the Regional Office and headquarters. Specifically the purpose of the mid-term review will be

- to determine the progress in the Focus Areas (if the expected achievements are on track)
- to identify impediments and potential risks that may require changes to Strategic Priorities or Focus Areas
- to identify actions required to improve progress during the second half of the CCS cycle.

The findings will be used to improve the performance including corrective actions such as revisiting the focus areas, country-level programme budget, resource allocations, etc.

Final evaluation

The final evaluation will be more comprehensive and assess mainly the contribution of WHO in achieving national goals including the targets of the CCS result framework. Through the final evaluation, issues such as critical success factors, impediments, lessons learnt and unfinished tasks will be identified, and to be applied in the next CCS cycle. The final evaluation criteria will include assessing relevance, effectiveness, efficiency and impact, using standard methods including the WHO evaluation practice handbook.
### Priority 1 – Transforming Health Systems: ensuring UHC and towards achieving the health related SDGs (FA: Health beyond health sector, Strengthen governance, Local stewardship, Workforce excellence, evidence-based decision making and knowledge management, Financial protection)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline (year) &amp; Source</th>
<th>Target HMP (2016-2025)</th>
<th>Target CCS (2018-2022)</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Pocket Spending on Health (OOPS) as % of Total Expenditure on Health (THE)</td>
<td>49.4 (2011) NHA</td>
<td>Reduce by 25% (2020) and 50% (2025)</td>
<td>TBD</td>
<td>An enabling socio-political environment will prevail and strong political commitment will continue. Stronger leadership at MOH is necessary to bring all partners together to build a robust health system and provide equitable and quality health services. It is expected that government will continue to strengthen its capacity to develop and implement equitable and efficient health protection policies.</td>
</tr>
<tr>
<td>% population coverage of essential health services</td>
<td>Not available QARD records, RAHS records Maintain at 100%</td>
<td>Maintain above 100%</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>No of Physicians per 10,000 population</td>
<td>23 (2015) HR data centrally, Licensing Registration</td>
<td>Maintain above 20%</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>Government spending on preventive health as % of general government health expenditure</td>
<td>5.9 (2011) NHA</td>
<td>Increase to 15% and maintain</td>
<td>TBD</td>
<td></td>
</tr>
</tbody>
</table>

### Priority 2 - Promote wellbeing: Empower people to lead healthy lives and enjoy responsive health services (FA: NCD, Mental Health, Migrant health, Road safety)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline (year) &amp; Source</th>
<th>Target HMP (2016-2025)</th>
<th>Target CCS (2018-2022)</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premature mortality from NCDs (age specific rates between 30 and 70 years) (&lt;000 population of the target age group)</td>
<td>% Not Available WHO global health Observatory data, VRS</td>
<td>Reduce by 1/4th (2020) and 1/3rd (2025)</td>
<td>TBD</td>
<td>Stronger focus would be required on diseases prevention and multi-sectoral collaboration. Government will be proactive to organize nationwide different awareness raising campaigns involving relevant stakeholders.</td>
</tr>
<tr>
<td>Age-standardized prevalence of current tobacco use among persons aged 15 years and older (Percentage of the population aged 15-64 years who are currently smokers. Percentage of the population aged 15-64 years who are currently using smokeless tobacco – Proxy Indicator)</td>
<td>18.8% ; 3.7% (2011) NCD Steps Survey</td>
<td>Reduce by 5% (2020) and 10% (2025) Reduce by 50% and above</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>Prevalence of overweight children &lt;5 years (weight for height above +2SD)</td>
<td>5.9 (2009) MDHS</td>
<td>Reduce by 1/3 and Maintain</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>Mortality due to road traffic injuries accidents (% &lt;000 pop)</td>
<td>0.032 (2014) VRS, injury surveillance reports</td>
<td>Reduce by 50% and sustain 75%</td>
<td>TBD</td>
<td></td>
</tr>
</tbody>
</table>

### Priority 3 – Ready to respond: addressing the emergencies (FA: Emergency preparedness, AMR, IHR, Food safety and Disease elimination)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline (year) &amp; Source</th>
<th>Target HMP (2016-2025)</th>
<th>Target CCS (2018-2022)</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of health facilities (public and private) with contingency plan for respondents to local and national outbreaks and public health emergencies/pandemics</td>
<td>14 Health Facilities HPA records</td>
<td>Increase to all health facilities and maintain</td>
<td>TBD</td>
<td>Emphasis will be given on “One Health approach” as recommended by the Joint External Evaluation (JEE) held in 2017. Initiative will be undertaken for greater collaboration among different ministries and units of the health ministry including the Maldives Food and Drug Authority (MFDA).</td>
</tr>
<tr>
<td>International Health Regulations (IHR) capacity and health emergency preparedness (Availability of information and data for International Health Regulations compliance monitoring and evaluation – Proxy Indicator)</td>
<td>Annually Reported HPA records</td>
<td>1 report completed annually</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>TB incidence per 1,000 population (Tuberculosis incidence rate Per 100,000 - Proxy Indicator)</td>
<td>41 (2015) TB Control Program-HPA</td>
<td>below 10/100,000 population</td>
<td>TBD</td>
<td></td>
</tr>
</tbody>
</table>

### Priority 4 – Protecting what matters the most: Create an enabling environment for safe and healthy living and address specific health issues of children, adolescents and women during reproductive age and beyond (FA: Climate resilience, Health of young people, Reproductive, maternal and newborn health)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline (year) &amp; Source</th>
<th>Target HMP (2016-2025)</th>
<th>Target CCS (2018-2022)</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Major national development projects that assessed health impact prior to implementation (such as artificial beaches, parks and harbours)</td>
<td>0% (2015) PO, Housing, MOED, Etc</td>
<td>Increase to 25% (2020) and 50% (2025)</td>
<td>TBD</td>
<td>Strong alliance will be build to initiate greening of the health sector by adopting environment-friendly technologies. Government will take the lead to involve private sector, NGOs, international organizations including UN agencies, civil society organizations, academic institutions and professional bodies. Quality of Care Framework will be implemented.</td>
</tr>
<tr>
<td>Number of government health facilities providing youth friendly services</td>
<td>3 Facilities (2016) Population Health Program – HPA</td>
<td>Establish 10 facilities(2020) and 20 facilities (2025)</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>% of children aged 12 to 23 months who received all basic vaccinations (EPI vaccine coverage)</td>
<td>92.9 (2009) MDHS</td>
<td>Increase to 95% and maintain above 95%</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>Prevalence of stunting (height for age &lt; -2 SD from the median of the WHO child growth standard) among children under 5 years of age</td>
<td>18.9 (2009) MDHS</td>
<td>Reduce by 1/3 and Maintain</td>
<td>TBD</td>
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</tr>
<tr>
<td>Neonatal mortality rate (&lt;000 live births)</td>
<td>5.11 (2014) VRS</td>
<td>Maintain below 06</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>Under 5 mortality rate (&lt;000 live births)</td>
<td>10 (2014) VRS</td>
<td>Equal or less than 10</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>Maternal mortality ratio/maternal deaths (&lt;100,000 live births)</td>
<td>41 (2014) VRS</td>
<td>Maintain below 50</td>
<td>TBD</td>
<td></td>
</tr>
</tbody>
</table>
References

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### Annex 1:

#### Key Health and Development Indicators of Maldives

<table>
<thead>
<tr>
<th>Key Indicators: Maldives</th>
<th>South-East Asia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WHO region</strong></td>
<td></td>
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<tr>
<td><strong>Child health</strong></td>
<td></td>
</tr>
<tr>
<td>Infants exclusively breastfed for the first six months of life (%) (2009)</td>
<td>48</td>
</tr>
<tr>
<td>Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%) (2015)</td>
<td>99</td>
</tr>
<tr>
<td><strong>Demographic and socioeconomic statistics</strong></td>
<td></td>
</tr>
<tr>
<td>Poverty headcount ratio at $1.25 a day (PPP) (% of population) (2004)</td>
<td>1.5</td>
</tr>
<tr>
<td>Gender inequality index rank (2014)</td>
<td>49</td>
</tr>
<tr>
<td>Human development index rank (2014)</td>
<td>104</td>
</tr>
<tr>
<td><strong>Health financing</strong></td>
<td></td>
</tr>
<tr>
<td>Total expenditure on health as a percentage of gross domestic product (2014)</td>
<td>13.73</td>
</tr>
<tr>
<td>Private expenditure on health as a percentage of total expenditure on health (2014)</td>
<td>21.67</td>
</tr>
<tr>
<td>General government expenditure on health as a percentage of total government expenditure (2014)</td>
<td>26.59</td>
</tr>
<tr>
<td><strong>Health systems</strong></td>
<td></td>
</tr>
<tr>
<td>Physicians density (per 1000 population) (2010)</td>
<td>1.579</td>
</tr>
<tr>
<td>Nursing and midwifery personnel density (per 1000 population) (2010)</td>
<td>5.617</td>
</tr>
<tr>
<td><strong>Mortality and global health estimates</strong></td>
<td></td>
</tr>
<tr>
<td>Neonatal mortality rate (per 1000 live births) (2015)</td>
<td>4.9 [3.6-6.3]</td>
</tr>
<tr>
<td>Under-five mortality rate (probability of dying by age 5 per 1000 live births) (2015)</td>
<td>8.6 [7.1-10.6]</td>
</tr>
<tr>
<td>Maternal mortality ratio (per 100 000 live births) (2015)</td>
<td>68 [ 45 - 108]</td>
</tr>
<tr>
<td><strong>Public health and environment</strong></td>
<td></td>
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<tr>
<td>Population using improved drinking-water sources (%) (2015)</td>
<td>99.5 (Urban)</td>
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<td></td>
<td>98.6 (Total)</td>
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<tr>
<td></td>
<td>97.9 (Rural)</td>
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<tr>
<td>Population using improved sanitation facilities (%) (2015)</td>
<td>97.5 (Urban)</td>
</tr>
<tr>
<td></td>
<td>97.9 (Total)</td>
</tr>
<tr>
<td></td>
<td>98.3 (Rural)</td>
</tr>
<tr>
<td><strong>Sustainable development goals</strong></td>
<td></td>
</tr>
<tr>
<td>Life expectancy at birth (years) (2015)</td>
<td>80.2 (Female)</td>
</tr>
<tr>
<td></td>
<td>78.5 (Both sexes)</td>
</tr>
<tr>
<td></td>
<td>76.9 (Male)</td>
</tr>
<tr>
<td>Births attended by skilled health personnel (%) (2012)</td>
<td>95.5</td>
</tr>
<tr>
<td><strong>World Health Statistics</strong></td>
<td></td>
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<tr>
<td>Population (in thousands) total (2015)</td>
<td>363.7</td>
</tr>
<tr>
<td>Population proportion under 15 (%) (2015)</td>
<td>27.5</td>
</tr>
<tr>
<td>Population proportion over 60 (%) (2015)</td>
<td>6.8</td>
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</tbody>
</table>

WHO Global Health Observatory, April 2017
http://apps.who.int/gho/data/node.cco
### Annex 2:

Validation Matrix: Linkage of CCS strategic priorities and focus areas with NHSSP, GPW outcomes, UNDAF outcomes and SDGs

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<tbody>
<tr>
<td>1. Transforming Health Systems: Ensuring universal health coverage (UHC) and towards achieving the health related Sustainable Development Goals (SDGs)</td>
<td>1.1. ‘Health beyond health sector’: Advocate for primary prevention of diseases by providing support to enhance intra ministerial and the multisectoral collaboration. Strengthen government’s oversight functions to adopt a broader view of different risk factors and diseases related to environmental and social determinants of health.</td>
<td>Strengthened health systems in support of universal health coverage without financial hardship, including equity of access based on gender, age, income, and disability. Improved human capital across the life course. Strengthened country capacity in data and innovation. Strengthened leadership, governance, management and advocacy for health.</td>
<td>UHC with focus on HRH and essential medicines</td>
<td>Institutional capacities strengthened for implementation of legislative reform, oversight and local and national level evidenced based inclusive equitable and sustainable policies and planning. Governance systems enhanced for improved performance in health care delivery. Support multi-sectoral policies, legislation, mechanisms and regulations to promote universal health coverage. Civil society and vulnerable groups have enhanced capacities to engage, contribute &amp; participate in national development processes.</td>
<td>SDG-3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all SDG- 3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing states.</td>
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1.2. Strengthen governance and local stewardship: Scaling up capacities of the national regulatory authorities to develop and implement more efficient, equitable, evidence-based and gender sensitive policies and procedures and ensuring effective delivery of essential service package and implement Quality of Care Framework.

1.3. Workforce excellence, evidence-based decision making and knowledge management: Provide support to strengthen skill development process of different cadre of health professionals especially frontline health workers and strengthen delivery of quality primary health care services. Strengthen use of appropriate digital platforms/tools for strengthening HMIS and facilitate informed policy decisions. Support to generate, utilize and disseminate local knowledge using innovative technologies on knowledge management and effective implementation of the NHRP.

1.4. Financial protection: Advocate and support strengthening national capacity to develop equitable and efficient social, economic and health protection policies and frameworks.

Establish an efficient health system governed by legislation, regulatory and oversight mechanism. Ensure public policy making is transparent, evidence-based and information-driven to meet the national health goals and SDG targets. Develop public-private partnerships in health promotion and delivery of preventive and curative health services. Ensure financial sustainability of the health system and the social health insurance scheme. Political commitment to achieve the goals and outcomes of this national health master plan and the health targets of the sustainable development goals (SDGs).

Strengthen the management of the health workforce to support equitable distribution with an appropriate skill mix, for defined services. Establish quality standards for delivering different health care services and build capacity to audit them. Ensure availability of essential medicines, vaccines, medical products and technology (such as reproductive health technologies) for primary care. Establish an integrated national health information system (disease reporting, surveillance and medical records) linking different levels of the health system and private health care providers. Identify research priorities and manage research to meet information needs for programming, planning and policy.
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<tr>
<td>2. Promote wellbeing - Empower people to lead healthy lives and enjoy responsive health services</td>
<td>2.1. NCD prevention and management: Reduce burden of noncommunicable diseases through promotion of lifestyle change interventions, early detection, prevention and effective management through intersectoral collaboration. Provide support and advocate effective implementation of the national “Multi-sectoral Action Plan for the Prevention and Control of Noncommunicable Diseases (2016-2020)”. Provide support for effective implementation of the Framework Convention on Tobacco Control (FCTC).</td>
<td>Strengthen health promotion and health education customized to the target audiences. Empower young people and adults to adopt healthy choices regarding food, physical activity and social behaviour through education and life skill development. Utilize modern Information Communication Technologies (ICT) to bring behaviour change in communities.</td>
<td>Noncommunicable diseases prevented, treated, managed, and their risk factors controlled, and mental health prioritized and improved</td>
<td>Prevention of Noncommunicable diseases through multi-sectoral policies and plans with a focus on “best buys”</td>
<td>Governance systems enhanced for improved performance in health care delivery. Enhancing delivery of and equitable access to quality health services through strengthened governance.</td>
<td>SDG-3.4 Reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being SDG-3.a Strengthen the implementation of the WHO Organization Framework Convention on Tobacco Control in all countries, as appropriate SDG-3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol SDG-3.6 Halve the number of global deaths and injuries from road traffic accidents. SDG-3.b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases.</td>
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<tr>
<td></td>
<td>2.2. Mental Health: Strengthen national capacities to scale up mental health services to prevent, diagnose, treat and rehabilitate people with mental health problems and work with partners to implement national mental health action plan.</td>
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<td></td>
<td>2.3 Migrant health: Increase access of migrants to health services and prevent introduction of noble or reintroduction of eliminated disease transmission in the country.</td>
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<td>2.4. Road Safety: Strengthen nationwide road safety campaign through multi-sectoral approach and build capacity on injury surveillance system and trauma care.</td>
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<tr>
<td>3. Ready to respond - addressing the emergencies and accelerate efforts to eliminate priority diseases and promote surveillance</td>
<td>3.1. Emergency preparedness: Support the national and sub-national level capacity building process on emergency preparedness and implementation of the Emergency Response Framework.</td>
<td>Strengthen implementation of a health sector response plan and standard operating procedures for disasters and more frequent emergencies in alignment with national disaster management plans. Advocate reducing and regulating import and availability of food products linked to ill health and chronic diseases, in the market. Coordinate and integrate the management of chemicals especially insecticides, pesticides and fertilizers in the country.</td>
<td>Strengthened national, regional and global capacities for better protecting people from epidemics and other health emergencies and ensuring that populations affected by emergencies have rapid access to essential lifesaving health services, including health promotion and disease prevention. Antimicrobial resistance decreased. Accelerated elimination and eradication of high-impact communicable diseases.</td>
<td>Scaling up capacity development in emergency risk management in countries Building national capacity for preventing and combating antimicrobial resistance Measles elimination and rubella control by 2020 Accelerate efforts to end TB by 2030 Finished the task of eliminating diseases on the verge of elimination (Kala-azar, Leprosy, Lymphatic Filariasis and Yaws)</td>
<td>Governance systems enhanced for improved performance in health care delivery. Growth and development are inclusive, sustainable, increased resilience to climate change and disasters, and contribute to enhanced food, energy and water security and natural resource management.</td>
<td>SDG- 3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks. [IHR capacity and health emergency preparedness] 3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.</td>
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<td>4. Protecting what matters the most: create an enabling environment for safe and healthy living and address specific health issues of children, adolescents and women during reproductive age and beyond.</td>
<td>4.1. Climate Resilience: Raise public and policy awareness on the health impacts of climate change across the entire society, and strengthen national capacity in building health systems resilience to climate change. Advocate and initiate greening of the health sector by adopting environment-friendly technologies, and using energy-efficient services; 4.2. Health of young people: Increase health awareness, improve health seeking behavior and support preconception care and scaling up of adolescent and youth friendly health services through multi-sectoral approach 4.3 Reproductive, maternal and newborn health: Advocate and support quality of care through implementation of MPDSR, ENAP and sustaining birth defects surveillance, prevention and management. Enable reproductive choices for all women and men by supporting the implementation of the reproductive health policy and facilitating the provision of appropriate reproductive health services and information. Advocate introducing new vaccines for well-being of people of the Maldives.</td>
<td>Monitor health impacts of climate change and develop strategies for reorienting programmes to address the emerging health issues. Develop strategies to reduce the carbon footprint related to health care services in alignment with national strategies. Empower young people to plan their pregnancies and seek health care from pre-conception, during the pregnancy and postnatal period through targeted health promotion, education and skill development. Provide access to essential obstetric and neonatal care services at all levels of health system and mechanism to access care in obstetric and neonatal emergencies. Monitor reproductive, maternal and child health morbidities and mortalities through facility and programme level data and population based research.</td>
<td>Health impacts of climate change, environmental risks and other determinants of health addressed, including in small island developing States and other vulnerable settings. Ending preventable maternal, newborn and child deaths with a focus on neonatal deaths. Growth and development are inclusive, sustainable, increase resilience to climate change and disasters, and contribute to enhanced food, energy and water security and natural resource management. National and subnational authorities have enhanced institutional and human capacity to offer equitable and quality child and youth friendly health services, including nutrition, child health, AYSRH, HIV/AIDS. Strengthen institutional capacity to prevent malnutrition and provide comprehensive child nutrition interventions, especially in the regions with high malnutrition rates.</td>
<td>SDG-3.9 Substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination SDG-3.1. Reduce the global maternal mortality ratio SDG-3.2 End preventable deaths of newborns and children under 5 years of age SDG-3.7. Ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.</td>
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</table>
The fourth Country Cooperation Strategy (CCS) is WHO’s medium term strategic vision and provides a framework for organizational collaborative work on health and development with the Government of Maldives and partners.

Informed by the changing epidemiological, demographic and economic transition and taking review and analysis of evolving health and development context, the CCS builds on extensive multi-stakeholder consultations, lessons learnt from implementation of previous CCS and is guided by the principles of equity and results driven approach.

To address the emerging health challenges and empower people to lead healthy lives, four strategic priorities are identified keeping WHO’s comparative advantage and value addition to address cross-cutting and intersectoral challenges to further health and development agenda in the country:

- Transforming health systems
- Promote well-being
- Ready to respond
- Protecting what matters the most

Using the CCS as a tool for multisectoral engagement, stimulating high level policy work and promoting integrated approaches to achieve health related SDGs, the WHO Country Office Maldives and the Government of Maldives are committed to work more closely for the well-being of the Maldivian people.