

MALDIVES

SECTION 1: TRENDS IN POLICY DEVELOPMENT

In the Maldives health is considered a basic right of every citizen and the government emphasizes the goal of *health for all* based on the primary health care approach. The island nature of the country poses a major challenge to providing equitable access to health care. To overcome this geographical barrier, Maldives established a four-tiered health care delivery system. Now, with the expansion of health care services, it is being re-organized into a five-tier referral system, beginning 2001. The potential doubling of the population every 20 years was considered a matter of grave concern, and the government has been working to reduce the rate of population growth through more active promotion of population control and educational programmes. Special importance is also given to the preservation of the environment, the concept of regional development, the central role of human beings and their quality of life, the basic right to health and education, the involvement of the people at community level, and the role of women in development. Given that health is a basic human right, the health policy of the government aims to further increase life expectancy by reducing preventable deaths, disease, suffering and disability, and to improve the quality of life. The health sector's vision is reflected in the National Vision 2020 statement that reads: "The people will have greater awareness of and commitment to healthy lifestyles. Good quality medical care will be available to all citizens in the area in which they live, and they will have easy access to a health insurance scheme that will enable them to meet their medical expenses." Necessary measures will be taken to provide and maintain public health needs and services within the overall framework of a sustainable health system.

SECTION 2: TRENDS IN SOCIOECONOMIC DEVELOPMENT

2.1 Economic trends

The Maldivian economy is characterized by its narrow base. It is based on fisheries and tourism, which account for more than 30% of the GDP and are the major sources of foreign exchange and government revenue. Health expenditure as a proportion of the national budget increased from 8.7% in 1998 to 10.9% in 2000.

2.2 Demographic trends

The population of Maldives was 270,101 in 2000. Between 1995 and 2000 the average annual population growth rate was 1.96%. Despite a declining population growth rate during the decade 1990-2000, it is still high and alarmingly significant given the size of the country and the available resources. The total fertility rate (TFR) continued at 5.4 during 1990-95, but has since reduced to 2.8 in 2000. The country is in the second stage of demographic transition. The crude death rate (CDR) declined from 6 per 1000 population in 1990 to 4 in 2000, and the crude birth rate (CBR) from 41 to 20 during the same period. The singulate mean age at marriage in 2000 was 24 and 18.9 years for males and females respectively. In 2000 the population below 15 years was 40.7% and above 65 years of age 3.7%, resulting in a high dependency ratio. In the same year, the average life expectancy at birth for males was estimated at 70.7 years and for females 72.2 years.

2.3 Social trends

The emphasis on education during the past 10 years was considerable. Primary school enrolment is over 98% and secondary school enrolment 44%. The literacy rate in the 10-45 years age group was 98.94 (1999). The proportion of females in the labour force increased from 27% to 34% during 1995-2000. Although there is no discrimination in the employment of women, in certain situations, such as for executive level jobs, men clearly have the advantage. Labour conditions continue to be

characterized by excess demands for both skilled and unskilled labour. As a result there is increased reliance on the use of expatriate labour, which in 1995 accounted for more than 25% of the total.

The Faculty of Health Sciences (previously, Institute of Health Sciences) provides basic professional training within the country for major categories of allied health professionals. The institute was re-designated when it came under the umbrella of the newly establishment Maldives College of Higher Education in 1999.

The Maldives accreditation Board was established in 2000 to support the development of a national framework for qualification and a mechanism for quality assurance that would, among other things, allow private parties to offer diploma and degree level academic programs.

2.4 Food supply and nutritional status

Maldives has achieved considerable success in achieving food security and food availability. Nevertheless, nutritional problems continue to exist. A survey (MICS2 -2001) showed that 25% of children under five years of age were stunted, 30% were under-weight. Anaemia too is common and available statistics indicate that 52% of children, 55.4% of pregnant women and 49.6% of non-pregnant women are anemic (MICS2 2001). A national action plan for nutrition and food security has been formulated which includes intersectoral action in support of food security and nutrition.

2.5 Lifestyle

Lifestyles started changing in the 1980s with the rapid development of the country. People's awareness on health matters increased, especially in the areas of preventing communicable diseases. However, certain unhealthy lifestyles such as insufficient physical activity and exercise, increased consumption of fast and junk food and insufficient relaxation have emerged, and adolescent health has become a major issue.

Ministry of Health has identified promotion of healthy lifestyles as the priority public health function and is implementing it through multiple approaches. These include special School Health Programs (eg. Anti-Tobacco School Campaign) and multisectoral interventions (eg. Sports for All) as well as the use of mass media and community based interventions. A 5-year national nutrition strategic plan was developed in 2001 to address the issue related to nutrition.

Substance abuse has emerged as a major problem. To give greater emphasis to the problem, a Narcotic Control Board (NCB) was established in 1997 under the direct supervision of the President's Office. The responsibilities for co-ordinating demand reduction efforts, management of rehabilitation programs and maintaining liaison with national and international drug control and law enforcement agencies were entrusted to NCB.

SECTION 3: HEALTH AND ENVIRONMENT

3.1 General protection of the environment

Health and environment taken together is an emerging area that has still to be reflected in health plans. A National Plan of Action for Health and Environment has recently been drafted, and awaits approval from the President's Office. Air pollution, both outdoor and indoor, is a major concern due to dust, smoke, and fumes from motor vehicles. Noise pollution too is a growing problem. A comprehensive system for collection and disposal of solid waste that is environmentally sound is an urgent need.

The question of food safety is now receiving attention and with WHO assistance food safety regulations have been drafted, but are still to be approved and implemented. No regulations exist for

the proper labeling of imported items. Overall there is an urgent need to formulate a comprehensive food act that will ensure safety of food and drink.

Congestion in Male is a risk factor for the spread of disease. Over 74,000 residents in Male live on 1.8 square miles of land, creating health, psychological and social problems. There are no statistics to assess work-related health problems and there are no legal provisions for either the protection or compensation of workers.

3.2 Water supply and sanitation

Maldives, with many small, highly dispersed islands, has limited sources of drinking water. The main sources are ground, rain and desalinated water. In 1994 the national target for water supply (2 litres per capita per day for drinking purposes in the dry period) had been achieved for the whole country.

This target has since been increased to 4 litres per capita (to include water for cooking purposes).

Overall, 77% of households have access to safe drinking water, the main source being rain water (63%). Urban/rural disparities, however, exist. Male (urban) has achieved 100% access to safe drinking water, though ground water contamination from sewage is still a major problem. It is estimated that 80.5% of households in the country have sanitary means of excreta disposal.

However, sanitation is still a major problem in the island communities, where the Gifili system (hole in the ground) or the beach is often used for defecation. Even households with sanitary latrines often depend on septic tanks that contaminate the ground water. To address this problem, a small-bore sewerage system has been completed in three islands so far.

SECTION 4: HEALTH RESOURCES

4.1 Human resources for health

An acute dearth of skilled personnel is a major constraint for sustainable health development in Maldives. In 2000 there were 226 doctors in the country giving a ratio of 8.4 per 10,000 population. However, more than three quarters of the doctors are expatriate. The number of registered nurses was 358 and other nurses 204 (2000). At the community level there were 825 locally trained health workers in 2000, including health assistants, nurse aides, auxiliary nurse midwives (ANMs), community health workers (CHWs), family health workers (FHWs) and traditional birth attendants (TBAs). There were 106 pharmacists (including pharmacy assistants) in 2000. Over 90% of health professionals are employed in the public sector (81% of all doctors and 91% of nurses).

Government has given high priority to HRH development in allocating resources, both its own as well as external, for in- country and training abroad. The out put was highest in the training of medical doctors and diploma level nurses, and lowest in the training of CHWs, paramedical and management personnel. The vertical training program for these categories failed to produce sufficient personnel to sustain the health status achieved during last two decades.

Priority categories for human resource development have been doctors, CHWs, nurses, paramedical and management personnel. There have been policy changes vis-à-vis in-country training in order to meet the shortage of community health workers (CHW). In 2001 about 23 candidates were sent to Sri Lanka for training in community health. The CHW curriculum has been revised.

The emphasis is now towards training of preventive, management and paramedical support staff. However, due to financial resource shortages the actual training conducted in these categories has been limited. Main sources of finance were WHO, UNFPA and Government budget. A large share of the WHO budget was spent for training of health personnel.

4.2 Financial resources for health

Health expenditure increased in the 1990s while revenue generated by this sector continued to remain low. The system of free government health care, which conferred many benefits, was under serious

strain, particularly following the addition to the government health infrastructure of an externally funded hospital in Male (Indira Gandhi Memorial Hospital - IGMH). Options that were promoted to meet this situation included private sector and NGO participation, increased cost sharing with island communities, and the introduction of user fees at the IGMH and regional hospitals.

In the private sector, health care primarily covers outpatient and diagnostic services. In 1996 the first private hospital with 40 beds was opened in Male. The government depends heavily on external funding for capital investment and human resource development in the health sector. The government health expenditure as a proportion of the total government expenditure increased from 10% in 1995 to 10.2% in 2000. The per capita expenditure on health was \$89 in 2000.

4.3 Physical infrastructure

In 2000 there were two hospitals in Male, and 5 regional hospitals, 3 atoll hospitals and 40 health centres (with beds) in the atolls. The total number of hospital beds was 470 giving a population to bed ratio of 577. In addition there were 30 private clinics in Male and 17 in the atolls. The Institute of Health Sciences was upgraded as the Faculty of Health Sciences of Maldives College of Higher Education in 1999. National Thalassaemia Centre was established in 1991.

The existing health infrastructure development suffers from a lack of foresight at the planning stage, which has resulted in future needs not being anticipated. Most islands do not have a health post from which the FHW can work. Food An acute shortage of biomedical expertise has created major problems with the maintenance and repair of equipment.

A Public Health Laboratory was established and became functional during 1998. It has facilities for water quality analysis, microbiological investigation of food samples, and diagnostic tests for disease control programs. The laboratory is also responsible for quality of control of fish exports.

4.4 Essential drugs and other supplies

As the Maldives lacks any drug manufacturing capacity all drugs are imported, either by the private or public sector. Procurement to government health facilities is done by the government procurement entity, the State Trading Organization (STO). In parallel to this, the private sector also imports and distributes to private pharmacies in Male and throughout the Maldives. Drugs meant for regional hospitals are procured from STO and distributed by the regional hospital section of the Ministry of Health, while drugs meant for health centers are similarly procured and distributed by the medicinal supplies section of the Department of Public Health.

There are 146 pharmacies in the Maldives, of which STO runs a single hospital pharmacy in the main referral hospital, IGMH. There are 46 pharmacies in the capital Male. However many islands do not have pharmacies. The bulk of drugs are financed by out of pocket payments, except for certain drugs used in tuberculosis and thalassaemia. The Maldives has a regularly updated the essential drug list and both the private and public sector are authorized to import only those included in the list. Since the beginning of 2002 Ministry of Health has also instituted individual pharmaceutical product registration.

A national drug policy has been launched and a draft formulary has been prepared. Drug utilization reviews are continuously done. Ministry of health also conducts regular workshops on rational drug use for health personnel in the country. Additionally, Ministry of health also conducts orientation interviews and provides rational drug use literature to all newly recruited doctors and pharmacists.

In order to ensure affordability of drugs, Ministry of Trade and Ministry of Health have set a ceiling on retail price markup, the maximum allowed being 50% of cost-insurance-freight (CIF) value.

4.5 International partnerships for health

During the last decade a series of meetings were held with the donor community. The first was in Geneva in 1989, followed by a number of meetings in Colombo, actively assisted by UNDP. In 1995, with WHO assistance, a document "Towards sustainable development of health" was presented at a donor meeting, which stimulated considerable interest. International assistance is critically needed for the reduction of maternal mortality, control of communicable diseases, nutrition, water and sanitation, and, particularly, development of human resources for health.

SECTION 5: HEALTH SYSTEMS DEVELOPMENT

5.1 Health policies and strategies

The Government of Maldives considers that the enjoyment of the highest attainable level of health is a basic right of every citizen. It lays emphasis on the accessibility and affordability of health care services and the health of women and other vulnerable groups in society. The government is committed to the goal of *health for all* and the goals set out at the World Summit for Children, the Earth Summit, the International Conference on Population and Development, the Social Summit and the International Conference on Women and Development. The government also recognizes that the PHC approach is the most appropriate path to the attainment of these goals. In the area of population and family planning, there has been a recent broadening of policy focus to include efforts at controlling population growth, along with the pre-existing objective of reducing reproductive health risks.

There is also a move to expand curative services to establish a 5 tier referral system, which is more decentralized, and which has greater NGO and private sector involvement in service delivery. Efforts are also being made to establish a social security system that includes basic health care and to encourage individual organizations to establish mechanisms to cover the health expenses of their employees.

5.2 Intersectoral cooperation

There are many areas where close links have been established between health and other sectors to achieve a common goal. For example, the MOH and Ministry of Education work closely on school health, MOH and the Ministry of Trade, Industries and Labour cooperate in food safety and sanitation, MOH and the Ministry of Atolls Administration collaborate in delivering health services at peripheral level, etc. The National AIDS Council has representation from all related sectors including NGOs. Since health receives priority in the country, the subject is included in all developmental plans, with the objective of fostering intersectoral cooperation for health. Recent outcomes of these efforts have been the development of 5-year strategic plans for priority issues such as health and environment, nutrition and HIV, as well as the mid-term review of Health Master Plan (1996-2005).

5.3 Organization of the health system

Health services are organized into a four-tiered system comprising central, regional, atoll and island levels. However, with the expansion of health services, atoll hospitals are being established, beginning 2001, changing the system to a 5-tier system. At the top of this pyramid is the MOH, under which are the DPH, IGMH, National Thalassaemia Centre (NTC), and Maldives Water and Sanitation Authority. At the regional level are 5 regional hospitals, each catering to 2-5 atolls. At Atoll level are the atoll health centres staffed by doctors and CHWs. Some of these health centers have recently been upgraded as atoll hospitals in order to provide emergency surgical facilities. An upgrading programme is currently underway to provide inpatient and enhanced maternal health care services. At island level, health services are provided by FHWs and *foolhumaas* (TBAs).

5.4 Managerial process

The MOH is responsible for formulating overall health policy and health development plans for the country, in addition to monitoring and evaluation of the health situation. The DPH is responsible for implementing preventive and promotive health programmes and for delivering basic health care services to the atolls and islands. Medium term (5-year) National Development Plans are guided by Maldives Vision 2020. Planning within the health sector is guided by Vision 2020, National Development Plans and Health Masterplan 1996-2005. Based on these a number of 5-year strategic plans have been developed for specific issues. Monitoring and evaluation is done at Ministry and Departmental levels.

5.5 Health information system

Efforts have been made to improve and strengthen the health information system. These mainly include introducing standardized formats for reporting and building capacity for data management at different levels of the health care delivery system. The vital registration system was reformed during 2000 and 2002 to improve accuracy and efficiency of reporting and record keeping. Efforts are also being made to improve two-way communication within the HIS. The communicable disease surveillance system has started producing and delivering monthly feedback reports to service points.

Ministry of Health publishes an annual health report based on data collected through the HIS. It uses compiled data to reflect major health issues and trends, and supports evidence-based health planning.

During the last five years a number of health researches have been carried out in the areas of reproductive health, maternal and child health including nutrition, access to safe water and sanitation and child rights indicators. Thus appropriate data is available for planning, through the routine reporting system as well as surveys.

Despite these improvements, the HIS faces major constraints due to lack of trained personnel particularly at the peripheral levels of service provision. Building capacity at those levels would enable addressing local health issues more appropriately.

5.6 Community action

In the Maldives the process of community organization and action has resulted in the official establishment of island development committees, women's development committees, and atoll development committees. These community groups have been instrumental in setting up drug cooperatives, raising funds for nutritional activities, and providing finances and labour for construction of health facilities, water tanks, etc. Community based organizations such as youth clubs have been active in health areas like tobacco and physical exercise at the island level.

5.7 Emergency preparedness

Maldives has national plans to meet certain kinds of emergency situations, such as plane crashes, oil spills and tidal waves. A multi-sector task force has been set up to promote preparedness and collaboration for emergencies. There is no systematic plan for management of epidemics, which remains *ad hoc*. Currently an intersectoral task force has been set up to promote preparedness and collaboration for emergencies. An epidemic emergency preparedness plan will form part of the National Disaster Management Plan.

5.8 Health research and technology

A number of researches have been carried out in the recent past, mainly to assess prevailing situations in reproductive health, nutrition and some other disease conditions, along with assessing knowledge, attitude and practice.

Almost all these researches have been carried out with expatriate technical assistance, as the country does not have appropriately trained personnel. Focus has not been given to clinical based research mainly due to lack of appropriate resources and manpower. However, this is an area the country needs to focus.

SECTION 6: HEALTH SERVICES

6.1 Health education and promotion

Health education is integrated into all public health programmes and is part of the curriculum of all preservice courses conducted at the IHS. The responsibility for health education was transferred in 1994 from the IHS to the DPH, but the situation with regard to the lack of human and financial resources has not changed significantly. International collaboration exists between the three key ministries of Health, Education and Information and Culture. Health education and promotion has been strengthened by a newly established media committee involving all concerned ministries and NGOs. Special emphasis is given to the areas of safe motherhood, child survival, prevention of thalassaemia and other non-communicable diseases (NCDs), reproductive health and family planning, prevention of substance abuse, and the promotion of healthy dietary habits and regular exercise.

6.2 Maternal and child health/family planning

Maldives has recognized the health and developmental needs of women by upgrading the Department of Women's Affairs to a Ministry of Women's Affairs and Social Welfare. As a result of the safe motherhood programme the maternal mortality ratio (MMR) has come down from over 400 per 100,000 live births in the early 90s to 75 in 2000. The proportion of deliveries in health care facilities is reported to be 60%. The major factors associated with the high maternal mortality are the geographical nature of the country, which makes access to essential obstetric services difficult in emergency situations, iron deficiency anaemia, late referral, and multiparity often associated with closely spaced pregnancies.

With the change in population policy during the early 90s, the commitment to promote family planning has increased, and annual population growth rate has come down from over 3% before 1990 to 1.96% in 2000, though much still needs to be done. At island level, access is available only to a limited range of family planning services, with the full range of contraceptive methods available at the central and regional hospitals. Contraceptives are provided free of charge to the consumer at all levels of the health care delivery system. The post ICPD goals and the broader concept of reproductive health are currently being incorporated into the health services programme in Maldives.

6.3 Immunization

High levels of immunization coverage have been achieved for the vaccine-preventable diseases of childhood, ranging from 98% for DPT, 98% for OPV, 99% for measles and 99.5% for BCG (2000). Proportion of pregnant women immunized against tetanus was 94% (1995).

6.4 Prevention and control of locally endemic diseases

Maldives has remained malaria free since 1984. Other mosquito-borne diseases however continue as public health problems in varying degrees. Filariasis has been brought under control with no cases reaching advanced stages of the disease. Dengue continues to be endemic. An effective vector control programme continues to be sustained. The other diseases of public health concern are tuberculosis and leprosy. The DPH runs special programmes for the control of locally endemic diseases such as tuberculosis, leprosy, malaria and filariasis. Drugs required for these disease control programmes are provided free of cost to all registered patients.

The goal for the tuberculosis (TB) control programme is to reduce disease prevalence from 0.66 to 0.1 per 1000 population. The main strategies are intensified case detection, both active and passive, standardization of management, treatment of cases including children exposed to sputum positive

cases, and introduction and expansion of directly-observed treatment, short course (DOTS) to all diagnosed cases.

The goal of the leprosy control programme is to achieve and maintain 100% multidrug therapy (MDT) coverage for all diagnosed cases until zero incidence is reached. The main strategies are an effective surveillance system, increasing awareness on leprosy prevention and control, and early identification and management of cases.

A national system of disease and epidemic notification on a daily basis has been established throughout the country. For selected diseases, like AIDS and the EPI-target diseases, sentinel surveillance sites have been introduced.

6.5 Treatment of common diseases and injuries

The tertiary care hospital in Male (IGMH) serves as the highest referral centre in the country. Five regional hospitals provide medical care and overall health care at regional level, including supervision of atoll hospitals and health centers. At present there are 4 atoll hospitals and 40 atoll health centres with both preventive and curative services, which include the management of common medical problems, maternal care and the treatment of minor surgical conditions. Until recently these centres were entirely managed by CHWs, but from 1993 doctors have been posted to these centers for medical services. At island level, health care is provided by FHWs and trained TBAs. The FHWs are initially trained for six months in simple curative and preventive care and supplied with a restricted list of drugs which include anthelmintics, iron, folic acid, aspirin, paracetamol and septran (for management of ARI). In some of the larger islands, private clinics are run by doctors, and people also have recourse to the use of community or private pharmacies.

Accidents and injuries are mostly minor, resulting from day-to-day living. The more serious accidents are due to fishing boat beachings/launchings, falls from coconut palm trees, and domestic burns/injuries following kitchen accidents and careless handling of petrol or kerosene.

SECTION 7: HEALTH STATUS

7.1 Life expectancy

Life expectancy at birth has increased to 70.7 years for males and 72.2 years for females (2000). According to population projections, the elderly population will increase by 40.8% by the year 2005, and will place further demands on the country's health and social welfare services.

7.2 Mortality

Over the past decade, the crude death rate (CDR) declined to 4 per 1000 population, largely due to the reduction in deaths due to communicable diseases. The infant mortality rate (IMR) also declined over the past decade, from 78 per 1000 live births to 21 (2000), with about 60% of infant deaths occurring in the neonatal period. The under-five mortality rate declined to 30 per 1000 live births (2000). Adolescent pregnancies, inadequate antenatal care, lack of trained personnel, closely spaced pregnancies, and limited access to emergency obstetric care are some of the main reasons for high maternal mortality. Disease specific mortality for the year 1995 lists diseases of the circulatory system as the leading cause of death followed by respiratory diseases.

7.3 Morbidity

Acute respiratory infection (ARI) is one of the major health problems among children and adults. Tuberculosis (TB), regarded as one of the most fatal diseases in the history of Maldives, has still not been brought totally under control. The TB prevalence rate of 35 per 1000 population in 1974 declined to 0.66 in 1995. Childhood tuberculosis is almost zero for the past three years due to the high BCG coverage of infants. Leprosy is well under control since the introduction of multidrug therapy in 1983. The prevalence rate for leprosy was 0.3 per 1000 population in 1995. With the successful implementation of the expanded programme on immunization (EPI), the vaccine-

preventable diseases of childhood are well under control. No indigenous polio cases have been reported since 1981. The spread of HIV/AIDS is still at an early stage. Worm infestation is high in the country and 50-75% of children below five years of age are estimated to be affected by intestinal parasites.

Maldives has one of the highest incidences of thalassaemia in the world. One out of every six persons is a thalassaemia carrier and about 60 to 70 children are born every year with the disease. Needless to say, significant efforts are focused on this disease. Cardiovascular disease and cancer are also perceived as important problems and an increasing trend is expected in the future. It is estimated that 37.4% males and 15.6% of females use tobacco (smoking survey 2001). The promotion of healthy lifestyles will be the main emphasis in the prevention of these noncommunicable diseases.

7.4 Disability

Physical disability, blindness, deafness and mental illness are the most common causes of disability. At present, efforts are underway to strengthen psychiatric services in the country and to expand physiotherapy facilities at the IGMH.

SECTION 8: OUTLOOK FOR THE FUTURE

8.1 Overall assessment and strategic issues

There have been remarkable achievements made in the health status of the people. The successful implementation of the EPI has resulted in a major decline of the vaccine-preventable diseases of childhood. Other public health programmes aimed at prevention and control of communicable diseases have yielded good results, thus contributing to the quality of life of the people. Life expectancy has risen sharply while infant mortality has declined steeply. However, maternal mortality and fertility have remained high. Following a shift in the population and family planning policy to include the control of population growth, the growth rate has come down to 1.96%. In keeping with the government policy that health is the basic right of every citizen, the main goal has been to improve the quality of life by reducing preventable diseases, dealing with disease problems, and minimizing disabilities. Also emphasized are strategies to promote healthy lifestyles to address some of the noncommunicable diseases that have now become significant health concerns. Human resource development has been given high priority, but a shortage of qualified health personnel still remains a major constraint. To meet this situation the government has attempted to increase in-country training capacity, as well as utilize training opportunities abroad and the services of expatriate health personnel. The four-tiered system of health care delivery is being re-organized into a 5-tier system to improve accessibility. Inter sectorial collaboration for health is actively promoted. The economy of the Maldives has been progressing well with a GDP growth rate of approximately 6%, but the economy has a narrow base, which makes it sensitive to external factors. External aid received by the country, as well as the number of donors, have shown a downward trend in recent years. To counter this the government, in collaboration with WHO and UNDP, has taken the initiative to improve collaboration with donors.

8.2 Futures vision

The health sector's vision is reflected in the National Vision 2020 statement that reads: "the people will have greater awareness of and commitment to healthy lifestyles. Good quality medical care will be available to all citizens in the area in which they live, and they will have easy access to a health insurance scheme that will enable them to meet their medical expenses."

8.3 Proposed strategies

There are a number of improvements in health resources and in the development of the health system that are likely to impact positively on the health system. These include health education and promotion programmes focusing on behavioral change and promoting healthy lifestyles. Nutrition status would be improved focusing again on behavioral change. Family and reproductive health

would take the form of a comprehensive package of quality services. Expanded programme on immunization would be further strengthened and expanded; disease control programmes would focus attention on tuberculosis, HIV/AIDS, ARI and leprosy as well as selective and cost effective vector-control measures. Port health and disease surveillance would be strengthened as measures to sustain the success in controlling communicable diseases and preventing import of new diseases into the country.

Non-communicable diseases will be addressed through IEC by promoting healthy lifestyles and adopting other key strategies aimed at early recognition and management of hypertension and diabetes, improving knowledge and screening services for cancer, all aspects of curative and preventive services with regard to thalassaemia, providing mental health services at central level and outreach services to regional hospitals, and better treatment for common diseases and injuries, improving environmental health and prevention of occupational hazards.

Measures will be taken to sustain and strengthen the existing health infrastructure, to develop human resources, to improve quality and to develop managerial capability and capacity to manage specific health programmes and activities at atoll and island levels. Promoting equity and fair financing of health care would be addressed through the development of a health insurance scheme. Rational use of appropriate technology such as telemedicine will also receive attention. International partnerships for health will be continued by strengthening links with current development partners and seeking fresh links with new donors. Private sector participation in service provision would be promoted.



The boundaries shown on the above map do not imply official endorsement or acceptance by the World Health Organization.

Country Reported Data for Basic Health Indicators

Indicator	Latest available data	Year	Source	Remarks
Population and Vital Statistics				
Total population	270,101	2000	9	Census results
Sex ratio (males per 100 females)	103	2000	1	
Population under 15 years (%)	40.7	2000	1	Computed value
Population 65 years and above (%)	3.7	2000	1	
Crude birth rate (per 1000 population)	20	2000	1	
Crude death rate (per 1000 population)	4	2000	1	
Annual population growth rate (%)	1.96	1995-2000	1	Exponential rate
Total fertility rate (per woman)	2.8	1995-2000	9	
Urban population (%)	27.4 ^a	2000	1	
Socioeconomic Situation				
Gross domestic product per capita (US\$)	1,965	2000	1	At constant 1995 prices
Adult literacy rate (%)	98.94	1999	1	
Prevalence of low birth weight (weight <2500 grams at birth) (%)	17.6	2001	10	
Prevalence of underweight (weight-for-age) in children <5 years of age (%)	30	2001	10	
Prevalence of stunting (height-for-age) in children <5 years of age (%)	25	2001	10	
Environment				
Population with safe drinking water available in the home or with reasonable access (%)	76.5	2001	10	
Population with adequate excreta disposal facilities available (%)	85	2001	10	
Health Resources				

Indicator	Latest available data	Year	Source	Remarks
<i>Facilities</i>				
Number of hospital beds	470	2000	1	
Population per hospital bed	577	2000	1	Computed value
Hospital beds per 10,000 population	17.4	2000	1	
Number of health centres	40	2000	6	
<i>Human resources</i>				
Number of physicians	226	2000	6	
Population per physician	1195	2000	6	
Physicians per 10,000 population	8.4	2000	6	
Number of staff nurses	358	2000	6	
Number of other nurses	204	2000	6	
<i>Budgetary resources</i>				
Total Expenditure on Health (THE) as % of Gross Domestic Product (GDP)	7.2 %	1998	8	
Public Expenditure on Health (PHE) as % of Total Expenditure on Health (THE)	72.3 %	1998	8	
Private Expenditure on Health (PvtHE) as % of Total Expenditure on Health (THE)	27.7 %	1998	8	
Public Expenditure on Health (PHE) as % of General Government Expenditure (GGE)	10.0 %	1998	8	
Social Security Expenditure on Health (SSHE) as % of Public Expenditure on Health (PHE)	0.0	1998	8	
Tax funded Health Expenditure (TaxFHE) as % of Public Expenditure on Health (PHE)	91.9 %	1998	8	
External Resources for Health (Ext Res HE) as % of Public Expenditure on Health (PHE)	8.1 %	1998	8	
Private Insurance for Health Risks (Pvt ins HE) as % of Private Expenditure on Health (PvtHE)	0.0	1998	8	
Out-of-Pocket Spending on Health (OOPS) as % of Private Expenditure on Health (PvtHE)	100 %	1998	8	

Indicator	Latest available data	Year	Source	Remarks
Per capita Total Expenditure on Health (THE) at official Exchange rate (X-Rate per US\$)	96	1998	8	
Per capita Public Expenditure on Health (PHE) at official Exchange rate (X-Rate per US\$)	69	1998	8	
Per capita Total Expenditure on Health (THE) in international dollars (int'l \$)	211	1998	8	
Per capita Public Expenditure on Health (PHE) in international dollars (int'l \$)	152	1998	8	
Health Services				
Pregnant women attended by trained personnel during pregnancy (%)	93	2001	10	
Deliveries attended by trained personnel (%)	97	2001	10	
Infants attended by trained personnel (%)	95	1995	3	
Women of childbearing age using family planning (%)	42.0	1999	7	Modern methods (32%)
Infants reaching their first birthday that have been fully immunized against diphtheria, tetanus, and whooping cough (%)	98	2000	6	
Infants reaching their first birthday that have been fully immunized against poliomyelitis (%)	98	2000	6	
Infants reaching their first birthday that have been fully immunized against measles (%)	99	2000	6	
Infants reaching their first birthday that have been fully immunized against tuberculosis (%)	99.5	2000	6	
Women that have been immunized with tetanus toxoid (TT) during pregnancy (%)	94	1995	3	Two doses
Health Status				
Life expectancy at birth (years): Total	71.4	2000	1	Based on population census data
Male	70.7	2000	1	
Female	72.2	2000	1	

Indicator	Latest available data	Year	Source	Remarks
Infant mortality rate (per 1000 live births)	21	2000	6	
Under-five mortality rate (per 1000 live births)	30	2000	6	
Maternal mortality ratio (per 100,000 live births)	75	2000	6	

^a The population of the capital city of Male'

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