



1. Executive summary

Maldives enjoys a truly Universal Health Coverage with a health facility (PHC) at every inhabited island, treatment offered by a qualified medical doctor and nurse, a pharmacy and majority of islands have laboratory facilities. Regional and Atoll hospitals attend to referred cases from Island Health Centers and offer outreach services to people living in proximity to these centers. All public and private hospitals in the Maldives offer a range of health services, including reproductive health services such as antenatal care with integrated and HIV & Syphilis testing. Complicated cases are referred to tertiary level hospitals like Indira Gandhi Memorial Hospital, ADK Hospital in Male'. Health care costs for citizens are borne by the government. Every citizen of the Maldives is covered under Aasandha insurance scheme, both in the country and abroad at empanelled centers. As per the latest estimates from NHA 2014, Maldives spent little over 9% of its GDP on health care.

All health services including preventive services are integrated into the general health system. The facilities are equally accessible to everyone living in the country, both Maldivians and migrants. Same tests, treatments and algorithms are offered irrespective of the nationality. All births take place in the health facilities and are managed by skilled birth attendants. In very rare occasions, even if a birth takes place outside of health facility, mother and baby are transferred and immediate care is provided at the nearest health facility. Abortions are illegal except under 5 circumstances as stated in the Fatwa endorsed by Ministry of Islamic Affairs. Birth registration is mandatory to obtain Maldivian citizenship and to access various services as a citizen, including accessing health services.

As per the Public Health Act (7/2012) and Health Services Act (29/2015), medical investigation or treatment can be provided only with the informed consent of the health care seeker or of the parent in case of minors. A consent form has to be signed by the service seeker to do an HIV test, though for syphilis, only verbal consent is sought. Although every pregnant woman attending ANC is encouraged to test for HIV and syphilis, they have option to 'opt out'. A high rate of compliance with recommendations of healthcare personnel is observed in the country.

The National Strategic Plan for the Prevention and Control of HIV/AIDS (2014-2018) guides the national efforts to maintain the low prevalence of HIV in the Maldives (**Annex 1**). The elimination of mother to child transmission (EMTCT) of HIV and syphilis in the Maldives is an important public health milestone reflecting effective and equitable national policies and services that place people first. Universal access to antenatal care and screening for syphilis and HIV is ensured through an extensive network of public sector hospitals, health centres and private health facilities. Prevention of MTCT of HIV and syphilis infection is given special attention within the Reproductive Health (RH) programme (**Annex 2**). An important target is to screen 100% of women attending ANC clinics for HIV and syphilis.

Transmission of HIV and syphilis has been very low in the Maldives. Since the first case of HIV was detected in 1991, the annual rate of new infections has ranged from 0-2 cases per year. During the same period, new cases of syphilis have fluctuated from 0-9 per year. Available data suggests low prevalence of both infections. No case

was found among the 102 sex workers, 168 MSM and 276 PWUD surveyed in BBS 2008. The second BBS is ongoing and results awaited to learn the present situation.

Furthermore, the risk of HIV or syphilis transmission during pregnancy, delivery and postpartum is nearly non-existent as evident from the universal screening of all pregnant women and appropriate management. During the last two years, no women or infants with HIV or syphilis was detected in the Maldives. Antenatal clinic (ANC) attendance and testing is universal. One maternal infection of HIV was detected in 2014 and has been managed successfully in a timely manner to prevent MTCT. Yet, until recently, data systems were insufficiently developed to look into coverage gaps, or the possibility of undetected mother to child transmission. The case for elimination today rests on findings of a two-year nationwide audit of records, which documents the coverage of PMTCT services to be exceeding 98%.

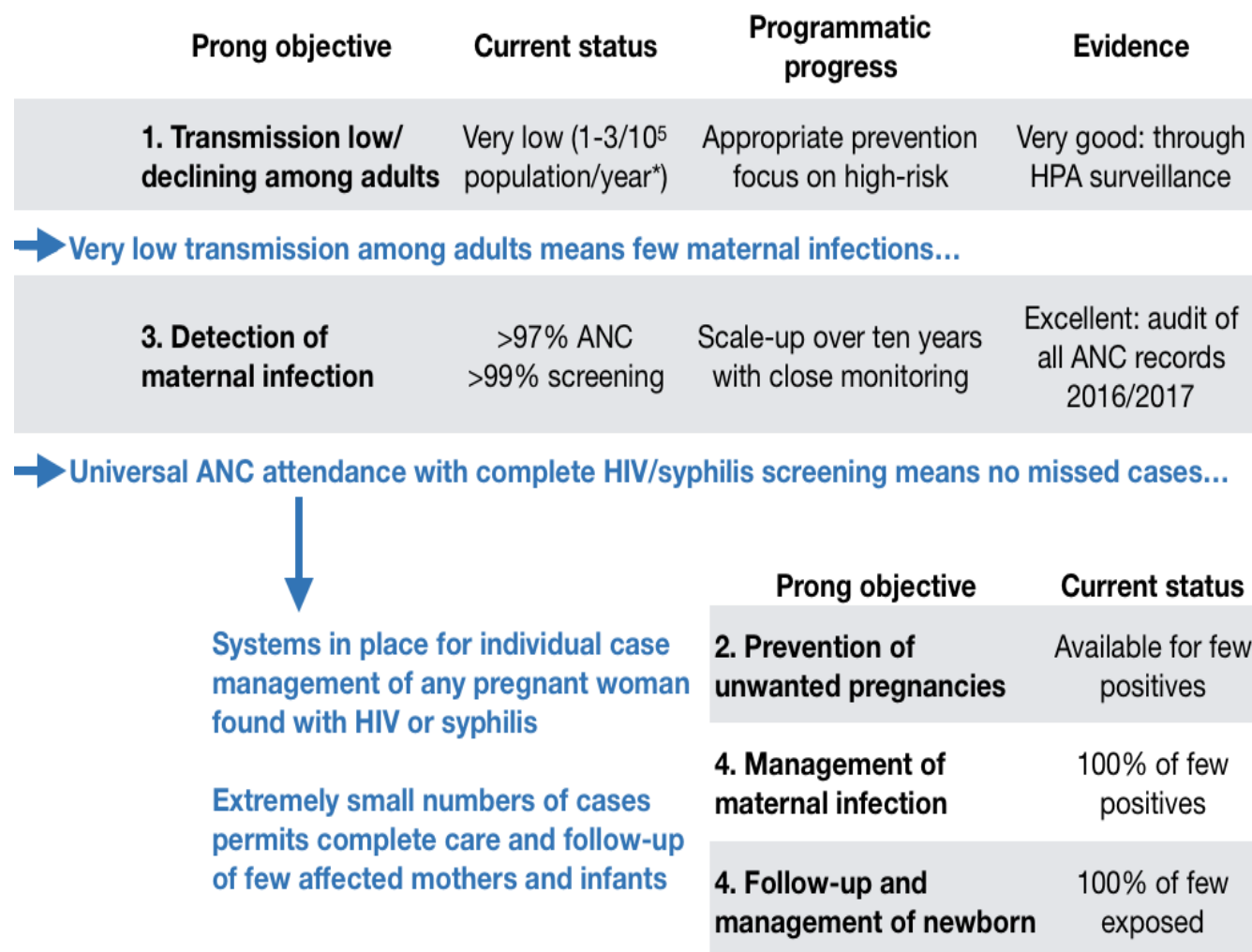
A national validation committee (NVC) and a national validation team (NVT) oversaw the validation process and efforts. The list of members and timelines of activities of NVC are depicted in **Annex 3**. A mixed method strategy with primary and secondary sources, and quantitative and qualitative methods were used for data collection, WHO standardized tools were used to assess areas of programme, data management, laboratory, equity and human rights.

The methods for assessing validation indicators start with routine reporting of HIV and syphilis, among ANC attendees. The lack of an integrated computerized patient ANC record system hinders reliable and timely monitoring of several indicators. To make up for these limitations, an extensive audit of all delivery records across the country was conducted for the years 2016 and 2017 to provide reliable data for the process and impact indicators. During the process of compiling data from different sources, duplicates were identified and addressed through verification of records and applying appropriate data cleaning. Data presented in this report has been analyzed using the National ID of the women seeking reproductive services and the birth record number as unique identifiers. To verify the sustainability of elimination, the EMTCT indicators will be included in the online DHIS-2 database system, which is under development.

The findings of the NVT review confirm that the impact and process indicators for validation of EMTCT of HIV and syphilis meet and surpass the minimum criteria as laid out in the WHO Guidance, with no case of either vertical infection reported during the last two years. Only one case of maternal HIV was detected through ANC screening in 2014, acquired through blood transfusion (details **Annex 5**). The woman received treatment following the national protocol and the newborn remains free of infection. Process indicators show high coverage, exceeding 98% coverage for ANC attendance, HIV and syphilis screening.

The PMTCT programme response in the Maldives adequately addresses each of the four prongs of preventing the transmission (Figure 1). Prongs 1 and 3, in particular, are sufficiently developed to sustain elimination in the future. HIV/STI prevention efforts (P1) prioritize key populations and other vulnerable populations with targeted services as a part of the HIV National Strategic Plan (NSP) (**Annex 1**), while the general population also has free access to a range of related preventive services. Although contraceptive usage is low (35% in 2009) in the Maldives, services (P2) are available to anyone including people living with HIV who needs them. **PMTCT** services during and following pregnancy and delivery (P3) ensure screening and treatment for all pregnant women. The number of women living with HIV (currently only one) is projected to remain very low, and a full range of HIV-related services for them and their families (P4) are provided free of charge, as well as for other PLHIV in the Maldives.

Figure 1: The four pronged approach for prevention of MTCT of HIV and Syphilis



* 0.5 (HIV) and 3 (syphilis) per 100 000 population 2017

Source: National program and audit data

This validation report provides additional details on the national response with attention to the four key areas of programme, data, laboratory and equity& human rights.

Prevention of mother to child transmission (PMTCT) is given very high priority by the government of Maldives, and is supported as a major component of the National Strategic Plan for Prevention and Control of HIV/AIDS, 2014-2018. PMTCT also is given special attention in the Health Master Plan 2016-2025, and is a major focus of the National Reproductive Health Strategy for 2014-2018 and beyond with the planned new strategy.

Management of PMTCT services in the Maldives is undertaken by a multidisciplinary team at central level, coordinated by focal persons at atoll and island level. National PMTCT guidelines, conforming to global guidance, have been developed and implemented across the country since 2013.

Laboratory services are available in majority of the health facilities in the Maldives, which are set up as per the health services grading, and designated facilities with laboratories have HIV and syphilis serological testing capacity. Every HIV, syphilis and hepatitis B and C case detected are reported on detection, to Health Protection Agency (HPA) while other STIs are reported monthly. This initiates immediate follow-up with special investigation to capture details, confirm and start appropriate care and treatment. The national laboratory policy, strategy and operational plans are in the process of being finalized. However, even now, specific disease quality assurance processes are practiced in the national laboratory system. Internal quality assurance exercises are conducted at facility level by IGMH. IGMH coordinates with regional level laboratories in quality exercises and maintains a network with selected overseas laboratories (NRL, Australia) following standard protocols. The Maldives Blood Services also participates in EQAS.

Equity and human rights are fundamental principles of public health in the Maldives. The STI/HIV programme within HPA has recently strengthened outreach efforts to key populations, including addressing stigma and discrimination in health care settings. Access to both screening and treatment services for HIV and syphilis is universal. The majority of new HIV and syphilis infections have been found among expatriates who are screened for selected diseases such as TB, HIV, Hepatitis and STIs. As part of the work permit acquisition process, on arrival, employer facilitates the migrant worker to undergo the medical checkup process, and then annually for renewal of work permits. Those detected positive during their stay in the Maldives receive free treatment for HIV and TB from the national programme while treatment related costs for other diseases are covered by employer-provided health insurance for the duration of their contracts. The validation activity found that 10% of all the migrants who sought services at IGMH during 2013-2017 were 'irregular' migrants (without valid work permits), which suggests that health care is often provided on humanitarian grounds.

In summary, the report of the National Validation Committee (NVC) confirms that no cases of MTCT of either HIV or syphilis were reported in the last few years in the Maldives. Furthermore, the findings of the nationwide audit of 2016 and 2017 data confirms universal ANC attendance, and >98% screening for both HIV and syphilis. This data includes women who delivered and received antenatal care in the private sector, which accounted for approximately 12% of pregnancies. Process indicator results from the lowest-performing subnational unit were 100 % for ANC attendance and HIV/syphilis screening for both 2016 and 2017, captured through the data audit in 2018. The lowest performing unit was chosen based on performance of other public health programme indicators like timeliness, completeness, accuracy of reporting and overall coordination, even though ANC coverage and testing in this unit was similar to the rest of the country.

Sustainability of these achievements is assessed to be strong based mainly on establishment, within an efficient and equitable public health system, of solid prong 1 and 3 services across the country. Incidence and prevalence of syphilis and HIV are among the lowest in the region due to strong prevention efforts. National level coordination and country wide access to ANC testing, accessible through an affordable universal health care system, helps in maintaining very high levels of ANC and testing coverage. Several potential risks to sustaining EMTCT have been identified and are being addressed by the programme.

The NVC recommends to RVC and GVAC for validation of Elimination of MTCT for HIV and syphilis in the Maldives as the requisite milestones, both on process and impact targets, have been achieved. .

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2. Country context

Geography

The republic of Maldives is an archipelago in the Indian Ocean located about 600 Km south west of India and Sri Lanka. It consists of approximately 1,192 coral islands grouped in a double chain of 26 atolls, spread over roughly 90,000 square Kilometers, making this one of the most dispersed countries in the world. The coral islands of Maldives form a chain 820 km long and 120 km wide. The total land area is 298 sq. km of which only 10% are suitable for agriculture. Most of the islands are small, few with a land area in excess of one square kilometre. On average, each atoll has approximately 5 to 10 inhabited islands; the uninhabited islands of each atoll number approximately 20 to 60.

Transport between the islands is commonly by boats payable by the traveller, which adds to the financial burden of accessing higher levels of health care and justifies the government's decision to locate a health facility on each inhabited island.

Demography

The Maldives has an ethnically homogenous population of 338,434 dispersed over 198 very small islands. Only 4 islands have a population exceeding 5000, and 51 of the islands (27%) are populated by less than 500 people. Two thirds of the population live near and around the Greater Malé region making it a crowded and congested capital city (NBS, 2018).

The latest Census in 2014 shows an increasing bulge in the adolescent and youth proportions of the population pyramid compared with the 2006 Census. The total fertility rate has declined from 6.4 in 1990 to 2.2 child per woman in 2014. The sex ratio of males per 100 females has been stable during the past 25 years with 107 in 1990 and 103 in 2014. The 2014 Census shows that there was one foreign migrant for every five Maldivians (63,637: 338,434). Internal migration is also significant, usually for education and employment purposes. Maldivian population is also a very mobile population internationally; India and Sri Lanka were visited by one-third of Maldivians in 2013 for business, education, health and leisure purpose (MMA 2012). Population projections for the next 12 years (Figures 2 and 3) show a contraction in the Maldivian female reproductive age groups 25-39, an increase in the Maldivian mature females (40-49), Maldivian adolescents (15-19), Maldivian young adults (20-24) and also in foreign female residents in the Maldives.

Figure 2: Population pyramid of resident Maldivians and Foreigners in Administrative islands 2018

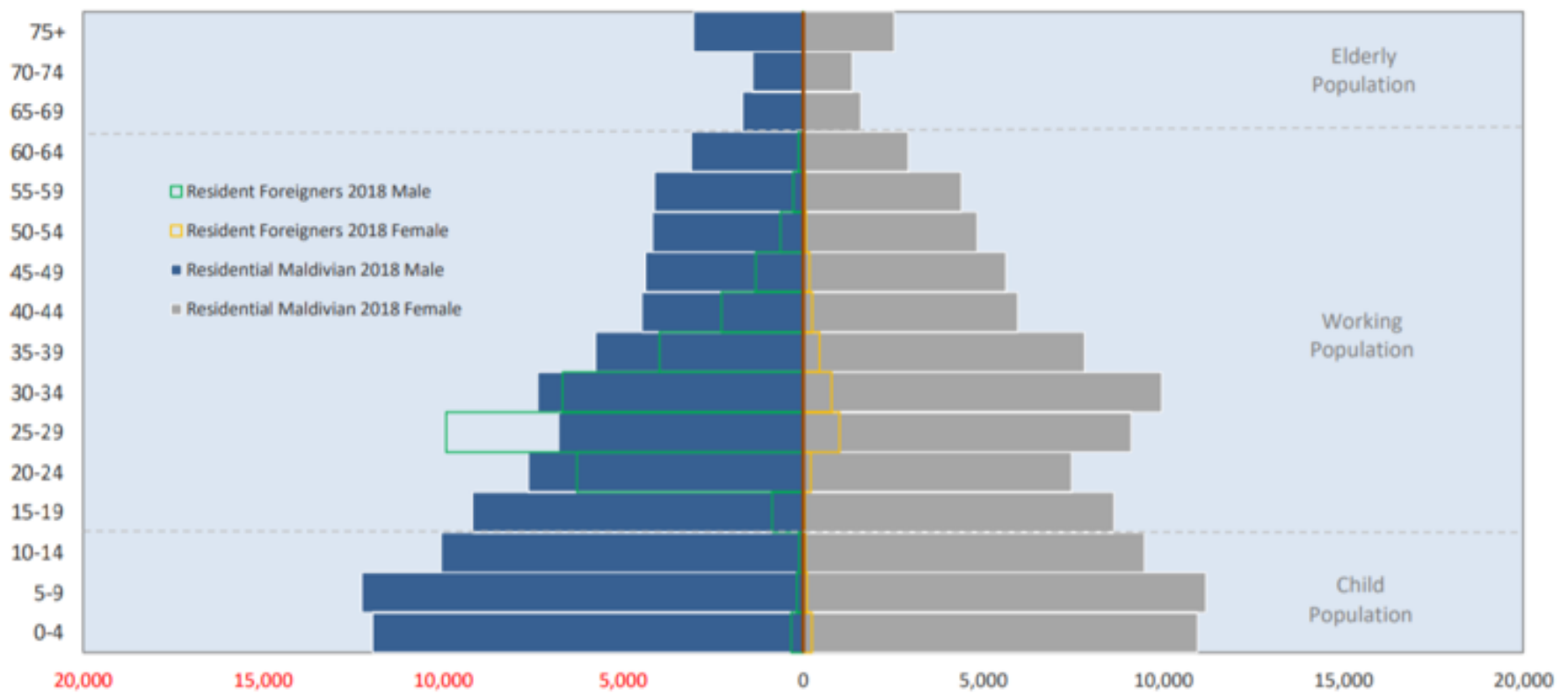
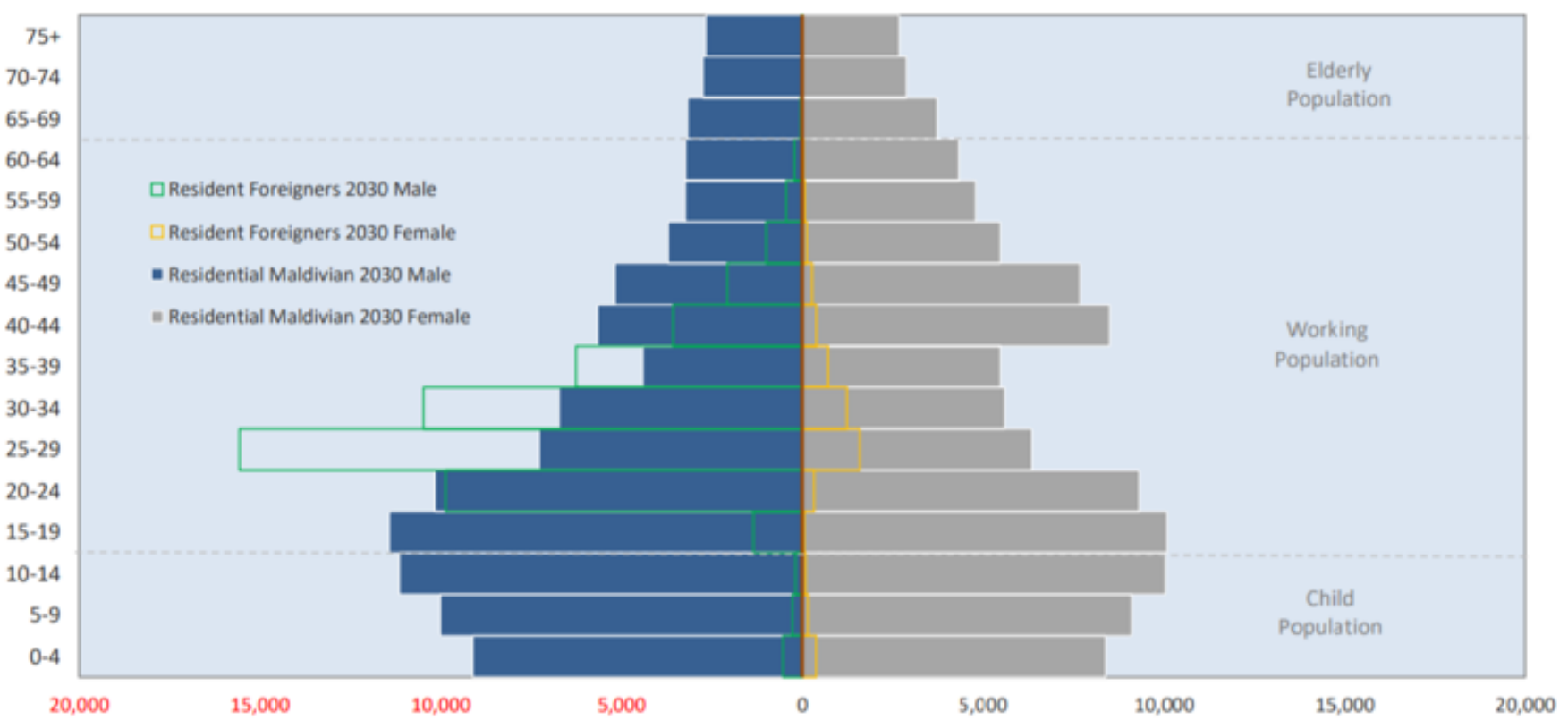


Figure 3: Projected Population pyramid of resident Maldivians and Foreigners in Administrative islands in 2030



Source: NBS, 2018

Basic health indicators, including MCH indicators

Table 1: Basic Health Indicators, (2016)

Key indicators: Maldives	
Child health	
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%) (Source: National Immunization Program, 2016)	99.5
Demographic and socioeconomic statistics	
Poverty head count ratio at \$1.25 a day (PPP) (% of population) (World Bank Report, 2004)	1.5
Gender inequality index (Source: Human Development Indices & Indicators: Statistical update, 2018)	0.343
Human development index rank (Source: Human Development Indices & Indicators: Statistical update, 2018)	101
Health financing	
Total expenditure on health as a percentage of gross domestic (Source: NHA, 2014)	9.1
Private expenditure on health as a percentage of total expenditure on health (Source: NHA, 2014)	31.8
General government expenditure on health as a percentage of total government expenditure (Source: NHA, 2014)	16.3
Health systems	
Physicians density (per 1000 population) (2010)	1.415
Nursing and midwifery personnel density (per 1000 population) (2010)	5.035
Mortality and global health estimates	
Life expectancy at birth (years) (Source: Human Development Indices & Indicators: Statistical update, 2018)	78.8 (Female) 76.7 (Male)
Neonatal mortality rate (per 1000 live births) (VRS 2016)	5.3
Infant Mortality Rate (per 1000 live births) (VRS 2016)	8
Under-five mortality rate (probability of dying by age 5 per 1000 live births) (VRS 2016)	9
Maternal mortality ratio (per 100 000 live births) (VRS 2016)	44
Reproductive Health Indicators	
Total Fertility Rate (2014 Census)	2.4
Contraceptive Prevalence Rate (MDHS 2009)	35%
Unmet need for family planning (MDHS 2009)	28%
Coverage of ANC visits (minimum 1 visit) (MDHS 2009)	99%
Births attended by skilled health personnel (%) (MDHS 2009)	95%

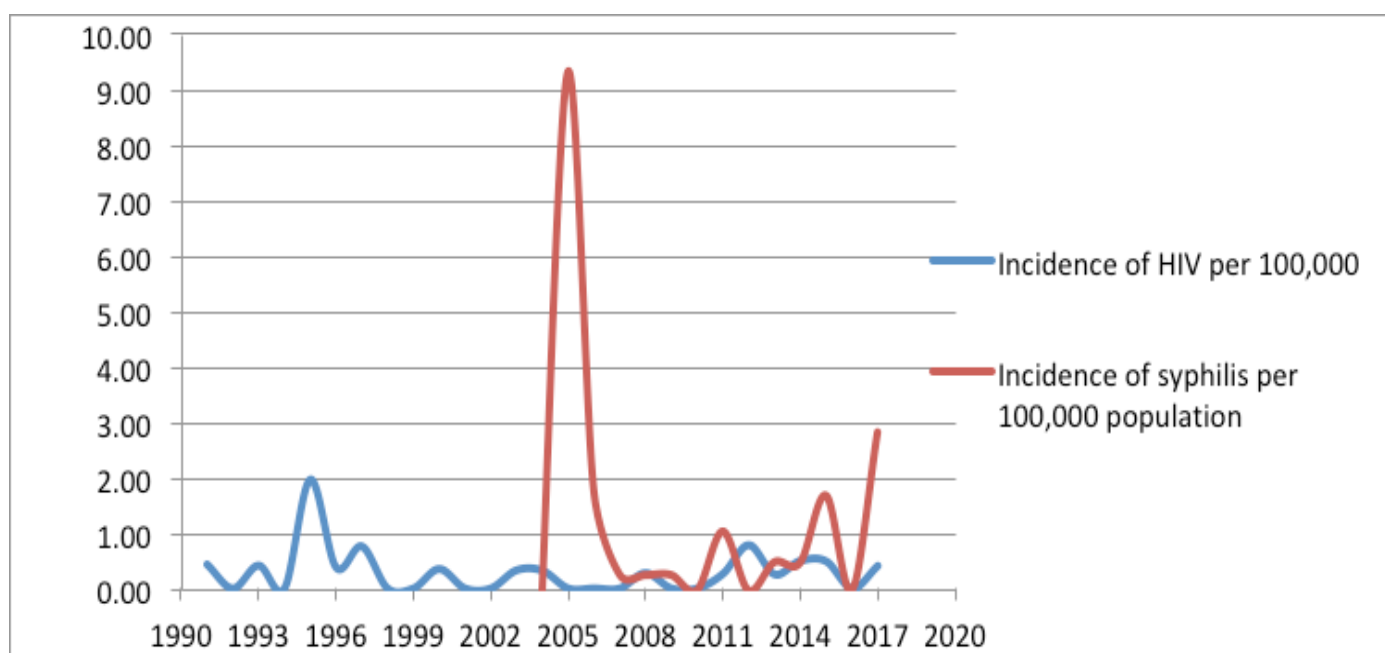
Summary of the national validation process and goals of the review

A national validation committee (NVC) and a national validation team (NVT) oversee the EMTCT validation process and efforts. (list of members is **Annex 3**). Timeline of activities of the National Validation for EMTCT of the NVC and NVT are in **Annex 8**.

Epidemiological profile of HIV and syphilis

Prevalence of HIV and syphilis has been low and is steadily declining in the Maldives. Since 1991 when HIV was first detected, the annual rate of new infections detected has ranged from 0-2 cases per 100,000 population (Figure 4, Programme data, HPA). During the same period new cases of syphilis have fluctuated from 0-9 per 100,000 population (Programme data, HPA). Even among key populations, limited data suggest very low prevalence of these infections (0% among 102 sex workers, 168 MSM and 276 PWUD surveyed in BBS 2008. The syphilis prevalence was 1.2% among resort workers in the 2008 BBS. The results from ongoing IBBS are likely to be available by 2019

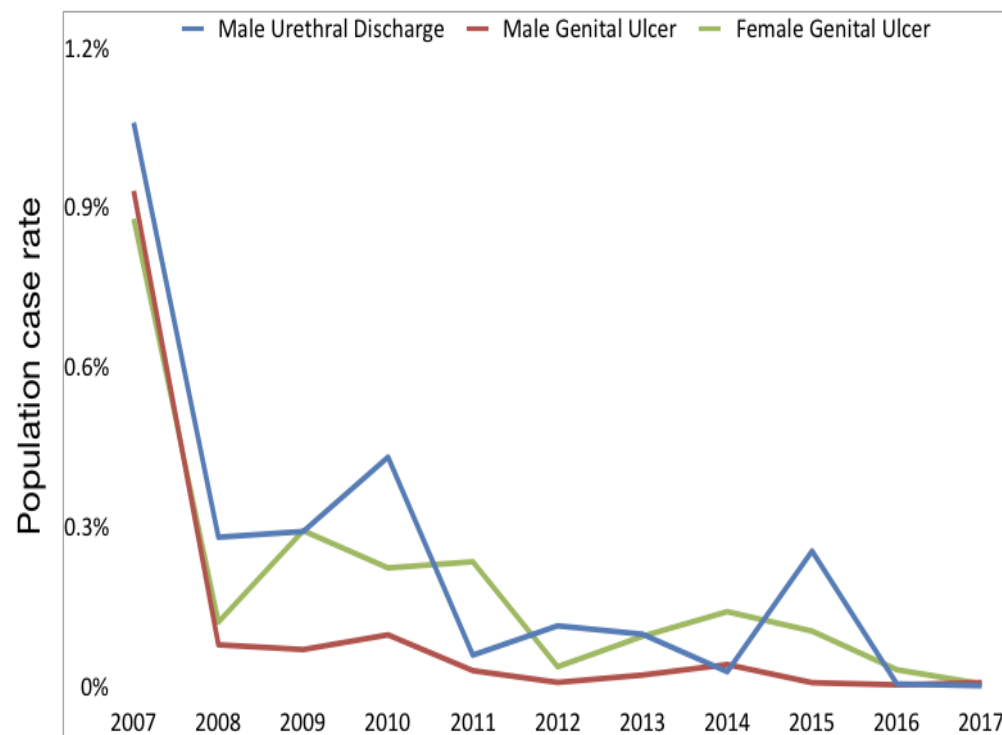
Figure 4: Incidence of HIV and Syphilis per 100,000 population in the Maldives



Source: National program data, HPA (monthly surveillance report)

STI/RTIs are not uncommon in the Maldives but have been in steady decline over the past decade (Figure 5). The large majority of cases treated among females are for vaginal discharge.

Figure 5: Sexually Transmitted Infections by syndromic diagnosis 2004-2015



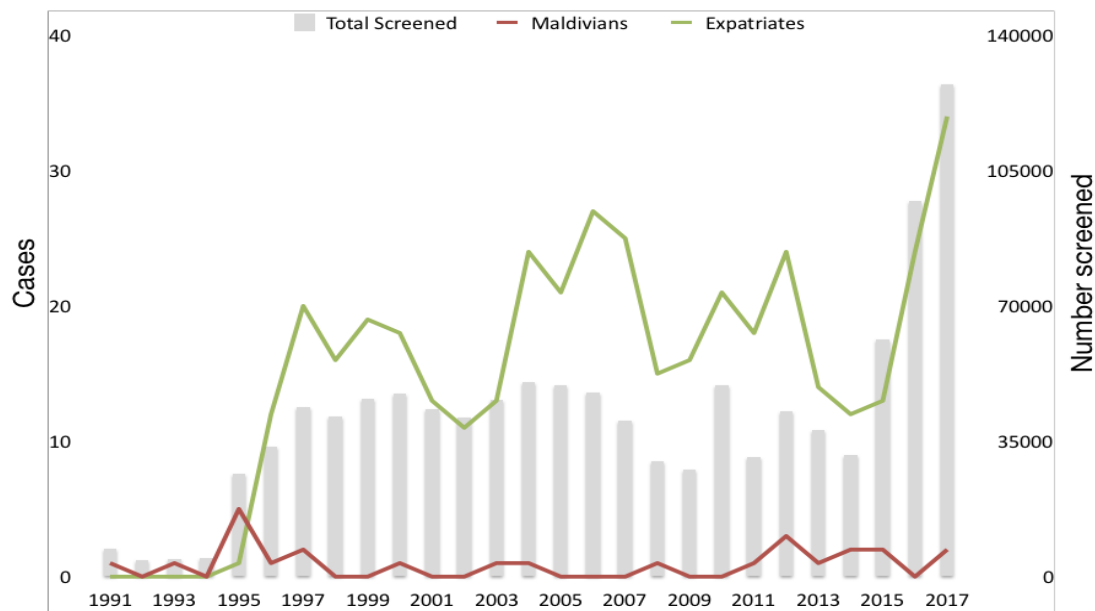
Source: Program data, HPA (monthly surveillance report)

Program data show that more than 98 % of ANC attendees are screened for HIV and syphilis in the Maldives for many years. Screening for HIV and syphilis is conducted for all pregnant women during first trimester with an “opt out” policy. Foreigners seeking work permits are screened prior to issue of work permits following the procedure laid out in Immigration Act (1/2007). Laboratory services are available in majority of the health facilities in the Maldives, which are set up as per the health services grading, and designated facilities with laboratories have HIV and syphilis serological testing capacity. Tests are offered to all ANC attendees - Maldivians and Non-Maldivians - during ANC and to women with suspected STI as advised by the attending physicians.

HIV and syphilis prevalence trends in the general population

The annual number of detected HIV infections has remained at very low levels and stable in the Maldives for the last twenty years. While few Maldivians with HIV are identified each year (0-3), about 10 to 25 HIV positive cases are detected annually among expatriates, increasing from every year from 12 in 2014 to 32 in 2017 (**Annex 12**). In the last four years, 18 women were positive but none of them was pregnant. They are mainly nationals from Asia, Europe, Africa. As per policy they are entitled to free HIV services including treatment and two migrants started the ART in Maldives. They have all left Maldives and probably returned home. Compliance to treatment amongst HIV and syphilis positive Maldivians is very high. Since HIV requires lifelong treatment, they are in regular contact with the treating physicians (details at **Annex 4**).

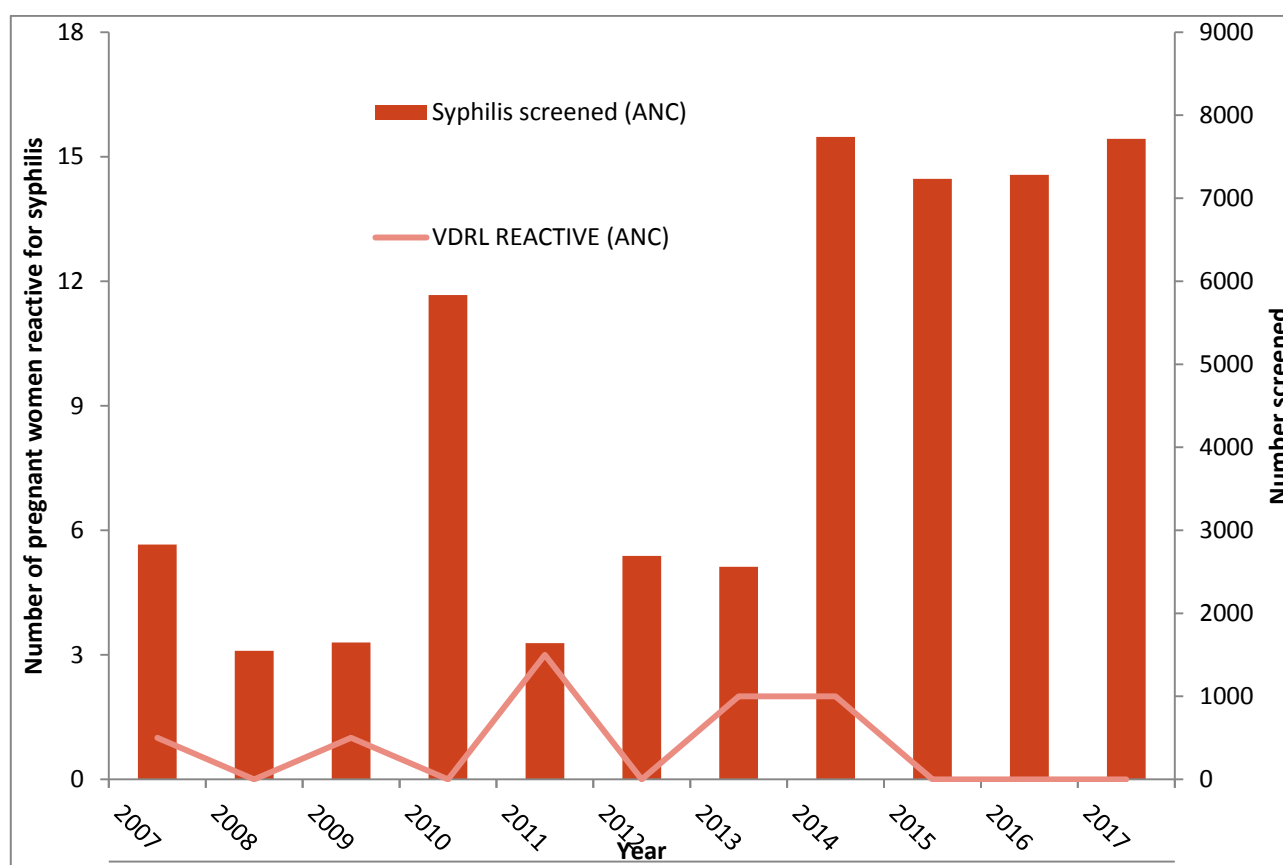
Figure 6: HIV screening trends, 1991-2017



Source: National Program data, HPA (monthly surveillance report)

Prevalence of syphilis among blood donors is very low at 0.09%. Figure 7 shows declining trends of syphilis in pregnancy in the country including from IGMH referral hospital, which screens approximately one-third of pregnant women in the Maldives each year.

Figure 7: Syphilis screening among ANC attendees, 2007-2017



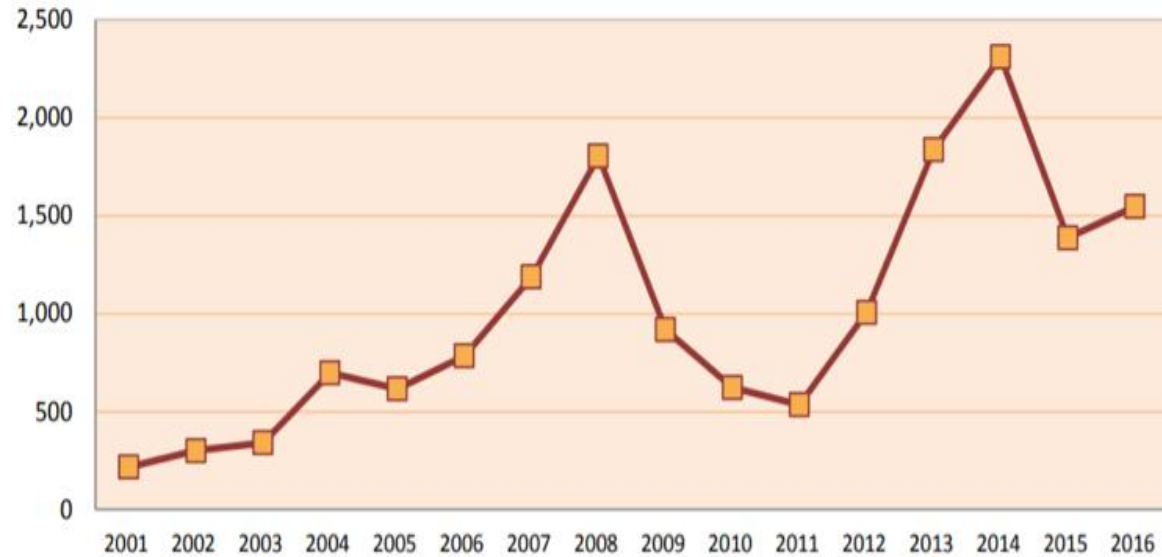
Source: National Program data (monthly surveillance report)

Modes and drivers of HIV/STI transmission

Although Maldives is one of the countries in the region with the lowest HIV/STI prevalence, risk behaviors for transmission certainly exist. Risk behavior mapping conducted in 2010 identified injecting and other substance use in the Maldivian population (Figure 8, Statistical year book 2017), prevalent female sex work through different venues, male to male sex, consensual premarital sex, low usage of condoms, multiple partners among the general population (Figure 9, Statistical year book 2017), prison and detention centre environments and

increasing internal and international inbound migration (Figure 10, UNFPA 2016) are potential drivers of HIV/STI transmission.

Figure 8: Number of Substance Use cases 2001-2016 (source: Statistical year book 2017)



Risk behavior mapping has estimated 1139 FSWs, 1199 MSMs and 793 PWIDs nationally, highly concentrated (FSW 37%, MSM 48% and PWIDs 53%) in Malé (MOHF 2011). The BBS of 2008 and the National Drug Use Survey of 2011/2012 showed considerable risk behavior among all three KPs and with networks stretching across KPs (more than one third FSWs also injected drugs) and into the general population (Fig 11). Among PWUDs in Addu and Malé, more than half reported non-regular partners and 2% of males sold sex to another man (UNDP 2008). Youth 18-24 were found to engage in buying and selling sex, MSM partnerships, and multiple partnerships through group sex and sex with non-regular partners (UNDP 2008).

Figure 9: Marriages by the number of times married by sex of bride and groom 2014-2016

Source: Statistical year book 2017

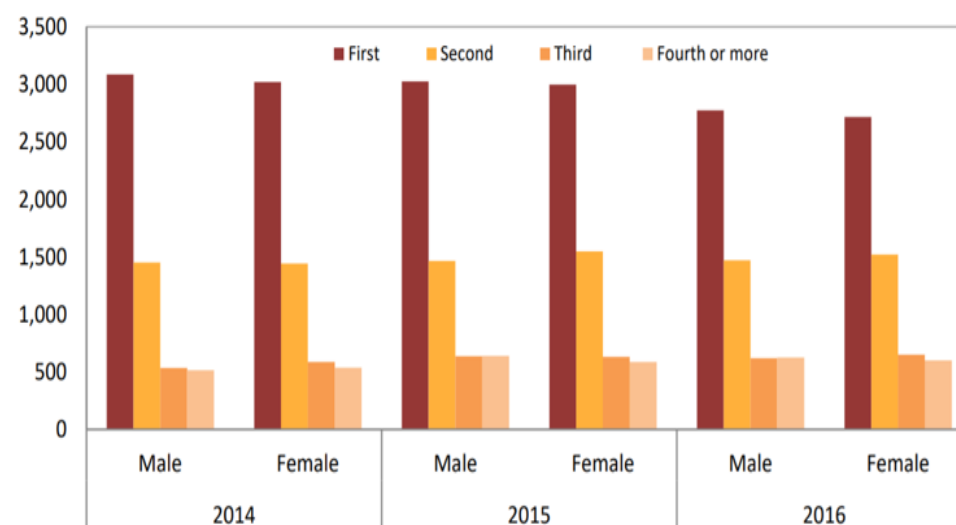
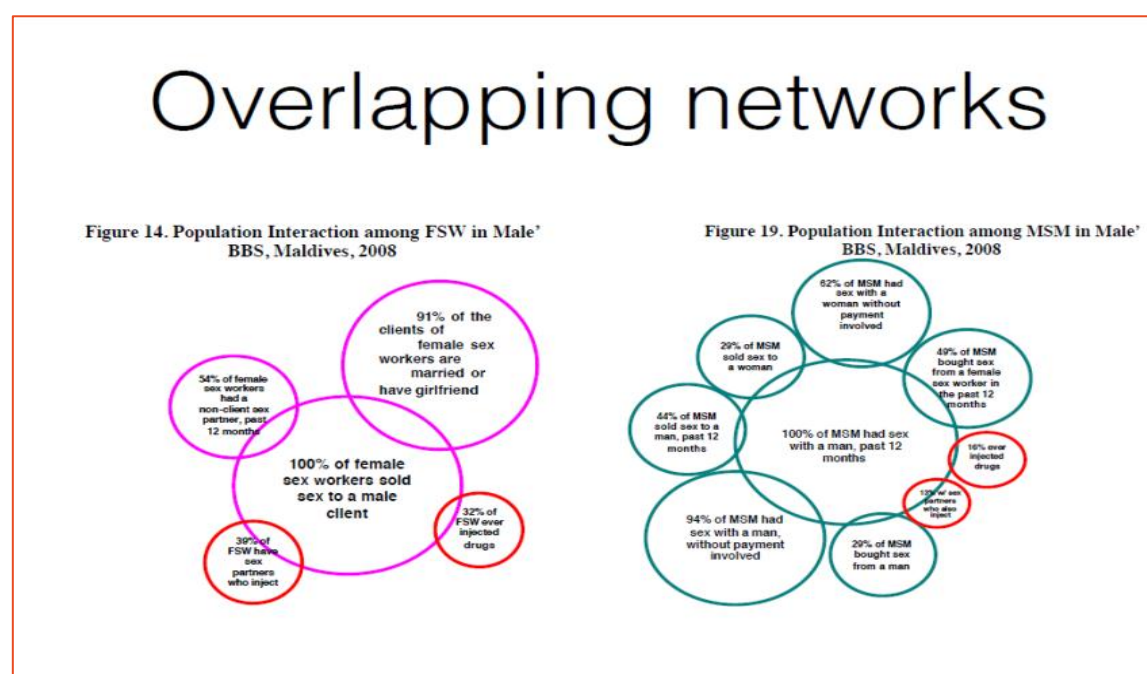


Figure 10: Summary of internal and international migration patterns in the Maldives



Source: UNFPA, 2016

Figure 11: Overlapping risk networks



Source-BBS2008

Interventions, including drop-in centres and opioid substitution therapy (OST) in Malé, were focused mainly on people who use drugs (PWUD), as data show relatively high proportion of Maldivians engaging in drug use, an apparent shift towards injecting rather than smoking, and high incidence of needle-sharing (UNDP 2008, NAP 2010). Yet, those harm reduction services were curtailed as Maldives interest was to ensure that people would become drug free and not just opiate free. The MMT clinic was therefore closed last year and the last client has been weaned out and this has been replaced with Naltrexone along with drug treatment and rehabilitation. The country sought technical assistance for providing naltrexone which was supported by WHO based on which a Standard Operating Procedure (SOP) was developed and which is now followed.

There are no specific targeted interventions for female sex workers as they can access services discreetly through the services that are open to the general public without having to disclose their occupation as has been documented by the NGO, Society for Health Education (SHE), in their records of clients accessing counselling services. Although there are no separate HIV prevention programs for MSM at present, there are plans to start services for sexually transmitted infections (STIs) and there are ongoing services that have been made available

to them. SHE provides psychosocial counselling (they have trained counsellors for MSM) and HIV testing and counselling through its own office. According to their data, they have provided HTC to 12 self-identified MSM since 2016 of whom none were HIV positive and seven used their counselling services.

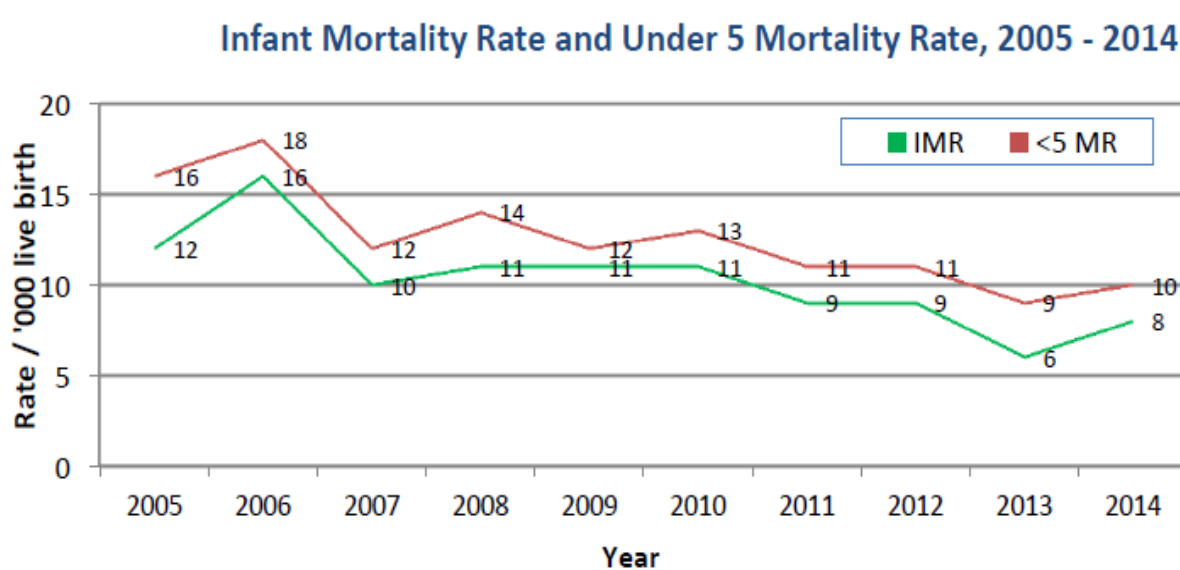
The National AIDS/HIV program have some young male doctors trained on STI management in males, one of whom is a dermatologist and regularly sees MSM clients. It is planned that STI services will be provided to MSM discreetly through an urban primary healthcare centre (Dhamanaveshi). Here trained staff on STI diagnosis and follow up after treatment will be present. Referral cards will be given to MSM clients for bringing their partners for STI management. SOPs have been developed and the service is expected to start in September 2018. Migrant populations are not targeted separately for HIV/STI despite overlapping sexual and injecting risk behaviors described in several studies (NAP 2015, UNDP 2008, MOHF 2011).

Pregnancy trends and the reproductive health programme

Both maternal and newborn outcomes have improved considerably in the Maldives in recent years. The maternal mortality ratio (MMR) decreased to 13 per 100 000 live births in 2012 reaching the MDG 5 target of reducing MMR by three-quarters by 2015. MMR fell steadily since the beginning of the last decade from 259 per 100,000 live births in 1997 to 44 per 100,000 live births in 2016. It should be noted that annual rates fluctuate, due to the few number of deaths - an additional death increases the rates.

During the past ten years, the infant mortality rate per 1000 live birth has declined by more than half (Figure 12, Maldives Health Profile 2016).

Figure 12: Infant and Under 5 mortality trend in the Maldives



The reproductive Health (RH) Programme and the full range RH services are described in detail at **Annex 2**. These include five core components: i) family planning; ii) maternal and newborn health; iii) preventing unsafe abortion; iv) prevention and management of sexually transmitted infections; and v) promoting sexual health.

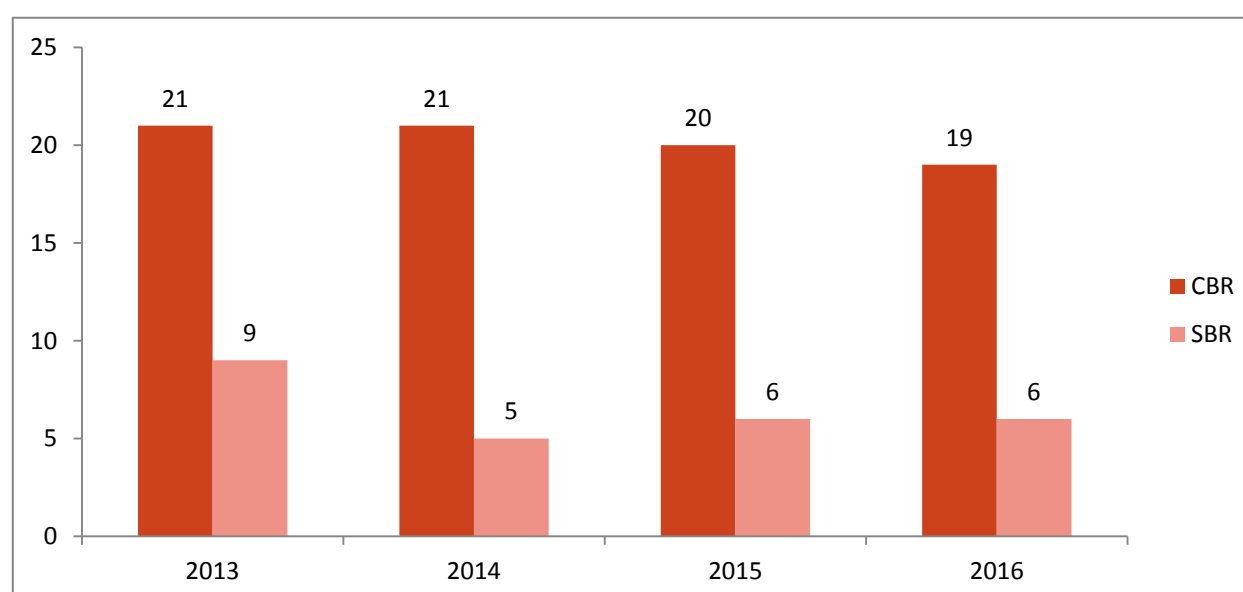
The coverage of antenatal care (ANC) reached 99% in 2009 (MDHS, 2009) with the majority of women having their first ANC visit in the first trimester of pregnancy. Pregnant women are advised to attend at least 9 ANC times. Almost all women (more than 97%) who received ANC were weighed, had their blood pressure measured,

urine and blood samples taken and their blood tested. In addition to the routine haematology and serology tests, screening for TORCH, syphilis, HIV and Hepatitis B is being carried out for all pregnant women seeking antenatal care in Maldives. Pregnant women are provided with comprehensive counselling on all aspects on PMTCT like mode of delivery, infant feeding and family planning etc. Partner counselling and testing in high risk cases is a part of the comprehensive services pregnant women and their families receive. National ANC guidelines are implemented in all health facilities including the public and private sector, and there are no differences in ANC coverage between rural or urban areas. ANC data are collected monthly at the central level. In case of a positive case for STI/HIV the national programme is immediately informed to facilitate confirmation and case management. The coverage of postpartum/postnatal (PNC) visit was 94%, with 67% receiving a postnatal checkup within two days of delivery. There are no significant discrepancies in PNC among regions and among various socio-economic status or residence.

Stillbirth trends and contributing factors

The Every Newborn Action Plan has the target of 12 or fewer stillbirths per 1000 live births in every country by 2030. In the Maldives, SBR have ranged very low at 5-9 per 1000 live births over a period of four years (Figure 13). Although no research has been done in the Maldives on factors that affect still births, findings from global research that are applicable to the Maldivian population includes parity, history of diabetes, mental health problems, antepartum hemorrhages, foetal growth restriction and modifiable risk factors such as maternal obesity and smoking in pregnancy. Majority of the cases confirm pregnancy early after missing the monthly period. After a pregnancy is confirmed, routine ANC screening including testing for HIV and Syphilis is offered.

Figure 13: Still birth rate and crude birth rate, 2013-2016,



Source: VRS, MOH

3. Description of health care delivery system of the country

Although the health system in Maldives comprises of both public and private providers, the majority of the facilities are public. The public tertiary hospital IGMH, is governed by a board appointed by the government. Dhamanveshi, the urban primary health centre in Male' is directly under the Ministry of Health. All the other public facilities are operated under the Regional and Atoll Health Services Division of the Ministry of Health.

The health care delivery system of Maldives is organized into a tier system with island level primary health centres, a higher level of health facilities with specialty care hospitals at atoll level and tertiary care facility at the urban level. Health policies with regard to public service delivery include establishing a public health facility (either a hospital or health centre) in each inhabited island and developing tertiary services at selected urban locations, for which the service level is decided based on population, patient load and other factors. Each atoll has a hospital catering to the population of that atoll. Kaafu Atoll is the exception where Malé city is located and has the country's referral tertiary care health facility Indira Gandhi Memorial Hospital (IGMH), Hulhumale' hospital and Villimale' Hospital along with hospitals managed by the National Defence Force and Police Service and an urban primary health care facility.

The hospitals at atoll level are referred to as regional or atoll hospitals, graded to three levels, based on the level of secondary and specialist care. Health centres have three levels. Administratively, the regional or atoll hospital in each atoll acts as the main coordinating body in providing primary and curative health care in that atoll and each atoll covers a population of 5,000 to 15,000 people. Hence, to ensure access to health care, health facilities are established even if the population number is low. In 2016 MOH records include 22 public hospitals (IGM Hospital (tertiary hospital), 6 regional hospitals and 13 atoll hospitals, Hulhumale' and Vilimale' Hospitals, and 172 primary healthcare centres. Primary level health care in Maldives is provided through health centres, Atoll and Regional hospitals and a separate PHC centre (Dhamanveshi) in Malé city. Health care services including medical examination, investigations, immunisation, antenatal care, drugs etc. are provided free to all Maldivian citizens.

In each health facility in the Maldives, health care is provided by at least a qualified doctor, nurse and public health worker. OPD, delivery room, beds for inpatient, laboratory and a pharmacy are the minimum part of the infrastructure, even at the Island health centres. Reproductive and STIs services are also inbuilt in the programme. This means that all cases missing menstrual periods are confirmed for pregnancy (by testing), and all pregnant cases go through the standard screening procedures outlined by the Ministry. Land and sea ambulances are available at each regional level and refer cases without any cost to patients and families. Every citizen of the Maldives is covered under Aasandha insurance scheme, both in the country and abroad at empanelled centers.

The private health sector in the Maldives is small and mainly confined to urban settings . Among the private hospitals, the ADK hospital is the main private hospital located in Malé. ADK hospital has 118 beds and provides a wide range of medical and surgical facilities. Outpatient visits at ADK are close to the levels seen at IGMH, the

tertiary public sector facility in Malé. The newest addition to the private sector is the Treetop hospital located in greater Male' region (Hulhumale'). Ministry of health sets minimum standards for services (eg; Test kits). All private sectors are mandated to use the government guidelines for treatment, and surveillance of diseases. They report to national programme promptly when a case of HIV is identified. The confirmation of the diagnosis is done in Indira Gandhi Memorial Hospital (IGMH). ADK also shares monthly report to the national programme on public health programmes.

Spending on health is high in Maldives when compared to other countries in similar developmental situations. The total health expenditure in 2011 was 9% of GDP. The per capita total health expenditure was US\$ 561, with the Government contribution of US\$ 247 per capita (Ministry of Health, 2013). As a result of high government spending on health, out of pocket expenditure has reduced from 45 percent during 2011 to less than 30 percent, in 2014. When the new reports come, is expected to significantly lower than 30%. Majority of the health programmes, including Maternal and Child Care and STI/HIV is almost exclusively funded by the government and without any financial implication to the people.

The Ministry of Health 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. Although public sector is the largest part of the Maldives' health system, it is supported by private sector as well as voluntary non-governmental agencies. External development partners have also been providing technical and financial support. Based on lessons learned from previous health planning cycles, future health needs and transitional socio-economic and political situation, the Ministry of Health has developed the Health Master Plan (HMP) for the next ten years (2016-2025) with a goal to achieve a healthy nation. This is the third long term plan for the health sector of Maldives which is developed in alignment with the global Sustainable Development Goals (SDGs). Two strategic frameworks were the basis for identifying the priorities and strategic actions of the HMP 2016-2025: 'social determinants of health' and the 'health system building blocks' (World Health Organization, 2013; 2010). The major shifts were to stewardship role of the Ministry of Health in ensuring public health policies and stronger intersectoral collaboration for sustainable health impacts. To build a robust health system in the country, greater emphasis has been given on health system building blocks. Three strategic focus areas like Governance, Public health protection and Health service delivery are the main pillars of the health master plan. The structure of the Ministry of Health is provided in **Annex 6**.

Health Protection Agency (HPA) is the central public health agency of the Government of the Maldives. The Director General of Public Health leads the HPA. It is mandated by the Public Health Act (7/2012) and functions as a department within the Ministry of Health. HPA's work is divided amongst 5 divisions (Public Health Preparedness and Surveillance, Communicable Disease Control, Population and Reproductive Health, Environmental and Occupational Health, and Health Promotion and Chronic Disease Control) and a Public Health Inspectorate. It leads health programme implementation including monitoring diseases, events and conditions of public health importance. Each Atoll and island health facility has a public health unit. Public health units provide basic public health services, such as immunisation, health awareness and advice, growth monitoring of children under 5, reproductive health services and monitoring and controlling communicable diseases. In each Atoll, the public health units of the health centres are monitored by the hospital of the Atoll

The National HIV Control Program is placed within the Communicable Disease Control Division, and is responsible for developing programs for those at high risk, collection of data for program and providing services

for patients including ARV. The clinical focal point for HIV is in IGMH and IGMH lab also provides confirmatory testing and viral load testing for patients. The program also has developed and trained people for VCT services, and coordinates the provision of VCT services across the country.

In addition to HIV, the program also coordinates activities for STI prevention across the country, including reporting, standards of treatment, etc. Since EMTCT is a cross-cutting issue, within HPA, EMTCT work is assigned to a working group from HIV Program, MCH Program and includes heads of CD Control and Population health divisions as well as DG and DDG of HPA. This is for overseeing the work at HPA level and coordination.

Surveillance is the ongoing, systematic collection, collation, analysis and dissemination of data for the purpose of taking action to prevent disease (Information for Action). Maldives has a fairly well-established indicator-based surveillance system for infectious diseases. This means that data is collected on incidence of persons developing infectious diseases identified or defined in the Notifiable Diseases List. This is mainly a passive surveillance system, where data is collected from health care providers nationwide. Currently, the system in use is a web-based system with access provided for each Atoll hospital. In addition, disease specific programmes collect and maintained at central level.

The (HPA is the lead agency implementing the disease surveillance system. The public health surveillance section of the Communicable Diseases (CD) Division has the overall responsibility of managing the system.

Health information generation starts at the Island Health Centre. The public health units in the health centers/hospitals manage data. The data on immunization, ANC, delivery, and laboratory results like HIV and Syphilis or communicable diseases, etc. are maintained in respective registers (which are computerized in some facilities). The blood sample of HIV positive case is referred for confirmation of diagnosis to IGMH. All confirmed HIV positive cases are promptly reported to the national programme manager at HPA and designated HIV treating physician at IGMH. Once the diagnosis is confirmed, the case is counselled for partner notification and testing with full engagement and consent of the new case. They are investigated and assessed for infection of HIV and STIs. This step is an integral part of all communicable disease response including STIs and Tuberculosis.

The communicable disease programme uses an electronic data management system called SIDAS (SEARO Integrated Data Analysis System). Surveillance focal person of the Ministry of Health regularly analyzes data and monitors the trends of all communicable diseases. SIDAS is a well-established indicator-based surveillance system for infectious diseases.

Special investigation forms are to be filled for patients suspected of suffering from the specified diseases or conditions requiring detailed investigation. These include cases for EPI programme related diseases, AEFI, TB, HIV, STIs, and food poisoning. Following receipt of the forms, HPA in coordination with the Regional/Atoll Hospital and their respective public health unit conduct detail assessment.

All health facilities, public and private, are regulated by the Quality Assurance and Improvement Division, Ministry of Health. Preventive services are provided under guidance from the HPA. Maldives Food and Drug Authority regulate all medicines, importers and pharmacies. Health services are governed by the Health Services Act and the Health Professionals Act. In addition, the Public Health Act (7/2012) provides a framework

for preventive services and also provides regulations governing clinical services that have a public health component or public health impact.

Health-care needs and access for transient and other marginalized populations

Migrants are a special groups under the Maldives health system. The census 2014 counted 402,071 residents, of which 63,637 were foreigners — about 16 percent of the Maldives' total resident population. Health care is covered as part of the employee contract and paid by the employer. Thus access of migrants to health care is good. They can seek care at the health facility at the island of their work. Migrants are special focus for health sector and important component of the Health Master Plan 2016-2025 and WHO Maldives Country Cooperative Strategy 2018-2022. Addressing their health is important to achieve and sustain low transmission of communicable disease and for their wellbeing during their stay in the Maldives.

The migrants undergo a health check up on arrival before they are issued a work permit. The national programme separately keeps a record of migrants with key communicable diseases like TB, HIV and STIs and offers free treatment as part of the national programme response. In addition, all migrants undergo annual health checkup for priority diseases which include TB, HIV, Malaria, Filariasis, Hepatitis and STIs as part of the visa/work permit renewal processes. All positive cases are promptly managed and free counselling and treatment is offered. As the English language proficiency of the migrants is limited, IEC materials with prevention messages are prepared in their local language and disseminated. As the country is maintaining low transmission of several diseases, health of the migrant and prevention of introduction of communicable diseases to the community is a high priority.

Laboratory services

Laboratory services are available in most of the health facilities in the Maldives (services are set up as per the health services grading- Fig 14), and all have HIV and syphilis serological testing capacity. However, the types of tests they do vary from level to level. Basic hematology and rapid tests are done at peripheral level (island health centres). They also support referral of samples of blood/urine etc. for more sophisticated tests.

The atoll level hospitals offer a variety of hematology, serology, routine tests for urine, stool culture etc.

At atolls, rapid tests are used; TriDot for HIV and SD Bioline for Syphilis. The rapid tests at the central level for HIV include TriDot SD Bioline, HIV Combi and RPR & SD Bioline for syphilis. The tertiary hospital in Male serve as reference laboratory and offer referral services and confirmatory tests which are unavailable at lower levels.

CD4 count is not performed in the country presently. The reagents have been procured and after lab training, CD4 count service is expected to restart in 2018. The national programme has started viral load from late 2016 using GenExpert. Earlier, viral load testing was referred to Ranbaxy laboratory in Mumbai, India.

Maldivian laboratories require a license to conduct HIV/STI testing which has to be renewed every two years. Communicable disease surveillance unit at HPA promotes clear case definitions through surveillance SOPs with

an EQA system in place. It was observed during field visits that all participating laboratories follow HPA SOPs and maintain them in separate files for lab staff to refer. The laboratory supplies available in the laboratory and pharmacies are supplied by the state company, State Trading Organization (STO) designated to undertake major procurement for public institutions. These products as well as those imported by private hospitals are WHO pre-qualified, as required by the law.

Figure 14: Categorization of laboratories in the Maldives

Atolls have rapid HIV screening test and samples from reactive cases are sent to IGMH, Male'. Maldives follows a standard HIV testing algorithm using three sequential tests in reference laboratory at IGMH Male'. Rapid tests are authorised at the lowest levels of the health system, with confirmatory testing done at the central level. If the first test result is positive, a second test is conducted using different antigens or platforms than the first. As Maldives is a very low prevalent country where false positives are likely, a third confirmatory test is carried out as per WHO guidelines using pre-qualified kits (**Annex 7**). If test results are inconclusive following the initial and the confirmatory tests, then the test is repeated after two weeks. Test results are labelled with a given code and not by the name of the individual to assure confidentiality for patients. All the lab personnel undertaking lab diagnosis have been trained and are proficient in their area of work.

Type of Laboratory	Number of Labs	Located at	Test performed	Results to be declared	
				Negative	Positive
Category 1	1	Referral lab at Central level	Rapid/simple supplemental assay, ELISA and Confirmatory tests	yes	yes
Category 2	20	Regional/atoll/private hospital and centers with both OPD and IPD services	Rapid/simple ELISA	yes	Preliminary report; refer sample for confirmation
Category 3	163	Island health centers and facilities with OPD services	Rapid/Simple	yes	No. Refer person for confirmation

The turn around time for Cat II & Cat III laboratories using rapid tests is 8 hrs and in the Cat I laboratory (IGMH) using rapid tests and ELISA it is 8 – 24hrs. The syphilis testing algorithm is at **Annex 9**.

The laboratory data includes Unique ID, and details of the test process and result and is maintained at the respective island health centres, atoll or regional Hospital. The IGMH and ADK (the major tertiary hospitals) maintain the data in the Hospital Management Information system. It is mandatory for all laboratories as per the National Public Health Act to report immediately to HPA when every HIV cases is detected. This initiates immediate active surveillance. Special investigation forms have been designed to capture detail information and based on the needs medical care is ensured to the affected. National Laboratory Policy, Strategy and Operational Plans are being finalized.

The current Quality Assurance Mechanism varies according to the laboratory category. Thus for IGMH Cat I – HIV EQAS is done from the National Reference Laboratory of Australia. The National Serology Reference Laboratory, Melbourne, Australia (NRL) maintains quality in serological testing, particularly for retroviral and other blood borne diseases and sets standards to provide accurate and cost-effective serological testing in screening, diagnostic and therapeutic programs. Internal QC is carried out using the Enhanced

Chemiluminescence Assay with daily controls, both negative and positive. For Cat II and Cat III laboratories EQAS is not done. Internal quality assurance exercises are conducted at IGMH automated laboratory and the soon will be extended to the regional laboratories.

Client initiated testing is done for HIV except for ANC cases and blood donors, while provider initiated testing is done for STIs. There are 12 facilities providing testing services for voluntary counselling and testing (VCT). Minimal list of equipment needed for testing of HIV/ STIs are listed in the VCT guideline. All equipment and commodities such as test kits, tools for quality assurance and anonymity maintenance (consent forms) are provided to the public sector facilities centrally by the HPA.

Case definitions used for (i) HIV diagnosis in adults and infants, (ii) congenital syphilis, (iii) syphilis diagnosis in adults and infants is presented on **Annex 10** and breast feeding policy is at **Annex 11**.

4. Methodology and use of tools and checklists to evaluate key areas:

The National Validation Committee (NVC) was formed by the Ministry of Health. The committee consists of policy makers, clinicians, epidemiologists, laboratory experts, surveillance experts, communicable disease experts, Maldives blood services, MCH Programme, WHO and community representatives. In addition, a National Validation Team (NVT) was also convened by the Minister of Health. The committees guided and oversaw the validation process and efforts (**Annex 3**). A mixed method strategy was administered in this evaluation. WHO tools were used to assess key EMTCT programme areas. Primary and secondary sources, quantitative and qualitative methods were used to collect data across a range of relevant areas.

Data assessment: All the data for calculation of the primary impact and process indicators were collected quantitatively. Data collection was first piloted at Alif Alif atoll Mahibadhoo atoll hospital, where the NVT members comprising mostly of staff from HPA visited the island accompanied by the local consultant leading the data collection training session. During the piloting, it was evident that data needed to be collected and verified from three major sources at each health facility – the public health unit of the hospital, the laboratory and the OPD gynaecology department. Teams of two staff visited each health facility in the country where deliveries and ANCs are conducted and data required for EMTCT validation were entered into a google sheet created for the purpose. An information technology consultant collated the data and 2 epidemiologists cleaned the quantitative data for analysis.

To complement the indicator data and assess other aspects of the program, in-depth interviews were held with hospital managers, obstetricians, STI experts, laboratory experts national program, public health units, doctors serving in the regional, atoll and island health centre levels. In addition, group discussions were held with pregnant women, mothers, migrants, female drug users, female sex workers to verify availability and quality of services. Availability of services was also verified with atoll and island counsels.

Existing surveillance reports were reviewed from the following sources: HPA HIV/TB/STI unit, HPA RH unit, main tertiary hospitals (IGMH (public) and ADK (private), and blood banks. Data available in ANC register, PNC register, laboratory registers, birth and death registers, high-risk pregnancy registers and the vaccine register were assessed. Each record is maintained with unique ID numbers. A number of women chose to get services from the hospital but failed to register at the public health unit of the hospital where ANC registers are maintained. However, the information for such women has also been captured by the HPA from birth forms during data Audit. Similarly, many women/families chose to receive services from atoll/regional or tertiary hospital instead of their island health centre. These were also captured through additional investigations on a case-by-case basis.

Data verification and impact assessment

Data was verified in multiple ways. Field visits were conducted to all public health facilities in the country to observe ANC/PNC recording/reporting mechanisms and verify data sent to HPA at central level. A sample of ten ANC cards from currently pregnant women all each field visit was verified by visiting the women at home. Complete (100%) screening for HIV and syphilis of these women was confirmed. However, the date of the test was not always indicated, making it difficult to verify whether screening for HIV and syphilis took place during the first or later ANC visit.

ANC/PNC records for randomly selected months of 2016 were counterchecked with laboratory registers. Records from individual institutions were counterchecked with VRS data made available by PIH/MOH.

For triangulation purpose, Neonatal/Perinatal database at IGMH (Central level) was reviewed for any CS/HIV screening. In addition, files of deliveries at the paediatric department of IGMH from January 2014 to November 2015 were reviewed. This file contained a sheet for each delivery conducted at IGMH, and contained information of HIV/Syphilis testing of the mother and information on the baby. This confirmed that all mothers were tested for HIV and syphilis, and that there were no records of positive syphilis or HIV cases.

Assessment of programmes and services

Programme Assessment

Interviews with policy makers at central level and 6 regions were held using a semi-structured questionnaire to review existing policies, plans, regulations and databases maintaining procurement and supplies information. Previous hospital managers were interviewed to identify historical cases and mechanisms for reporting of HIV/syphilis cases. Upon finding that few cases refused to register at the public health unit of the island, two of these cases were interviewed to assess reasons for not registering. An in-depth assessment of STI program services and reporting using WHO tools was undertaken in September 2016. Findings from the assessment have been included in this report. Participants interviewed are listed in **Annex 13**.

Laboratory assessment

Observational visits to laboratories at all the public health facilities in the country and the central laboratory (IGMH) were conducted. Semi structured interviews with laboratory in charge and staff, a desk review of laboratory SOPs, database and reporting mechanisms were conducted. The details of tests used and algorithms followed have been described in the earlier sections of the report

Assessment of human rights, gender equality and civil society engagement

Semi structured interviews with vulnerable groups, selected NGOs in 3 regions of the country were conducted. Vulnerable groups interviewed include migrants (27), females who use drugs (7), female sex workers (6). Civil society, NGOs and members of vulnerable populations interviewed for this evaluation are listed under the participants in **Annex 13**. The assessment did not show any violation of human rights or gender inequality or any major discrimination incident in the society or health care setting.

Report on the key elimination indicators

This report confirms that no MTCT cases of either HIV or syphilis were detected in the last few years in the Maldives. Furthermore, improved monitoring methods for 2016 and 2017 increase confidence in the reliability of these results. An extensive nationwide audit of pregnancy records documented 98% ANC attendance and coverage for HIV and syphilis screening in 2017 and 2016. Antenatal clinic attendance is nearly universal, and all women attending are screened for both HIV and syphilis. These data includes women who delivered and received ANC in the private sector, (accounting for approximately 12% of pregnancies in 2016 and 2017).

EMTCT implementation has reached a uniformly high level across the country with no areas failing to meet EMTCT targets during the last two years. Gaaf Alif Atoll was selected as the lowest-performing subnational unit based on performance of other public health programs indicators like timely reporting, completeness, accuracy and coordination , even though ANC coverage and testing in this unit may be almost equal to rest of the country. EMTCT indicators for Gaaf Alif Atoll were found to be consistent with the national average.

An integrated health seeking behavior and prevention strategies (prong-1 of Fig 1) have helped maintain a very low HIV and syphilis prevalence in the Maldives, and consequently maternal infections are rare. Despite these low numbers, systems are in place to detect maternal infections and provide individual case management when needed to ensure optimal outcomes. The last pregnant woman with HIV was successfully managed in 2014, and no syphilis positive case has been identified. Lifelong ART and related HIV services, as well as effective syphilis treatment are available to all persons living in the Maldives who need them.

5. Limitations of evaluation methods

The EMTCT indicators were calculated using data from the health audit that covered all health facilities providing ANC and delivery services.

Problems to assess ANC visits and testing coverage by Atolls was difficult due to highly mobile population. It is very common for a pregnant woman to seek confirmation of pregnancy at the Island Health Center, conduct the first ANC in the same facility, second ANC in Atoll or Regional hospital and delivering at ADK or IGMH or any other site chosen by the women. Thus in the context of Maldives, it is impossible to acquire a complete report of ANCs at one site. Such unique situation made data analysis difficult; however, for the requirement of validation record of only one ANC visit is required, which was easily available as the norm for ANC in the country is 9 visits.

Data on pregnant women tested for HIV (high number of HIV tests among ANC attendees) reflected number of tests conducted, not individual women or new pregnancies. As a result, one pregnant woman may be screened

more than once during her pregnancy if she travels to another setting, or during her first and third trimester and again if she needs a caesarean section. At some regional hospitals, the number of women attending first visit ANC services who are tested for syphilis is not recorded as a first ANC visit test. This discrepancy was eliminated by analyzing data using the national ID as reference unique identifier.

At the central level, HPA collates data from all health facilities. However, currently there is insufficient monitoring of the number and completeness of reports received (HPA HIV unit categorizes reports by late, on time and not received). To eliminate this, data verified during data audit is only reported. Having one central point for EMTCT data and introducing a health information management system (DHIS-2) to capture data across both public and private sector health facilities are planned for future evaluations.

6. Key findings

Country context for assessing the EMTCT programme

The elimination of mother to child transmission (EMTCT) of syphilis and HIV in the Maldives is a public health achievement that builds on strong and equitable national policies and services. Universal access to antenatal care and screening for syphilis and HIV is ensured through an extensive network of public sector clinics and hospitals that provide services at no cost to the patient.

Transmission of HIV and syphilis has been low and is declining in the Maldives. Since 1991 when HIV was first detected, the annual rate of new infections detected has ranged from 0-2 cases per 100,000 population. During the same period new cases of syphilis have fluctuated from 0-9 per 100,000 population. Even among key populations, limited data suggest very low prevalence or absence of these infections (0% among 102 sex workers, 168 MSM and 276 PWUD surveyed in 2008)

Table 2: EMTCT of HIV and syphilis impact and process indicators.

Impact indicators					
	Target	Current year* 2017 (Numerator/Denominator)	Previous Year 1**2016 (Numerator/Denominator)	Data sources	Comments
Annual # live births		6736	6756	2016: VRS data, 2017: WHO UNICEF Joint Reporting form (JRF) on Immunization. (VRS data for 2017 was not completed at the time of the calculations)	VRS records all births and deaths. Registration of the birth in VRS is mandatory to obtain Maldivian citizenship and to electronically generate the national ID card. JRF includes all validated live births. Births of non-Maldivian mothers also need to follow VRS form.
HIV mother-to-child transmission (MTCT) rate by birth cohort	<2% for non- breastfeeding (BF) countries	0	0	National Program data	No reported HIV case and Congenital Syphilis case detected among pregnant women from 2016-2017
Annual rate of new paediatric HIV infections per 100 000 live births	≤50	0	0		
Annual rate of congenital syphilis cases (including syphilis- associated stillbirths) per 100 000 live births	≤50	0	0		
Process indicators					
ANC1 coverage	≥95%	6853 / 6971 = 98%	6932 / 7022 = 98%	Numerator: National Program data Denominator : Estimated pregnancies derived from VRS in 2016 and JRF in 2017	VRS captures all birth outcomes: Live births, still births, abortions.
HIV testing coverage of pregnant women	≥95%	6853 / 6971 = 98%	6932 / 7022 = 98%		Audit data shows 100% HIV/Syphilis testing coverage for 2016 and 2017. The National policy for ANC is to offer and screen all pregnant women for HIV & syphilis during the first trimester or their first ANC visit.
Syphilis testing coverage of pregnant women	≥95%	6853 / 6853 = 100%	6932 / 6932 = 100%	Numerator: National Program data Denominator : Number of pregnant women in ANC	
ART coverage of HIV-positive pregnant women	≥95%	No case	No case	National Program data	
Adequate treatment coverage of syphilis-positive women	≥95%	**1/1	**No case		

** After re-verification of the reported cases in the audit data in 2016 and 2017, checking the lab records, the 2 cases were reported found to be non-reactive for VDRL. Lab records of the 2 cases were submitted to RVT as evidence. One case in 2017 could not be verified when this report is prepared

Table 3: Achievements of lowest-performing subnational unit (Gaaf Alif Atoll)

Impact indicators				
	Target	Year 1 (2017) numerator/denominator	Year 2 (2016) numerator/denominator	Data sources
Annual # live births		39	46	Programme data verified by data audit
HIV mother-to-child transmission (MTCT) rate by birth cohort	<2% for breastfeeding (BF) countries	0/0 (0)	0/0 (0)	Audit data for 2016 & 2017
Annual rate of new paediatric HIV infections per 100 000 live births	≤50	0	0	National Program data

Annual rate of congenital syphilis cases per 100 000 live births	≤50	0	0	
Process indicators				
ANC1 coverage	≥95%	40/40=100%	47/47=100%	Programme data verified by data audit
HIV testing coverage of pregnant women	≥95%	40/40=100%	47/47=100%	Audit data shows 100% HIV/Syphilis testing coverage.
Syphilis testing coverage of pregnant women	≥95%	40/40=100%	47/47=100%	
ART coverage of HIV-positive pregnant women	≥95%	No case	No case	Programme data verified by data audit
Treatment coverage of syphilis-positive women	≥95%	No case	No case	

Table 4: Overall summary of HIV-exposed and -infected infants .

# of HIV-exposed infants: 1	# of HIV-exposed infants with final infection status : 1	# HIV-infected: 0	# HIV-uninfected: 1	# with missing or unknown HIV status : 0
Estimated HIV MTCT rate	One foetus was exposed to HIV infection from an infected mother in 2014. Effective prophylactic treatment resulted in the baby being born HIV free.			

Table 5: For HIV-exposed and -infected infant.

# with 1 polymerase chain reaction (PCR) (+): 0	# Antibody (Ab)+ @ 18 months: 0	Comments: Sample confirmed at Ranbaxy, Mumbai.
# with >1 PCR (+): 0	# Antibody (Ab)+ @ 18 months: 0	Comments: Sample confirmed at Ranbaxy, Mumbai.

Table 6: For HIV-exposed and -uninfected infants.

# with 1 PCR (+) and subsequent negative testing: 0	# with 1 PCR (-): 0	# with ≥2 PCR (-): 0	# with 1 PCR (-) and antibody (Ab) (-) @ 18 months: 0	Overall # (%) with Ab (-) @ 18 months (of all those considered uninfected: 1 (Mother was exposed)
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Table 7: Syphilis data table

	Year (2017) (include numerator and denominator)	Year (2016) (include numerator and denominator)
Prevalence of syphilis in pregnant women (# syphilis cases in pregnant women/# pregnant women)	1/6971**	0/7022

tested)		
Number of congenital syphilis (CS) cases	0	0
Number of CS stillbirths	0	0
Number of CS live births	0	0
Number of CS cases in untreated mothers	0	0
Number of CS cases in mothers treated late in pregnancy (less than 30 days prior to delivery)	0	0

Table 8: Review of issues around human rights, gender equality and civil society engagement

Issue	Yes	No	If yes, does this affect the decision to validate for elimination? Why? What are the suggested recommendations for the country?
Is there criminalization of vertical transmission?		<input checked="" type="checkbox"/>	
Is there mandatory or coerced testing and/or treatment for HIV and syphilis?		<input checked="" type="checkbox"/>	<p>The exceptions are :</p> <ol style="list-style-type: none"> 1. An employer wishing to renew the work permit will suggest their employee to undergo medical exam for a list of diseases. If the employee consents, he undergoes through a screening process. This screening includes for TB, HIV, Syphilis, Hepatitis, Diabetes, Malaria, Filaria etc. Based on the result of the medical an employer may decide to retain the employee or not. Similarly, after knowing the status, if the workers want to go back to their country and community, the cost of the travel is usually borne by the employer. There is no written government policy mentioning that the employment be refused to people infected with HIV however the Immigration Act states that serious contagious disease can be ground for refusal of work permit or revoking of work permit. 2. In rape or abuse cases reported from formal authorities, the Maldives police service facilitates HIV testing of both victim and perpetrator. Consent is taken from both parties before performing the test. In a largely literate society and after explain the reason of the test; such suggestions of test are very welcome.
Is there lack of informed consent?		<input checked="" type="checkbox"/>	As per the Health services Act, medical investigation or treatment can only be provided following consent of the health care seeker or of the parent of minor children. For HIV and STIs screening, opt out policy exists. However, in an informed literate society of the Maldives, there is high compliance to scientific recommendations and explanations for the need for testing and treating.
Is there forced and coerced abortion, contraception and/or sterilization?		<input checked="" type="checkbox"/>	<p>Abortion is banned in Maldives except under 5 conditions: ANC checkup shows severe birth defects or Thalassemia Major, Victims or Rape, Victims of Incest, or when pregnancy seriously threatens the life of the mother.</p> <p>Every citizen can easily access contraceptives, whether married or not.</p>

Is there a lack of confidentiality and privacy?	<input checked="" type="checkbox"/>	Confidentiality is strictly maintained by their doctor, as required by Law.
Is there lack of equality and non-discrimination?	<input checked="" type="checkbox"/>	Everyone, everywhere in the country can access health care in the island they stay and beyond, irrespective of gender or nationality. No instant of any major discrimination or inequality reported from public or private health care facility or from the society
Is there lack of availability, accessibility, acceptability and quality of sexual and reproductive health (SRH) and ANC services?	<input checked="" type="checkbox"/>	Free consultations, medicine and health care available for ANC and SRH services throughout the country. The services are available through a medical doctor, nurse and public health unit.
Is there a lack of accountability and absence of participation and community engagement?	<input checked="" type="checkbox"/>	Treatment seeking behavior is very good in the Maldives. Community participation in Public Health Programmes is high since generations and continues.
Are there laws to protect women from gender-based violence?	<input checked="" type="checkbox"/>	Public Health Protection Act (7/2012), Domestic violence Act (3/2012), Human rights Act (6/2006)
Is there a lack of access to justice, remedies and redress?	<input checked="" type="checkbox"/>	Legal instruments such as laws, courts are in existence. A family legal clinic has been in operation together with family centers run by Ministry of Gender.

Assessment of strengths for sustaining EMTCT

Sustainability of these achievements is assessed to be strong, based mainly on solid prong 1, and 3 services established across the country under an efficient and equitable public health system and prong 4 services offered at the IGMH and ADK.

At a national level, the ongoing development of reliable reporting systems for EMTCT has created the foundation for achieving and sustaining EMTCT process and impact indicators. National level coordination and countrywide access to ANC testing, accessible through an affordable universal health care system, ensure high levels of ANC coverage. All screening services are free of charge, for all deliveries and caesarean sections. A multi-level surveillance mechanism through SIDAS (capturing STIs), the HIV surveillance system and the RH surveillance system helps to monitor epidemic trends and identify any gaps in MTCT coverage. Importantly all new HIV positive cases are promptly notified to the national programme and immediate care is offered through HIV experts in IGMH and involvement of the national programme. Out of Pocket expenditure for the case is negligible and thus the case does not face any financial hardship.

At a subnational level, consistent testing protocols, deployment of trained and committed staff to laboratories and public health units at every inhabited island has strengthened ANC services and increased awareness among mothers and women of reproductive age. Ongoing awareness programs to targeted sub-populations at regional and island levels were noted by evaluation participants as a major strength of the system. These include nutrition, family planning, adolescent programmes, premarital information and counselling on STIs and FP.

In addition, the coordination and reporting systems established at the health facility level is an asset – for example, daily coordination between laboratory and public health units of the hospital. Routine screening for HIV and STIs in the first trimester or first ANC visit have become routine practice for years.

Potential risks to sustaining EMTCT.

A number of challenges and risks to sustaining EMTCT in the Maldives were identified by those participating in this evaluation. The high-risk behaviours in the community exists and is continuing.

Presence of female sex workers, injecting drug users, men who have sex with men, people having multiple partners and migrants are considered to be potential challenges to prevent new infections despite special focus to reach them with prevention messages and measures. It must be acknowledged that the national programme has delivered a remarkable outcome, as the annual new infections detected are rare.

An insufficient number of community based programmes for vulnerable groups may limit their access to services. High population mobility, norms of the new generation are potential risks.

Limited government spending on KAP specific programme and limited free condom distribution is a concern that the national programme is trying to address.

7. Description of EMTCT programme context, implementation and performance

The Maldives formed its National AIDS council in 1987 and National AIDS Control Program in 1990. Key policies and program are summarized in **Annex 1**. The government recognizes the right to prevention and treatment where everyone in the Maldives is able to access the service of testing, counselling and free ARV treatment once diagnosed with HIV, including expatriate migrant workers with a valid work permit.

The country recognizes that an effective HIV/AIDS response should be built on the strengths, as well as challenges, posed by prevailing traditional values and societal norms. National and community leadership is essential to ensure that Maldives remains a low prevalence country for HIV by engaging key leaders.

The main goal of the country is to maintain the low prevalence of HIV in the Maldives and prevent further transmission.

National EMTCT policies and programme for HIV and syphilis

Prevention of mother to child transmission (PMTCT) of HIV infection is given special attention by the government of Maldives. PMTCT is a major target of the National Strategic Plan for Prevention and Control of HIV/AIDS 2014-2018. PMTCT is also reflected in the current Health Master Plan 2016-2025. Prevention and management of STI/HIV is a major focus of the National Reproductive Health Strategy for 2014-2018 and beyond.

Management of PMTCT services in the Maldives is undertaken by a multidisciplinary team at central level by HPA. It is nationally coordinated through national focal persons at atoll and island level. A national PMTCT guideline which is in line with global standards has been developed and implemented across the country since 2013. Universal screening of HIV and Syphilis for ANC attendees and voluntary testing have been implemented since 2006. Screening for HIV and Syphilis is offered to all pregnant women, with near universal ANC attendance and high HIV and Syphilis testing rates among ANC attendees.

Early ANC registration and universal HIV and syphilis screening of all pregnant women is promoted, and standards set according to WHO recommendations. Pregnant women are routinely screened for HIV, syphilis and hepatitis B (HBV), usually during first trimester. Screening for HIV, syphilis and HBV is conducted at all atolls, regional and tertiary hospitals, which provide the large majority of antenatal clinic services. Some women (mostly in Malé) use private providers but generally transfer to tertiary hospitals in late pregnancy before delivery. Guidelines on PMTCT and guidelines for management of HIV-positive mothers and their infants are available with all health care providers.

PMTCT of HIV and syphilis infection is also given special attention within the Reproductive Health (RH) programme (**Annex 2**). An important target is to screen 100% of women attending ANC clinics for HIV and syphilis with an “opt out” option. The national standard for ANC service requires that pregnant women who opt

out of screening complete a written signed statement. However, almost all pregnant women opt for HIV testing and in rare instance of opt out, the women is counselled again on a different occasion.

Breast feeding policy for EMTCT is to recommend exclusive formula feeding, with state providing free formula for the first year and continued if required, clubbed with ongoing counselling. For women who choose to breast feed, the national breast feeding policy is highly supportive (**Annex 11**).

Currently only one woman is known to be living with HIV in the Maldives and is on lifelong ART.

Status of EMTCT services

EMTCT services have strengthened considerably over the years since the first PMTCT efforts beginning in 2007. As confirmed by the recent national audit, EMTCT services function at a high operational level across the Maldives. HIV/STI prevention efforts reach are accessible to the entire population and reach vulnerable groups. At all health facilities serving pregnant women, ANC attendance has surpassed EMTCT criteria for years, and all women attending during the past four years have been screened for HIV and syphilis. Although numbers of maternal infections are extremely small, services are universally available for the correct management of any positive mothers and exposed infants.

EMTCT services are accessible in both public and private sector health care facilities in the Maldives. In 2016 and 2017 about 21-23 % of deliveries took place at ADK (data audit), the only private hospital then offering delivery services. ANC attendance and HIV/syphilis screening are provided in the same way, following national guidelines, at private facilities, and reporting to HPA is done in the same way, using the same forms as in the public sector. In 2017, 1488 women were reported to receive ANC at ADK, all of whom were screened and found to be negative for HIV and syphilis.

Equity of EMTCT services

EMTCT services are equally accessible to all populations resident in the Maldives. The following section summarizes responses from policymakers, vulnerable and high-risk groups who were interviewed to assess equity in MTCT services.

Laws and regulations are in place to protect women and others seeking testing and treatment. These include the Human rights Act (6/2006), Child Protection Act (9/91), Family Act (4/2000), Social protection Act (2/2014), Domestic violence Act (3/2012), Public health protection Act (7/2012), and the guideline on Health Sector Response to GBV (2014). Protocols address health sector response to gender-based violence (GBV) describe referral pathways for service provision within the health sector, sources of assistance to survivors and instruments for documenting incidents (UNFPA, 2013). The Public Health Act provides for development of mandatory reporting provisions for communicable diseases to ensure that necessary information is collected for public health interventions and monitoring the health of the public (MOH, 2012)

Respondents agreed that stigma exists in the community. However, they all accepted that health facilities were clear of any such stigmatisation issues. Participants noted that they had experienced individual health personnel

who treated them or their friends differently. For instance, a PWID with withdrawal syndrome complained that the nurse attending to her was annoyed when she screamed of intolerable pain. Yet, it was generally accepted that health facilities are the safest places with regard to stigmatisation. Fair treatment and care is being provided. Policymakers also reported that stigma has not been addressed at a society level. Works towards minimising stigma were mostly targeted via sessions and trainings for policymakers and health care workers. Strengthening measures for reduction of stigma such providing a checklist for stigma-free health facility environment are ongoing interventions.

Reports of human rights abuses are non-existent at health facility level and reported to be very rare in the community as well according to respondents. However, at family level, forced abortions and testing were mentioned by some participants, no formal complaint has been filed but ministry of health along with other ministries are trying to address this issue

Adolescents and youths are vulnerable groups for sexually transmitted infections. In Maldives, an estimated 52% of its population is younger than 25 years. Most young women in Maldives report their first sexual intercourse after age 18. The proportion of women who have had sex before age 18 is highest in Malé (8%) and lowest in North Central (3%). Very few teenagers have begun child bearing at age 18, while 7% have started at age 19 (Health Master Plan 2016-2025). HIV/STI prevention, SRH and EMTCT programmes all conduct special activities and services for adolescents and young people.

There are no laws or policies in place that criminalize HIV transmission. Societal taboos, denial and stigma of risk behaviors and people living with HIV are addressed in multiple advocacy, information and education activities. These include a range of media, including message development to create awareness about HIV risk behaviors, to strengthen support for targeted interventions and reduce stigma and discrimination of those most at risk.

Migrants

According to UN statistics on migration stock as a percentage of its population, the Maldives ranks 34th in the world. Maldives is one of the small island developing states of the United Nations (SIDS) with severe manpower shortages due to its small population. Hence, the government enforces a manpower facilitating policy.

Maldives as a destination country for migrants attracts the healthy, working age group who contributes to building the economy of the country in a variety of occupations. The average monthly earnings of a migrant worker in the Maldives is \$343 while they remit on average 75% of their earnings (IOM, 2018). According to the latest census of the Maldives in 2014, the resident foreign population accounts for 16% of the total population out of which 88% are males (NBS, 2018).

Foreigners employed in the civil service are employed as temporary staff. As a civil servant they are eligible for the government health insurance scheme. And both temporary and permanent staff receives similar health care. In addition, an expatriate is eligible for safe accommodation, food allowance, 30-day holiday, 8-hour work, treatment for workplace injuries, ensures Health, Safety and Security Standards at Workplace, ensures that employees are screened for health before departure and after arrival and on an yearly basis for visa renewal.

Migrant and Expat workers are special groups under health system. While pre-departure health screening for a number of communicable diseases, including syphilis and HIV, is a criterion for work permits, one third of the

migrants reported not having undertaken pre-departure health screening from their home country. Most of them (>95%) underwent health screening after arrival in the Maldives, although 4.4% did not as their respective employers chose not to (IOM, 2018). In addition, all expats undergo annual health check up against priority diseases which include TB, HIV, Malaria, Filariasis, Hepatitis and STIs as part of the visa/work permit renewal processes. Any positive cases are promptly managed and free counselling and treatment is offered. A total of 32 migrants were found to be HIV positive in 2017 (**Annex 12**). The migrants who choose to stay in the country after being detected HIV positive in the pre permit checkup are provided with HIV treatment as there is one documented case in 2018 and another in 2014 who were actually provided treatment for some time before they decided to go back. To tackle the issue of migrants treatment, the honorable minister for health has asked for a migrant health policy moving towards providing services to all migrants and as a first step in migrant health assessment is being undertaken currently.

All residents of Maldives are entitled to free health care and it is mandatory for all employers of migrant residents to purchase the 'expatriate health insurance' package that provides free health care for migrants as well. Vulnerable groups of irregular migrants are, however, left out from the official mechanisms of accessing health care. Irregular migrants are defined as ones who are residing in the country after their visa has expired and living illegally. When an expat is diagnosed with HIV or Syphilis, they are not termed irregular. There are no official estimates of the proportion of irregular migrants in the country. Health facilities require photo identification to provide health care services. During the period 2013-2017, IGMH served 1908 migrant inpatients. 21.9% of whom did not present work permits (IGMH, 2013-2017). Thus health care is not denied to seekers, but often provided on humanitarian grounds. Irregular migrants are provided services when they are brought to ER in an emergency or when it is an issue handled by the public health program, the program provides service free of cost, regardless of nationality or legal status. ADK, the major private hospital offers services irrespective of whether they are regular or irregular. For other services, the last known employer is contacted (records with immigration) and this is worked out with employer.

Access of migrants to health care is generally good. They can seek care at the health facility at the island of their work. The national programme separately keeps a record of the expatriate workers with key communicable diseases like TB, HIV and STIs and offers free treatment as part of the national programme response. As English language proficiency of migrants is limited, IEC materials with prevention messages are prepared in their local language and shared to protect their health. As the country is maintaining low transmission of several of these diseases, health of the migrant and prevention of introduction of communicable diseases to the community is a high priority.

Community involvement

The health system of the country is devised under Primary Health Care approach. Community participation is at the heart of the approach through which the country has celebrated successes against major communicable diseases like Polio, Measles, Malaria, Lymphatic Filariasis, Leprosy, Neonatal tetanus and Small Pox. The national HIV programme values the approach and community representatives are involved in different levels of planning and implementation.

The National AIDS Program represents vulnerable groups in the National AIDS Council, and in national planning forums. In addition, active NGOs such as 'Journey', and 'SHE' are members of the steering committee of the

National AIDS Council. Journey consists of current and recovering PWUD and was established in 2005. They work in collaboration with the National Drug Agency, to provide assistance and guidance to PWUD. They are also actively involved in HIV and STI prevention efforts and run a VCT clinic for the community it serves, funded partly by the national HIV program. They also provide clients with information and commodities for prevention of HIV and STIs. Journey also has a community outreach program.

Society for Health Education (SHE) is one of the oldest NGOs in the area of voluntary testing and counselling services and sexual and reproductive health (SRH). SHE works with migrants, youth and other vulnerable groups, through providing health information, screening, and counseling services. Although they are based in Male', SHE conducts regular trips to atolls to take their services directly to the community. SHE also runs a VCT centre which is partly funded by the national program (the consumables are provided). SHE conducts monthly meetings with PWUD/PWID to provide information, counselling, condoms where HTC is done but syphilis is not tested yet although it is expected that testing will start soon. SHE also provides psychosocial counselling for MSM (they have trained counsellors for MSM) and HTC through its own office. According to their data, they have provided HTC to 12 self-identified MSM since 2016 of whom none were HIV positive (HTC data from SHE) and seven used their counselling services. They also provide SRH services to women (which likely includes female sex workers) including HIV testing through camps in different islands and atolls.

The programme is delivered in close coordination with the Atoll and Island counsels throughout the country. At the implementation level women group, teachers, Key Affected Populations, civil society, media, academic institutions etc. support program delivery and thus the HIV/AIDS and STI response amongst others is a truly multisectoral one. A good practice of the country is introduction in school curriculum of sessions of reproductive process amongst Class 6 and 7 students on physiology of adolescents and in Class 8 and 9, health education on HIV and STIs and protective measures that can prevent these diseases. The Ministry of Education and SHE use reference materials shared by the National programme while delivering the key messages.

Awareness programme has been held at each community through Interpersonal communication, use of the mass or social media. The DHS 2009 showed that 41.7% of women had comprehensive knowledge about HIV (MOHF and ICF Macro 2010), while the Global School-Based Student Health Survey (2009) found that nationwide, 67.2% of boys and 74.3% of girls in grade 8-10 had heard of 'HIV infections or the disease called AIDS' (MOE 2009). Despite these high levels of knowledge about HIV/AIDS and using condoms, perceived linkages of HIV to immoral behaviors and low self-perceived risk has led to low condom use across all most-at-risk populations (MOHF 2011). Thus further efforts are required to reduce knowledge and practice gaps. One of the main challenge that persists is the limited number of civil society partners available to support the state-run National AIDS Programme. This limits opportunities to tap into communities and networks to implement target interventions for KAPs.

Annex 1: National AIDS response

The Maldives formed a National AIDS council in 1987, a multisectoral body with representatives from various ministries and NGOs, and National AIDS Control Program was established in 1990, one year before the first HIV case was reported. To avoid complacency, the government continues to take HIV & AIDS as a serious public health concern and directs efforts to reduce risk behaviours and prevent transmission of HIV in the country. Guided by the National AIDS Council, the HIV program has adopted a multisectoral approach in implementing National AIDS Control Program. Policies and related approaches of the National program include the following

- To increase the uptake of HIV testing services, the HIV testing policy has moved from solely voluntary counseling and testing (VCT) to provider-initiated and client-initiated counseling and testing (PICT and CICT).
- To build and strengthen programme capacity and commitment to lead, coordinate and provide a comprehensive response to the epidemic.
- To strengthen strategic information systems for HIV, including integrated biological and behavioural surveys.
- To promote convergence of HIV and sexual/reproductive health services, as part of integrating HIV into the wider health system.
- 'Memorandum of Understanding' between public health agencies and law enforcement agencies, allowing for HIV prevention interventions focusing on 'vulnerable women' (sex work) and 'vulnerable men' (including men who have sex with men) to occur without fear of police intervention.
- Ensure availability of latest recommended treatment and care to people living with HIV.
- Focus on taboo, stigma of risk behaviors and people living with HIV in advocacy, information and education activities.
- Continue media communications activities, including message development to create awareness about HIV risk behaviors, to strengthen support for targeted interventions and reduce stigma and discrimination of those most at risk.
- It is recommended that a phased program focusing on improving male sexual health is designed based on the findings of the BBS, the upcoming size estimation and risk behavior mapping study, taking into account what is feasible within the socio-cultural context.
- Ensure regular supply and utilization of HIV, Hep B, Syphilis, Hep C test kits in regional hospitals and health centres by instituting a logistic supply chain and monitoring system.

Annex 2. Reproductive Health Program

The Government continues to recognize that reproductive health (RH) is a crucial component of general health. Reproductive Health issues are addressed in an integrated and comprehensive manner through the National Reproductive Health Strategy, 2005-2007 and 2008-2010 in the past and currently 2014-2018. It is seen as a major facilitating service towards achieving the right of the individual and couples to protect their reproductive health and to take responsibility for their reproductive functions. These show the Government's commitment to implement the Programme of Action ICPD 1994 and Millennium Development Goals. In addition, with the adoption of the Sustainable Development Goals, the new Health Master Plan (2016-2025) incorporates the new SDG goals and targets, including those on reproductive health and communicable diseases.

The National Reproductive Health Strategy 2014-2018 consist of 5 core components of reproductive health: i) family planning; ii) maternal and newborn health; iii) preventing unsafe abortion; iv) prevention and management of sexually transmitted infections (STIs)/HIV; and v) promoting sexual health.

Reproductive health programme emphasizes further and promotes a continuum of care along the life course. This approach has two dimensions of care that include continuity in terms of time, e.g. from pre-pregnancy, pregnancy, childbirth, postpartum and neonatal periods; as well as reproductive health needs during adolescence, adulthood and that of the elderly. Another dimension is related to the levels of care that links care at household level up to primary care and referral levels. Such approach can reduce costs by allowing greater efficiency and provide opportunities for promoting related health services.

The Ministry of Health recognizes the importance to achieve equity in both access to quality health care and health status. With worldwide revitalization of Primary Health Care since 2008, the country aims to also strengthen service delivery through strengthening the health system, leadership for better accountability and promote healthy public policy in all sectors. This Strategy embraces the Primary Health Care approach with its five key elements: i) reducing exclusion and social disparities in health (universal coverage reforms); ii) organizing health services around people's needs and expectations (service delivery reforms); iii) integrating health into all sectors (public policy reforms); iv) pursuing collaborative models of policy dialogue (leadership reforms); and v) increasing stakeholder participation.

Maldives with its small population size has a large proportion of young people (Figure 1), while the number of elderly citizens is increasing. This requires programmes targeting adolescent sexual and reproductive health for the young, as well as health care for the elderly. There is inadequate knowledge on reorganization of services and sensitization of health care professionals in pace with changes to the demographic profile of the country leading to inadequate services for adolescent/young people and elderly in general, as well as specific services for other society members, such as people with different ability.

There are other components of RH that include infertility, RH needs of specific groups (e.g. young people, men, elderly, people with different ability, etc) and cancers related to RH system. There are also other situations/conditions that are closely related to RH, such as gender-based violence and RH services in

emergency situation. Each component has its own issues and challenges that need to be addressed within Maldives' health systems setting, while considering the existing social determinants of health.

MMR fell steadily since the beginning of the last decade from 259 per 100,000 live births in 1997 to 44 per 100,000 live births in 2016. It should be noted that annual rates fluctuate due to the few number of deaths since one additional death increases the rates.

In-depth review of maternal deaths was initiated in the year 1997 to identify and focus interventions in reducing maternal deaths. Emergency Obstetric Care (EmOC) at atoll level was strengthened. In order to provide comprehensive EmOC in all atolls, the atoll level health centers were upgraded to Atoll Hospitals with comprehensive EmOC facilities. Institutional deliveries are in place and encouraged to bring positive outcomes in reducing maternal mortality.

Because maternal deaths occur infrequently, it is difficult to draw inferences, however more than a half of deaths are attributable to indirect causes. During the last few years Cardiac causes, Pulmonary embolism, hypertensive disorders have been seen and rarely postpartum haemorrhage.

The National Family Planning Standards was revised in 2016 to provide in-depth technical details about the safety of different contraceptive methods in context to specific health conditions. Family planning services are provided by all health facilities throughout the country. Family planning counselling is an integral element of quality family planning services and it is extensively covered under the standards. The standards also cover clients' rights extensively.

Contraceptive prevalence rate in Maldives is 34.7% (MDHS, 2009). A range of contraceptive methods are available in Maldives and couples can choose a method most suitable for them with advice from family planning service providers. The most common types of contraceptives used are oral pills, condoms and female and male sterilization.

In highly informed society a woman will immediately consult a doctor when she misses her period. The coverage of antenatal care (ANC) is more than 99% from 2009 (MDHS, 2009) with the majority of women having their first visit in the first trimester of pregnancy. Pregnant women are advised to attend at least 9 ANC visits. Almost all women (more than 97%) who received ANC (Majority in 1st trimester) were weighed, had their blood pressure measured, urine and blood samples taken and their blood tested. In addition to the routine hematology and serology tests, screening for TORCH, maternal syphilis, HIV and Hepatitis B is being carried out for all pregnant women seeking antenatal care in Maldives. There is no discrepancy on ANC coverage between rural or urban residence. The national ANC guidelines are implemented in all health facilities including the public and private sector.

Iron-folic acid supplements are provided as part of the national programme and almost 90% of pregnant women take iron supplements during pregnancy. Tetanus and diphtheria toxoids (Td) is routinely given to pregnant women with more than 75% receiving tetanus vaccine at the same time as they receive antenatal care. The national tetanus vaccine coverage target for pregnant women is 100%.

All ANC data is collected monthly at the level of HPA but this does not include laboratory results. In case of a positive case for STI/HIV the national programme is immediately informed for facilitation for sample movement for reconfirming the case.

The proportion of births assisted by a skilled provider was >98.1% (MDHS 2009), with 71% assisted by a gynecologist; 9% by a doctor and 14% by a nurse or midwife. The Caesarean-section rate is very high with 32% of births delivered by C-section (MDHS 2009). The coverage of postpartum/postnatal visit was 94%, with 67% received a postnatal checkup within two days of delivery and 3% of women had a checkup 3-40 days after delivery (MDHS 2009). There is no significant discrepancy in PNC among regions and among various socio-economic status or residence. The majority of women (92%) received a postnatal checkup from a gynaecologist, doctor or nurse/midwife.

Abortion is permitted in the Maldives for following conditions 1) for thalassaemia major and sickle cell major within 120 days of pregnancy and 2) for multiple congenital anomalies and anencephaly within 120 days of pregnancy (3) Abortion for rape (4)) Abortion for incest (5) when health of mother is endangered. Thalassaemia is relatively common among Maldivians with a prevalence of 0.38% in 2005, carried by 18% of the population and affects one child in every 250.

Prevention of mother to child transmission (PMTCT) of HIV and syphilis infection is given special attention within the Reproductive Health (RH) programme. The target is in 2016 to achieve 90% of pregnant women visiting ANC clinics have comprehensive knowledge on HIV infection and prevention and access to PMTCT programme. An important target is achieved by screening 100% of women attending ANC clinics for HIV and syphilis, but pregnant women are provided with an opt out option, though all pregnant women so far have opted to go for testing.

Annex 3: National Validation Committee, National Validation Team members

National Validation Committee	National Validation Team
<p>Abdulla Nazim Ibrahim, Minister of Health (Chair)</p> <p>Dr Aishath Rameela, Minister of State for Health, MoH</p> <p>Ms. Khadeeja Abdulla, Permanent Secretary, MoH</p> <p>Ms. Maimoona Aboobakuru, DG of Public Health, HPA</p> <p>Dr Arvind Mathur, WHO Country Representative to Maldives</p> <p>Ms. Shahula Ahmed, Program Specialist, UNICEF country office Maldives</p> <p>Dr Ali Nazeem, Medical Director, IGMH</p> <p>Dr Aseel Jaleel, Consultant Gynecologist, IGMH</p> <p>Dr Ibrahim Saeed, Consultant Pediatrician, IGMH</p> <p>Ms. Thasleema Usman, Deputy Director General, MOH</p> <p>Mr. Mohamed Rameez, DDG, NDA</p> <p>Ms. Fazna Shakir, Society for Health Education, Civil society (Vulnerable population)</p> <p>Mr. Ahmed Nazim, COO, Journey, Civil society (People who use drugs)</p> <p>Ms. Aishath Noora, Secretary General, MRC- (Migrants)</p> <p>Ms. Aishath Samiya, Deputy Director General ,Planning and International Health, MoH(Health Policy)</p> <p>Dr Mariyam Jenyfa, Head of Population health division, HPA (Reproductive, Maternal Child Health)</p> <p>Dr. Fathmath Nazla Rafeeq, Head of communicable disease control division , HPA (TB/HIV/STI program)</p> <p>Ms. Mariyam Mirfath, Statistician ,National Bureau of Statistics</p> <p>Dr Milza Abdul Muhusin, Consultant Pathologist IGMH Lab, Laboratories</p> <p>Ms. Mariyam Nilfa, Director, Human Rights Commission of the Maldives (Human rights)</p> <p>Person(s) affected by disease (Reservations)</p>	<p>Data Analysis</p> <p>Ms Maimoona Aboobakuru, DG of Public Health, HPA, MOH</p> <p>Mr Ibrahim Nishan, Deputy Director General, HPA, MOH</p> <p>Dr. Mariyam Suzana, Senior Lecturer, Faculty of Health Science, Maldives National University (Local Consultant)</p> <p>Dr. Ibrahim Afzal, Epidemiologist, HPA, MOH</p> <p>Program Analysis</p> <p>Dr. Ali Nazeem, Medical Director, IGMH (HIV treatment)</p> <p>Dr. Mariyam Jenyfa, Senior Medical Officer, MCH, HPA</p> <p>Dr. Fathmath Nazla Rafeeq, Medical Officer, Communicable Diseases , HPA</p> <p>Mr. Abdul Hameed, Senior Public Health Programme Officer, NAP, HPA</p> <p>Laboratory Analysis</p> <p>Ms. Shareefa Adam Manike, Director General, MFDA</p> <p>Dr. Milza Abdul Muhusin, Head of Laboratory, IGMH</p> <p>Ms. Thasleema Usman, Deputy Director General, MOH</p> <p>Human Rights Analysis</p> <p>Ms Fazna Shakir, CEO, Society for Health Education</p> <p>Ms. Mariyam Nilfa, Director, Human Rights Commission of the Maldives</p> <p>Ms. Noora Mohamed, Secretary General, Maldivian Red Crescent</p> <p>Mr. Ahmed Nazim, COO, Journey, Civil society (People who use drugs)</p>

Annex 4: PLWHA in Maldives as of August 2018

#	Gender	Marital status	Age (when tested positive)	Date, tested positive	Possible place/route transmission occurred	ARV initiated on (Registered date)	Regimen	Last VL	Remarks
1	M	Widower	40	7-Oct-95	Abroad	Oct-07	Lamivudine+ Zidovudine+ Efavirenz	Ranbaxy result requested	
2	M	Married	23	12-Aug-04	Abroad	2007	Lamivudine+ Zidovudine+ Nevirapine	242000 CD4:411 12-sep-2016	Unmarried at diagnosis, married later, couple under program counseling and guidance, spouse negative Patient is living in a remote Island, where construction is going on, will be assessed as soon as he has access to a Health Center.
3	M	Unmarried	26	13-Nov-11	Sexual, MSM	Nov-11	Viraday	<40 Cd4:554 (24-1-2018)	Local transmission, sexual partner not in country now
4	M	Unmarried	20	2012	Maldives, Client of sex worker, Drug use (injecting?)	2012	Viraday	3480 (28-Aug-2018)	Local transmission, source not able to trace/link
5	M	Unmarried	22	2013	Sexual, MSM	16-Jan-13	Viraday	<40 (17-nov-2015)	Transmission abroad
6	F	Married	32	19-Feb-14	Blood transfusion	20-Feb-14	Viraday	499000 (9-Sep-2018)	Local transmission; pregnant mother, married at the time of diagnosis, but now divorced, ex-spouse negative
7	M	Married	49	21-Feb-14	Client of a sex worker	22-Feb-14	Viraday	<40 19-jul-2018	Transmission abroad, spouse negative
8	M	Married	30	4-Mar-15	Occupational exposure?	5-Mar-15	Viraday	<40 2-may-2017	Transmission abroad, spouse negative
9	M	Divorced	42	12-Oct-15	Client of sex worker	22-Oct-15	Viraday	<40 18-jan-2018	Transmission abroad
10	M	Unmarried	20	1-Aug-17	Client of sex worker	1-Aug-17	Viraday	53000 31-jul-2018	Transmission abroad
11	M	Unmarried	25	7-Nov-17	Sexual transmission	8-Nov-17	Viraday	Ranbaxy result requested	Local transmission; possible source to be confirmed

Annex 5: Case study of HIV Positive pregnancy case of 2014

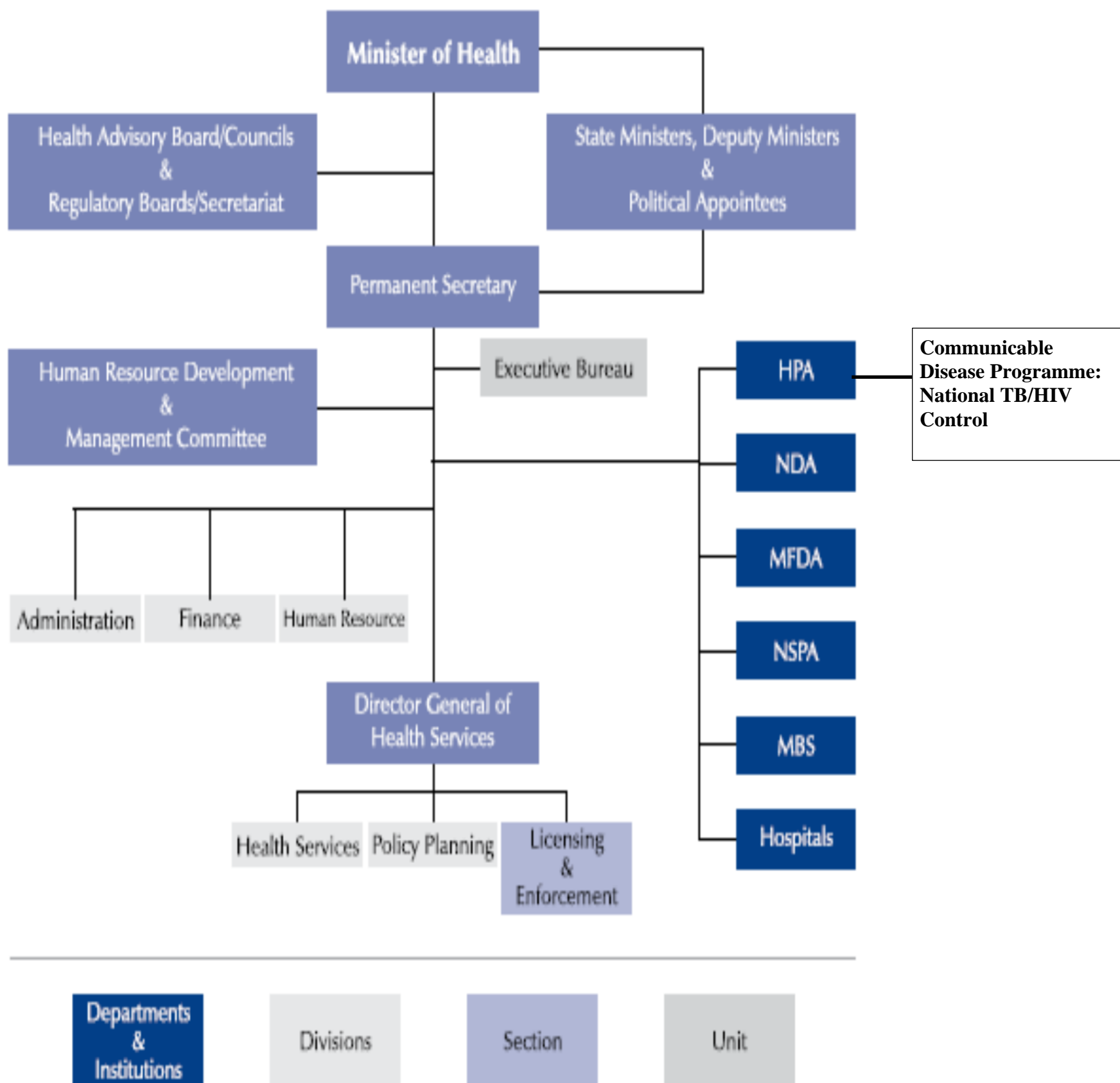
The case was a ~30-year-old female, 34-weeks into her pregnancy, who was transfused with HIV-positive blood from a family-referred donor that had been mistakenly recorded as HIV negative. Blood transfusion was required as her hemoglobin was low. As per her ANC reports in the previous pregnancy and earlier during ANC visit, she tested negative for HIV and Syphilis. Upon spotting the error in reporting of the positive blood sample, the hospital laboratory alerted the HIV Physician as well as the National AIDS Programme (NAP). The woman and her partner then received counseling and other related screenings as per the Guidelines. She was reported as HIV positive on 19th February 2013. Her baseline CD4 count was 371.

The woman was started on ART treatment immediately and received 10 days of the treatment prior to delivery- this step was recounted by the HIV Physician as the first of 4 steps undertaken by the attending team (which included pediatricians, obstetrician-gynecologists, NAP, and international specialists) that were instrumental to the positive outcome of the treatment. The baby was delivered through a Caesarian Section in March 2013 as a second step to ensure safe and controlled delivery of the baby. The mother had chosen to deliver at ADK, a private hospital and her requests were respected.

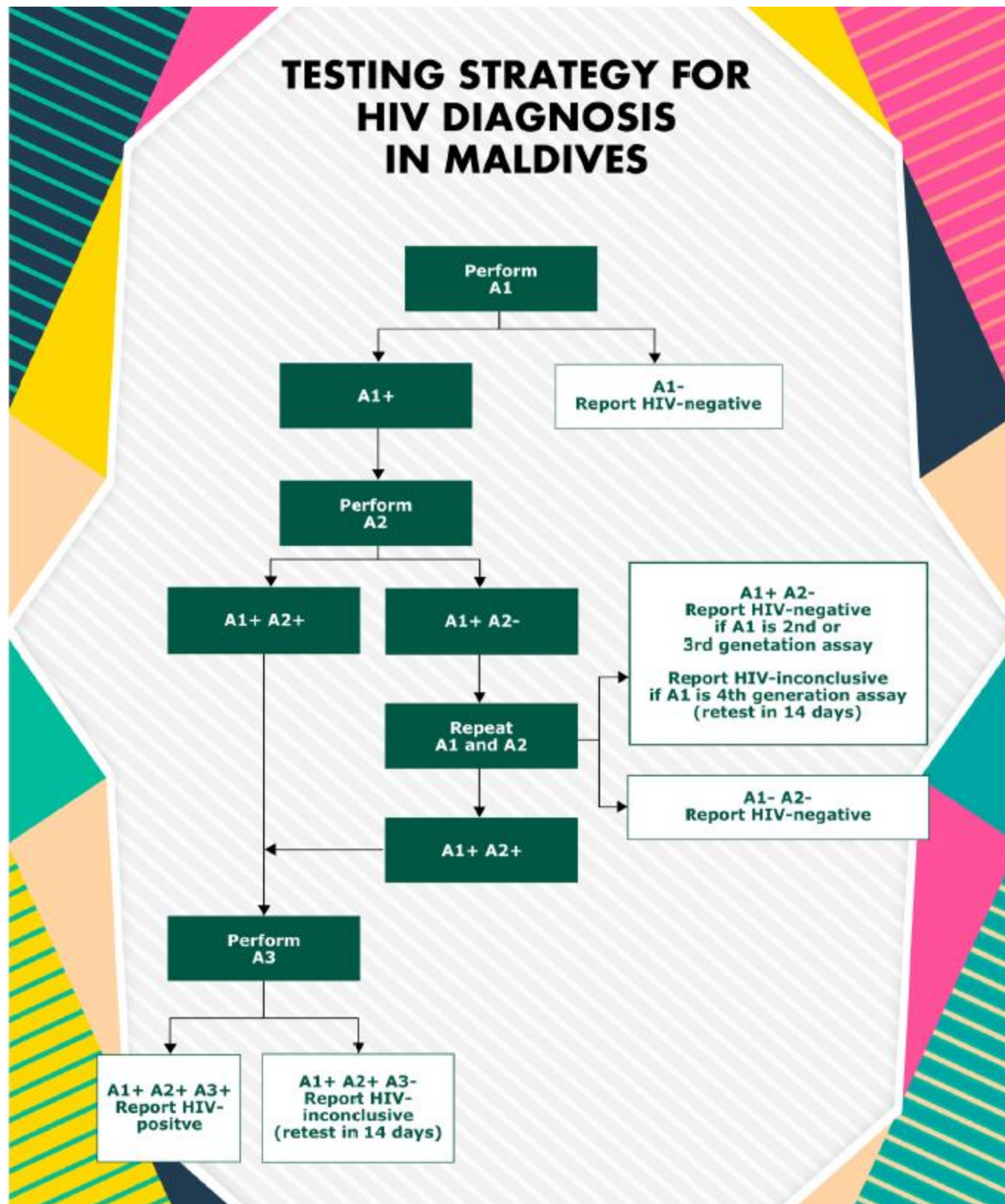
The follow up treatment for the newborn was held in collaboration between the physicians in both hospitals. The baby was negative for HIV at birth and samples were sent to Ranbaxy, Mumbai for determination of the viral load. The baby was born at 2.4kg and was started on ART treatment within 2 hours of birth- this marks the third crucial step taken by the team. Due to high the high viral load (as the HIV exposure was through blood transfusion), considering the mother started receiving ARV 2-3 weeks after the transfusion, and emerging literature particularly on the 'Mississippi Baby' in the US, the baby received 3-drug ART (NVP/AZT/3TC) for ~12 weeks. The baby is about 4 years old now and continues to be HIV free.

Annex 6: Organization structure of the Ministry of Health, Maldives

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



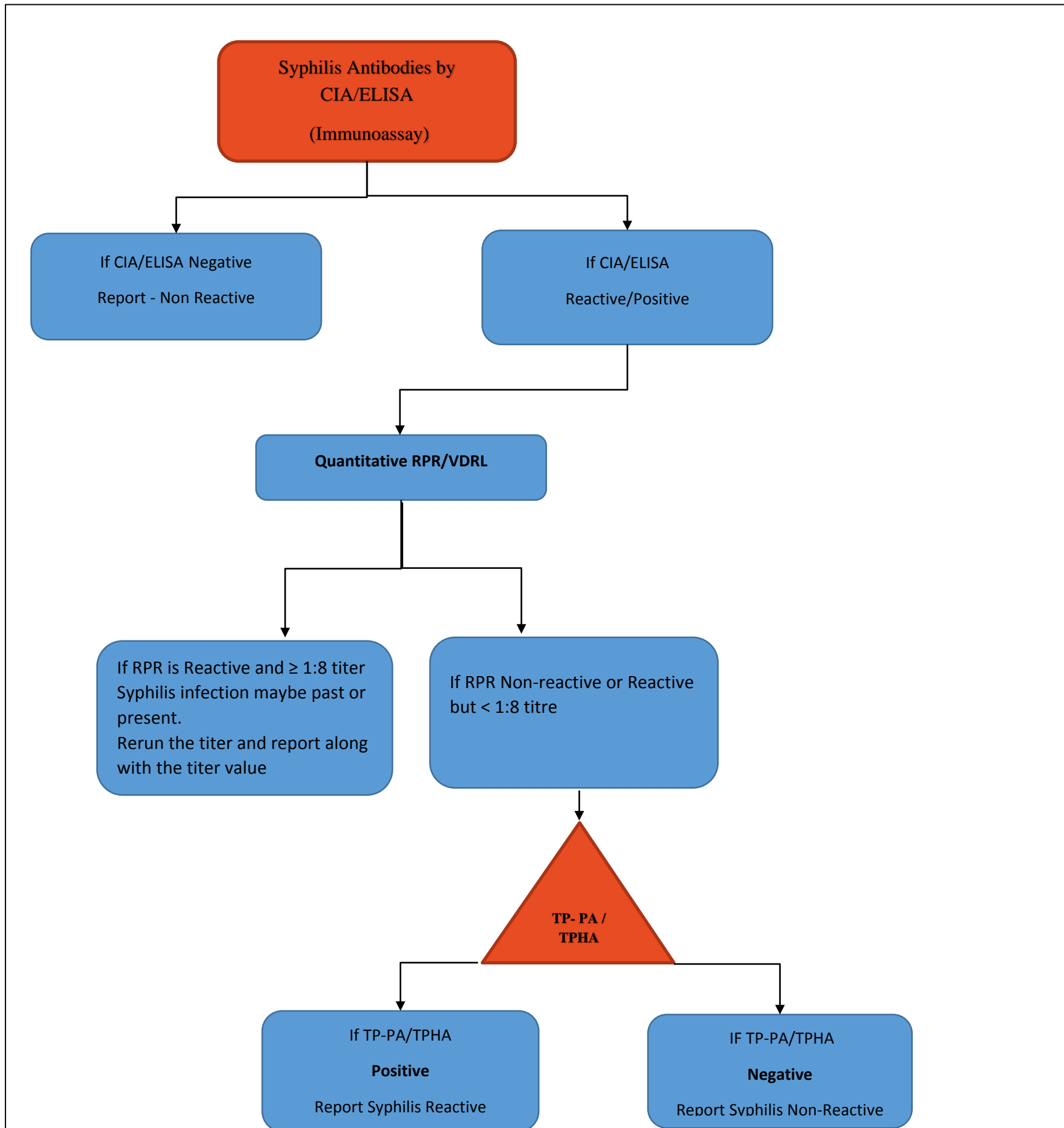
Annex 7: Algorithm for HIV testing



Annex 8: Timeline of the National Validation for EMTCT

November 2015:	NVC was formed and first meeting held (Decision, plan and time line endorsed)
December 2016:	Data collection was initiated by Dr Suzana (including the first draft report)
January 2017:	WHO/SEARO Regional Advisor for HIV and STI, Dr Razia Pense visited Maldives to support the ongoing data collection and report writing process.
10 January 2017:	2nd Meeting of the NVC to update on the ongoing data collection and report writing process and share the preliminary findings, and interaction with WHO/SEARO Regional Advisor for HIV and STI, Dr Razia Pense
February 2017:	Based on the technical advice from WHO new members were included in the NVC
April 2017:	Online data verification in Hdh, Seenu and Ga, prior to national data audit.
Feb-March 2018:	National Data Audit conducted across all health facilities providing ANC and delivery services
23rd May 2018:	NVC meeting to endorse the National report (The report was finalized, and conditionally endorsed, to further improve before the submission)
1 August 2018:	NVC meeting to endorse the final report and pass the decision to send the validation request to RD
6 August 2018:	Minister of Health, Hon Abdulla Nazim Ibrahim officially requested the RD to facilitate the validation process for Maldives
8 August 2018:	Mock review was held, facilitated by Dr B.B. Rewari
11 August 2018:	Maldives submitted the validation request to WHO/SEARO with the final report.
9-14 September 2018:	RVT visit to Maldives for verification of the report.

Annex 9: Algorithm for Syphilis testing



Annex 10: Case definitions

Disease / ICD code	Local surveillance case definition (Source: Case definitions for notifiable diseases in Maldives (2014), Health Protection Agency / Ministry of Health)
<p>Syphilis (A50-52)</p>	<p><u>Syphilis, secondary: ICD 10: A51.3, A51.4</u></p> <p>A stage of infection caused by T.pallidum and characterized by localized or diffuse mucocutaneous lesions, often with generalized lymphadenopathy. The primary chancre may still be present.</p> <p>Laboratory criteria for diagnosis:</p> <p>Demonstration of T.pallidum in clinical specimens by darkfield microscopy, DFA-TP, or equivalent methods.</p> <p><u>Syphilis, early latent</u></p> <p>A subcategory of latent syphilis. When initial infection has occurred within the previous 12 months, latent syphilis is classified as early latent.</p> <p>Case classification:</p> <p>Suspected: Not applicable</p> <p>Probable: latent syphilis (see syphilis latent) in a person who has evidence of having acquired the infection within the previous 12 months based on one or more of the following criteria:</p> <ul style="list-style-type: none"> - Documented seroconversion of four fold or greater increase in titer of a non treponemal test during the previous 12 months - A history of symptoms consistent with primary or secondary syphilis during the previous 12 months - A history of sexual exposure to a partner who had confirmed or probable primary or secondary syphilis or probable early latent syphilis (documented independently as duration <1years) - Reactive non treponemal and treponemal tests from a person whose only possible exposure occurred within the preceding 12 months <p>Confirmed: Not applicable</p> <p><u>Syphilis, late latent: (ICD 10: A52.8)</u></p> <p>A subcategory of latent syphilis. When initial infection has occurred >1 year previously, latent syphilis is classified as late latent.</p> <p>A reactive serologic test for syphilis and reactive VDRL in cerebrospinal fluid (CSF)</p> <p>Case classification:</p> <p>Probable: syphilis of any stage, a negative VDRL in CSF and both of the following:</p> <ul style="list-style-type: none"> - Elevated CSF protein or leukocyte count in the absence of other known causes of these abnormalities - Clinical symptoms or signs consistent with neurosyphilis without other known causes for these clinical abnormalities

	<p>Confirmed: syphilis of any stage that meets the laboratory criteria for neurosyphilis.</p> <p><u>Congenital syphilis: (ICD 10: A50-50.9)</u></p> <p>A condition caused by infection in utero with <i>Treponema pallidum</i>. A wide spectrum of severity exists, and only severe cases are clinically apparent at birth.</p> <ul style="list-style-type: none"> - A live birth or fetal death at >20 weeks of gestation or >500 g (including stillbirth) born to a woman with positive syphilis serology and without adequate syphilis treatment* Or - a live birth, stillbirth or child aged <2 years born to a woman with positive syphilis serology or with unknown serostatus, and with laboratory and/or radiographic and/or clinical evidence of syphilis infection (regardless of the timing or adequacy of maternal treatment). <p>* Adequate maternal treatment is defined as at least one injection of 2.4 million units of intramuscular benzathine benzyl penicillin at least 30 days prior to delivery.</p>
<p>HIV infection (B20-24)</p>	<p>Clinical description: There is no clinical description; the diagnosis is based on laboratory criteria.</p> <p>Laboratory criteria for diagnosis:</p> <p>HIV positive serology (ELISA)</p> <p>Confirmation should be a second ELISA or simple/rapid assay based on a different antigen preparation and/or a different test principle.</p> <p>Case classification</p> <p>Confirmed HIV case: A laboratory-confirmed case.</p> <p>Note: Except for unlinked anonymous testing, serological testing should only be done in combination with appropriate pre- and post-counselling services.</p> <p>Western Blot is used for individual confirmation in discordant cases using WHO algorithms</p>
<p>AIDS (B20-B21-B22-B23-B24)</p>	<p>1A. Without laboratory evidence of HIV infection (no other causes of immune suppression)</p> <p>Indicator disease diagnosed definitively</p> <ul style="list-style-type: none"> - Candidiasis of the oesophagus, trachea, bronchi, or lungs - Cryptococcosis, extrapulmonary - Cryptosporidiosis with diarrhoea persisting >1 month - Cytomegalovirus diseases of an organ other than liver, spleen, or lymph nodes in patient >1 month of age <p>- Herpes simplex virus infection causing a mucocutaneous ulcer persisting >1 month; or bronchitis, pneumonitis, or oesophagitis for any duration in a patient >1 month of age</p> <p>- Kaposi sarcoma in a patient <60 years of age</p> <p>- Lymphoma of the brain (primary) affecting a patient <60 years of age</p> <p>- <i>Mycobacterium avium</i> complex or <i>M. kansasii</i> disease, disseminated (site other than/in addition to lungs, skin, cervical or hilar lymph nodes)</p> <p>- <i>Pneumocystis carinii</i> pneumonia</p>

- Progressive multifocal leukoencephalopathy
- Toxoplasmosis of the brain in a patient >1 month of age
- In children <13: 2 or more bacterial infections within a 2-year period (septicaemia, pneumonia, meningitis, bone or joint infections.) or abscess of an internal organ or body cavity . excluding otitis media or superficial abscesses.

1B. With laboratory evidence of HIV infection

Indicator disease diagnosed definitively

- Coccidioidomycosis, disseminated (at a site other than or in addition to lungs or cervical or hilar lymph nodes)
- HIV encephalopathy

Histoplasmosis, disseminated (other than or in addition to lungs or cervical or hilar lymph nodes)

- Isosporiasis with diarrhoea persisting >1 month
- Kaposi sarcoma at any age
- Lymphoma of the brain (primary) at any age
- Non-Hodgkin.s lymphoma
- Any mycobacterial disease caused by other than *M. tuberculosis*, disseminated
- Disease caused by *M. tuberculosis*, extrapulmonary
- Salmonella (non-typhoid) septicaemia, recurrent
- HIV wasting syndrome

Indicator disease diagnosed presumptively

- Candidiasis of the oesophagus
- Cytomegalovirus retinitis with loss of vision
- Kaposi sarcoma
- Mycobacterial disease, disseminated
- *Pneumocystis carinii* pneumonia
- Toxoplasmosis of the brain in patient >1 month of age
- In children <13: lymphoid interstitial pneumonia and/or pulmonary lymphoid Hyperplasia

CONDITIONS ADDED TO SURVEILLANCE DEFINITION FOR AIDS WITH LABORATORY EVIDENCE OF HIV INFECTION (1B above)

In addition to those in the surveillance definition:

- CD4+ T-lymphocyte count <200 x 10⁶/litre (or a CD4 percentage <14%)
- Pulmonary tuberculosis
- Cervical cancer, invasive
- Recurrent pneumonia (more than one episode within a 12-month period)

Annex 11: National breastfeeding policy

Breast feeding policy for EMTCT is to recommend exclusive formula feeding, with state providing free formula for the first year, clubbed with ongoing counselling. For women who choose to breast feed, the national breast feeding policy is highly supportive.

National breast feeding Policy: Exclusive breastfeeding for the first six months is promoted, encouraged with counselling provided to all ANC women and mothers. Feed within the first hour after birth is practiced together with rooming in. A cross-sectional survey of 251 Maldivian mothers recruited from the 'well baby' clinics in Malé city showed that exclusive breast-feeding rate at hospital discharge was 93% and the median duration of breast-feeding was 24 months (R. Abduraheem et al, 2007). The global breast feeding scorecard 2017 developed by WHO and UNICEF analyses indicators on how countries protect, promote and support breastfeeding through funding or policies (WHO, 2017). According to the scorecard, the Maldives fared higher than regional and world averages in the four dimensions of the score card; early initiation of breast feeding in less than one hour after birth, exclusive breastfeeding till 6 months, continued breast feeding till one year and continued breast feeding until two years of age. Regulation on the import, produce and sale of breast milk substitutes in the Maldives has been enacted and implemented in the country with a published list of registered importers and designated list of products which was updated in August 2017. Breast feeding policy for EMTCT is exclusive formula feeding, with state providing free formula for the first year, clubbed with ongoing counselling.

Annex 12 Migrants testing positive for HIV in 2014-2017

Number	Sex	Age	Currently in Maldives
2014			
1	F	26	No
2	M	38	No
3	M	36	No
4	M	37	No
5	M	32	No
6	F	38	No
7	F	30	No
8	M	41	No
9	F	27	No
10	M	46	No
11	M	47	No
12	M	56	No
2015			
1	M	33	No
2		42	No
3	M	34	No
4	F	30	No
5	F	28	No
6	M	40	No
7	M	31	No
8	M	20	No
9	M	30	No
10	M	33	No
11	M	45	No
12	F	34	No
13	M	32	No
2016			
1	M	24	No
2	M	35	No
3	F	39	No
4	M	34	No
5	M	27	No
6	M	38	No
7	F	32	No
8	F	29	No
9	M	34	No
10	F	34	No
11	M	27	No
12	M	36	No
13	M	29	No
14	M	35	No
15	M	29	No
16	M	28	No
17	M	33	No
18	F	43	No
19	M	49	No
20	M	31	No
21	M	33	No
22	M	23	No
23	M	23	No

2017			
1	M	36	No
2	M	28	No
3	M	41	No
4	M	25	No
5	M	32	No
6	F	33	No
7	F	30	No
8	M	49	No
9	M	46	No
10	M	31	No
11	M	27	No
12	M	34	No
13	M	24	No
14	F	32	No
15	M	40	No
16	M	37	No
17	F	33	No
18	M	41	No
19	F	41	No
20	M	32	No
21	F	28	No
22	M	47	No
23	M	28	No
24	M	38	No
25	M	54	No
26	M	37	No
27	M	37	No
28	M	30	No
29	M	24	No
30	M	35	No
31	M	46	No
32	M	42	No

Annex 13: List of Participants interviewed for program, laboratory and human rights assessment.

Civil Society, NGOs, Migrants, FSWs PWIDs Total: 56 participants	Lab heads and lab staff Total: 10 participants	Current and Past Policymakers (Public sector) Total: 12 participants	Private sector Policymakers Total: 4 participants
<p>Respondent 1 GaVAH: Vice president and one member of the Womens' committee of Villingili island, President of the National women's development society in Ga.Villingili</p> <p>Respondent 2 GaVAH: 3 migrants, aged 35, 28 and 24 years, working as construction, shop keeper, fiber boat building</p> <p>Respondent 3 GaVAH: 1 female PWID , 22 years</p> <p>Respondent 4 KRH:Womens committee of the island</p> <p>Respondent 5 KRH: 3 members of the MRC Kulhudhuffushi branch</p> <p>Respondent 6 KRH: female PWID, 20year</p> <p>Respondent 7 KRH: FSW, 45 years</p> <p>Respondent 7 KRH: FSW, <20years</p> <p>Respondent 8 KRH: Female migrant, Bangladesh, has worked 8 years in the Maldives</p> <p>Respondent 9 Male':3 FSWs</p> <p>Respondent 10 Male': 4 PWIDs</p> <p>Respondent 11 Male': Migrant</p> <p>Respondent 12 SRH: 22 Migrants working in Maradhoo Feydhoo island</p> <p>Respondent 13 SRH:3 Female PWIDs Respondent 14 SRH:</p> <p>Unmarried pregnancy case</p>	<p>Respondent 1GaVAH: Ms. Mariyam Faheem, Laboratory</p> <p>Respondent 2 KRH: Ms.Khadheeja Ali, Laboratory Technologist Gr2, KRH, 6years experience</p> <p>Respondent 3 IGMH: Ms. Sofie</p> <p>Respondent 4 SRH: Ms. Majdha Saeed, Laboratory technologist, 12 years of experience</p> <p>Respondent 5 IMDC:Mr. Bala Subramanian, Laboratory technologist, IMDC</p> <p>Respondent 6 AIMS: Dr. Bhaskar Srivasta, Laboratory technician, 12 years of experience</p> <p>Respondent 7 F&C: Mr. Mohamed Faiz, MD, 14 years of experience</p> <p>Respondent 8 LGRH: Ms. Fathmath Saudha, Laboratory technician, 2 years experience</p> <p>Respondent 9 SHE: Ms/ Khadheeja Shakir, Director, 1year of experience</p> <p>Respondent 10 IGMH: Dr.Milza, Laboratory Incharge</p>	<p>Respondent 1 GaVAH: Mr. Ahmed Shaheem, Previous inchargeof Hospital, in service from 1980-2016</p> <p>Respondent 2 KRH: Mr. Hassan Ahmed (Hassanbe), Previous Manager (Regional health officer), in service from 1960-2008</p> <p>Respondent 3 KRH: Ms. Fathmath Hassan, Ms. Sameena Mohamed, Community health officers, 10 & 13 years experience</p> <p>Respondent 4 KRH: Mr. Ibrahim Waheed, Hospital Manager,</p> <p>Respondent 5 HPA: Mr. Abdul Hameed, HIV program/HPA</p> <p>Respondent 6 IGMH: Dr. Ali Nazeem, Consultant physician for NAP, Director medical /IGMH</p> <p>Respondent 7 IGMH: Dr. Faisal, Paediatrician/IGMH</p> <p>Respondent 8 HPA: Ms. Nazeera, Previous Program manager of RH</p> <p>Respondent 9 HPA: Dr. Fathimath Nazla Rafeeg,Medical Officer, Communicable Disease Control</p> <p>Respondent 10 SRH: Mr. Mohamed Saeed, Previous Hospital Manager/SRH , 8years</p> <p>Respondent 11 SRH: Mr. Mohamed Najeeb, Hospital Manager, 6months</p> <p>Respondent 12 SRH:Ms. Sama Hassan, A.MRO, 5 years experience</p>	<p>Respondent 1 LGRH: Ms. Aminath Fakhriyya, Assistant Community Health Officer, 6 years of experience</p> <p>Respondent 2 SHE: Ms. Khadheeja Shakir, Director, 1 year experience</p> <p>Respondent 3 IMDC: Mr. Shafaq Hussain, Assistant Manager, 8years of experience</p> <p>Respondent 4 AIMS: Mr.Saeed, 2years of experience</p>

Annex 14: List of Non Maldivians who accessed antenatal services, 2016-2017

#	Nationality	RESIDENT ATOLL	AGE	TYPE OF BIRTH	Province of ANC Facility	SYPHILIS TEST RESULT	BABY HAVE CS	HIV TEST RESULT	ARV GIVEN
1	Not stated	Kaafu Atoll	38	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
2	Not stated	Kaafu Atoll	34	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
3	Not stated	Kaafu Atoll	28	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
4	Pakistan	Kaafu Atoll	34	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
5	Russia	Kaafu Atoll	27	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
6	India	Kaafu Atoll	35	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
7	Russia	Seenu Atoll	38	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
8	Kazakhstan	Kaafu Atoll	26	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
9	Philippines	Noonu Atoll	24	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
10	India	Laamu Atoll	33	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
11	India	Kaafu Atoll	32	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
12	Not stated	Kaafu Atoll	35	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
13	Pakistan	Kaafu Atoll	29	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
14	India	Laamu Atoll	34	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
15	Not stated	Gnaviyani Atoll	21	Spontaneous abortion	North Central Province	Negative	NO	Negative	Not applicable
16	Philippines	Kaafu Atoll	25	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
17	India	Kaafu Atoll	23	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
18	Bangladesh	Kaafu Atoll	27	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
19	Bangladesh	Kaafu Atoll	35	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
20	Indonesia	Kaafu Atoll	36	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
21	Not stated	Kaafu Atoll	19	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
22	France	Kaafu Atoll	36	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
23	India	Kaafu Atoll	38	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
24	Not stated	Kaafu Atoll	38	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
25	Not stated	Alif Dhaal Atoll	28	Live Birth	Central Province	Negative	NO	Negative	Not applicable
26	Sri Lanka	Noonu Atoll	35	Live Birth	Not stated	Negative	NO	Negative	Not applicable
27	Italy	Baa Atoll	38	Spontaneous abortion	North Province	Negative	NO	Negative	Not applicable
28	Bangladesh	Baa Atoll	31	Spontaneous abortion	North Province	Negative	NO	Negative	Not applicable
29	India	Gaaf Alif Atoll	34	Live Birth	South Central Province	Negative	NO	Negative	Not applicable
30	Not stated	Gaaf Dhaal Atoll	33	Spontaneous abortion	South Central Province	Negative	NO	Negative	Not applicable
31	Not stated	Haa Alif Atoll	31	Live Birth	Upper North Province	Negative	NO	Negative	Not applicable
32	Not stated	Haa Dhaal Atoll	33	Live Birth	Upper North Province	Negative	NO	Negative	Not applicable
33	Bangladesh	Alif Alif Atoll	20	Live Birth	Not stated	Negative	NO	Negative	Not applicable
34	India	Shaviyani Atoll	36	Live Birth	Upper North Province	Negative	NO	Negative	Not applicable
35	UAE	Noonu Atoll	41	Live Birth	Not stated	Negative	NO	Negative	Not applicable
36	China	Seenu Atoll	27	Live Birth	South Province	Negative	NO	Negative	Not applicable
37	Not stated	Seenu Atoll	26	Live Birth	South Province	Negative	NO	Negative	Not applicable

38	India	Seenu Atoll	30	Live Birth	South Province	Negative	NO	Negative	Not applicable
39	India	Dhaalu Atoll	30	Still Birth	Central Province	Negative	NO	Negative	Not applicable
40	Not stated	Noonu Atoll	33	Live Birth	Not stated	Negative	NO	Negative	Not applicable
41	Not stated	Raa Atoll	24	Live Birth	Not stated	Negative	NO	Negative	Not applicable
42	Not stated	Raa Atoll	27	Live Birth	Not stated	Negative	NO	Negative	Not applicable
43	Not stated	Raa Atoll	28	Live Birth	Not stated	Negative	NO	Negative	Not applicable
44	India	Raa Atoll	35	Live Birth	Not stated	Negative	NO	Negative	Not applicable
45	Not stated	Raa Atoll	54	Live Birth	Not stated	Negative	NO	Negative	Not applicable
46	Pakistan	Kaafu Atoll	29	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
47	Sri Lanka	Kaafu Atoll	29	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
48	Ukraine	Kaafu Atoll	35	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
49	India	Kaafu Atoll	29	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
50	Kazakhstan	Kaafu Atoll	31	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
51	India	Kaafu Atoll	37	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
52	Indonesia	Kaafu Atoll	29	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
53	Not stated	Kaafu Atoll	22	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
54	Kerala	Kaafu Atoll	28	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
55	Indonesia	Kaafu Atoll	NA	Live Birth	North Central Province	Negative	NO	Negative	Not applicable
56	Indonesia	Kaafu Atoll	29	Live Birth	North Central Province	Negative	NO	Negative	Not applicable

Source: National Program Records 2016-2017 and birth record form as part of the Vital Registration System.

Note: Both Maldivians and non-Maldivians have to follow the “birth record form” as part of the Vital Registration System. The form records all birth outcomes, i.e., live births, still births, induced abortion and spontaneous abortion (See annex 15)

Annex 15: Template for birth record form

Department of National Registration
Male', Republic of Maldives



ދިވެހިރާއްޖޭގެ ޖުމްހޫރިއްޔާ ގުޅިގެން
ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން


Birth Record Form

Birth Record Serial Number
ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން

Current Birth Information			
Gestational Age ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން		Birth Type / ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	
Induced Abortion <input type="checkbox"/>		Spontaneous Abortion <input type="checkbox"/>	
Still Birth <input type="checkbox"/>		Live Birth <input type="checkbox"/>	
Birth Weight (in Grams) ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން		Mode of Delivery / ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	
Sex of Child ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން		Assisted Vaginal (non-instrumental) <input type="checkbox"/>	
Number delivered ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން		Spontaneous Vaginal <input type="checkbox"/>	
Country of Birth ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން		Vaginal Vacuum extraction <input type="checkbox"/>	
Place of Birth ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން		Vaginal Forceps extraction <input type="checkbox"/>	
Atoll and island of Birth ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން		Emergency Caesarian <input type="checkbox"/>	
Hijri / ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން		Elective Caesarian <input type="checkbox"/>	
Birth Time C.E. / ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން		Birth Date ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	
Informant's Bio-Information		Birth Attendant's Bio-information	
ID No. <input type="checkbox"/>	Passport <input type="checkbox"/>	ID No. <input type="checkbox"/>	Passport <input type="checkbox"/>
Work permit <input type="checkbox"/>	NIC NO. <input type="checkbox"/>	Work permit <input type="checkbox"/>	NIC NO. <input type="checkbox"/>
ID not Produced <input type="checkbox"/>	ID Produced <input type="checkbox"/>	ID not Produced <input type="checkbox"/>	ID Produced <input type="checkbox"/>
Date of Birth ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	NIC serial NO. ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Name ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Official address ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން
Name ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Permanent Address (with atoll and island) ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Nationality ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Nationality ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން
Nationality ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Relation with newborn ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	No Midwifery Training <input type="checkbox"/>	Midwifery Training <input type="checkbox"/>
Mother's Bio-Information		Father's Bio-Information	
ID No. <input type="checkbox"/>	Passport <input type="checkbox"/>	ID No. <input type="checkbox"/>	Passport <input type="checkbox"/>
Work permit <input type="checkbox"/>	NIC NO. <input type="checkbox"/>	Work permit <input type="checkbox"/>	NIC NO. <input type="checkbox"/>
ID not Produced <input type="checkbox"/>	ID Produced <input type="checkbox"/>	ID not Produced <input type="checkbox"/>	ID Produced <input type="checkbox"/>
Age ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Date of Birth ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Age ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Date of Birth ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން
NIC serial NO. ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Mother's Name ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	NIC serial NO. ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Father's Name ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން
Name ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Permanent Address (with atoll and island) ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Name ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Permanent Address (with atoll and island) ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން
Nationality ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Place of usual Residence (with atoll and island) ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Nationality ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Place of usual residence (with atoll and island) ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން
Contact number ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Nationality ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Contact number ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Nationality ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން
Past Obstetric History			
Total no. of pregnancies ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Total no. of prior abortions / miscarriages ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Total no. of prior live births ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Age at first pregnancy ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން
Total no. of deliveries ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Total no. of prior still births ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Age at first marriage ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	
Marriage Information			
Marriage Duration ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Widowed <input type="checkbox"/>	Divorced <input type="checkbox"/>	Married <input type="checkbox"/>
Marriage Date ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	Single <input type="checkbox"/>	Mother's Marital Status at delivery ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	
Marriage certificate number ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން			
I hereby declare information I have given above are correct to the best of my knowledge ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން			
Signature of Mother ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން		Signature of Birth Attendant ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	
Official Stamp & Date ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން			
Signature of Father ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން		Signature of Informant ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ގެޒެޓް ގަޑިއެއްޗެއްގެ ދަށުން	

V3.00/150513/26/P1

Annex 16: Communicable disease notification

 Communicable Disease Notifying Form Health Protection Agency Male', Republic of Maldives	
Reporting Facility	<input type="checkbox"/> *Re-notification (required for changes in diagnosis (e.g. Dengue Fever to DHF), case confirmation or outcome (e.g. death).
Notifiable Diseases (place ✓ appropriately)	
Immediately notifiable via form and Telephone (+960 3014496)	Notifiable within 24 hrs to HPA
<input type="checkbox"/> Acute Flaccid Paralysis (use Polio investigation form) <input type="checkbox"/> Cholera <input type="checkbox"/> Diphtheria <input type="checkbox"/> Encephalitis (specify organism if known) _____ <input type="checkbox"/> Food Poisoning (use investigation form) <input type="checkbox"/> Measles (complete measles investigation form) <input type="checkbox"/> Meningitis (specify organism if known) _____ <input type="checkbox"/> Mumps <input type="checkbox"/> Rabies <input type="checkbox"/> Rubella <input type="checkbox"/> Tetanus / <input type="checkbox"/> Neonatal tetanus <input type="checkbox"/> Tuberculosis (use TB investigation form) <input type="checkbox"/> Whooping Cough <input type="checkbox"/> Yellow Fever	<input type="checkbox"/> Chikungunya <input type="checkbox"/> DF/ <input type="checkbox"/> DHF/ <input type="checkbox"/> DSS <input type="checkbox"/> Filariasis <input type="checkbox"/> Hepatitis A / B / C / D / E (circle appropriately) <input type="checkbox"/> Leprosy <input type="checkbox"/> Leptospirosis <input type="checkbox"/> Malaria <input type="checkbox"/> Plague <input type="checkbox"/> Pyrexia of unknown origin (PUO) <input type="checkbox"/> Scrub Typhus <input type="checkbox"/> SARI (Severe Acute Respiratory Infection = ARI requiring hospital admission) <input type="checkbox"/> Typhoid/ <input type="checkbox"/> Paratyphoid (complete case investigation form) <input type="checkbox"/> Toxoplasmosis/ <input type="checkbox"/> Congenital toxoplasmosis <input type="checkbox"/> Others (specify) _____
Case Details (Mandatory fields are marked with (*) and underlined. Please make sure to complete them.)	
1- *Case classification: Suspect <input type="checkbox"/> Probable <input type="checkbox"/> Confirmed <input type="checkbox"/> (as per surveillance case definition)	
2- *Patient Nation ID No: A _____ <small>For foreigners include passport number</small>	3- *Patient Name: _____
4- *Age: <u>YY/MM</u>	5- *Sex: <input type="checkbox"/> M <input type="checkbox"/> F If pregnant <input type="checkbox"/>
6- *Patient's residential Address (pls confirm with patient.) _____	7- *Atoll/Island _____
8- Contact number _____	9- Foreigners country of origin _____
10- *Date of onset of illness: <u>DD / MM / YYYY</u>	11- Date of consultation: <u>DD / MM / YYYY</u>
12- *Patient category <input type="checkbox"/> Out-patient <input type="checkbox"/> In-patient: <input type="checkbox"/> Ward _____ Bed _____ <input type="checkbox"/> ICU _____ Bed _____	13- *Case outcome: <input type="checkbox"/> Death <input type="checkbox"/> On treatment <input type="checkbox"/> Referred to higher center <input type="checkbox"/> Recovered with disability <input type="checkbox"/> Recovered fully
14- Recent travel history if relevant (include countries visited)	15- Date of arrival in Maldives: <u>DD / MM / YYYY</u>
16- Clinical details (include risk factors, mode of transmission, etc.)	18- Laboratory Confirmation: <input type="checkbox"/> Confirmed: Test specifics _____ <input type="checkbox"/> If Requested, Date: <u>DD / MM / YYYY</u> <input type="checkbox"/> Not Requested
17- Condition of patient: <input type="checkbox"/> Stable <input type="checkbox"/> Sick <input type="checkbox"/> Critically ill	
Notifier details (eg: Dr, Nurse, HW or other designated person) Name: _____ Designation: _____ Signature: _____ Date: <u>DD / MM / YYYY</u>	Data entry use (use by PHUs and entry users) Date received: <u>DD / MM / YYYY</u> Date of entry: <u>DD / MM / YYYY</u> Checked and entered by: _____
For further information or inquiries, please contact: Health Protection Agency, Ministry of Health, Roshanee Building, Sosun Magu, Male'. Telephone: +960-3014 496, Hotline: +960-3014 333, Fax: +960-3014 484 Forms and case definition booklet are available on http://www.hpa.gov.mv , http://www.health.gov.mv	

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