HEALTH MASTER PLAN 2016 - 2025

MINISTRY OF HEALTH
REPUBLIC OF MALDIVES

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This Health master plan (HMP) is the 3rd long term plan of Maldives health sector which was formulated by the international consultant, Dr.Sheena Moosa, under the overall guidance of Ministry of Health (MoH). The overall formulation process was a collaborative and a consultative effort by national stakeholders. Consecutive meetings and discussions were carried out with stakeholders including public and private sectors as well as participation from political parties, Non-Governmental states, independent commissions and authorities, international development agencies and public in general.

The whole process of HMP was initiated with the full support from World Health Organization (WHO) under the direction of State Minister Hussain Rasheed, Permanent Secretary Khadeeja Abdul Samad Abdulla and State Minister Dr. Mohamed Habeeb.

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The views expressed are those of the draws on lessons learnt from previous planning cycles and challenges in implementing long-term plans in volatile political context and is based to the primary and secondary data collections from the relevant authorities.

The designations in this publication do not imply an opinion on legal status of any country or territory, or of its authorities, or the delimitation of frontiers.

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Foreword by Minister of Health

The Health Master Plan 2016-2025 provides strategic direction and guidance to all partners in health and collaborative sectors to further develop policies, plans, and programs to improve the health of the population.

A review of the Health Master Plan 2006-2015 was carried out in 2014 and the new Health Master Plan 2016-2025 was formulated. Emphasis was made on the lessons learned from the implementation of the preceding plan and focus was given to new priorities while sustaining the achievements of the previous plan. This process was a collaborative and a consultative effort by national stakeholders. Consecutive meetings and discussions were carried out with stakeholders including public and private sectors as well as participation from political parties, Non-Governmental states, independent commissions and authorities, international development agencies and public in general.

I take this opportunity to express sincere appreciation for the generous and continued support of the World Health Organization in developing this 10-year plan and convey gratitude to the WHO supported consultant, Dr. Sheena Moosa for her invaluable input and dedication in compiling this plan. I would also like to collectively acknowledge all the stakeholders, individuals and contributors at different sectors and levels who contributed to the process of formulating this plan. Their hard work, dedication, and enthusiasm are noteworthy and it was indeed encouraging to see such support.

I convey my sincere appreciation to the senior management team of Ministry of Health and relevant staff from Policy Planning and International Health Division of Ministry of Health for their dedicated efforts in the compilation of this plan.

I believe Health Master Plan 2016-2025 will greatly contribute to strengthening the national health system in the country. Ministry of Health will continue to play a key role in leading efforts of partners in health and other collaborative sectors to ensure linkages of their plans with the outputs and goals of this plan. I am confident the implementation of this plan will take the Maldives health sector to greater heights towards achieving national, regional and international development targets including Sustainable Development Goals.

Abdulla Nazim Ibrahim
Minister of Health

Foreword by WHO Representative

The Health Master Plan 2016-2025 for the Development of the Health Sector in the Maldives will serve to mobilize and coordinate its resources towards the attainment of healthier Maldives. This Plan lays vision and strategic directions for Health but also other sectors that contribute to improving Health of the people and provides guidance to further develop policies, plan, programs, activities and targets for implementation for the coming 10 years.

The Health Master Plan was developed through participatory multi-stakeholder consultations and iterative process. I must congratulate all those involved in preparing the document for their thoughtfulness in forecasting the needs of the people and health sector so well. On review of the document I am confident the planned strategic directions and its implementation will adequately address these needs.

The Health Master Plan preserves country's best practices and success stories, builds on country's achievements and is ambitious enough to strive for greater excellence and achieve newer milestones in health. It also provides a roadmap and focus to achieve related Sustainable Development Goals (SDG). Taking into account various global and regional developments such as Convention of Parties on Climate Change and Health, International Health Regulations, International Conference on Nutrition, global and regional efforts on tobacco control and WHO regional flagship programs; the Health Master Plan brings in commensurate strategic focus and activities within the Plan. It also outlines the directions for streamlining of the multi sectoral approaches and partnerships for inclusion and implementation of health in all relevant policies, plans and programmes.

The Republic of Maldives continues to experience rapid economic and epidemiological changes and will face new challenges in the years ahead- from epidemiological, social and economic ones to mitigating the effects of Climate Change. The Health Master Plan will be used as the strategic tool to prepare and respond to such challenges by strengthening the health systems and keeping focus on the priorities of the country and responding to changing needs of the people.

WHO Country Office for Maldives considers it a matter of great privilege for extending technical support to the Ministry of Health for development of National Health Master Plan. As a trusted and reliable partner, I assure continued support of WHO in implementing and monitoring this plan in the coming years.

Dr. Arvind Mathur
WHO Representative to Maldives

Introduction

This Health Master Plan 2016-2025 outlines the principles and the national health goals, and provides strategic guidance and direction to the public and the partners in health, to further develop programs and business plans to improve the health of the population and develop the health system in the country.

Development planning in the health sector started in the late 80's. The first health sector plan was a 3-year medium term plan developed in 1980 which followed the principles of primary health care approach adopted at Alma Ata in 1978. The Health Master Plan (HMP) 1996-2005 was the first long-term plan which was developed in 1995. The HMP 2006-2015 was implemented satisfactorily, particularly in the first half of the plan period. The latter half of the plan period was challenging with a shift in policy direction to short term planning. Despite the challenges, HMP 2006-2015 proved to be a valuable guidance for health planning. This HMP 2016-2025 is the third long-term plan and draws on lessons learnt from previous planning cycles and challenges in implementing long-term plans in volatile political context.

Process

The process for developing of the HMP 2016-2025 was undertaken in a stepwise manner. These included situation analysis, identification of priority focus areas, consensus building, followed by the development of the monitoring and evaluation framework and final endorsement of the plan. The mechanism set to support the development of the plan also included the formulation of a technical committee, technical support to develop the draft plan and consultative approach to review the draft HMP. The process was initiated in June 2014 and Stages 1-3 were completed in seven months. Due to gaps in baseline data considerable time and effort were needed to update baseline data of HMP monitoring and evaluation framework and complete the final stages.

Stage 1: Situational analysis included an evaluation of the previous HMP, desk reviews, and interviews with key informants, service providers, individual meetings with stakeholders and consultation workshops.

Stage 2: Identification of priority focus areas and national goals involved analysis of the outcomes and suggestions from situation analysis, inputs from social media forum, further consultations with key informants and stakeholders including public and political parties.

Stage 3: Consensus building involved discussion and feedback from technical health professionals within the health sector, workshops with service providers, public health service providers and collaborating sectors, workshop and separate meetings with senior management of health sector, policy makers, and political parties. As part of the

consensus-building the draft was reviewed by key informants as peer reviewers and partners in other sectors and subjected to public opinion.

Stage 4: Development of the monitoring and evaluation framework involved identification of appropriate indicators to measure the goal, outcomes, and outputs, obtaining baseline data on the indicators and discussions with partners to set targets.

Stage 5: Endorsement of the plan by the Government of Maldives followed by publication on the website of Ministry of Health.

The Planning Model

The planning cycle for the Health Master Plan (HMP) 2016-2025 asks five basic questions.

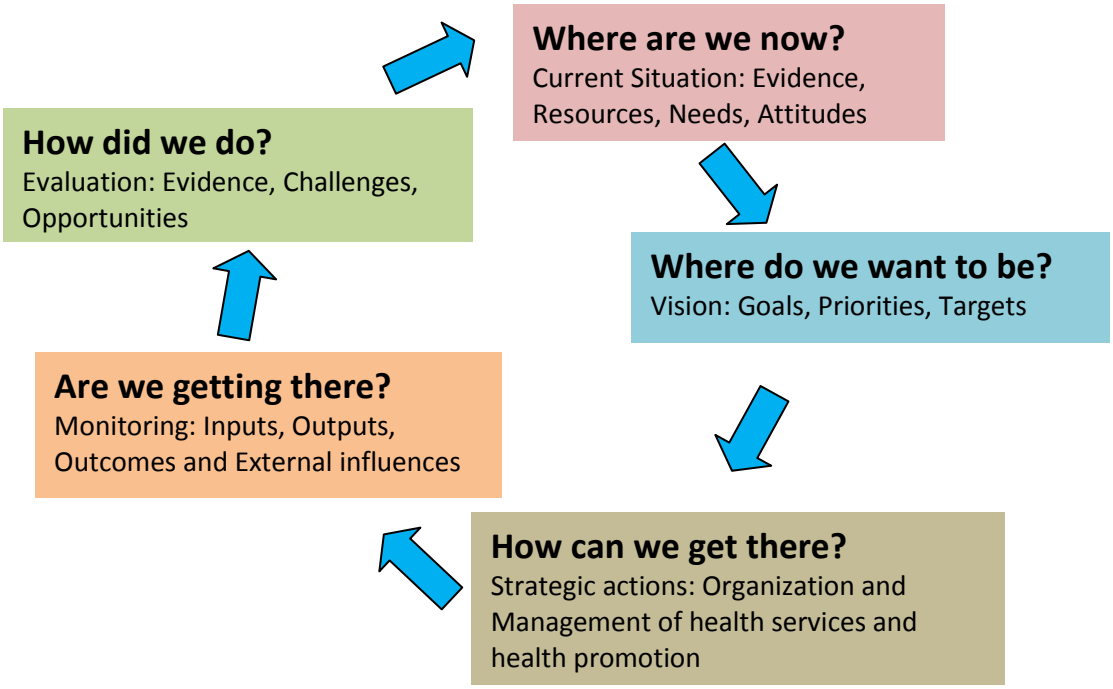

Figure 1: Planning Cycle for Health Master Plan 2016-2025

This HMP sets out high-level strategic directions for the health sector and its public, private and international partners for the period 2016-2025. The model adopted for this Plan is based on a strategic management framework.

In accordance with this model, the HMP focuses on general strategic directions—outcomes, broad strategies and the operating environment—but does not focus on detailed operations or resource requirements. As the HMP 2016-2025 is expected to traverse at least two presidential election cycles; this model provides the political

contenders the flexibility to integrate their manifestos' health priorities to contribute to the population health goals.

In this framework, all the partners in health (government and its institutions and private for profit and non-profit institutions, development partners) are provided guidance that enables them to establish:

- Medium-term policies or strategic priorities identifying the intended contributions that each partner of the health system hopes to have on the health of the people.
- Statements or strategic actions which show how each partner will contribute to achieving the national health targets identified in this plan.
- Specific outputs, which are the specific deliverables implemented by partners.

The business plan for each financial year will, thus, translate the high-level strategic directions identified in the HMP 2016-2025 into specific action plans relevant to the government's manifesto in the public sector and institutional priorities in the private health care providers and non-governmental parties for the upcoming fiscal year. It will also link the resource envelope with the performance measures and targets for the institution that contribute to the national heath targets.

Figure 2: Strategic management framework for the Health Master Plan 2016-2025

Legal and Regulatory Framework

The constitution of Maldives and legislations that govern health and its determinants provide the regulatory framework within which Health Master Plan 2016-2025 was developed and will be implemented. This includes:

Constitution of the Maldives

Article 21, under Right to Life, the Constitution of Maldives states that: "Everyone has the right to life, liberty and security of the person, and the right not be deprived thereof to any extent except pursuant to a law made in accordance with Article 16 of this Constitution".

Article 23, under Economic and Social Rights Provision, the Constitution of Maldives states that: "The State undertakes to achieve the progressive realization of these rights by reasonable measures within its ability and resources:
(a) Adequate and nutritious food and clean water;
(b) Clothing and housing;
(c) Good standards of health care, physical and mental;
(d) A healthy and ecologically balanced environment;
(e) Equal access to means of communication, the State media, transportation facilities, and the natural resources of the country;
(f) The establishment of a sewage system of an adequate standard on every inhabited island;
(g) The establishment of an electricity system of an adequate standard on every inhabited island that is commensurate to that island."

Article 35, under the 'Provision; Special protection to children, young, elderly and disadvantaged people', the Constitution of Maldives states that,
"(a) Children and young people are entitled to special protection and special assistance from the family, the community, and the State. Children and young people shall not be harmed, sexually abused, or discriminated against in any manner and shall be free from unsuited social and economic exploitation. No person shall obtain undue benefit from their labor.
(b) Elderly and disadvantaged persons are entitled to protection and special assistance from the family, the community, and the State".

Laws directly addressing health

The following laws and regulations directly impact health:

- Food Establishment's Hygiene Act (27/78)
- Dhivehibeys, Fandhithahedhun, Circumcision and Midwifery Act (74/78)
- Medicines Act (75/78)
- Port Health Act (76/78)
- Import Products and Food Establishments Act (60/78)
- Export Import Act (31/79)
- Birth and Death Registration Act (7/92)
- Disability Act (8/2010)
- Tobacco Control Act (15/2010)
- Drug control Act (17/2011)
- Social Health Insurance Act (15/2011)
- Public Health Protection Act (7/2012)
- Thalassemia Control Act (4/2012)
- Health Professionals Act (13/2015)
- Health Services Act (29/2015)

Laws in other areas impacting health issues

The following laws and regulations also impact health:

- Child Protection Act (9/91)
- Environment Protection Act (4/93)
- Consumer Protection Act (1/96)
- Family Act (4/2000)
- Human Rights Act (6/2006)
- The Maldives Immigration Act (1/2007)
- Civil Service Act (5/2007)
- Employment Act (2/2008)
- Land Transport Act (5/2009)
- Pension Act (8/2009)
- Decentralization Act (7/2010)
- Customs Act (8/2011)
- Prevention of Domestic Violence Act (3/2012)
- Penal Code (9/2014)
- Social Protection Act (2/2014)
- Anti Human-Trafficking Act (12/2013)
- Anti Torture Act (13/2013)
- Prisons and Parole Act (14/2013)

International treaties and Global and Regional Initiatives

- International Health Regulations 2005 (IHR 2005)
- Framework Convention on Tobacco Control (FCTC)
- Sustainable Development Goals (SDGs)
- Breast Milk Substitute code (BMS),
- Health Human Resources code,
- INCB, CEDAW, CRC
- Climate Change and Health (Paris declaration)

Situation Analysis

The situation analysis include identification of health needs and guides priority areas for action in the period 2016-2025. In carrying out the situation analysis, desk reviews, interviews and discussions were carried out with technical and management personnel of the health system (public, private, voluntary and external partners), other sectors, key informants, community leaders and members of political parties.

Geo-spatial context

Maldives is an archipelago consisting of 1192 tiny coral islands that form a chain stretching 820 km in length and 120 km in width in the Indian Ocean located 600 km south of Indian sub-continent. These islands cover a geographical area approximating 90,000 square kilometres of the ocean with a land area of only 298 square kilometres. The islands form 26 natural clusters (atolls) which are administratively grouped into 20 atolls (National Bureau of Statistics, 2016). At present, a total of 188islands are officially declared as administrative islands. As there is an on-going population consolidation program, the number of inhabited islands is gradually decreasing. In addition, to the officially inhabited islands, there are 239 islands of which 109 designated as tourist resorts and around 128 islands used for agriculture and industrial purposes (Census 2014, National Bureau of Statistics, 2015a; 2016).

Governance

In the past seven years, the country has seen major transformations of its governance structure with a new constitution ratified in the year 2008. The key changes in relation to the 2008 Constitution of Maldives is a presidential system that is geared towards a full democratic governance system with the separation of powers of the executive, judiciary and legislature, multi-party elections, decentralized governance and a bill of rights and freedoms for its citizens. The transition in governance has been erratic; with the first president elected under the new constitution in 2008 resigning in 2012, a transition government till November 2013, followed by a new multiparty election in 2013 and parliamentary election in early 2014. The result of these elections is a new President with a ruling party majority in the Parliament (Ministry of Finance and Treasury and UNDP, 2014).

Economic context

Maldivian economy had shown a steady growth averaging 7% over the past decade, which dropped following Asian financial crisis and started picking up in 2013 with a real GDP growth of 3.7 (World Bank Group, 2014). The economy is highly dependent on the tourism industry which accounts for around 30% of the direct GDP and almost 75% when counting direct and indirect income (Ministry of Finance and Treasury and UNDP, 2014). Currently, Maldives is placed as a middle human development country with an HDI of 0.688 (in 2012) with a per capita GDP of US$7,177 (Ministry of Finance and

Treasury and UNDP, 2014; World Bank, 2014). The consistent growth led to the graduation of Maldives from a least developing country to a middle-income country with implications for external development assistance to Maldives. Poverty in Maldives has also shown a consistent reduction. As measured by US$2 per capita per day, poverty in Maldives reduced from 31% in 2003 to 24% in 2010 (World Bank, 2014). However, the poverty gap continues to be a concern, with only a small reduction from 5-4% in the Atolls, while the poverty gap increased in Male' from 2003-2009/10.

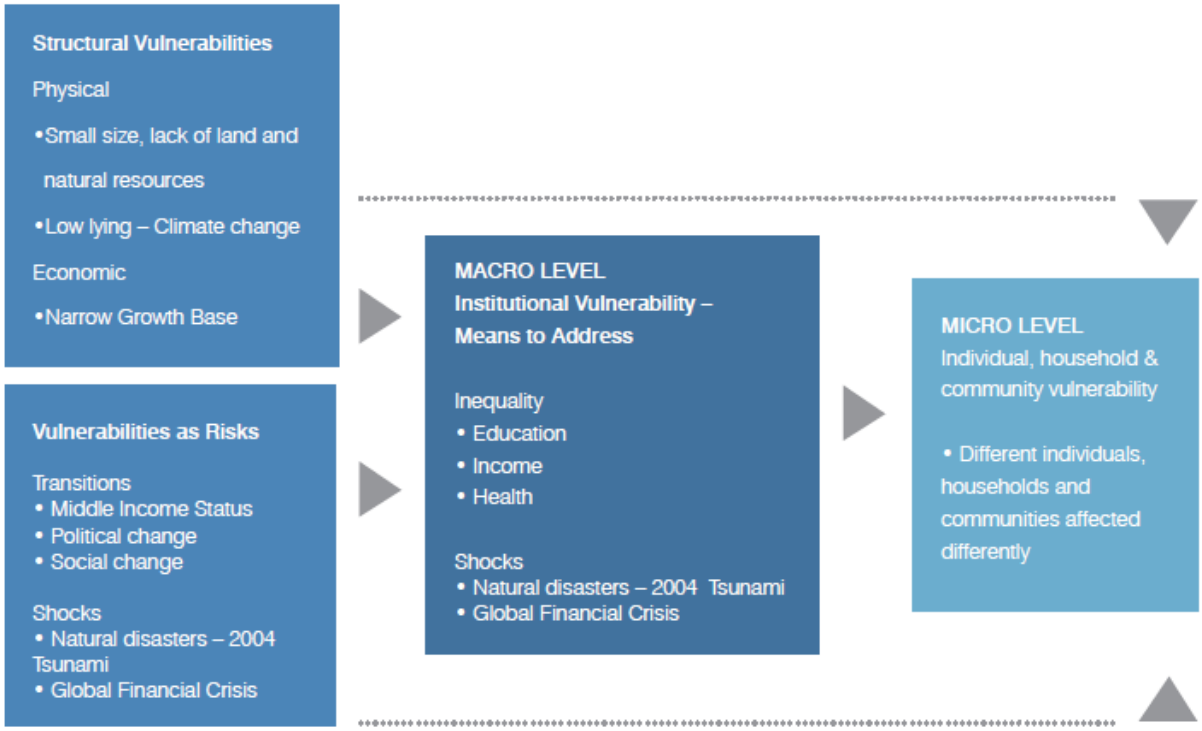

Figure 3: Vulnerability links to inequality in Maldives *(Ministry of Finance and Treasury & UNDP, 2014)*

Although the Maldivian economy is recovering, continued high levels of the fiscal deficit are threatening the macroeconomic sustainability. In 2013 the current account deficits stood at 20% of GDP and the gross reserves were at US$386 million (World Bank, 2014). A review of the public expenditure and financial accountability in 2014, that indicated the high public spending, is one of the main drivers of the public and external fiscal imbalances challenging the macroeconomic situation. The recent introduction of welfare schemes of utility subsidies and allowances for vulnerable populations, social health insurance and old age pensions that solely drive on government contribution adds further pressure on the fiscal deficit. Added to this, are the recent economic policies that waive resort lease rents and import duties for tourism constructions and concessions on imports directly to regional ports in the atolls. According to World Bank, the high public expenditure with short-term borrowing is putting Maldives at a high risk of an external debt crisis. As Maldives is highly dependent on imports for food, fuel and consumer products, the country is particularly vulnerable to the changes at a global level.

Many of the aspects of the country's economy present a challenging situation of it being vulnerable to external shocks. Most of the staple food stuffs, basic necessities, and items for the tourism industry and the country's population are imported. This external dependence on commodities along with geo-spatial vulnerabilities of Maldives makes sustainable development a continuous challenge. The Maldives Human Development Report (Ministry of Finance and Treasury and UNDP, 2014) identified two sets of vulnerabilities (Figure 3). The structural vulnerabilities related to economic development and the vulnerabilities associated with socio-economic transitions and natural disasters.

Demography

The population of Maldives grew at a rate of 1.65 percent from 2006 to 2014 resulting with a population of 402, 071 in Census 2014 (Population and Housing Census 2014). Maldivians represent 84% of the population with 43% males and 41% females while 16% of the resident population are expatriates (Figure 4). The expatriate population is however, predominantly male with 14% and 02% women. According to the Census 2014, the population continues to be concentrated in the capital city Male' with 38% of the population residing in Male's city. A similar pattern is observed when the population is disaggregated by Maldivian and expatriate populations. While the Maldivians are a homogenous population speaking one language (Dhivehi) and follow Islam, the increasing expatriate migrant population is creating multiple ethnicities and religious beliefs among migrant population.

Census 2014 indicated that children under 15years decreased (from 32% to 28%) and accompanied by an increase of young people under 25 years as previously estimated, forming the majority (40% of Maldivians; 43% of the total population including foreigners) of the population of Maldives (National Bureau of Statistics, 2016). Furthermore, there is an increase in dependent age populations (<5 years and 65+ years) associated with the high percentage of young people entering the reproductive age and increased life expectancy. The 2014 census showed that 0-4years aged population increased from 28% in 2000 to 38%in 2014 and older people 65+ years remained at 5% of the population (Population and Housing Census 2014).

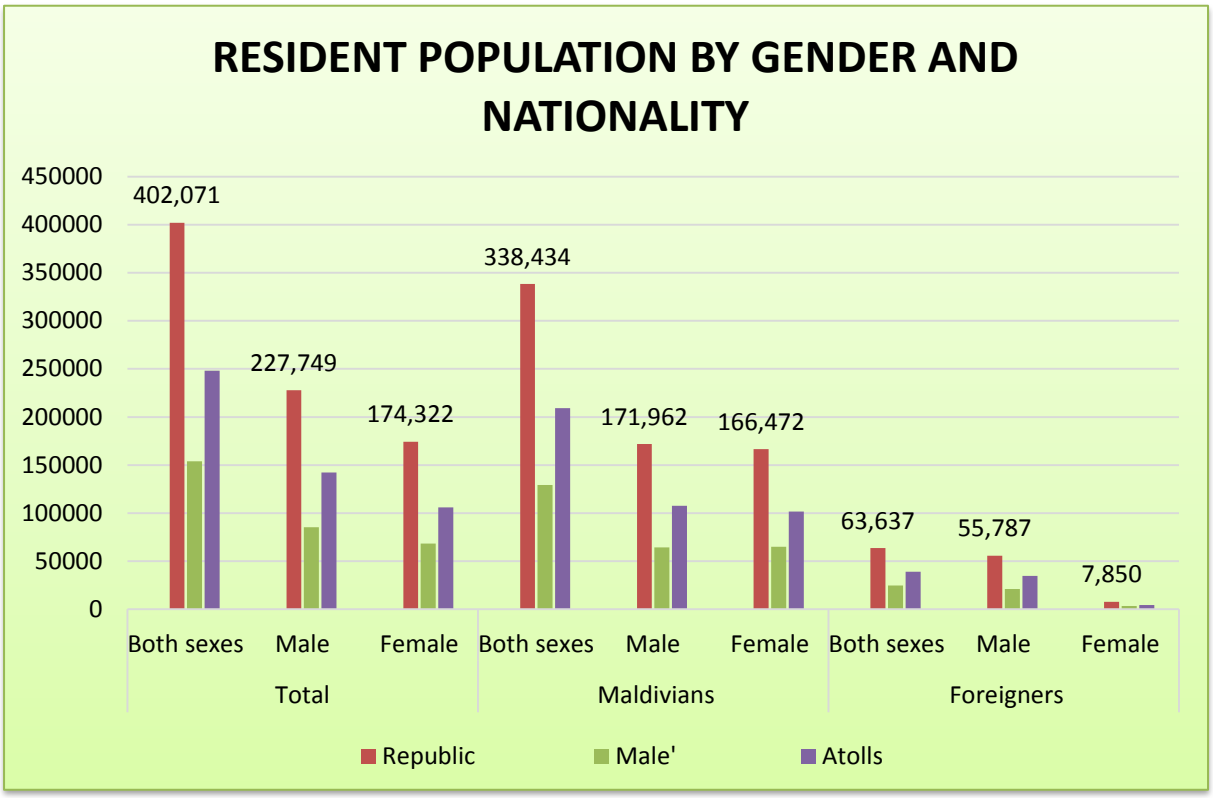

Figure 4: Population of Maldives, by gender and citizenship, Census 2014 ***(National Bureau of statistics, 2015a)***

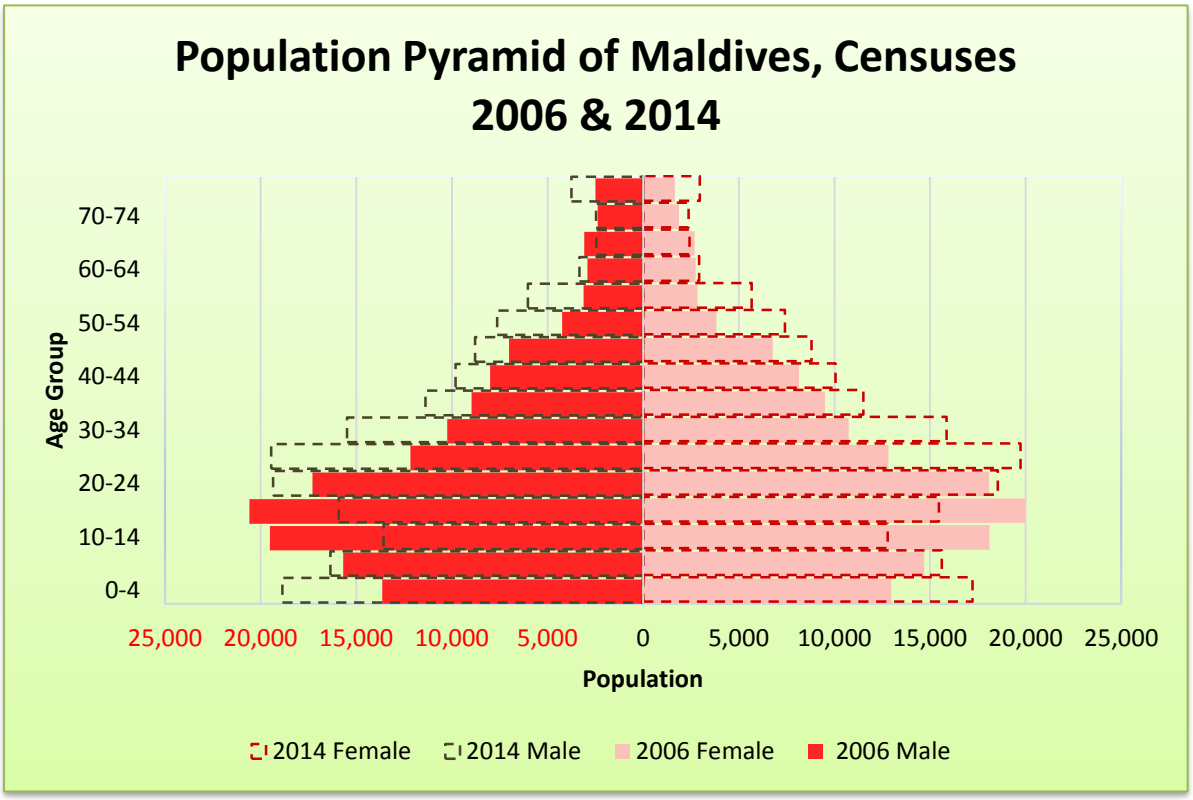

Figure 5: Population Pyramid, 2006 and 2014 Censuses ***(National Bureau of statistics, 2015a)***

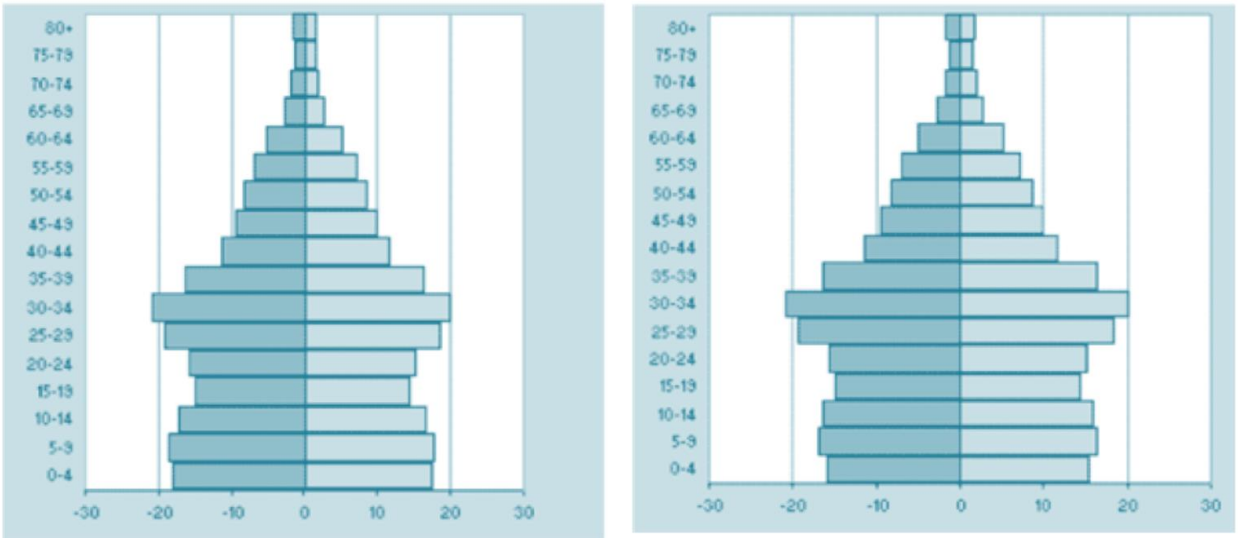

Figure 6: Low (left) and high (right) projections of the population structure for the year 2020
(Ministry of Planning and National Development, 2008)

The total fertility rate (TFR) declined from a high of 6.4 children from 1990 to 2.5 in 2014.However; it is a small rise in rate from census 2016, which is 2.2 births per thousand women. There was a significant rise in TFR of Male' in Census-2014 against Census-2006 while TFR of Atolls shows a slight increase if to compare with Census-2006. The highest TFR in Census-2014 was reported in North Nilandhe Atoll (F) and it was followed South Ari Atoll (Adh) and South Huvadhu Atoll (GDh) with 3.88, 3.30 and 3.13 respectively. The lowest TFR was observed in Census-2014 is Felidhu Atoll (V) which is 2.34 births per 1000 women and it was followed by South Maalhosmadulu (B) with 2.45 and Addu (S) with 2.50 births per 1000 women. (Population and Housing Census, 2014).As a consequence of the population cohort of the high fertility period reaching the reproductive age, increases in the crude birth rate has been observed in recent years. The patterns of age-specific fertility rates (ASFR) have shown an increased age of childbearing. The ASFR peaked at 20-24 years in the year 2000 and increased to 25 – 29 years in 2014 (Ministry of Health, 2016a).

A high rate of literacy among the Maldivian population has been maintained for several years and the literacy rate stood at 97.4% for males and 98% for female consecutively (Population and Housing Census 2014) The goal of the universal primary education has been achieved at national level, however there are emerging concerns due to the increasing number of drop-outs from primary schools, with a net attendance of 88% at primary level (6-12 years) in 2014 (Department of National Planning, 2010).

In 2014 census it was observed that more than one-third (36.2%) of the Maldivian resident population 15 years and above are outside the labour force and using the revise ILO definitions of unemployment in the census, the unemployment rate decreased at national level from 5.5% to 5.2%from 2006 to 2014 (Population and Housing Census 2014). However, the results of 2014 census showed that this is mainly

due to decrease in the atolls (from 6.0% to 5.2%) but in Male' unemployment increased from 5.9% to 6.3% during this period.

Health system

The public sector conforms to the largest share of the health system in Maldives. The public sector is supported by private health care providers, mainly providing curative and diagnostic services, and medicines and medical products located within the country. Another key sector that forms part of the health system is the voluntary non-governmental parties working on specific health issues. While the public system extends to all inhabited islands, private and voluntary services are concentrated in Male'. The health system is also supported by external foreign development partners.

Health care delivery in the public sector

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 would be decided depending on the level of population, patient load etcetera. Each atoll has a hospital catering to the population of that atoll. Kaafu Atoll is the exception where Male' city is located and has the country's referral 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. Therefore, the distribution of PHC centres are island based and not population-based resulting in inefficiencies in terms of material, human and financial resources (eg:– HaaAlif Atoll has 13 centres serving over 13,672 populations, while in Vaavu there exist 4 HCs for a population fewer than 1811)(National Bureau of Statistics, 2016). In 2016 MOH records show that there were 23 public hospitals (IGM Hospital (the tertiary hospital), 6 regional hospitals and 14 atoll 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 (Dhamanaveshi) in Male' city. Health care services including medical examination, investigations, immunization, antenatal care, drugs etc. are provided free to all Maldivian citizens. However, the delivery of services at primary health centres at rural level is challenged due to the geographic isolation of

islands and inadequate human resources, specialties, supplies and equipment and poor management. Additionally, there is no adequate service demand due to the small populations and health needs which compromise the skills of health professionals. Hence, despite the high ratios of skilled health personnel-to-population ratios, (eg: the doctor-population ratio in 2014 was 1:447, (Ministry of Health, 2016a)), the disparity in the distribution of the population leads to the limited availability of skilled health workforce in the smaller islands. Although there are continuous training and re-training of primary health care staff, nurses, doctors and other health professionals ensuring quality service delivery to all inhabited islands continues to be a challenge. Added to the geographic challenges, is the poor human resource management, limited career development and professional development opportunities leading to low retention of trained staff.

The dispersed islands pose challenges to logistic management, particularly in providing necessary supplies and equipment, assuring quality services and regular maintenance and administration of the service delivery. Even though, there are public pharmacies in all inhabited islands, due to diseconomies of scale the private sector is not attracted to provide pharmacy services in smaller islands. Despite the challenges in distribution and difficulties to maintain health service delivery at the peripheries, the health system in Maldives has been able to operate and substantially expand access to health care.

In addition to the provision of routine health care, health services have in-built systems for preparation and response to public health emergencies and disasters. As such, national protocols are developed and drills are conducted for public health emergencies and to a lesser extent on national emergency situations. However, emergency medical services with adequate equipment and trained staff are not well established in the country. Sea Ambulance service has been initiated since 2014 with the aim of providing emergency transport between islands to ensure appropriate emergency care. Maldives Red Crescent was established in 2009 and this party actively promotes volunteerism and develops community capacity for emergency preparedness, first response including in public health epidemics and pandemics.

However associated with the transition in governance and political context, major changes were brought to the health system with the corporatisation of the public healthcare delivery system and dissolution of the single coordinated system into six separate systems in the years 2010-2011. This change was associated with breakdowns in the supply of medical equipment and skilled human resources as well as health information systems. This transition to the system was accompanied by the loss of a number of the skilled health workforce, resulting in a gap, especially in preventive health and primary health care. The system was reorganized again in 2012 into a single system.

Since the beginning of 2014, a number of reforms were brought into the public health care system. A policy to establish a general practice (GP) service is being piloted as the

gate keeper to entry into the public health care system and establishing a referral model, linking with secondary and tertiary care facilities. The management of public health care facilities in the Male' city region (the national referral hospital IGMH, Villimale' hospital, and Hulhumale' hospital) have been delegated to be managed by corporate management boards independent of the Ministry of Health. The government has entered into a partnership with the State Trading Organisation (STO) in 2014 outsourcing the supply of medical supplies to the public health care delivery system. Other policy initiatives proposed include increasing the level of specialized care at IGM Hospital in terms of cardiac care and treatment of renal diseases, the establishment of a national diagnostic centre that can be accessed by all health care facilities.

Private and voluntary health sector

The private health sector in the Maldives, although small, is vigorous and distributed widely across the islands. Among the private hospitals, the ADK hospital is the main private hospital located in Male'. ADK hospital has 58 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 Male'. Other hospitals have emerged in the past five years and new private hospitals are being developed in Male' urban region along with smaller specialist clinics. The majority of private health facilities are located in Male' city. According to the register of private health care establishments maintained by the Ministry of Health, out of a total of 202 institutions, about 50% are located in Male' (Ministry of Health, 2016b).

Although the private sector predominantly provides allopathic services, a few provide traditional Maldivian medicine (Dhivehi beys) and alternative medicine services such as Acupuncture, Ayurvedic medicine, and Chinese medicine. However, the country capacity to ensure the quality of these services and medicinal products used in these services are weak.

Supply and provision of medicines are managed by the STO (a state-owned company), and the private sector. There are 168 pharmacies in the private sector and 187 STO pharmacies across all locations with the greatest number (80) in Male' (Ministry of Health, 2016b)

Although a large number of Nongovernment Organisations (NGOs) are registered (over 700), the NGO capacity is limited in the country due to a number of reasons, including limited resources and organized voluntarism (Australian High Commission Colombo & UNDP Maldives, 2009). NGOs that have been able to provide sustained services in the past decade include Society for Health Education, Diabetes Society of Maldives, Care Society, Aged Care Maldives and Journey. In addition to these NGOs, a number of NGOs have emerged working on specific disease conditions, disability, child rights, youth and human rights contributing to health outcomes.

Public-private partnerships (PPPs) experimented in 2009-2012 in Maldives in the provision of health care. The lessons learned indicate a lack of exposure to a mode of working as a financier (rather than provider), lack of knowledge of implementation PPP models (among the private and public sector), the uncertainty of outcomes and retrenchment worries were contributing factors for negative outcomes of the effort. These risks were noted in the assessment report for opportunities for PPP conducted prior to implementation of the corporatisation policy in 2010 (Amaltas Consulting, 2009). Future initiatives in building PPPs need to address capacity building to carry out the appraisal of projects define and conduct performance assessment and undertake supervision and audit in the public sector.

Health care financing

Although the primary focus of the government is to provide equitable access to primary health care services and sustain uninterrupted service delivery at all levels there has been a move towards curative and hospital-based care (Ministry of Health, 2011). The public funds for health are primarily spent on curative care (66.8%), 11% spent on administrative cost, 5.5% on preventive care and 17% on pharmaceuticals (Ministry of Health & World Health Organisation, 2013). The country spent US$ 130 per capita on inpatient curative services and the same amount on inpatient treatment abroad and US$ 95 per capita has been spent on medicine in 2011, while US$ 11 per capita was spent on public health programs (Ministry of Health & World Health Organisation, 2013).

Spending on health is high in Maldives when compared to other countries in similar developmental situations. The total health expenditure (THE) 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). There are three main sources of financing for the health sector: the public, private and external sources. The major source of health funds is from people, which accounts out of pocket expenditure of 49% followed by 44% from the government. External sources, such as donations and grants for multilateral and bilateral aid contributed less than 3.3%.

Overall, more than 49% is managed and spent directly by the household, 45% by the public financing agents and 3% by donors and NGOs. Public sector providers are the major recipients of the total health expenditure (THE). Out of THE IGMH accounts for 10.6%, regional and atoll hospitals 30%, health centres 7.5% and health posts 1%, Private service providers (physicians, clinics, dentists and private pharmacies) account for 28%. Providers in other countries account for 23.7%, mainly overseas treatments, paid for mostly by the people.

The social health insurance scheme (SHI) 'Madhana' was established to protect the public from catastrophic health expenditure and also cover some of the cost of curative services provided to the Maldives population in 2009. Since then, the scheme has undergone a number of policy changes from a contributory scheme to a non-

contributory scheme with an annual limit of MVR 100,000. In 2012, the social health insurance scheme was universalised and rebranded as 'Asandha'. The current SHI scheme, HusnuvaaAasandha, has been in use since January 2014 without annual individual financial limits. At present, the scheme is administered to a state-owned company 'Asandha Pvt Ltd', for which the Ministry of Health (MoH) is the main provider of health care and the National Social Protection Agency (NSPA) is the governing agency of this scheme. The private sector provides curative services on a fee-for-service basis and package prices for curative care received from health facilities abroad. The scheme does not cover foreign nationals resident in the country. Under the health insurance system, the rural population had access to free public health care with free referrals to the nearest hospital including sea transport in emergencies as well as treatment abroad for services not available in the country.

Quality of health care

Ensuring access to good quality of health services is a priority of Ministry of Health. Interventions focused on improving the quality of health care are assured through relevant health regulations by licensing of health care facilities, pharmacies, health care professionals and the registration of medicines and vaccines. In addition, a number of national standards and protocols are developed and implemented to ensure patient safety in the provision of care and management of disease conditions. However, due to high professional staff turnover and the high reliance on expatriate health professionals, maintaining consistent use of the standard guidelines and protocols is a challenge. As major reforms are continuing in areas of the health system building blocks, the Health Services Act provides direction for the public health system, responsibilities of the government in service provision and quality control of health services.

Health situation

The health situation has improved significantly in Maldives as evidenced by the improvements in the life expectancy, reductions in fertility and mortality rates and remarkable progress towards achievement of the Millennium Development Goals (MDGs). With the endorsement of the Sustainable Development Goals (SDGs), there is recognition that ensuring healthy lives and promoting wellbeing for all ages is a central goal for sustainable development (Goal 3 of SDGs). Hence there is continued the emphasis on sustaining progress in population health indicators, universal health coverage and reducing communicable and non-communicable disease conditions and conditions resulting from exposure to environmental factors with health risks.

Crude Death Rate (CDR) over the years had shown a steady decline and it has stabilized around 3 per 1000 population during the years 2010-2014 (Ministry of Health, 2016a). Significant falls in CDR was seen to be mainly associated with the fall in the infant and child mortality rates over the last two decades (Ministry of Health, 2016a). Access to

better health care and expansion of health services to the atoll populations and effective immunization programs played a major role in the fall of death rates.

Trends in the age-sex ratio of the deaths show that the disparity in deaths among males and females in the child population have been declining over the years while deaths among the older population groups were seen to be declining among women.

The life expectancy trends in the population show marked improvement in the health status of the population. The life expectancy at birth has increased from 72.0 to 73.13 for males while it has increased from 73.2 to 74.77 for females from year 2000to 2012 respectively (Ministry of Health, 2016a). Several factors may have contributed to the increase in life expectancies such as improved accessibility to health care, improved levels of education and economic standard of living, access to safe water and hygiene technologies, increased awareness within the population leading to increased healthcare seeking behaviour and healthy practices at household levels.

Maternal health

Maternal health is a critical area for sustainable development and highlighted in the SDGs and earlier in MDGs. Maternal mortality ratio (MMR) decreased from 69 to 13 per 100,000 live births during the period 2006 to 2012 and jumped to 41 per 100,000 population in 2014 (Ministry of Health, 2016a). This variability is due to the small size of the population (as the denominator), that causes MMR to fluctuate widely from year to year as an increase in one death also causes a significant increase in the ratio. The regular review of maternal and perinatal morbidity and mortality indicate that the causes of maternal deaths during the period 2009-2011 were, among others, eclampsia, complications of abortion, postpartum haemorrhage, puerperal sepsis, amniotic fluid embolism, and rupture of the uterus (Maternal and Perinatal Mortality and Morbidity Review Committee, 2013).

Unsafe abortion is a challenge in Maldivian society that contributes to maternal mortality and morbidity. Abortion is allowed only within 120 days of conception and only on five grounds; major congenital anomalies, Thalassemia and other hemoglobinopathies, maternal medical conditions and fatal conditions endangering the life of the mother and for victims of rape and incest (Maldives Fiqh Academy, 2013).

A number of pregnant women suffer from poor nutritional status. According to the Maldives Demographic Health Survey (DHS) of 2009, about 12% of Maldivian women have short stature below 145 cm. About 4.6% has a Body Mass Index (BMI) less than 18.5, which denotes under-nutrition (Ministry of Health and Family and ICF Macro, 2009). The DHS 2009 showed that the indicators of poor nutrition increases with age are higher in rural areas, and decreases with increasing level of education and wealth status. Micronutrient deficiencies are also high among reproductive-aged women and the results of the survey to establish baselines for micronutrient deficiencies among

women and children showed that 38% of reproductive-aged women were iron deficient and 44% vitamin A deficient(AGA khan University, Ministry of Health and Family and UNICEF, 2010). Zinc deficiency and iodine deficiency among reproductive-aged women remained at 27% for both minerals. The DHS 2009 however, showed that 65% of women took iron supplements during pregnancy for 90 days or more and 7% took iron tablets for fewer than 60 days. Anaemia prevalence among women was 15.1% in 2007. The high prevalence of Thalassemia and other hemoglobinopathies is a factor that underlies the situation of anaemia among pregnant women in Maldives. The coverage of antenatal care (ANC) was 97% in 2009, with the majority of women (90%) having their first ANC visit in the first trimester of pregnancy (Ministry of Health and Family and ICF Macro, 2009). More than 97% of those who received ANC were weighed had their blood pressure measured, urine and blood samples were taken and their blood tested. Blood testing is of particular importance in the screening for maternal Syphilis, HIV, Anemia and Hepatitis B. The majority of births (95% in 2011) occur in a health facility, with 85% in a public facility and 10% in a private health facility. The proportion of births assisted by a skilled attendant was 95%, with 71% assisted by a gynaecologist; 9% by a doctor and 14% by a nurse or midwife. The coverage of postpartum/postnatal visits was 94%, with 67% receiving a postnatal check-up within two days of delivery and 3% of women had a check-up 3-40 days after delivery. The majority of women (92%) received a postnatal check-up from a gynaecologist, doctor or nurse/midwife (Ministry of Health and Family and ICF Macro, 2009).

The C-section rate is high (32%), which may subject some women to unnecessary risks during childbirth and postpartum (Ministry of Health, 2016a). The quality of care is an issue, as preventable causes of maternal deaths, such as rupture of the uterus and puerperal sepsis are still found. As many specialists from different countries work at all hospital levels, the standard of care and written clinical protocols are required to ensure the practice of evidence-based standards in managing pregnant clients. In addition team work and communication among team members, ensuring availability and standards of medical equipment for obstetric care, and investigation of near misses are important areas of action to ensure further improvements in maternal health and progress towards sustaining the target set in the SDGs for maternal health.

Child health

Child health and nutrition is another key area of action noted in the SDGs and at a national level, previous targets of MDGs have been achieved in the infant and under-five mortality rates as well as neonatal mortality rates, however, further progress needs to be made towards sustaining the achievements and meeting the targets of the SDGs related to children's health. During the period 2006 -2015, infant mortality decreased from 16 to 9 per 1,000 live births and under-five mortality decreased from 18 to 11 per 1,000 live births. Neo-natal morality rates also decreased substantially during this period from 11.5 to 5.3 per 1,000 live births (Ministry of Health, 2016a). Despite these

improvements in averting child deaths, there continues to be a number of concerns related to new-born care and child health. These include a slow reduction in stillbirth rates, low birth weight in babies and increasing premature and large for gestational age babies and congenital abnormalities and defects. These indicate the need for action targeting the child during the ante-natal and neonatal period.

Child health monitoring is in place from new born to under five years aimed at monitoring growth, developmental delays and providing vaccinations and nutrition supplements. Although the aim is to provide comprehensive care, the focus is on ensuring EPI vaccination coverage, resulting in 93% coverage for all EPI vaccines in 2012 (Ministry of Health and Family and ICF Macro, 2009). However, the increasing observance of disabilities, especially Autism Spectrum of Diseases (ASDs), Global Developmental Delay (GDD) and congenital heart diseases (CHDs) are emerging areas of concern that needs to be addressed for improving the quality of life of children.

In addition, child malnutrition continues to be a major concern despite the growth monitoring efforts. The demographic health survey of 2009 showed that under-nutrition was at 17.3% of children under 5 years being underweight (weight-for-age). There is also an indication of emerging obesity among children with 5.9% of children under 5 years being over-weight (weight-for-height above +2SD)(Ministry of Health and Family and ICF Macro, 2009). Micronutrient deficiencies are of concern in all age groups and more prevalent in north and south central regions of the country. The micronutrient survey conducted in 2007 showed that anaemia prevalence among children 6 months to 5 years is 26%, with more than half the children (57%) being iron deficient(AGA khan University, Ministry of Health and Family and UNICEF, 2010). Similarly, more than half the children 6 months to 5 years are vitamin A deficient (5.1% severely and 50.1% moderately deficient). Zinc and iodine deficiencies though less severe is a public health concern with 16% of children being zinc deficient and 19% iodine deficient. The survey didn't show a statistically significant difference in micronutrient deficiencies between boys and girls (AGA khan University, Ministry of Health and Family and UNICEF, 2010).

Although there is no data on consumption patterns, infant feeding practices, and dietary practices show that grains are the most frequently fed to children, followed by milk and milk products. Beans, legumes, and nuts are usually not fed to infants, while the fruit and vegetable intake is less than twice a day (AGA khan University, Ministry of Health and Family and UNICEF, 2010). It must be noted that only 48% of infants are breastfed exclusively for 6months, with 25% of babies mixed fed with breast milk substitutes. According to MDHS, 2009, at the time of weaning 53% of infants are given commercial baby food as their first food (Ministry of Health and Family and ICF Macro, 2009).

While availability of nutritious food and cost play a role, the main reasons for the poor nutrition status are over reliance on processed food, including breast milk substitutes and commercial food services as a result of easy availability and marketing (Ministry of

Health and Family and UNICEF,2011). This is coupled with limited functional knowledge of food and infant feeding among the caregivers due to poor nutrition education and awareness from health services and school system. Furthermore, there are no mechanisms to coordinate between food security and food safety interventions and the nutrition program interventions. Agricultural and fisheries programs are primarily implemented as economic activities and food security features as a secondary output. There is also no proper system in place for food quality control (Ministry of Health and Family and UNICEF, 2011). Emphasis needs to be given to addressing these gaps and develop health, food security and food safety systems with clear links between programs to contribute to national goals while achieving sector-specific goals.

Adolescent and young people's health

About30% of the Maldivian population are in the age group 15-25 years(National Bureau of Statistics, 2015a), which calls for health action supporting adoption of healthy choices and practices related to reproductive and sexual health, diet and physical activity, tobacco use and substance abuse and mental health.

The school health program is a key area of action towards empowering adolescents with correct information on healthy practices and life skills to respond to peer pressure and support their peers. Hence, the school health program continues to implement programs to make the school environment one which is health promoting through standards on canteens, tobacco-free environment, and health education and life skills programs. Furthermore, the national curriculum has been revised to include health and physical education as a separate subject area throughout primary school. Despite the efforts, tobacco use among the 13-15 year age group increased from 10.4 to 11.2 during the period 2001 to 2011. The estimated prevalence of drug use for Male and atolls were 6.64% and 2.02% respectively and the majority of the drug users are in the age group 15-19 years and unmarried and about half are unemployed (UNODC, 2013). However, school health programs are also facing challenges providing need-based sexual and reproductive health information and support to students due to changing religious beliefs in the society.

The drug use survey 2011/12 shows that opioid and cannabinoids were most common among drug users in Male, and slightly more than a third of opioid and cannabinoids users were likely to be dependent on these drugs (UNODC, 2013). In the atolls, 65% of the drug users depend on opioids. In terms of medical problems, weight loss was common among respondents from both Male and atolls. About 6% in Male and 16% in the Atolls reported that they had experienced symptoms of the overdose at least once. The Biological and Behavioural Survey (BBS) that used snow ball sampling method identified, 144 injecting drug users (IDUs) in Male and 129 IDUs in Addu Atoll and also revealed that the most common method of sharing of unsterile needle and syringes by(31% Malé, 23% Addu)(Ministry of Health and Family and UNDP, 2011). Although a large proportion of current drug users were aware of HIV, not many were informed or

had undergone any testing or vaccinations against Hepatitis B, Hepatitis C or Tuberculosis (TB). Although alcohol use is prohibited in Maldives, the alcohol consumption is an emerging problem. Among school children aged 13-15 years, 6.7% reported consuming alcohol in a self-enumerated survey (Ministry of Education, 2009). Among prison inmates serving a sentence for the drug-related offense, the majority had used heroin (69.1%) and cannabis (63.3%) followed by alcohol (47.9%) (Ministry of Health and Family and UNDP, 2011).

Among the drug users, about 15% in Malé and 9% in the Atolls had been diagnosed with a psychological disorder (UNODC, 2013). In addition, close to three-fourths of current drug users had experienced eating and sleeping problems, both in Malé and the atolls. More than a third of current drug users in Male stated that they were affected by a mental problem, while the situation is slightly better in the atolls with one in six respondents facing the same problem. About 13% of the drug users in the atolls and 7% in Male sought help from a certified treatment centre. In the last one year, 28% of the current drug users in the atolls were admitted in a detoxification centre while only 4% of current drug users in Male were admitted at the rehabilitation centre (UNODC, 2013).

Reproductive health practices are another area that has not seen significant progress and needs focused attention. The proportion of women who had sex before age 18 is high among women who live in urban areas and in Male (8%) compared to those living in the atolls. The rate of young women having sexual intercourse by age 18 decreases rapidly by their degree of education, from 14% among women with primary education to 5% among women with secondary education. The median age at first intercourse has increased from 17.0 years among women age 45-49 to 21.8 years among women age 25-29. Very few teenagers have begun childbearing at age 18; while 7% have started at age 19 (Ministry of Health and Family and ICF Macro, 2009).

Premarital sexual activity was found among 11.6% youths of 18-24-year-olds. About 36% of men reported having had sex with more than one partner in a lifetime (Ministry of Health and Family and ICF Macro, 2009). These men have on average 2.3 partners ranging from 1.7 among men age 15-24 to 2.9 among men age 40-49. The mean number of lifetime sexual partners is highest among men who are divorced, separated or widowed (3.9). Men living in urban areas, those in the South and men with no formal education have higher proportions of multiple partners. As the divorce rate and the remarriage rate in Maldives are high, it contributes to a high number of lifetime sexual partners (Ministry of Health and Family and ICF Macro, 2009).

The results of the DHS showed that contraceptive prevalence rate for all methods decreased, by 4% from 2006 to 2009. Although the use of condoms increased from 6% to 9% (1999- 2009), the use of oral pills decreased from 13% to only 5% during this period (Ministry of Health and Family and ICF Macro, 2009). At the same time, the proportion of married women who used sterilization for family planning declined from 10% to 7% in 2004 but reverted back to 10% in 2009. Among the reasons for the

discontinuation of all methods were; wanting to become pregnant (28.3%), became pregnant while using contraceptives (13.8%) and FP side effects (10.4%). The situation is, however, unique in Maldives in that while it has a low CPR (27% for modern methods) and a high unmet need (29%), the TFR is low (2.5) ((Ministry of Health and Family and ICF Macro, 2009). Possible reasons for this might be because of a very high divorce rate, termination of pregnancy, infertility and use of traditional contraceptive methods. Knowledge about the fertile period is deficient in young women as well as young men: 51% among women and 53% among men with only 16% of women and 11% of men giving the correct response. However, knowledge about contraceptive methods is high and equal to women and men with 94% and 93%, respectively (Ministry of Health and Family and ICF Macro, 2009).

The quality of care for FP could be one of the reasons for the discontinuation of contraceptive methods. One of the main issues deterring family planning service delivery is the lack of adequate infrastructure providing adequate privacy in health facilities as well as limited primary care workers who have competing priorities in the workload of management and technical work. Youth health café was a project initiated in Male' to identify an appropriate model for delivery of youth-friendly health services to young people in Male'. However, this service is limited to health education and use referrals to health facilities for counselling and accessing reproductive health services from NGOs. Another model is the establishment of an adolescent health clinic at health facilities and was piloted in IGMH in Male'. The clinic provides several services to adolescents such as information services on general health issues, health education, nutritional advice, counselling, medical screening, immunization, treatment of sexually transmitted infections, contraceptive technologies including emergency oral pills and referral to other units when necessary. However, the services of the adolescent health clinic are under-utilized as the service environment is stigmatizing to young people and has ceased to function. Additional efforts are in place to establish Adolescent Friendly Health Services (AFHS) in collaboration with UN organizations. National Standards for AFHS have been developed followed by the establishment of the services in health facilities. HPA in collaboration with health facilities, services have been established in 3 sites. It is planned to implement AFHS across all government health facilities.

The national estimates of most-at-risk populations (MARPs) for STIs/HIV in Maldives include IDUs, female sex worker (FSW) and men having sex with men (MSM). These MARPs include not only Maldivian population but also foreign expatriates working in the country. According to the BBS survey (2009), IDUs are the most likely trigger for an HIV epidemic, as there is a relatively large number of Maldivians using drugs with a high prevalence of needle sharing as previously noted(Ministry of Health and Family and UNDP, 2011). FSW and IDUs both reported very low consistent condom use, while a high percentage of MSM reported they had also had sex with women. The situation calls for customized health education and intervention for promoting safe sexual and reproductive health practices. Prevention of mother to child transmission (PMTCT) of

HIV infection is given special attention and 100% of women attending ANC clinics are screened for HIV and other STIs.

Gender-related issues are of particular importance in this age group and have specific relevance to SDG goal 5 for gender equality. Gender-based-violence is a key aspect affecting young people's health, especially young women. Around 19.5% women aged 15-49 who had ever been in a relationship reported experiencing physical and/or sexual violence by an intimate partner (in2004). About 29% of ever-partnered women aged 15-49 reported experiencing emotional abuse by an intimate partner and non-partner violence was experienced by 13.2% of women (Ministry of Gender and Family, 2006). Those who experienced intimate partner violence are more likely to report miscarriage, stillbirth, and abortion. The experience of physical and/or sexual partner violence tends to be accompanied by highly controlling behaviour by intimate partners. There was a significant overlap between physical and sexual partner violence. Women who are younger (aged 25-29), have lower levels of education and have been separated or divorced appear to be at increased risk of partner violence (Ministry of Gender and Family, 2006).

Efforts to address gender-based-violence are implemented at national level. The health sector response has been weak to establish a coordinated system of medical examination and health care for those victims of GBV. Efforts to establish early detection of GBV cases have had limited success due to factors such as space for privacy and frequent change of focal points for coordination at health facilities and other sectors involved in the response teams.

Adult health

Adult health is an area that has not been studied or given adequate attention, predominantly as this age group is a group with lesser health needs. However, with the growing burden of chronic and non-communicable diseases, there is growing recognition of designating health interventions targeting this age group. The MDHS indicated that a number of unhealthy practices such as tobacco use, drug use, physical inactivity and unhealthy diet leading to obesity are prevalent in this age group. In Male' smoking prevalence among adults was at 18% in 2011, while 15% had obesity (BMI>30kg/m2), 42% had low levels of physical activity (defined as < 600 MET-minutes per week) (Centre for Community Health and Disease Control (CCHDC) and World Health Organization, 2011).

Interventions to promote healthy lifestyles targeting adult population have not been sustained in the past few years. Legislation on tobacco use was enacted in 2010, but policy and intersectional support to implement the law and its regulation are weak, thus undermining public health efforts to reduce tobacco use. Similarly, availability and promotion of unhealthy food and drinks are on the rise, often conflicting with the health messages. The focus of interventions has thus been for early detection and management

of chronic illnesses and conditions in this age group. A number of NGOs are working in the area of chronic disease prevention and support towards behaviour change for healthy dietary practice and physical activity.

Similar to young people, reproductive health practices continue to be low among the adult age group. The predominant action is focussed on women; yet, issues such as infertility are inadequately addressed. Furthermore, men's reproductive health issues have not been addressed systematically.

Other aspects with specific relevance to the adult population such as occupational health and mental health of local and foreign workers of the reproductive age population are areas that have had limited health and intersectoral intervention.

Older people's health

The majority of deaths in Maldives occur in the older ages. The health of older people is characterized by chronic diseases as observed in the cause of death statistics in Maldives. Common disease conditions among older people include cardiovascular disease, chronic respiratory diseases, renal diseases, cancer, oral and dental health as well as functional limitations and dementia/cognitive impairment requiring long-term care (WHO SEARO, 2010). Furthermore, about 8 -10% of the older population are receiving home care services as they are bed ridden and frail.

Although a healthy aging strategy has been developed in 2010, it has not been implemented. However, responding to the growing number of older people, health services have been initiated to provide home-care support through primary health care centres in the atolls. In Male', NGOs are providing health education, skill development of families caring for bed-ridden older people and social engagement services to older people.

Morbidity and epidemiological trends

Maldives is moving from a high burden of communicable diseases towards an increasing burden of non-communicable diseases. We now face the challenge of controlling non-communicable diseases and addressing social determinants of health while also continuing to strengthen preparedness and control of emerging and re-emerging communicable diseases. This situation is emerging in many developing countries and thereby addressed in the SDGs to emphasize the importance of addressing this double burden to achieve health gains.

Although progress towards achievement of the MDG goals combating HIV/AIDS, malaria, and other diseases has been made, the focus needs to be maintained to achieve the SDG commitment to end the epidemics of AIDS, tuberculosis, malaria and other communicable diseases. Notable achievements have been made in the control of many

of the communicable diseases. The country is malaria free and no indigenous cases of malaria have been seen since 1984. Vaccine-preventable diseases have also been controlled to such an extent that diseases like polio, neonatal tetanus, whooping cough and diphtheria are non-existent. Maldives have received Malaria and Filaria free status and certification in 2016 and Leprosy is progressing towards the regional elimination target.

However, tuberculosis is re-emerging and recent years have not shown consistent results with the prevalence of sputum positive cases per 1000 cases varying from 0.124 (2001) to 0.16 (2007) and to 0.07 (2011) (Ministry of Health, 2012). This is associated with poor case detection and case management. Case detection activities are not effective as the screening of immigrants into Maldives from countries with high TB prevalence, are not rigorous and there is continued stigma associated with TB among the local population. Poor case management is reflected in lowering of the treatment success rate and the emergence of MDR-TB and XDR-TB indicating poor case management.

Furthermore, there is an emerging indication of the in-country spread of HIV in recently detected cases. Furthermore, the risk of HIV and STIs are significant due to unsafe and harmful practices such as unprotected sex, commercial sex work, and needle sharing among injecting drug users. Hepatitis B is also a significant disease that has the high risk of transmission, particularly among adults. While infants are vaccinated under the routine EPI and safe blood practices are maintained, surveillance needs to be strengthened, and Maldives needs to develop a comprehensive strategy for prevention and control of Hepatitis B, with a particular emphasis on women of reproductive age.

Dengue, diarrhoeal diseases and acute respiratory infections (ARI) continue to cause significant morbidity among children and adults. In 2012, ARI, viral fever and diarrhoeal diseases were the communicable diseases with the highest incidence, amounting to 4748, 2130 and 694 per 100,000 population respectively (Ministry of Health and Family, 2012). Diseases such as scrub typhus and toxoplasmosis have also emerged and continue to be endemic. Although there have been significant improvements in access to safe water and improved toilet facilities, further improvements are still required regarding access to safe drinking water, improving sanitation and waste management. In addition, continued interventions for public education on personal and environmental hygiene and disease prevention practices need to be conducted for further reductions of infectious diseases.

An emerging public health concern is that of diseases spread through animals, birds, rodents and insect. Although a mechanism for screening and quarantine of animals along with a veterinary health standards has been initiated, this service is in its infancy and need further strengthening for effective control of infectious diseases transmitted through these agents. Furthermore, there is emerging animal farming (of chicken and goats) as well as the practice of keeping pets, (including cats, birds, guinea pigs, lizards,

and others). The health risks posed by these activities needs to be further studied to ensure appropriate standards for animal health, care and veterinary services need to be established, not only for the health and safety of the owners and their families but also for the animals' health. These standards further have implications for the national commitment to the implementation of the International Health Regulations 2005 and preparedness of pandemics and national epidemics.

With the improvements in environmental hygiene and living standards of the population and changes in lifestyle, chronic non-communicable diseases have emerged as the main cause of morbidity and mortality in the country. Cardiovascular diseases, chronic respiratory diseases, accidents and injuries and cancers are the leading causes of death in the country. In terms of the number of lives lost due to ill-health, disability, and early death (DALYs), NCDs (inclusive of injuries) account for 78% of the total disease burden (World Health Organization, 2014; 2015). As highlighted in the NCD policy brief, only 22% of the DALYs come from communicable diseases, maternal and child health, and nutrition issues all combined (World Bank, 2011). As discussed before, risk factors for NCDs such as smoking, physical inactivity are high among young people and adults in Maldives. Hypertension (16% in Male') (CCHDC & World health Organizations, 2011) and diabetes continues to be highly prevalent (national estimate of type 2 diabetes: 2-7%) in the country (World Health Organization, 2014; 2015).

Other chronic diseases of public health concern in Maldives are Thalassemia and other haemoglobinopathies, chronic renal diseases, congenital heart diseases. There is also concern among the expert in the field that auto-immune diseases could be emerging as an area of public health concern and needs further study. Disabilities continue to be a challenge with a prevalence of functional difficulties in vision as high as 18% in the population (Ministry of Health and Family and ICF Macro, 2009), followed by mobility restriction (7.4%) and hearing defects (5.7%). Moreover, Autism Spectrum of Diseases and other development and behavioural disorders are increasingly observed among children. Added to these physical disease conditions is the issue of mental health and psychosocial wellbeing which have not been in the limelight till very recently, thus needing a high focus and investment. The national estimate of mental and neurological disorders combined is as high as 18.7% (World Health Organization, 2011).

Interventions to address the NCD burden have been focused on health promotion, improving the management of diseases through standard treatment guidelines and strengthening of the provision of health services for early detection of non-communicable diseases. Addressing the social determinants of chronic diseases and disabilities is essential to achieve and sustain positive changes for reducing chronic disease burden and disabilities and improve the quality of life of those affected.

A number of legislations have been enacted to support public health protection, promotion of healthy choices (such as tobacco control), and social protection for people with disabilities, long-term illnesses and older people. However, many of these laws are

not being adequately implemented which undermines the efforts of health promotion and public health programs, resulting in poor health outcomes of the population.

Summary

Maldives is in transition where transformations are observed in the macro, meso and micro levels. At the macro level, transitions are seen in governance, economic and social aspects and demographic structure of the Maldives population. At the Meso level with regard to health, transitions are seen in the epidemiological pattern of disease and disability and the health system financing and management. At the micro level, transitions are observed at household and individual levels in family structures, living arrangements and individual behaviour and lifestyle.

In this transition, the structural vulnerabilities and risks are accentuated in Maldives due to the volatilities in the economic and political situation, calling for specific commitments to concerted action by all partners. In the health sector, the challenges relate not only to reducing diseases and disabilities among the population but to strengthen the health system to a sustainable and efficient system that is responsive to the changing population and health needs of the country. Critical areas that need concerted action in the coming years include:

- The health concerns of the vulnerable groups, particularly young adolescent people, pregnant women and children, people with mental health conditions and disabilities, the aging population and foreign migrants, taking into consideration their socio-economic position in the society.
- Health promotion and addressing social and environmental determinants of health to reduce Noncommunicable chronic diseases burden, communicable disease control and improving the quality of life of people with disabilities and long-term illnesses.
- Providing unified action across the government and with the private sector for positive health outcomes, complementary to the global sustainable development goals (SDGs).
- Health system particularly filling the gap in human resources for health, improving health information systems, supply systems of medicines, vaccines, and medical products, and quality of care.
- Financing inefficiencies and instability in providing health care services that impact universal access and coverage.

Frameworks for Action

The frameworks adopted in developing the HMP 2016-2025 include the legislative framework in Maldives and the country's international commitments (refer to section on Legal and Regulatory Framework) and the post-2015 Sustainable Development Goals (SDGs) set at the global level. Although goal 3 of the SDGs is specific to Health, other goals of the SDGs have a direct impact on health.

Figure 6: Areas of Sustainable Development Goals

In addition, we adopted two technical frameworks in identifying priorities and strategic actions in the HMP2016-2025. These are the 'determinants of health' and the 'health system building blocks' (World Health Organization, 2013; 2010).

In the past decade, the policy focus has been to target actions of the health sector in addressing midstream factors through the delivery of preventive and curative health care services. Recent years have seen actions that have been initiated to address downstream factors such as rehabilitation and therapy that contribute to enhancing quality of life and survival.

Despite this, effective results in reducing ill-health and disease burden among the population were not achieved due to the neglect of upstream factors in policy action subsequent to the different priorities of the manifesto of the ruling parties. Hence, for this plan we have adopted the determinants of health approach focusing action on all three levels; upstream, midstream and downstream factors (Figure 7). The move towards taking action on upstream factors requires intersectional action and the stewardship of the Ministry of Health in ensuring healthy public policies in other sectors.

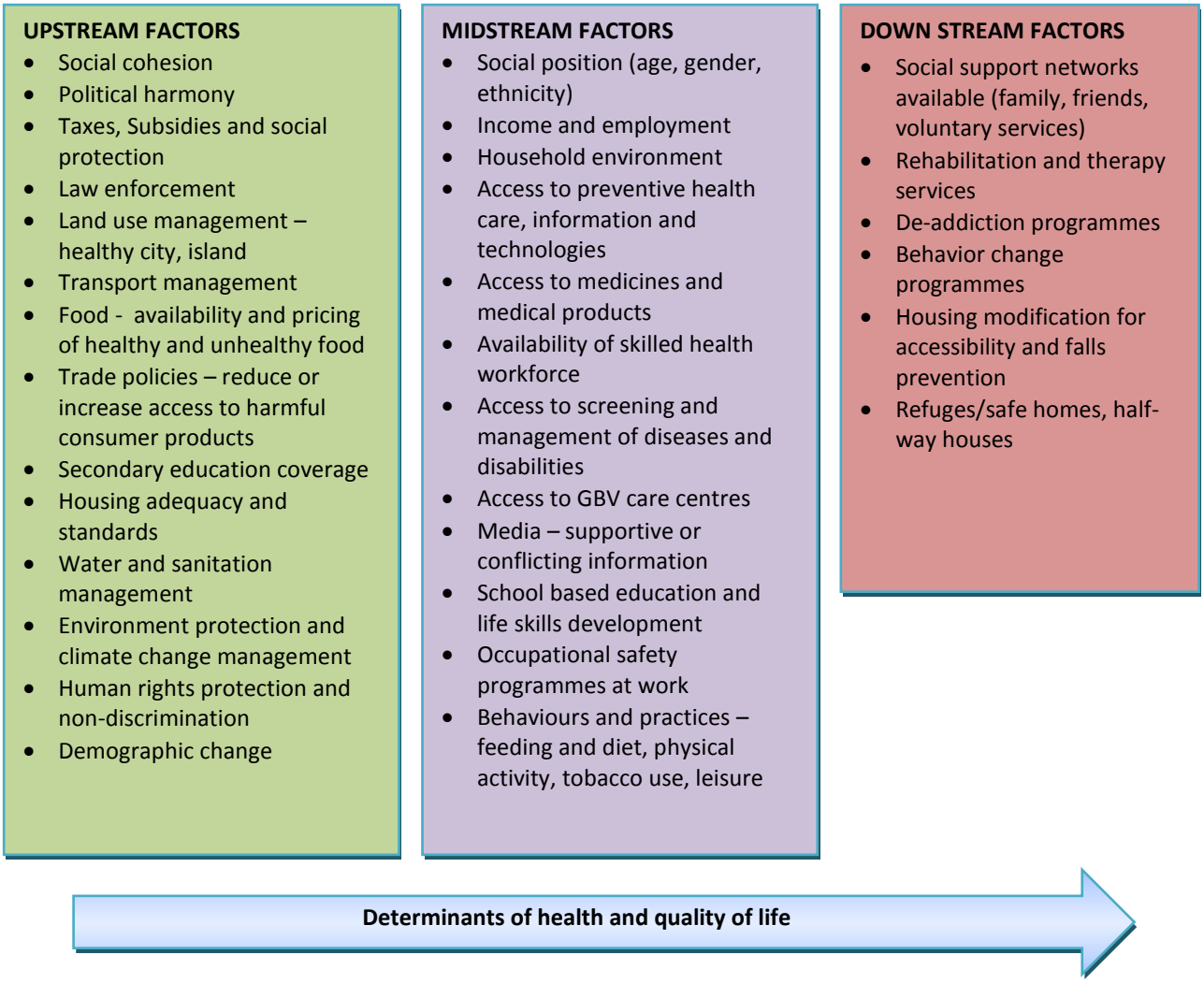

Figure 7: Upstream, midstream and downstream factors affecting health and quality of life in Maldives

The second framework used in the HMP2016-2025 is the health system building blocks, specifically targeted towards developing health system action addressing midstream factors (Figure 8). This framework is especially significant in the current situation of the Maldives health system. The action of the six building blocks is required to bring about stability and re-build the health system, improve efficiency and quality of services as well as improving access and coverage of population with essential health services.

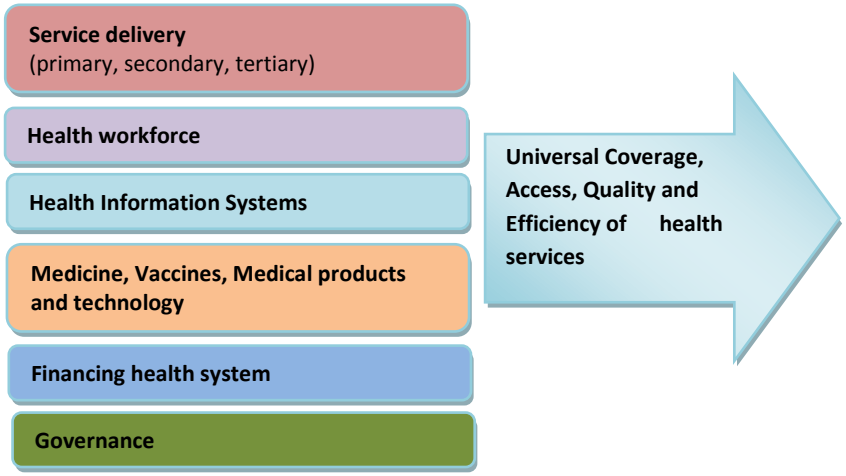

Figure 8: Health system building blocks (adapted from WHO, 2010)

Vision:

Together as a nation for excellence in health.

Mission:

To ensure nation's participation in attaining excellence in quality health services, in an affordable, equitable and accessible manner leading to a healthy population.

Core Values:

The principle values required to ensure accomplishment of our Vision are:

Human rights

Commitment to health as a human right in all policies, programs and services.

Equity

Assurance that the health system provides equitable access to health servicesthat is responsive to age, gender, ethnic and socio-economic situation of the individual.

Inclusion

Emphasize collaboration and partnerships in health to ensure coverage of all segments of population's health.

Accountability

Rely upon transparent and evidence-based decision-making at all levels towards achieving health gains.

Sustainability

Commitment to efficient use of resources and effective delivery of health services that are responsive to epidemiological and population health needs.

Professionalism

Competent health personnel with commitment to ethical and moral obligations of health care.

National Health Goals& Outcomes

We have adopted an overall national goal to "Enhance health and well-being of the population", aligning with the global Sustainable Development Goals. The government and all health partners will endeavour to achieve this goal in the period 2016-2025 focusing on three specific health outcomes. These goals are based on the current and perceived health situation, the socio-economic and political context for the next ten years.

Goal: Enhance health and wellbeing of the population.

Outcomes:

1. Build trust in the national health system.
2. Reduce disease and disability among the population.
3. Reduce inequities in access to health care services and medicines.

Outputs at national level

The national health goals can be realized through achievements of critical outputs during the period 2016-2025. We acknowledge the interconnectedness of the outputs and recognize that each output will contribute to achieving one or more of the three national goals. The desired outputs are:

1. Improved health policy making that is value-oriented, evidence-based to achieve health gains.
2. Strengthened partnerships for health within government, with private, voluntary sectors and civil society.
3. Improved sustainability of health system and health care financing mechanisms.
4. Improved enforcement of legislations for health.
5. Enabled a healthy start in life and healthy childhood through the health system.
6. Enabled young people and adults to adopt healthy lifestyles and safe practices.
7. Enhanced the quality of life of older people, people with disabilities and long-term health conditions.
8. Improved coordination of health care delivery by the public, private and voluntary sectors.
9. Improved skills and commitment of the health workforce.
10. Improved responsiveness of the health information system.
11. Improved supply and management of medical products, medicines, vaccines, technologies and other medical supplies.
12. Ascertained quality and responsiveness of the health services.

The outcomes and outputs provide the framework to identify strategic focus areas and directions of the HMP2016-2025 (see Figure 9). Specific indicators for measuring the national health outcomes and outputs are provided in the logical framework outlined in the monitoring and evaluation matrix of the Health Master Plan 2016-2025 (Appendix 1).

Monitoring and evaluation summary matrix

Vision	Together as a nation for excellence in health		
Goal	Enhance health and wellbeing of the population of Maldives		
Outcomes (OC)	**OC1**: Improved trust in the national health system	**OC2**: Reduced disease and disability among population	**OC3**: Reduced inequities in access to health care services and medicines
Outputs (OP)	1. Improved health policy making that is value-oriented, evidence-based to achieve health gains.	2. Strengthened partnerships for health within government, with private, voluntary sectors and civil society.	3. Improved sustainability of health system and health care financing mechanisms.
	4. Improved enforcement of legislations for health.	5. Enabled a healthy start in life and healthy childhood through the health system.	6. Enabled young people and adults to adopt healthy lifestyles and safe practices.
	7. Enhanced the quality of life of older people, people with disabilities and long-term health conditions.	8. Improved coordination of health care delivery by the public, private and voluntary sectors.	9. Improved skills and commitment of the health workforce.
	10. Improved responsiveness of the health information system.	11. Improved supply and management of medical products, medicines, vaccines, technologies and other medical supplies.	12. Ascertained quality and responsiveness of the health services.

Strategic Inputs
1.Governance 1.1 Establish an efficient health system governed by legislation and oversight mechanisms 1.2 Ensure public policy making is transparent, evidence-based and information-driven 1.3 Develop public private partnerships in health promotion and delivery of preventive and curative health services 1.4 Ensure financial sustainability of the health system and the social health insurance scheme 1.5 Political commitment to achieve the health targets of the global sustainable development goals (SDGs) and the goals of this national health master plan
2.Public health protection 2.1 Provide a healthy start in life through effective reproductive, maternal and child health services 2.2 Reduce chronic diseases and improve mental and psychological health of the population 2.3 Maintain successes in control of communicable diseases and prevent re-emergence and introduction of new communicable diseases 2.4 Develop health promoting skills and promote safe sexual and reproductive health behaviours and practices among adolescents and young adults 2.5 Improve quality of life of older people and people with long-term illnesses and disabilities 2.6 Strengthen health promotion and health education customized to the target audiences 2.7 Provide a clean, safe and supportive environment to enable healthy choices and

prevent injuries and spread of diseases
3. Health care delivery 3.1 Ensure public delivery of primary health care services in all inhabited islands 3.2 Establish a coordinated system of care from primary care to secondary and tertiary care providers (public, private and voluntary) 3.3 Enable timely surveillance of diseases, births and deaths, morbidity patterns as well as social determinants of health through an integrated health information system and research 3.4 Ensure uninterrupted supply of good quality essential medicines, vaccines and medical products, technologies and other medical supplies 3.5 Invest in training and retention of a professional and ethical health workforce 3.6 Establish capacity for health and medical response in national disasters and emergencies

Strategic Focus Areas and Directions

Based upon the situation analysis, national goals and expected outcomes the critical areas that must be addressed are categorized under three focus areas; Governance, Public health protection and Health service delivery. It is important to note that there are inter-linkages between the strategic directions and together they contribute to the outputs and outcomes. The distinct areas provided here are for the ease of planning and monitoring purposes. The critical Strategic inputs in the focus areas include:

Strategic Inputs

1. Governance:

1.1 Establish an efficient health system governed by legislation and oversight mechanisms

- Determine clear roles and responsibilities of the State and its institutions at national, local governance levels for preserving the stability of the health system through legislation.
- Establish a “one system approach” through defined primary, secondary and tertiary care services across the country.

- Sensitise political actors and harness support and capacity for enforcement of enacted laws and regulations.
- Establish a National Health Council that is representative of key stakeholders in health as an oversight mechanism.

1.2 Ensure public policy making is transparent, evidence-based and information-driven

- Strengthen health sector's leadership in advocating healthy public policies within the sector and in other sectors that impact health of the population.
- Conduct health impact assessments and resource requirement of policy options and use them in decision making on health projects.
- Use internationally available tools such as "One-choice" in identifying effective and sustainable policy options.
- Conduct regular monitoring of health programmes and projects using the results-based framework.
- Facilitate a research culture and support regular research such as demographic health surveys, national health accounts and other research to address national health information needs.

1.3 Develop public private partnerships in health promotion and delivery of preventive and curative health services

- Communicate clearly the areas of public investment in health to avoid duplication of investments in health at national level.
- Establish contractual and audit mechanisms to facilitate out-sourcing of selected services.
- Establish mechanisms to finance and support NGO programmes on health promotion and community based health projects.
- Establish mechanisms to attract private and foreign investments in health care delivery

1.4 Ensure financial sustainability of the health system and the social health insurance scheme

- Ensure allocation of adequate financial resources for preventive health and primary care.
- Prioritise resource allocation to interventions that produce high health returns towards achieving population health goals.
- Review the coverage of the social health insurance scheme with respect to population, services and cost.
- Identify alternative financing sources for the social health insurance scheme and prepayment mechanism for provider payments.
- Review the coverage of the social health insurance scheme with respect to population, services and cost

- Regular awareness of public, policy and law makers on effective use of social health insurance.
- Conduct regular audit of the national health expenditures to identify ways to improve efficiency of the health system.

1.5 Political commitment to achieve the health targets of the global sustainable development goals (SDGs) and the goals of this national health master plan

- Conduct regular advocacy and lobbying events to ensure political actors are aware of the different aspects of SDGs and UHC and the national health goals.
- Conduct annual coordination and joint planning exercise to support alignment of policies and programmes to national goals as outlined in this plan.
- Develop mechanism for regular liaison with political parties and the parliament to maintain focus practical strategies at country level for making gains towards SDGs, UHC and other goals of this HMP.

2. Public health protection

2.1 Provide a healthy start in life through effective reproductive, maternal and child health services

- Empower young people to plan their pregnancies and seek health care from pre-conception, during the pregnancy and post natal period through targeted health promotion, education and skill development.
- Provide access to essential obstetric and neonatal care services at all levels of health system and mechanism to access care in obstetric and neonatal emergencies.
- Maintain skills of the health workforce on provision of integrated management of neonatal, infant, child and maternal care.
- Empower caregivers to vaccinate and provide appropriate nutrition including breastfeeding to infants and young children.
- Raise awareness of caregivers on neglect as a cause of accidents, injuries and illnesses among children and pregnant women.
- Expand childhood vaccination programmes based on changing disease patterns and developments in vaccine technologies.
- Monitor reproductive, maternal and child health morbidities and mortalities through facility and programme level data and population based research.

2.2 Reduce chronic diseases and improve mental and psychological health of the population

- Empower young people and adults to adopt healthy choices regarding food, physical activity and social behaviour through education and life skill development.
- Empower young people and adults to avoid and quit tobacco use, substance abuse through targeted interventions
- Adopt standard management guidelines and up-skill health care providers for early detection and management of priority NCDs including those with co-morbidities and multiple morbidities.
- Implement a national food and nutrition strategy targeting different age groups.
- Provide access to cancer screening services and maintain national registers of cancer to facilitate early detection, treatment, rehabilitation, social and palliative support.
- Provide access to health care, counselling for those with mental/psychological health problems and support community re-integration.
- Advocate for political commitment and public demand for enforcement of tobacco control law and its regulations.
- Advocate for taxation policies and pricing measures that promote healthy choices and discourage unhealthy goods and services.
- Support programmes for prevention of substance abuse and drug rehabilitation services as required by drug control law and its regulations.
- Develop and implement strategic action plans in the area of NCDs as integrated and individual plans as required
- Develop programmes for oral heath targeting children and older people.

2.3 Maintain successes in control of communicable diseases and prevent re-emergence and introduction of new communicable diseases

- Maintain vaccine coverage and introduce new vaccines as per new developments and disease context.
- Improve nutrition status of vulnerable and high risk populations.
- Maintain reporting of modifiable diseases and disease surveillance system that links public, private and voluntary providers.
- Develop country capacity for IHR 2005 and conduct regular up-skilling of the partners involved in IHR 2005 implementation.
- Strengthen screening of foreign workers for infectious diseases prior to entry into the country.
- Develop and implement strategies for control of TB/HIV/STIs based on epidemiological information on these diseases.
- Maintain elimination strategies for identified diseases and those already eliminated (e.g. Malaria, Polio, and Filariasis) from the country.

- Establish standards on health and hygiene related to pets and veterinary services.
- Empower and educate stakeholder institutions and civil society regarding measures and practices for prevention and control of spread of communicable diseases and vector control.
- Advocate and raise awareness for effective enforcement of public health protection law and its regulations.

2.4 Develop health promoting skills and promote safe sexual and reproductive health behaviours and practices among adolescents and young adults

- Facilitate health promoting and life skills education through the school system and in higher education institutes.
- Provide opportunities for young people to impart correct knowledge and health promotion among their peers.
- Provide access to age and gender appropriate adolescent and youth friendly health services.
- Develop health service capacity and mechanisms to support national efforts to address gender-based violence.
- Empower young people to make healthy choices with age and gender appropriate education, interpersonal/social skills and access to reproductive health information and services.
- Provide targeted health education to young migrant populations on safe sexual and reproductive health practices and prevention of sexually transmitted infections.

2.5 Improve quality of life of older people and people with long-term illnesses and disabilities

- Advocate for disability prevention, early detection and rehabilitation.
- Strengthen social support mechanism for home healthcare service to assist families in providing care for older people, people with disabilities and long-term illnesses.
- Strengthen capacity of health facilities and health professionals to provide appropriate services for the older people and for the disabled.
- Empower families with the information and skills to provide home-based care for bed-ridden people and people with mobility restrictions.
- Establish a need assessment mechanism to identify those in need of home-based nursing care and occupational and rehabilitation therapy.
- Support establishment of separate facilities at national level for providing a good standard of care for older people and people with disabilities who require institutionalized care on a day-to-day basis.

2.6 Strengthen health promotion and health education customized to the target audiences

- Promote joint public policy action that contributes to ensuring safer and healthier goods and services, healthier public services, and a cleaner, more enjoyable environment.
- Develop the capacity and skills of primary care workers and public health professionals on health promotion.
- Develop programme to reach foreign migrant population and create awareness on healthy practices and behaviours.
- Reach civil society and empower communities for health promotion through education and access to reliable, relevant information.
- Create supportive environments using the healthy settings approach among schools and higher education institutes, hospitals, work places as well as healthy cities and islands.
- Develop joint programming with schools and higher education institutions for health promotion targeting young people.
- Utilize modern Information Communication Technologies (ICT) to bring behaviour change in communities.

2.7 Provide a clean, safe and supportive environment to enable healthy choices and prevent injuries and spread of diseases

- Enforce regulation and standards on reduction and management of waste: communal, health care and hazardous waste.
- Empower communities to demand for safety of drinking water and food safety and enforce quality assurance measures for drinking water and food products.
- Advocate reducing and regulating import and availability of food products linked to ill health and chronic diseases, in the market.
- Coordinate with stakeholders to implement quality standard for reducing air, ground water, sea and soil pollution and contamination.
- Advocate for safe and accessible housing and public infrastructure.
- Establish mechanisms to ensure occupational safety, workplace safety, and safety in land and sea transport.
- Coordinate and integrate the management of chemicals especially insecticides, pesticides and fertilizers in the country.
- Establish quality standards for animal husbandry aligned with the current quality control mechanism of fish processing in the country.
- Monitor health impacts of climate change and develop strategies for reorienting programmes to address the emerging health issues.
- Develop strategies to reduce the carbon foot print related to health care services in alignment with national strategies.

3. Health care delivery

3.1 Ensure public delivery of primary health care services in all inhabited islands

- Identify the basic package of essential health services to be delivered as primary care services in all islands, including economic/industrial islands.
- Define clear roles and responsibilities of Local Councils and Ministry of Health in the financing, management and delivery of the defined health care services.
- Ensure that the basic package of essential services is provided free to all customers including foreign residents.
- Ensure availability of essential medicines, vaccines, medical products and technology (such as reproductive health technologies) for primary care.
- Establish a system of contact with families on the island or neighbourhood of each primary care centre to create opportunities to educate and empower families for healthy practices.

3.2 Establish a coordinated system of care from primary care to secondary and tertiary care providers (public, private and voluntary)

- Define the organization of the health system with clear roles and responsibilities of institutions in the public and private sector as well as lines of reporting and accountability.
- Establish quality standards for delivering different health care services and build capacity to audit them.
- Establish tertiary care services at designated regional locations.
- De-concentrate specialty care from Male' city to other atolls by establishing demand-based specialised centres in other atolls or industrial or resort islands.
- Develop mechanisms for distant diagnosis through effective sample transport, image transfer and other telemedicine technologies.
- Define services that can be outsourced or made open for private or foreign investment in the country.
- Establish referral links with health care centres within the country and in neighbouring countries in coordination with the social health insurance provider.
- Promote need-based health care utilisation and effective use of over- the-counter medicines for minor ailments.
- Expand provision of blood banking services towards a coordinated blood transfusion service throughout the country mediated by voluntary blood donations.
- Establish a mental health service and care facility for people needing institutional support.
- Establish an emergency medical service linked to other emergency services such as fire and rescue, coast guard and disaster management services.
- Develop medical tourism through public private partnerships.

- Promote local Alternative Medicine (Dhivehi beys), services of good quality.
- Develop the national capacity to support post-mortem examination and forensic analysis of human samples.
- Re-define healthcare services and service levels on needs based priority.

3.3 Enable timely surveillance of diseases, births and deaths, morbidity patterns as well as social determinants of health through an integrated health information system and research

- Establish an integrated national health information system (disease reporting, surveillance and medical records) linking different levels of the health system and private health care providers.
- Establish more effective mechanism for screening of foreign migrants for communicable diseases prior to their entry into the country.
- Strengthen the health system management information system by collating the data on human, material and financial resources of different health care providers in the country.
- Expand digitization of the vital registration system by linking different health care providers.
- Identify research priorities and manage research to meet information needs for programming, planning and policy.
- Strengthen research management, ethics and publication of academic literature based on research.
- Build capacity in the area of health information management and research.

3.4 Ensure uninterrupted supply of good quality essential medicines, vaccines and medical products, technologies and other medical supplies

- Establish a central supplies mechanism to strengthen the forecasting and management of vaccines, reproductive technologies, essential medicines and other medical supplies as well as maintenance of medical equipment.
- Ensure timely procurement and delivery of childhood vaccines, essential medicines, reproductive technologies and other medical supplies to health care centres.
- Establish a mechanism to reduce cost of essential medicines by introducing generic drugs and a dispensing mechanism in the public health care system and for drugs covered under social health insurance scheme.
- Strengthen quality control of medicines, vaccines and medical products through regulatory, quality assurance and practice of rational use of medicines.
- Establish a digital inventory of medical equipment products and tools and implement a preventive maintenance programme.
- Strengthen bio-medical engineering services to provide uninterrupted and continued support to health care facilities.

3.5 Invest in training and retention of a professional and ethical health workforce

- Strengthen the management of the health workforce to support equitable distribution with an appropriate skill mix, for defined services.
- Market the health sector as an attractive workplace by providing incentives, and fostering a work culture that will encourage the work life balance and motivate employee.
- Advocate for establishing Occupational health and safe work environments.
- Establish mechanisms for maintaining ethical conduct of health professionals along with protection mechanisms from undue negligence claims.
- Strengthen personnel appraisal system and advocate to establish a reward system in order to enhance workforce productivity and retention of qualified staff.
- Strengthen regulatory frameworks as required by the health professionals' law to assure professional conduct and performance.
- Expand the scope of professional groups into emerging areas.
- Establish a mechanism to coordinate higher education and training at national and regional level as per national health workforce requirements.
- Establish a medical education institution to train medical doctors locally.
- Strengthen the mechanism to link long and medium term service-related trainings to service agreements to optimize human resources for health.
- Strengthen management and administration of health sector institutions and health care facilities to ensure effective use of available health workforce.
- Increase funding from public, private and international sources for training and re-training human resources for health.

3.6 Establish capacity for health and medical response in national disasters and emergencies

- Strengthen implementation of a health sector response plan and standard operating procedures for disasters and more frequent emergencies in alignment with national disaster management plans.
- Develop rapid response teams in urban (Central and Regional) and rural levels as first responders and conduct regular drills to maintain necessary skills and effectiveness of the response.
- Strengthen implementation of contingency plans to deliver health care services in situations where health services get disrupted in disaster or emergency situations.
- Maintain a national stock of emergency health supplies and health technologies for prevention of diseases and provision of health care in emergencies.
- Support establishment of integrated national emergency services (such as 911 services).

- Develop country capacity for the delivery of ambulance services (land, sea, air) supported by trained paramedics towards establishing an emergency medical service in the country.
- Enhance the capacity within the health sector to respond to public health emergencies such as epidemics and pandemics.
- Strengthen partnership with Maldivian Red Crescent and other non-governmental bodies to develop health sector preparedness and responses in provision of relief, rehabilitation and mitigation in disasters and emergencies.

Stakeholders of health

We acknowledge the close collaboration and partnership among government institutions, with private and voluntary sectors, and developmental partners for successful achievement of the national goals, outcomes and outputs. Furthermore, we recognise that the implementation of other SDG goals (other than Goal 3) will impact health and the targets set out in this plan.

This calls for joint action and recognising health as everybody's business in developing strategic action plans at national and institutional levels. The key stakeholders for successful implementation of the HMP 2016-2025 are:

State institutions: Parliament, Local councils, Judiciary, Human Rights Commission, Civil Service Commission, Maldives Inland Revenue Authority, Maldivian Red Crescent, Maldives Customs Service, Maldives Immigration, Maldives Police Service and Maldives National Defence Force, etcetera.

Government institutions: Ministries and departments of Health, Education, Environment, Youth, Gender, Housing, Fisheries and Agriculture, Economic Development and Trade, Finance, Foreign Affairs, Home Affairs, Disaster Management, National University, Labour Relations Authority, National Drug Agency, Family Protection Authority, etcetera., National Statistics Bureau, Attorney General's Office, Government companies and corporations, etcetera.

Private and Voluntary sector: Non-Governmental Bodies/Organizations working in different health and social areas, Private hospitals, Medical Clinics, Pharmacies, Alternative medicine clinics and services, Medical products and technology suppliers, Utility providers, Suppliers and retailers of food and consumer goods, Provides of amenities and services, Banks and financial institutions, etcetera.

External Development Partners: World Health Organisation, UNICEF, UNFPA, UNODC, Financial institutions such as World Bank, Asian Development Bank, International Funds (e.g. Global Fund for HIV/AIDS), other health partners and friendly countries, etcetera.

Stakeholders in HMP Dissemination Workshop, 25th Sep 2016, Paradise Island Resort

Minister of Health In HMP Dissemination Workshop, 25th September 2016, Paradise Island Resort.

Dr.Yasir, the Facilitator of HMP Dissemination Workshop, 25th Sep 2016, Paradise Island Resort

WR of WHO at HMP Dissemination Workshop, 25th Sep 2016, Paradise Island Resort

Aishath Samiya, DDG of Policy Planning & International Health Division, HMP Dissemination Workshop, 25th Sep 2016, Paradise Island Resort.

Starting of HMP Formulation , 2014 at Nasandhura Palace Hotel

Strategic Risks

The HMP 2016-2025 presents a disciplined attempt to guide and align policies and programs of the government and private sector to contribute to the attainment of specific population health outcomes at a national level. The actual ability of the government, private and voluntary sectors to achieve the identified outputs as stated herein is dependent upon the following:

1. Political commitment to public policies that facilitate positive health gains.
2. Stability of the public health care delivery system.
3. Sustainability of public expenditure on health.
4. Contributions by the private and voluntary sectors as well as other government sectors.
5. Availability of the information architecture to allow for evidence-based management and decision-making.
6. Extent to which unplanned projects or intuitive decisions conflict with oris given precedence over this HMP.
7. Extent to which the health workforce is committed to achieving the goals of the HMP.

Organizational Capability and Resources

The resources available at the time of developing this HMP are as follows. The output targets during each business plan cycle must carefully consider the changes to the resource availability.

CAPACITY AND RESOURCES	STATUS	YEAR & SOURCE
MATERIAL RESOURCES		
Number of hospital beds (Pvt 1626, public 90)	1716	2015, HI-MOH records
Hospital beds per 10,000 population	49	2015, HI-MOH records
Number of Government Health Facilities	187	2016, QARD-MOH records
Number of private medical centres/medical clinics	202	2015, HI-MOH records
Number of "Dhivehi beys"	8	2016, QARD-MOH records
Number of alternative medicine centres (excl. spas)	9	2016, QARD-MOH records
Number of pharmacies (STO and private)	546	2016, MFDA records
Number of centres providing drug rehabilitation services	7	2015, NDA-
HUMAN RESOURCES		
Doctors per 10,000 population	23	2015, HI-MOH records
Practicing nurse per 10,000 population	66	2015, MOH records
Primary Health Care/PHC workers per 10,000 population	14	2015,HI-MOH records
Percent of local doctors in health workforce.	23	2015,Hi-MoH records
Percent of local nurses in the health workforce	56	2015HI-MOH records
FINANCIAL RESOURCES		
Total health expenditure	MRV 2.8 billion	2011, NHA survey
Total Expenditure on Health (THE) as % of Gross Domestic Product (GDP)	9.2	2011, NHA survey
General Government Health Expenditure (GGHE)as % of Total Expenditure on Health (THE)	44.0	2011, NHA survey

Private Expenditure on Health (PvtHE) as % of Total Expenditure on Health (THE)	52.7	2011, NHA survey
General Government Health Expenditure (GGHE) as % of General Government Expenditure (GGE)	9.5	2011, NHA survey
Per capita Total Expenditure on Health (THE) at official Exchange rate (X-Rate per US $)	561	2011, NHA survey
Out-of-Pocket Spending on Health (OOPS) as % of Total Expenditure on Health (THE)	49	2011, NHA survey

Abbreviations:
HI: Health Information and Research Section.
MFDA: Maldives Food and Drug Authority
MoH: Ministry of Health
NDA: National Drug Agency
NHA: National Health Accounts
QARD: Quality Assurance and Regulations division

Implementation

As shown in Figure 2 under the section 'Planning model', it is expected that government and each partner will develop their medium term plans and annual business/operational plans using the high level strategic directions identified in the HMP2016-2025 as a guide. Furthermore, Ministry of Health will play key role in lobbying, advising and providing support partners in the public sector, private health care providers and non-governmental parties to ensure linkages of their plans with the priority areas of the HMP 2016-2025.

Towards ensuring this, it is also proposed to establish a national level steering committee to oversee the implementation of the Health Master Plan annually. The objective of this committee would be to provide support and coordination in aligning annual action plans, implementation of assigned activities and overall monitoring and evaluation.

It is recognised that costing for implementation of this plan, although required is impractical at the current stage, as there are no detailed costing data available at country level for prior years. Hence, with the availability of costing data, detailed costing of this plan could be a deliberation for Ministry of Health in the future years.

Monitoring and Evaluation

The biannual priority areas of Health Master Plan would be identified every two years by the policy level of Ministry of Health. Annual action plans would be aligned with identified priorities by the departments each year with the budget allocated by the government and health partners.

Since the HMP is expected to be the basis against which the government and its partners will measure and report its achievements. The indicators for monitoring outputs and outcomes are provided in the results based logical framework (Appendix 1). HMP will be monitored quarterly (including a midterm and end of term evaluation) with all partners of health, led by Ministry of Health. A mid-tem review of the HMP 2016-2025 in the year 2020 shall be undertaken to guide adjustments to the strategic priorities and inputs to meet the changing health needs of the population and the changing socio-economic and political context of Maldives. Such monitoring is expected to provide evidence for making necessary adjustments to the business plans of the partners towards meeting the national priority areas. A final evaluation of the HMP 2016-2025 will be conducted in the years 2024-2025 by the Ministry of Health.

Conclusion

The Health Master Plan (HMP) 2016-2025 represents a strategic framework for the prioritization, implementation and monitoring of the health services and programmes, as well as a guide for development of a comprehensive business plan for all partners in health in Maldives.

The stewardship of the Ministry of Health is critical to ensure effective utilisation of the HMP2016-2025 as a guide in developing strategic action plans and business plans within the government health sector as well as other partners of health.

Bibliography

- Aga Khan University, Ministry of Health and Family and UNICEF. (2010).
- *National Micronutrient survey, 2007*. Male', Maldives: Ministry of Health and Family.
- Amaltas Consulting.(2009). *PPP for better health and family services in the Maldives*. Male', Maldives: Author
- Centre for Community Health and Disease Control (CCHDC) and World Health Organization. (2011). *STEPS Survey on Non Communicable Disease Risk Factors Maldives, 2011.*Male', Maldives.
- Department of National Planning (2010).*Millennium development goals. Maldives country report 2010*. Male', Maldives:Ministry of Finance and Treasury.
- Department of National Planning. (2012). *Household Income and Expenditure Survey (HIES) 2009-2010: Summary*. Male', Maldives: Author.
- Department of National Planning.(2013). *Maldives MDG assessment 2013*.Male', Maldives: Author.
- Maldives Bureau of Statistics. (2015). *Maldives population and housing census2014: Statistical release I: Population and households*. Male', Maldives: Ministry of Finance and Treasury.
- Maldives Bureau of Statistics. (2015b). *Maldives population and housing census2014: Statistical release III: Education*. Male', Maldives: Ministry of Finance and Treasury.
- Maldives Bureau of Statistics. (2015c). *Maldives population and housing census2014: Statistical release IV: Employment*. Male', Maldives: Ministry of Finance and Treasury.
- Maldives Bureau of Statistics.(2016). *Statistical year book of Maldives 2016*. Male', Maldives: Ministry of Finance and Treasury.
- Maldives Fiqh Academy (2013).*Fatwa on circumstances for abortion*. Male', Maldives: Author.
- Maternal and Perinatal Mortality and Morbidity Review Committee. (2013). *Maternal Death in the Maldives 2009-2012*. Male', Maldives: Ministry of health.
- Ministry of Gender and Family. (2006). *The Maldives study on women's health and life experiences*. Male', Maldives: Author
- Ministry of Health and Family and ICF Macro (2009).*Maldives demographic health survey, 2009*. Male', Maldives: Ministry of Health
- Ministry of Health.(2012). *Maldives health statistics 2012*. Male', Maldives: Author.
- Ministry of Health.(2016). *Maldives health statistics 2016*. Male', Maldives: Author.
- Ministry of Health. (2016b). *Private health facilities registered under Ministry of Health*. Retrieved from http://www.health.gov.mv.
- Ministry of Health. (2013). *Maldives national health accounts 2011*. Male, Maldives: World Health Organization country office for Maldives.
- Ministry of Finance and Treasury and UNDP (2014).*Maldives human development report 2014*. Male', Maldives.
- Ministry of Planning and National Development. (2008). *Analytical report 2006: Population and housing census 2006*. Male', Maldives: Author.
- Ministry of health and Family and UNDP.(2011*). Biological and behavioural survey (BBS) on HIV and AIDS, 2008.*Male', Maldives: Author.
- United Nations.(2015). *Sustainable development goals*. Retrieved from http://www.un.org/sustainabledevelopment/#

- UNICEF and Ministry of Health and Family.(2011). *Status of nutrition, food safety and food security in Maldives*.Male', Maldives.
- UNODC (2013).*National drug use survey, Maldives - 2011/2012*. Male', Maldives: Author.
- World Bank. (2011). *Non communicable diseases: Maldives' major health challenge.* Washington, DC: Author
- World Bank.(2014). *Maldives country snapshot*. Washington, DC: Author.
- World Health Organization Regional Office for the South East Asia (WHO SEARO).(2010). *Strategy for active and healthy ageing/ elderly health care in the Maldives*.Unpublished.
- World Health Organization. (2010). *Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies.* Geneva, Switzerland: Author.
- World Health Organization.(2011). *Mental Health Atlas, 2011.* Geneva, Switzerland: Author.
- World Health Organization. (2013). *The economics of the social determinants of health and health inequalities: a resource book.* Geneva, Switzerland: Author.
- World Health Organization. (2014). *Non communicable Diseases country profiles 2014.* Geneva, Switzerland: Author.
- World Health Organization. (2015). *Maldives: WHO statistical profile.* Geneva, Switzerland: Author.

Appendix 1: Logical Framework for Monitoring and Evaluation

LEVEL	INDICATORS	MEANS OF VERIFICATION	FREQUENCY		BASELINE (Year)	TARGET 2020 and 2025	SUSTAINABLE DEVELOPMENT GOALS	ASSUMTIONS & RISKS
Goal								
Enhance health and well-being of the population of Maldives	Life expectancy at birth	VRS, Census	Annually	All 4 Quarters	Male : 73.13 years, Female: 74.77 years (2014)	Increase by 1 year and by 2 years (both sexes)		
	Total fertility Rate	DHS/Census	5 years	Mid Term-End Term	2.46 (2014)	Maintain at current level		
	Crude birth rate	VRS	Annually	All 4 Quarters	21 (2014)	Maintain at current level		
	Crude death rate	VRS	Annually	All 4 Quarters	3 (2014)	Maintain at current level		
	Neonatal mortality rate ('000 live births)	VRS	Annually	All 4 Quarters	5.11 (2014)	Maintain below 06	SDG 3.2.2	
	Infant mortality rate ('000 live births)	VRS	Annually	All 4 Quarters	8 (2014)	Maintain below 09		
	Under 5 mortality rate ('000 live births)	VRS	Annually	All 4 Quarters	10 (2014)	Equal or less than 10	SDG 3.2.1	
	Maternal mortality ratio/maternal deaths ('100,000 live births)	VRS	Annually	All 4 Quarters	41 (2014)	Maintain below 50	SDG 3.1.1	
	Premature mortality from NCDs (age specific rates between 30 and 70 years) ('000 population of the target age group)	WHO global health Observatory (GHO) data, VRS	5 years	Mid Term-End Term	Not Available	Reduce by 1/4th and by 1/3rd		
	Mortality rate attributed to cardiovascular disease,	VRS	Annually	All 4 Quarters	2.77%(2014)		SDG 3.4.1	

	cancer, diabetes or chronic respiratory disease as defined as number of deaths from the 4 NCDs between the ages 30 and 70 years over population at exact age 30				(indicator taken from ICD 10 codes –I00-I99, COO-C97, E10-E14andJ30-J98)			
	Total Expenditure on Health (THE) as a percentage of GDP)	NHA	5 years	Mid Term-End Term				
	Still birth Rate (per 1000 live births)	VRS	Annually	All 4 Quarters	5 (2014)	Maintain below 10		
Outcomes (OC)								
OC 1: Improved trust in the national health system	Overall satisfaction with health services (% of sample)	Facility-based user surveys	5 years	Mid Term-End Term	Not Available	Increase by 10% and 15%		Achievement of the indicators depends on the extent of stewardship at political level for accountability, evidence-based resource allocation and engagement with health partners for need-based utilization and provision of health services. Leadership at
	Total net official development assistance to medical research and basic health sector (Percentage of Donor support to Total Health Expenditure -Proxy Indicator)	NHA	5 years	Mid Term-End Term	3.3(2011)	Increase to 5% and maintain above 5%	SDG 3.b.2	
	Out-of-Pocket Spending on Health (OOPS) as % of Total Expenditure on Health (THE)	NHA	5 years	Mid Term-End Term	49.4 (2011)	Reduce by 25% and by 50%		

								MOH is necessary to bring all partners together to attain the outcomes and outputs.
OC 2: Reduced disease and disability among population	Prevalence of underweight (weight-for-age) in children <5 years of age (%)	MDHS	5 years	Mid Term-End Term	17.3 (2009)	Reduce to 15% and maintain below 15%	SDG 2.1.1	The main challenges for achieving this goal are limited intersectoral support in providing supportive environment and policies for healthy lifestyles. In addition, due to double burden of disease and expected double burden of vulnerable populations of under 5 years and older people, the resource allocation for programmes need careful
	Prevalence of wasting children <5 years (weight for height below-2SD)	MDHS	5 years	Mid Term-End Term	10.6 (2009)	Reduce by1/3 and Maintain	SDG 2.1.1 SDG 2.2.2	
	Prevalence of overweight children <5 years (weight for height above +2SD)	MDHS	5 years	Mid Term-End Term	5.9 (2009)	Reduce by1/3 and Maintain	SDG 2.2.2	
	Prevalence of stunting (height for age < -2 SD from the median of the WHO child growth standard) among children under 5 years of age.	MDHS	5 years	Mid Term-End Term	18.9 (2009)	Reduce by1/3 and Maintain	SDG 2.1.1 SDG 2.2.1	
	Percentage of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being	Ministry of Education / HPA	5 years	Mid Term-End Term	NA		SDG 4.2.1	
	TB incidence per 1,000 population (Tuberculosis incidence rate Per 100,000 - Proxy Indicator)	TB Control Program-HPA	Annually	All 4 Quarters	41 (2015)	below 10/100'000 population	SDG 3.3.2	
	Tuberculosis prevalence rate (per 100,000)	TB Control Program-HPA	Annually	All 4 Quarters	56 (2015)	Reduce to less than		

						0.05% and maintain below 0.05%		assessment of health gains that can be achieved. Social-economic empowerment of vulnerable populations is essential for reducing inequalities in health
	Leprosy prevalence rate (per 10'000 population)	Elimination Disease Unit-HPA	Annually	All 4 Quarters	0.02 (2014)	Reduce to less than 0.01 and maintain below 0.01		
	Number of new HIV infections per 1000 uninfected population ('000 population) (HIV incidence rate -Proxy Indicator)	Disease surveillance system - HPA	Annually	All 4 Quarters	0.01 (2014)	Maintain below 0.05	SDG 3.3.1	
	HIV prevalence rate ('000 population)	Disease surveillance system - HPA	Annually	All 4 Quarters	0.001 (2014)	Maintain below 0.05	SDG 3.3.1	
	Malaria incidence ('000 population)	Elimination Disease Unit-HPA	Annually	All 4 Quarters	Elimination Certified in 2015	Maintain elimination status of Malaria (<0.01%)	SDG 3.3.3	
	Hepatitis B incidence(per 1000 population)	Disease Surveillance System-HPA	Annually	All 4 Quarters	Not Available		SDG 3.3.4	
	Number of people requiring interventions against neglected tropical diseases.	Disease Surveillance System-HPA	Annually	All 4 Quarters	Not Available		SDG 3.3.5	
	Filaria incidence ('000 population)	Elimination Disease Unit - HPA	Annually	All 4 Quarters	Elimination certified in 2015	Maintain elimination status of Filaria		
	Prevalence of hypertension (%)	NCD STEPS survey	5 years	Mid Term-End Term	16.6 (2011)	Reduce to 15% and maintain below 15%		

	Prevalence of cancer in adult population (%)	Aasandha Records, Cancer register-HPA	5 years	Mid Term-End Term	Not Available	Reduce by 2%		
	Prevalence of diabetes (%, type 2)	NCD STEPS survey,	5 years	Mid Term-End Term	Not Available	Maintain below 5%		
	Prevalence of Mental, Neurological and Substance Abuse (MNS) Disorder	Mental Health Survey-HPA	5 years	Mid Term-End Term	Not Available			
	Number of registered Beta Thalassemia Major patients	MBS Records	Annually	All 4 Quarters	622 (2016)	Reduce to 10% and maintain below 10%		
	Mortality due to road traffic Injuries/ accidents (% '000 pop)	VRS, injury surveillance reports	Annually	All 4 Quarters	0.032 (2014)	Reduce by 50% and sustain 75%	SDG 3.6.1	
	Suicide mortality rate (per 100,000 Population)	Police, VRS	Annually	All 4 Quarters	4.32 (2015)	Maintain below 4	SDG 3.4.2	
	Mortality rate attributed to unintentional poisoning	Police, VRS	Annually	All 4 Quarters	0 (2014)	Maintain at 0	SDG 3.9.3	
	Mortality rate attributed to unsafe water, unsafe sanitation, and lack of hygiene. (Exposure to unsafe WASH services)	VRS,	Annually	All 4 Quarters	0	Maintain at Same level.	SDG 3.9.2	
	Mortality rate attributed to household and ambient air pollution	VRS,	Annually	All 4 Quarters	0	Maintain at Same Level.	SDG 3.9.1	
	Frequency rates of fatal and non-fatal occupational injuries, by sex and migrant status (Mortality due to workplace	VRS, injury surveillance reports	Annually	All 4 Quarters	Not Available	Reduce by 50% and sustain 75%	SDG 8.8.1	

	accidents (% '000 pop) – Proxy Indicator)							
	% of obesity (BMI>30) (adolescents 13 - 15yrs and adults 15-64yrs)	School health survey (2014)	5 years	Mid Term-End Term	Not Available	Decrease by 5% and 10%		
	% of obesity (BMI>30(adults 15-64yrs)	NCD STEPS survey, MDHS	5 years	Mid Term-End Term	11.5% (2011)	Decrease by 5% and 10%		
	Number of persons with physical impairment registered in disability register	Ministry of gender and family, NSPA	Annually	All 4 Quarters	1782 (2016)			
	Number of persons with visual impairment in disability register	NSPA,	Annually	All 4 Quarters	577 (2016)			
	Number of persons with hearing impairment in disability register	NSPA	Quarterly	All 4 Quarters	1094 (2016)			
OC 3: Reduced inequities in access to health care services and medicines.	Proportion of the population with access to affordable medicines and vaccines on a sustainable basis (percentage of the population who have access to medicines listed in Essential Medicine list in inhabited islands - Proxy Indicator)	MFDA Records	Annually	All 4 Quarters	Not Available	Maintain 100%	SDG 3.b.1	The outcome indicators are possible with commitment for improving system efficiency and provision of care that match the

	Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, new born and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population). (No. of Inhabited Islands with access to essential services which are covered under Social Health Insurance - Proxy Indicator)	QARD records, RAHS records	5 years	Mid Term-End Term	Not Available	Maintain at 100%	SDG 3.8.1	population health needs. Adequate resource allocation for cost effective health care interventions and partnerships with private and voluntary sectors are important for success.
	Doctors per 10,000 population	HR data centrally, Licensing Registration (for PVT clinics and Hospitals), Health Facilities.	Annually	All 4 Quarters	23 (2015)	Maintain above 20		
	Nurses per 10,000 population	HR data centrally, Licensing Registration (for PVT clinics and Hospitals), Health Facilities.	Annually	All 4 Quarters	66 (2015)	Maintain above 50		

	Public Health workers per 10,000 population	HR data centrally, Licensing Registration (for PVT clinics and Hospitals), Health Facilities.	Annually	All 4 quarters	14 (2015)	Increase to 20 and maintain above 20		
	Hospital beds per 1,000 population	HI records	Annually	All 4 Quarters	5 (2015)	Increase to 10 and maintain above 10		
	Health worker density and distribution (Skilled health professionals density (per 10 000 population) - Proxy Indicator)	HI records	Annually	All 4 Quarters	126 (estimated fig.)	Increase by 50% and maintain.	SDG 3.c.1	
Outputs								
OP1: Improved health policy making that is value-oriented, evidence-based to achieve health gains	% of Major national development projects that assessed health impact prior to implementation) (such as artificial beaches, parks and harbors).	PO, Housing, MOED, Etc	5 Years	Mid Term- End Term	0% (2015)	Increase to 25% and 50%		Commitment of government and policy makers to interest in information system and use of evidence
	% of action plans in the Health sector which links with the HMP outputs or outcomes	MOH - Health Facilities, Departments, Divisions	5 Years	Mid Term- End Term	Not Applicable	100% of action plans developed in health sector linked to and outcomes.HMP outputs		

OP 2: Strengthened partnerships for health within government, private and voluntary sectors	Percentage of local private health care institutions who are registered providers of Aasandha	Aasandha information system, QARD records	Annually	All 4 quarters	38.3 (2016) (51 empanelled pvt clinics/ total registered clinics)	Maintain above 40%		Government and policy makers recognize the role of other sector in impacting health as well as the role of private and voluntary health sector
	Number of international health care institutions who are registered providers of Aasandha	Aasandha information system	Annually	All 4 quarters	Hospitals	39 (2016)	Empanel 71 Hospitals and 111 and Maintain above.	
	Number of Non-Governmental states working jointly with health sector in conducting public health activities .(Number of NGOs working with HPA and MBS to conduct public health programs - Proxy Indicator)	HPA and MBS	Annually	All 4 quarters	Not Available	Increase the number of Non-governmental states quarterly.		
OP 3: Improved sustainability of health system and health care financing mechanisms	Private Expenditure on Health (PvtHE) as % of Total Expenditure on Health (THE)	NHA	5 years	Mid Term- End Term	52.7 (2011)	Decrease to 50% and maintain below 50%		Government and law makers' commitment to allocate adequate resource allocation for sustainable health care financing options in budgetary allocations
	Social security funds as percentage of general government health expenditure.	MoFT– NHA, NHA	Annually	All 4 quarters	19.6 (2011)	Maintain below 20%		
	Government spending on preventive health as % of general government health expenditure	NHA,	5 Years	Mid Term- End Term	5.9 (2011)	Increase to 15% and maintain		
	Per capita Total Expenditure on Health	NHA	5 years	Mid Term-	561 (2011)	Maintain below 700		

	(THE) at official Exchange rate (X-Rate per US $)			End Term				and setting resource envelopes
	Proportion of total government spending on essential services (education, health and social protection) (General Government Health Expenditure (GGHE) as % of General Government Expenditure (GGE)- Proxy Indicator)	MoFT (National Accounts)	Annually	Mid Term- End Term	9.5 (2011)	Maintain above 10%	SDG 1.a.2	
	General Government Health Expenditure (GGHE)as % of Total Expenditure on Health (THE)	NHA	5 years	Mid Term- End Term	44.0 (2011)	Increase to 50% and maintain above 50%		
	Total government spending in social protection and employment programmes as percentage of the national budgets and GDP	Ministry of Finance and Treasury/ NHA	5 years	Mid Term- End Term			SDG 8.b.1	
	Proportion of the population covered by social protection floors/systems by sex, and distinguishing children, unemployed persons, older persons, persons with disabilities, pregnant women, new-borns, work injury victims, poor and vulnerable (Population coverage of social health insurance	NHA, Aasandha records, NSPA Records	5 years	Mid Term- End Term	100% (2016)	Maintain 100%	SDG 1.3.1	

	scheme (% of population) – Proxy Indicator))							
	Lack of financial protection coverage in health as defined as proportion of population with large household expenditure on health as a share of total household expenditure or income	NBS, NSPA	5 years	Mid Term- End Term	NA		SDG 3.8.2	
OP 4: Improved enforcement of legislations for health	% of regulations under Public Health Protection Act enforced	Legal Section Records	Annually	All 4 quarters	10% (1 of 10 Regulation Enforced) (2016)	Increase to 100% and monitor implementation		Law makers and government's commitment to enforce enacted laws with policy support and resource allocation for enforcement functions. Public support for law enforcement
	% of regulations under Health Services Act enforced	Legal Section Records	Annually	All 4 quarters	0% (total 12 regulations to be enforced)	Increase to 100% and monitor implementation		
	% of regulations Health Professionals Act enforced	Legal Section Records	Annually	All 4 quarters	0% (total 30 regulations to be enforced)	Increase to 100% and monitor implementation		
	Food Act enforced	Legal Section Records/MoH and MFDA	Annually	All 4 quarters	Drafting completed (2016)	1		
	Number of food safety and quality standards developed	MFDA – MoH	Annually	All 4 quarters	2 standards endorsed and 3 regulations implemented (2016)	increase to 20 and 25		

	Number of countries with laws and regulations that guarantee women age 15-49 years access to sexual and reproductive healthcare, information and education. (Number of Laws and regulations that guarantee women age 15-49 years access to sexual and reproductive healthcare, information and education enforced - proxy indicator)	legal records	Annually	All 4 quarters	0	1	SDG 5.6.2	
OP 5: Enabled a healthy start in life and childhood enabled through the health system	% low birth weight (weight <2500 grams at birth) newborns	VRS	Annually	All 4 quarters	9.49 (2014)	Maintain below 10%		Socio-economic empowerment, women's empowerment with adequate material, human and financial resource allocation
	Proportion of births attended by a skilled health professional (%)	VRS/MDHS	5 years	Mid Term-End Term	95.58 (2014)	Maintain above 95%	SDG 3.1.2	
	% of near-miss maternal deaths	Programme records	Annually	All 4 quarters	Not Available	Reduce by 50% and 75%		
	% of live births by mothers aged below 20 years	VRS	5 Years	Mid Term-End Term	3% (2014)	Maintain below 3%		
	% of pregnant women receiving 4 or more ANC check-ups by a skilled provider	MDHS	5 Years	Mid Term-End Term	85.1% (2009)	Increase to 90 and Maintain		
	% of pregnant women who receiving iron-folate supplements during pregnancy (Iron-folate supplements coverage)	MDHS	5 Years	Mid Term-End Term	64.5%(2009)	Increase to 75% and maintain above 75%		

	% of children	MDHS	5 Years	Mid Term- End Term	48%(2009)	Increase to 60% and 75%		
	% of mothers receiving preconception folic acid	HPA Program Records	Annually	All 4 quarters	Not Available	Increase to 30% and 50%		
	% of children aged 12 to 23 months who received all basic vaccinations (EPI vaccine coverage)	MDHS, HPA programme records	5 Years	Mid Term- End Term	92.9(2009)	Increase to 95% and maintain above 95%	SDG 3.1.b	
	% of children <1 year with measles vaccination (Measles vaccine coverage)	MDHS	5 Years	Mid Term- End Term	94%(2009)	Increase to 95% and maintain above 95%		
	% of children aged 6-59 months provided with Vitamin A supplements	MDHS	Annually	All 4 quarters	48.1% (2009)	Increase to 95% and maintain above 95%		
	% of children introduced with complementary foods at 6 months	MDHS	5 Years	Mid Term- End Term	90%(2009)	Increase to 95% and maintain above 95%		
	Proportion of breast milk substitute products registered and sold	MFDA –MoH	Annually	All 4 quarters	35% (2016)	95% and maintain Above		
	% children <5 years with diarrhea treated with ORT/increased fluids	MDHS	5 Years	Mid Term- End Term	84%(2009)	Increase by 50% and 75%		
	Number of government hospitals compliant with breast feeding hospital initiative(BFHI)	HPA Program Records	Annually	All 4 quarters	9 (2009)	Increase to 50% and 100% of all govt hospitals		
	% of caesarean sections	VRS	Annually	All 4 quarters	42%(2015)	Decrease to less than 30%		

						and maintain		
OP 6: Enabled young people and adults to adopt healthy lifestyles and safe practices	Adolescent Birth rate per 1000 women in the age group 10-14 Years	VRS	5 Years	Mid Term-End Term	0%(2014)		SDG 3.7.2	Intersectoral support, particularly form economic sectors for promoting healthy food and consumer products and services together with intersectoral action in different settings to support health promoting practices
	Adolescent Birth rate per 1000 women in the age group 15-19 Years	VRS	5 Years	Mid Term-End Term	13.26 (2014)	Decrease to 13 and maintain.	SDG 3.7.2	
	Proportion of women (aged 15-49) who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care (Contraceptive prevalence rate (%) all methods and modern methods – Proxy Indicator)	MDHS	5 years	Mid Term-End Term	all methods: 35 (2009)	Increase by 5% and 10%	SDG 5.6.1	
	% who currently smoke cigarettes, (adolescents 13 - 15yrs)	Global Youth Tobacco Survey,	5 years	Mid Term-End Term	16.5% (2011)	Reduce by 5% and by 10%		
	Age-standardized prevalence of current tobacco use among persons aged 15 years and older (Percentage of the population aged 15-64 years who are currently smokers; Percentage of the population aged 15-64 years who are currently using smokeless tobacco –	NCD Steps Survey	5 years	Mid Term-End Term	18.8% ; 3.7% (2011)	Reduce by 5% and by 10%; Reduce by 50% and Above		

	Proxy Indicator)							
	% currently use smokeless tobacco (adolescents 13 - 15yrs)	Global Youth Tobacco Survey,	5 years	Mid Term- End Term	6.2 (2011)	Reduce by 5% and by 10%		
	% who currently use addictive drugs (adolescents 13 - 15yrs)	National Drug Survey, School health survey	5 years	Mid Term- End Term	5.4 (School Health Policy,2010)	Reduce by 5% and by 10%		
	% who currently use addictive drugs (adults 15-64)	National Drug Survey	5 years	Mid Term- End Term	81.56 (2009)	Reduce by 5% and by 10%		
	Number of NCD Clinics or facilities providing Tobacco cessation service(Government Facilities)	Facilities and HPA-Programme Records	Annually	All 4 quarters	1 (Dhamanaveshi) (2016)	Increase by 20% and 50%		
	Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders (%of identified drug users provided with rehabilitation treatment – Proxy Indicator)	National Drug Survey	5 Years	Mid Term- End Term	0.038% (2012)	Increase by 5% and 10%	SDG 3.5.1	
	Harmful use of alcohol defined according to the national context as alcohol per capita (15+ years old) consumption within a	Police	Annually	All 4 quarters	Not Available		SDG 3.5.2	

	calendar year in litres of pure alcohol. (Number of reported cases of alcohol use for 15+ years -Proxy Indicator)							
	% who consume < than 5 servings of fruit and/or vegetables (adolescents 13 - 15yrs and adults 15-64)	NCD STEPS survey, School health survey	5 years	Mid Term- End Term	93.6% (2011) 15-64 yrs.	Increase by 5% and 10%		
	% o with low levels of activity (defined as < 600 MET-minutes per week) (adolescents 13 - 15yrs and adults 15-64)	NCD STEPS survey, School health survey	5 years	Mid Term- End Term	45.9% (2011) 15-64 yrs.	Increase by 5% and 10%		
	% of population with comprehensive correct knowledge of HIV/AIDS (adults 15-49 ever married women)	MDHS	5 years	Mid Term- End Term	41.5% (2009)	Increase by 5% and 10%		
	% % of population with comprehensive correct knowledge of HIV/AIDS (adults 15-24 ever married women)	MDHS	5 years	Mid Term- End Term	35.0% (2009)	Increase by 5% and 10%		
	% of population with comprehensive correct knowledge of HIV/AIDS (adults 15-49 ever married men)	MDHS	5 years	Mid Term- End Term	43.6%(2009)	Increase by 5% and 10%		
	% with knowledge of contraceptive methods (modern method) (adults 15-49 ever married women)	MDHS	5 years	Mid Term- End Term	99.2% (2009)	Increase by 5% and 10%		

	% with knowledge of contraceptive methods (modern method) (adults 15-49 ever married men	MDHS	5 years	Mid Term- End Term	98.9% (2009)	Increase by 5% and 10%		
	No. of episodes of food products confiscation for health risks or non-compliance with national food safety standards	MFDA records	Annually	All 4 quarters	7 products (2016)	Reduce by 1/4th and 1/3rd		
	Proportion of women of reproductive age (15-49 years) who have their need for family planning satisfied with modern methods (Percentage of currently married women aged 15-49 years with met need for family planning – Proxy Indicator)	MDHS,	5 years	Mid Term- End Term	34.7% (2009)		SDG 3.7.1	
	% of currently married women aged 15-49 years with an unmet need for family planning.	MDHS	Annually	All 4 quarters	28% (2009)	Reduce to 25% and maintain below 25%		
	% of smear positive leprosy cases cured with MDT (cure rate)	CD Programme - HPA	Annually	All 4 quarters	84%(2009)	Increase to 95% and maintain above 95%		
	Number of women (30-65) screened for cervical cancer	Dhamanaveshi	Annually	All 4 quarters	18 (2016)	Increase to 20% and 30%		
	Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by	Ministry of Gender and Family/Police/ Family Protection Authority	5 years	Mid Term- End Term			SDG 5.2.1	

	a current or former intimate partner, in the previous 12 months, by form of violence and by age							
	Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner, in the previous 12 months, by age and place of occurrence	Ministry of Gender and Family/POLICE / Family Protection Authority	5 years	Mid Term- End Term			SDG 5.2.2	
	Proportion of women aged 20-24 years who were married or in a union before age 15 and before age 18	CENSUS	5 years	Mid Term- End Term			SDG 5.3.1	
	Proportion of girls and women aged 15-49 years who have undergone female genital mutilation/cutting, by age	Ministry of Health/ Ministry of Gender and Family	5 years	Mid Term- End Term			SDG 5.3.2	
	Proportion of persons victim of physical or sexual harassment, by sex, age, disability status and place of occurrence, in the previous 12 months	Ministry of Gender and Family/ Police	5 years	Mid Term- End Term			SDG 11.7.2	
	Proportion of population subjected to physical, psychological or sexual violence in the previous 12 months	Ministry of Gender and Family/ Police	5 years	Mid Term- End Term			SDG 16.1.3	
	Proportion of young women and men aged 18-	Ministry of Gender and	5 years	Mid Term-			SDG 16.2.3	

	29 years who experienced sexual violence by age 18	Family/ Police		End Term				
	Proportion of time spent on unpaid domestic and care work, by sex, age and location	HIES 2015/2016	5 years	Mid Term- End Term			SDG 5.4.1	
	Proportion of wastewater safely treated	Ministry of Environment and Energy	5 years	Mid Term- End Term			SDG 6.3.1	
	Proportion of bodies of water with good ambient water quality	Ministry of Environment and Energy	5 years	Mid Term- End Term			SDG 6.3.2	
	Number of government health facilities providing youth friendly services	Population Health Program - HPA	Annually	All 4 quarters	3 Facilities (2016)	Establish 10 facilities and 20 facilities.		
	Proportion of population using safely managed drinking water services (Proportion of population using improved drinking-water sources (% of population) – Proxy Indicator))	MDHS, Census	5 years	Mid Term- End Term	97.7 (2009)	Maintain above 95%	SDG 6.1.1	
	Proportion of population using safely managed sanitation services, including a hand- washing facility with soap and water (Proportion of population using improved sanitation (% of population) – Proxy Indicator))	MDHS, Census	5 years	Mid Term- End Term	94.5 (2009)	Maintain above 95%	SDG 6.2.1	

Output 7: Enhanced the quality of life of older people, people with disabilities and long-term health conditions enhanced	% of disabled persons provided with assistive devices among those who require	NSPA	Annually	All 4 quarters	Not Available			Scio-economic empowerment of families and appropriate housing and social support mechanism.
	Number of people with disabilities receiving social security benefit (financial)	NSPA records, NGO records	Annually	All 4 quarters	6522 (2016)			
OP8: Improved coordination of the health care delivery by the public, private and voluntary sectors	Number of government health facilities s providing BEONC (Basic emergency obstetric and neonatal care)	RAHS – MoH Records/HPA	Annually	All 4 quarters	More than 95% Achieved(2016)	Maintain at above 95%		Political commitment for health system stability and partnerships with private and voluntary sector.
	% of Patients with waiting time for GP appointment<1 week (Once GP system is established)	IGMH Records, RAHS records	Annually	All 4 quarters	Not Available (GP system to be established)	Increase and Maintain at 80%		
	% of Patients with waiting time for Specialist appointment at IGMH <2weeks (% of patients)	IGMH Records	Annually	All 4 quarters	Not Available	Increase to 20% and 25%		
	Average length of stay per admission (days per patient, by hospital)	HI records	Annually	All 4 quarters	Not Available	Decrease to less than 5 days		
	Bed occupancy rate at hospitals	HI records	Annually	All 4 quarters	Not Available	Increase by 10% and 30% in all hospitals		
	% of atoll hospitals with diagnostic facilities (medical laboratory, radiology/imaging tests)	RAHS records	Annually	All 4 quarters	100%	Maintain at 100%		

	Number of atoll health facilities with established laboratory sample transport mechanism	RAHS records	Annually	All 4 quarters	Established in 2 atolls(Alif Alifu and Thaah Atoll,2016)	Increase to 50% and 100% and maintain		
OP9: Improved skills and commitment of the health workforce	% of Maldivian doctors serving at government atoll health facilities.	HR records, HI records	Annually	All 4 quarters	2% (2015)	Increase to 15% and increase by 20%		Socio-political transition does not have large influence on human resource policies and management of health care institution in the public sector. Local training institutionseff ectivelyattract students and funding intuitions develop partnerships with health sector to develop necessary skill set required for national workforce
	% of Maldivian doctors serving at government health facilities in Male' city	HR records, HI records, IGMH records	Annually	All 4 quarters	51% (2015)	Increase to 100% and Maintain		
	% of local doctors in the health workforce (of total doctors)	HI records	Annually	All 4 quarters	23% (2015)	Increase to 30% and 35%		
	% of local nurses in the health workforce (of total nurses)	HR records, IGMH, Aasandha, HI records	Annually	All 4 quarters	56% (2015)	Increase to 60% and 75%		
	Percentage of locally trained health workforce joining the workforce (nurses, PHC Lab technicians,)	HR records, FHS records	Annually	All 4 quarters	Not Available	Increase to 50% and 60%		
	Percentage of public funded health graduates studying abroad and locally joining health workforce (fully funded)	HR records, DHE records	Annually	All 4 quarters	Not Available	Increase to 50% and 60%		
	Attrition rate of health workforce	HR records	Annually	All 4 quarters	Not Available	Decrease by 20% and 50%		

OP10: Improved responsiveness of the health information system	% of public and private hospitals implementing ICD 10 (ICD codes used in inpatient report and /or death certification forms - proxy indicator)	HI records, VRS	Annually	All 4 quarters	Not Available	Increase to 50% and 75%		Commitment to evidence-based policy and a culture of information driven decision making in health planning and programming.
	Two or more data points for coverage of key health interventions in the past five years	HPA and HI records	5 Years	Mid Term-End Term	DHS conducted in 2016/17	Minimum 2 Surveys conducted every 5 years.		
	One or more data point on adult health (tobacco use, physical activity, nutrition, disabilities ,etc) in the past 5 years	HPA and HI records	5 years	Mid Term-End Term	DHS conducted in 2016/18	Minimum 1 Survey conducted every 5 years.		
	Proportion of children under 5 years of age whose births have been registered with a civil authority, by age (% of births registered – Proxy Indicator))	MDHS, VRS	5 Years	Mid Term-End Term	92.5% (2011)	Maintain Above 95%	SDG 16.9.1	
	% of deaths with validated cause of deaths.	Survey, VRS validation study	5 years	Mid Term-End Term	Not Available	1 study conduct every 5 years		
	Availability of a health data quality assessment using internationally agreed criteria such as Data Quality Assessment Framework (DQAF) (in the past 5 years)	Health Data Quality Assessment by HI	5 years	Mid Term-End Term	0%	1 assessment conducted by 2020, 2 assessment conducted by 2025		
	International Health Regulations (IHR) capacity and health emergency	HPA,	Annually	All 4 quarters	Annually Reported	1 report completed annually	SDG 3.d.1	

	preparedness (Availability of information and data for International Health Regulations compliance monitoring and evaluation – Proxy Indicator)							
	Availability of up-to-date National Health Accounts	MOH	5 years	Mid Term-End Term	Conducted in 2011 and 2016	At least one health accounts exercise completed in every 5 years		
	Availability of National database with public and private sector health facilities and geocoding	HI records, IT records	5 years	Mid Term-End Term	Not Available	Establish a GIS system for Health Data by 2020		
	Availability of an update national database with health workers by region/atoll and main cadres (HR Registry/ Database)	HR records	5 Years	Mid Term-End Term	Not Available	Establish Database by 2018 and maintain		
	Availability of an operational national micro data archive for health surveys conducted by MoH	HI records	5 years	Mid Term-End Term	Not Available	Establish and operationalized an Archive system by 2020 and maintain		
	Availability of up-to-date information on social determinant of health and health systems performance assessment	Survey / Health Equity Assessment	10 years	Mid Term-End Term	Health Equity Assessment done in 2009	Complete 1 assessment by 2025		

	Number of Research Bulletins issued	HI records	Annually	Mid Term-End Term	Health Research bulletin issued in 2014,2015 and 2016(2016 update)	1 bulletin per year.		
	TB case notification rate	TB Program Records	Annually	All 4 quarters	38/100,000 (2015)	Increase to 90% and 95%		
	Number of Schools where health screening was carried out in grade 1	MoE School health Program records	Annually	All 4 quarters	All Schools with grade 1 (2016)	Maintain at 90% and Above		
	Number of school children provided with health check-up at grade 7	Health Promotion/School health program/HPA	Annually	All 4 quarters	All Schools Covered (2016)	Maintain at 90% and Above		
OP11: Improved supply and management of medical products, medicines, vaccines and technologies	Proportion of essential medicines registered	MFDA records	Annually	All 4 quarters	41.2% (2016)	50% and 80%		Commitment to corruption free management of medical supplies system by all partners involved
	%of health facilities receiving biomedicine service through an established mechanism (% of govt hospitals with semi annual preventive maintenance visits - Proxy Indicator)	RAHS records	Annually	All 4 quarters	Not Available	Increase and maintain at 100%		
	% of inhabited islands with pharmacy service	MFDA	Annually	All 4 quarters	100% (2016)	Maintain at 100%		

OP12:Assertained quality and responsiveness of the health services	Number of health facilities (public and private) with contingency plan for responding to local and national outbreaks and public health emergencies/pandemics	HPA records	Annually	Mid Term-End Term	14 Health Facilities	Increase to all health facilities and maintain		Commitment of service providers towards moral values of service to people to reduce harm and improve health, together with adequate resource allocation for quality, safety and relevance of the services provided.
	Hospital acquired infections (% of MRSA & other indicator infections)	QA and MFDA, RAHS	Annually	All 4 quarters	Not Available	Reduce by 50% and 75%		
	Medical and medication errors in the past year (% of patients)	QA and RAHS records	Annually	All 4 quarters	Not Available	Decrease by 50% and 75%		
	Mortality from communicable diseases (per 100 patients)	VRS, CD Program-HPA	Annually	All 4 quarters	Not Available	Decrease to less than 10% and 5%		
	Mortality during admission for Acute coronary syndrome (per 100 patients)	VRS, Disease Surveillance Program-HPA	Annually	All 4 quarters	Not Available	Decrease to less than 15% and 10%		
	TB treatment success rate	TB Program-HPA	Annually	All 4 quarters	79% (2015)	Increase to 95% and maintain above 95%		
	Number of deaths, missing people, injured, relocated or evacuated due to disasters per 100,000 people / Number of deaths, missing and persons affected by disaster per 100,000 people	NDMC records	5 Years	Mid Term-End Term	Not Available		SDG 1.5.1/13.1.2	
	% of health facilities (public and private) that use national standard	Relevant Programs of HPA, QARD	Annually	All 4 quarters	Not Available	Increase to 95% and maintain		

	guidelines for case management (e.g.: for EOC, Dengue, childhood illnesses, NCDs)					above 95%		
	% of pharmacies operating to the level of national standards	MFDA-MoH	Annually	All 4 quarters	100%	Maintain above 95%		
	% of antibiotic prescriptions issued without sensitivity testing	Aasandha, QARD	Annually	All 4 quarters	Not Available	Decrease by 20% and 30%		
	% of health facilities (private and public) that meets infection control standards	QARD records	Annually	All 4 quarters	Not Available	Increase to 80% and 100%		
	% of health facilities (private and public) that meets health care waste management standards	QARD records, EH Program-HPA	Annually	All 4 quarters	Not Available	Increase to 75% and 90%		
	Episodes of suspension of health care services due to non-compliance to national standards and regulations	QARD records, RAHS records	Annually	All 4 quarters	Not Available	Decreased by 25% and 50%		
	Number of medico legal cases filed	QARD records, RBC records	Annually	All 4 quarters	Not Available	Increase 50% and 100%		
	Number of health professionals whose license to practice was not granted or not renewed (doctors, nurses, PH practitioners, pharmacist)	RBC records	Annually	All 4 quarters	Not Available			

Abbreviations:

CD: Communication Disease
DHE: Department of Higher Education
EH: Environmental Health program
FHS: Faculty of Health Services
HI: Health Information Section
HPA: Health Protection Agency
HR: Human Resources Division
IGMH: Indira Gandhi Memorial Hospital
MBS: Maldivian Blood Services
MDHS: Maldives Demographic Health Survey
MFDA: Maldives Food and Drug Authority
MNDF: Maldives National Defense Forces
MoE: Ministry of Education
MoFT: Ministry of Finance and Treasury
MOH: Ministry of Health
MoHI: Ministry of Housing and Infrastructure
NCD: Non Communicable Disease
NDA: National Drug Agency
NDMC: National Disaster Management Centre
NHA: National Health Accounts
NSPA: National Social Protection Agency
PHC: Primary Health Care
PO: Presidents Office
QARD: Quality Assurance and Regulations Division
RAHS: Regional and Atolls Health Services Division
RBC: Regulatory Boards and Councils Section
VRS: Vital Registration System
WHO: World Health Organization

Appendix -2: Result-based Planning Tool for Annual Planning & Monitoring

OUTCOMES AT NATIONAL LEVEL	OUTPUTS AT NATIONAL LEVEL	STRATEGIC INPUT AREAS (GOVERNANCE)	ORGANISATIONAL LEVEL OUTPUTS /MANIFESTO OUTPUTS	INSITUTIONAL LEVEL ACTIVITIES
OC1. Build trust in the national health system	OP1. Improved health policy making that is value-oriented, evidence-based to achieve health gains.	1. Establish an efficient health system governed by legislation, regulatory and oversight mechanism.		
OC2. Reduce disease and disability among the population.	OP2Strengthened partnerships for health within government, private and voluntary sectors	2. Ensure public policy making is transparent, evidence-based and information-driven.		
OC3. Reduce inequities in access to health care and medicines	OP3. Improved sustainability of health system and health care financing mechanisms.	3. Develop public-private partnerships in health promotion and delivery of preventive and curative health services.		
	OP4. Improved enforcement of legislations for health	4. Ensure financial sustainability of the health system and the social health insurance scheme (Aasandha).		
		5. Political commitment to achieve the goals and outcomes of this national health master plan and the health targets of the sustainable development goals (SDGs).		

OUTCOMES AT NATIONAL LEVEL	OUTPUTS AT NATIONAL LEVEL	STRATEGIC INPUT AREAS (PUBLIC HEALTH PROTECTION)	ORGANISATIONAL LEVEL OUTPUTS /MANIFESTO OUTPUTS	INSITUTIONAL LEVEL ACTIVITIES
		5. Provide a healthy start in life through effective reproductive, maternal and child health services.		
OC1. Build trust in the national health system	OP5. Enabled a healthy start in life and childhood enabled through the health system.	6. Reduce chronic diseases (diabetes, cardio-vascular diseases, stroke and cancers) and improve mental and psychological health of the population.		
OC2. Reduce disease and disability among the population.	OP6. Enabled young people and adults to adopt healthy lifestyles and safe practices.	7. Maintain successes in control of communicable diseases and prevent re-emergence and introduction of new communicable diseases.		
OC3. Reduce inequities in access to health care and medicines	OP7. Enhanced the quality of life of older people, people with disabilities and long-term health conditions enhanced.	8. Enable healthy behaviours, safe sexual and reproductive health practices among adolescents and young adults.		
		9. Improve quality of life of older people and people with long-term illnesses and disabilities.		
		10. Strengthen health promotion and health education customized to the target audiences.		
		11. Provide a clean, safe and supportive environment to enable healthy choices and prevent injuries and spread of diseases.		

OUTCOMES AT NATIONAL LEVEL	OUTPUTS AT NATIONAL LEVEL	STRATEGIC INPUT AREAS (HEALTH SERVICE DELIVERY)	ORGANISATIONAL LEVEL OUTPUTS /MANIFESTO OUTPUTS	INSITUTIONAL LEVEL ACTIVITIES
	OP8. Improved coordination of the health care delivery by the public, private and voluntary sectors.	12. Ensure public delivery of primary health care services in all inhabited islands.		
OC1. Build trust in the national health system	OP9. Improved skills and commitment of the health workforce.	13. Establish a coordinated system of care from primary care to secondary and tertiary care providers (public and private).		
OC2. Reduce disease and disability among the population.	OP10. Improved responsiveness of the health information system	14. Enable timely surveillance of diseases, births and deaths, morbidity patterns as well as social determinants of health through an integrated health information system and research.		
OC3. Reduce inequities in access to health care and medicines	OP11. Improved supply and management of medical products, medicines, vaccines and technologies.	15. Ensure uninterrupted supply of essential medicines, vaccines and medical products and technologies.		
	OP12. Ascertained quality and responsiveness of the health services.	16. Invest in training and retention of professional and ethical standards of the health workforce.		
		17. Establish a capacity for health and medical response in national disasters and emergencies.		

Appendix-3: Dhivehi Summary of the Health Master Plan 2016-2025

ސިއްޙަތުގެ ޤައުމީ ޕްލޭން 2016-2025

ޕްލޭން ބައްޓަން ކުރެވިފައިވާގޮތް

މިޕްލޭން ބައްޓަން ކުރެވިފައި މިވަނީ ފަސް ސުވާލެއްގެ މައްޗަށް ބިނާކޮށް. މިސުވާލުތަކަކީ:

- މިހާރުގެ ސިއްޙީ ޙާލަތަކީ ކޮބާ؟
- ޙާސިލްކުރަން ބޭނުންވާ އަމާޒަކީ ކޮބާ؟
- އިސްލާޙުކުރަން ޖެހޭ ކަންކަމަކީ ކޮބައިތޯއ؟
- ނަތީޖާ ޙާސިލް ކުރެވޭނެ އުސޫލީ ކިހިނެއް؟
- ޙާސިލްވީ ކަންނޭނގޭނެ ކިހިނެއް؟

މިޕްލޭން ބައްޓަންކުރެވުނުއިރު މިވަނީ ރާއްޖޭގައި ސިއްޙީ ޚިދުމަތް ފޯރުކޮށްދިނުމުގައި ރާވާ ހިންގަން ބޭނުންވާ ފަރާތްތަކަށް ގައުމީ ފެންވަރުގައި ރާއްޖޭގެ ސިއްޙީ މިސްރާބު ފަށަރުގަ ޖަހާދޭގޮތަށް. މިގޮތުން މިޕްލޭން ތައްޔާރުކުރުމުގެ ބޭނުމަކީ މިޕްލޭނާއި ޚިދުމަތް ތަމްރީނު ދިނުމާއި، އިންސާނީ ވަސީލަތާއި، ވިއްތަރުއަގާއި ހިސާބަށް ސިއްޙީ ޚިދުމަތް ފޯރުކޮށްދީ ފަރާތްތަކާ ރާއްޖޭގެ ސިއްޙީ ނިޒާމުގެ އިޞްލާޙުތަކާ ގުޅޭ ސިޔާސަތުތަކާއި ތަރުތީބުތަކާއި އެކަށައެޅުމަށް ދިރާސާކޮށް ޙާލަތު ހެދުމަށް. ސިއްޙަތުގެ ހުރިހާ ދާއިރާއަށް ފަރާތް ހިއްސާވުން އަދި ދަރަޖަ ކަނޑައަޅައި ތަރުތީބު ދީފައިވާ ގޮތް ރާވާ ދިރާސާކުރުމަށް.

އެގޮތުން މިޕްލޭނުގައި ފާހަގަކޮށްފައިވާ ނަތީޖާތައް ޙާސިލްކުރުމަށް ކުރަންޖެހޭ ކަންތައްތައް ބާރުއަޅަންޖެހޭ ތަރުތީބުގެ ވަޒީފާތަކާއި ތަކެތި ފަރާތުގެ ކަނޑައަޅައި ބޭނުންކުރަން ޖެހޭ ވަސީލަތްތަކާއި ފަރާތްތަކުގެ ރޯލާއި ކުރާނެ ކަންކަން ނަގާފައެވެ. އަދި މިއީ ދައުލަތުގެ ޤައުމީ ޕޮލިސީއެއް ކަމުގައިވާ މިޕްލޭނުގެ ދައުރުތަކުގައި އިލެކްޝަންތަކާ ބެހޭ ސަރުކާރު ބަދަލުވާއިރު ގެދަލުކުރުމުގެ ބަދަލުތަކާ ނުގުޅި ޙަރަކާތްތެރިވުމަށް ކަމާއިބެހޭ ރިސޯސް ޖެހިގެން ސަރުކާރުން ކުރަންޖެހޭ ކަންތައްތަކުގެ ޕްރޮގްރާމްތަކަށް ގައުމީ ސިއްޙީ އަމާޒުތަކަށް ދަރަޖަ ދީ އިސްކަން ދީގެން ރާއްޖޭގެ ސިއްޙީ ނިޒާމް ކުރިއަރުވައި ބަދަލުކުރުމަށް ވަކި ރޭވުމެއް ގެނެސްދިނުން ބޭނުންވެއެވެ.

2014 ވަނަ އަހަރުގައި ރާއްޖޭގެ ސިއްޙީ ހާލަތު

ދިވެހިރާއްޖޭގެ އާބާދީގެ ސިއްޙީ ހާލަތު ކުރިއަރަމުންދާއިރު، ތަފާސް ހިސާބުތައް ދައްކާގޮތުން ގެއިންގަނޑަކު އަހަރު ބަލިތަކުން ވިސްނުމާއި ދެމެދުން މީހުން މަރުވާ ނިސްބަތް މަދުވެފައިވެއެވެ. ދިރިއުޅުމުގެ ފެންވަރު ރަނގަޅުވެފައިވާއިރު ދިރިއުޅުމުގެ ސަގާފަތް، ރާއްޖޭގައި މިހާރު އުފެދިފައިވާ ދިރިއުޅުމުގެ އަސާސީ ބަދަލުތަކުގެ ސަބަބުން އާބާދީގެ ޙާލަތު ބަދަލުވަމުންދެއެވެ.

މިކަންތައް ކުރިޔަށް އައިސްގެން ރާއްޖޭގައި ޒުވާން ޖީލެއް ފަތުރާއިރު ރާއްޖޭގެ ސިއްޙީ ޙާލަތުތަކަށް ބަދަލުތަކާއި ނުރައްކާތަކެއް ބަދަލުވަމުން އަންނަ ކަމަށް ފާހަގަވެއެވެ. ދިރާސާތަކުން ރާއްޖޭގެ އާބާދީ ގެރުވެރިއަކަށް ވަމުންދާއިރު ދިރާސާތަކުގެ ޙިސާބު ރާއްޖޭގެ އާބާދީގެ ޖީވިތަކާއި އާބާދީގެ ސިއްޙީ ޙާލަތަށް ބަދަލު ގެނެވެމުންދާކަން ފާހަގަކޮށްލެވެއެވެ.

2014 ވަނަ އަހަރު ރާއްޖޭގެ ސިއްޙީ ދާއިރާގެ ޙާލަތު ދިރާސާ ކުރިއިރު ފާހަގަކުރެވުނީ:

- ފާއިތުވި ހަތްއަހަރު އަހަރުގެ ތެރޭގައި ރާއްޖޭގެ ސިއްޙީ ހިދުމަތް ދިނުމަށް ކޯޕަރޭޓިވް އުސޫލު ބޭނުންކުރުމާއި ލާމަރުކަޒީ ކުރުމަށްފަހު މަރުކަޒީ އުސޫލަށް އަނބުރާ ގެނައުމުގެ ސަބަބުން ސިއްޙީ ހިދުމަތް ދިނުމުގެ ނިޒާމު އަދި މުޅިން ހަމަޖެހިފައި ނުވުން.
- ސަރުކާރުންނާއި، އަމިއްލަ މުއައްސަސާތަކުންނާއި، އާއިލާތަކުން ސިއްޙަތަށް ޚަރަދު ކުރަމުން ދިޔައިރު، އެކަށީގެންވާ ގޮތެއްގައި ސިއްޙީ ނިޒާމު ދެމެހެއްޓުމަށް ގޮންޖެހުންތަކެއް ހުރިކަން.
- އިބްތިދާއީ ސިއްޙީ ހިދުމަތްދިނުމުގެ ނިޒާމާއި އާބާދީގައި އިތުރުވުމުން އަންނަ ބަދަލުތަކާއި ސިއްޙީ ހިދުމަތްދޭން ފަށާ މީހުން ސިއްޙީ ދާއިރާގައި އެކަށީގެންވާ އަދަދަށް ނެތްކަން.
- އާބާދީގެ ސިއްޙީ ޙާލަތާއި ސިއްޙީ ދާއިރާއަށްބަލާ މަޢުލޫމާތާއި ބޭނުން ހިސާބު ރިޕޯޓުކުރުމުގެ ނިޒާމު ފުރިހަމަކޮށް ތަރައްޤީވެފައި ނުވުމުގެ ސަބަބުން ސިއްޙީ ހިދުމަތްތަކުގެ ރޭވުން ސިޔާސަތުތަކުގެ ކަނޑައެޅުމުގައި އެކަށީގެންވާ މައުލޫމާތު ފޯރުކޮށްދިނުމަށް ބަޔާން ހިސާބާއި ދިރާސާކުރުމުގެ ނިޒާމު އިތުރަށް ހަރުދަނާ ކުރަންޖެހޭކަން.
- ސިއްޙީ ހިދުމަތަށް ބޭނުންވާ ބޭހާއި ބޭސްކުރާ ސާމާނު ލިބުމުގެ ދަތިތަކާ ކުރިމަތިވެ ފާއިތުވެދިޔަ ކުރިޔާ ބައެއް ހިދުމަތްތަކެއް ދެމެހެއްޓުން ދަތިކަން.
- ސިއްޙީ ދާއިރާއާއި ސަރުކާރުގެ އެހެން ދާއިރާތަކާއެކު ގުޅުމާއި ސިއްޙީ ހިދުމަތް ފޯރުކޮށްދޭ އަމިއްލަ ފަރާތްތަކާއި ތަޢުލީމީ ތަމްރީނު މުއައްސަސާތަކާއި ގުޅުން ހިންގުމުގެ ސަބަބުން ސިއްޙީ ހިދުމަތްތަކުގެ އަމާޒު ތަފާތުވެފައި އާބާދީގެ ސިއްޙަތަށް ނުފޫޒު އަސަރުކުރާކަން.
- ސަރުކާރުގެ ސިޔާސަތުތަކާއި ޤާނޫނުތަކުގައި އާބާދީގެ ސިއްޙަތަށް ކުރާ އަސަރު ބެލުމަށް ފަރާތްތަކުން ވަޒީފާ ދިނުމާއި އަމިއްލަ ފަރާތްތަކާއެކު ގުޅިގެން ސިއްޙީ ކަންކަމުގައި މަސައްކަތްކުރުމާއި، ހިދުމަތްތަކަށް ބޭނުންވާ ވަސީލަތްތައް ފޯރުކޮށްދިނުމުގައި ހުރުމާ މިނިސްޓްރީގެ ބާރާއި ދައުރު ކުޑަވެފައިވާކަން.

ރާއްޖޭގެ އާބާދީގެ ސިއްޙަތަށް ބަލާއިރު ދިރިއުޅުމުގެ އާދަތައް، ހަރަކާތްތެރިވުން މަދު ގޮތްތަކާ ބަރުބޮޑުވުމާއި، ދިރިއުޅުމުގައި ދުންފަތުގެ ބޭނުން (ސްމޯކިންގ) އިތުރުވުމުން ދިއުމާއި، އެކްސިޑެންޓްތަކުގެ ކުރިމަތިވާ ފުރުސަތު ބޮޑު ފާހަގަކުރެވޭ ދިރިއުޅުމުގެ ގޮތްތަކުން އާބާދީގައި ނަސީބުކަމުގައި (އިންޖަރީތަކާއި)، ގައިންގަނޑު ނުފެތުރޭ ބަލިތަކާއި ނަފްސާނީ ބަލިތަކާއި މިފަދަ ސިއްޙީ ހާލަތުތަކުން މިނޫން މަރުވާ އަދަދު ރާއްޖޭގައި މިވަގުތު ދައްކައެވެ. އަދި ހަމައެއާއެކު ކޮންމެ ބަލިތަކެއްގެ ސަބަބުން ރާއްޖޭގައި ބޮޑު މުޅި ކަންކަމަށް ފާހަގަކުރެވެއެވެ.

މިޕްލޭން އެކުލަވާލިއިރު ރާއްޖޭގެ ސިއްހީ ހާލަތާއި ބެހޭގޮތުން ލިބެންހުރި މައުލޫމާތަށް ރިއާއަތްކޮށް މިޕްލޭންގެ މުއްދަތުގައި އާބާދީގެ ސިއްހަތަށް ނުރައްކާ އަސަރުކުރާނެ ކަންތައްތައް ކަމަށް ބެލެވުނީ:

ގައިންގަޔަށް ނާރާ ދިގު މުއްދަތުގެ ބަލި ހާލަތްތައް

- ހިތާއި ލޭ ދައުރުކުރާ ނިޒާމުގެ ބަލިތައް
- ހަކުރު ބަލި
- ކެންސަރު
- ކިޑްނީގެ ދިގު މުއްދަތުގެ ބަލިތައް
- ލޭގެ މާއްދާތަކުގެ ބަލިތައް (ހިމޮގްލޮބިނޮޕަތީސް)
- އަނގައާއި ދަތްފިލައިގެ ބަލިތައް

ހާނިއްކަތަކާއި ނުކުޅެދުންތެރި ހާލަތްތައް

- ގޭގައި، މަސައްކަތުގެ މާހައުލުގައި، މަގުމަތީގައި، ކަނޑުމަތީގައި ކުޅިވަރު ކުޅުމުގެ ތެރޭގައި ކުރިމަތިވާ އެކްސިޑެންޓްތަކާއި ހާނިއްކަތައް
- އުފަންވާއިރު ނުވަތަ އުމުރުން ދުވަސްވުމުން ފެންނަ ނުކުޅެދުންތެރިކަން

ނަފްސާނީ ދުޅަހެޔޮކަން

- މަސްތުވާތަކެއްޗަށް ދެވިހިފުން
- ދުންފަތަށް ދެވިހިފުން
- ޑިޕްރެޝަން (އެންޒައިޓީ)
- އިންސާނާގެ އިހުސާސްތަކާއި ގުޅުންހުރި ބަލިތައް (ބައިޕޯލަރ ބަލިތައް)
- އަމިއްލައަށް މަރުވުން
- އޮޓިޒަމް އާއި ނަފްސާނީ-އިޖްތިމާއީ ބަލި ހާލަތްތައް

ދަރިމައިވުމާއި ޖިންސީ ދުޅަހެޔޮކަން

- މާބަނޑު މީހުންގެ ސިއްހަތާއި ހަށިގަނޑަށް ބޭނުންވާ ކާނާގެ މާއްދާތައް
- އުފަންވާ އުމުރުން ފެށިގެން ތުއްތު ކުދިންގެ ސިއްހަތާއި ހަށިގަނޑަށް ބޭނުންވާ ކާނާގެ މާއްދާތައް
- ފުރާވަރަށް އަރާ އުމުރުގެ ކުދިންގެ ދަރިމައިވުމާއި ޖިންސީ ދުޅަހެޔޮކަން
- ޖިންސީ ގުޅުމުންޖެހޭ ބަލިތައް

ގައިގެތަކުން ތަނާ ބެހެއްވުން

- ހާލު
- ކެއުން/ބޯންބޯ.ދަށ.ވ ތަނަށް ގެންދިއުން ދެއްވުން ފުރިގައި ބެހެއްވުން
- ހެދުމުގެ ތަނަށް ކިބައިގެންދިއުން
- ތަނުގައި ފުންމަގެ ގައިގެތަކުން ތަނާ ބެހެއްވުން (ގެއްލުން ގަދަވެގެންދާ ގޮތަށް ބެހެއްވުން)
- ތަނުގައި ތާވަކުރެވުމާ ގުޅިގެން ކަންކަން ކުރުމަށް ކުރިއަށް ގެންދާ ގޮތް (ދަށ، ސާބަވެ، ކަނޑަ ގަނެ)
- ފާނިއްގެ ދާނައަށް ބަލައިގެން ފުރިގައި ހުންނަ ގޮތް

ކާނާ ހެދުމާ ގުޅިގެން ހިފަހައްޓަންޖެހޭ ކަންކަން

- ތެލު
- ކާނާ ހެދުމަށް ބޭނުންކުރާ ތަށިތަކާ ގުޅިގެން
- ކާނާ ހެދުމަށް ބޭނުންކުރާ ތަށިތައް
- ކާނާ ހެދުމަށް ބޭނުންކުރާ ތަށިތަކާ ގުޅިގެން

ކާނާ ހެދުމުގައި ކުރަންޖެހޭ ހިދުމަތްތައް

- ކާނާ ހެދުމަށް ބޭނުންކުރާ ތަކެތި ހޯދުން
- ހުރަލުން (ބެލުން، ހުއްދަ، ވަރު) ތަކެތިތަކުން (ހުވިދާ،ކަނޑަ)
- ހަނގުރާމަ ތެދުވެގެންދާ ކާނާ ހެދުމުގައި ކަންކަން ދެއްކުމުގައި ކުރިން ދަންނަންޖެހޭ (ގެންދާ ގޮތް، ކަލާ ގޮތް ގެންދާ ގޮތް ހަމައަށް ކާނާ ހެދުމުގައި ބޭނުންކުރާ ތަށިތަކާ ގުޅިގެން ކުރަންޖެހޭ ކަންކަން)
- ހުސްކުރާ ކާނާ ހެދުމުގައި ކުރަންޖެހޭ ކަންކަން ކަނޑައެޅުމުގައި ހަނދާންކުރަންޖެހޭ ކަންކަން

ތަނުގައި ކާނާ ބެހެއްވުމާ ގުޅިގެން ހަނދާންކުރަންޖެހޭ ކަންކަން ކުރިއަށް ގެންދިއުން

- ކާނާ ބެހެއްވުމަށް ކުރިން ދެކެވޭ ކަންކަން ކަނޑައެޅުން، ކަލާ ގޮތް ބަލައި ކަނޑައެޅުން ކުރަން ހުރި ކަންކަން
- ތަނުގައި ކާނާ ބެހެއްވުމުގައި ކަނޑައެޅިފައި ހުންނަ ގޮތް ބަދަލުކުރުން ކަނޑައެޅުން ކަނޑައެޅިފައި ހުންނަ ގޮތް ބަދަލުކުރުމަށް ކުރަންޖެހޭ ކަންކަން
- ކާނާ ބެހެއްވުމަށް ކުރިން ކާނާ ހެދުމުގައި ބޭނުންކުރާ ތަށިތަކާ ގުޅިގެން ކަނޑައެޅިފައި ހުންނަ ގޮތް ބަދަލުކުރުން
- ތަނުގައި ކާނާ ބެހެއްވުމަށް ކުރިން ކާނާ ހެދުމުގައި ބޭނުންކުރާ ތަށިތަކާ ގުޅިގެން ކަނޑައެޅިފައި ހުންނަ ގޮތް ބަދަލުކުރުން
- ކާނާ ބެހެއްވުމަށް ކުރިން ކާނާ ހެދުމުގައި ބޭނުންކުރާ ތަށިތަކާ ގުޅިގެން ކަނޑައެޅިފައި ހުންނަ ގޮތް ބަދަލުކުރުމަށް ކުރަންޖެހޭ ކަންކަން

ރާއްޖޭގެ ސިއްޙީ ނިޒާމު މިފަދަ ގޮންޖެހުންތަކާ ކުރިމަތިލާން ޖެހިފައިވާއިރު، ރާއްޖޭގެ އާބާދީގެ ބޮޑު އިންސައްތައަކީ ދަރިމައިވުމުގެ އުމުރުގެ މީހުންނާއި، މަސައްކަތުގެ މާރުކެޓަށް ނުކުންނަން ފަށާ އުމުރުގެ މީހުންނެވެ. އެހެންކަމުން އާބާދީގެ ބޮޑު ހިއްސާއެއްގެ މީހުންނަށް ދަރިމައިވުމުގެ ސިއްޙަތުގެ ޚިދުމަތްތަކާއި، މާބަނޑުވުމާއި، އުފަންވާ ތުއްތު ކުދިންނަށް ބޭނުންވާ ޚިދުމަތްތަކުގެ ނިސްބަތުން ބޮޑުތަނެއް އިތުރުވެގެންދާނެއެވެ. އަދި މިއާއެކު ރާއްޖޭގައި އުފަންވާއިރު ދިރިހުރުމުގެ ކަމަން ގާތްވާ އުމުރު މަތިވެ، އުމުރުން ދުވަސްވީ މީހުންގެ ނިސްބަތް އިތުރުވުމުން، ހާއްސަ ސިއްޙީ އަދި އިޖްތިމާޢީ ޚިދުމަތްތަކަށް ބޭނުންވާ މިންވަރު އިތުރުވެގެންދާނެއެވެ. އާބާދީގެ މިގިންތިތަކުގެ އިތުރުން ރާއްޖޭގައި އިތުރުވަމުންދާ ބިދޭސީންނަކީވެސް ރާއްޖޭގެ ސިއްޙީ ނިޒާމަށް ސީދާ އަސަރު ފޯރުވާ ބައެއްކަމުގައިވާތީ ރާއްޖޭގައި އުޅޭ ބިދޭސީންނަށްވެސް ސިއްޙީ ޚިދުމަތް ފޯރުކޮށްދިނުމުގެ ނިސްބަތް ދަނީ އިތުރުވަމުންނެވެ.

ރާއްޖޭގެ އާބާދީގެ ގިނަ ބައެއް ރާއްޖޭގެ ސިއްޙީ ޕްރައިމަރީ ޚިދުމަތްތަކާއި ހިދުމަތެއް ރަށް ފެންވަރުގައި އިންސާނުންގެ އުމުރުގެ ހުރިހާ މަރުހަލާތަކުގައި ދިރިއުޅެމުންދެއެވެ. މިގޮތުން މިފެންވަރުގެ މަރުކަޒުތަކުގައި ހުރި ސަހުލު ގަނޑުބަސްތަކުން އާބާދީގެ ގިނަ ބައެއް ބޭނުންކުރެއެވެ:

- ފުރަތަމަ އަރާމުން އަންނަކަށްދިނުމާއި ޖެހިލުން
- މާބަނޑު މީހުން
- އެއް އަހަރުން ދަށުގެ ކުދިންނާއި ފަސް އަހަރުން ދަށުގެ ކުދިން.
- އުމުރުން ދުވަސްވީ މީހުން (އިސްވެރިވެރިން)
- ބިދޭސީން

މިގޮ އިތުރުން ރާއްޖޭގެ ސިއްހީ އަދި އިޖްތިމާޢީ މަސްއަލަތަށް އަންނަ ބަދަލުތަކުގެ ސަބަބުން ދުނިޔޭގެ ގޮތުގައި ސިއްޙީ ހިދުމަތް ފޯރުކޮށްދިނުމަށް ހުރަސްއެޅޭނެ ކުރިމަތިވެދާނެއެވެ. މިގޮތުން ކުރިމަތިވާނެ ހުރަސްތައް ކަމަށް ބެލެވެނީ:

- ސިއްހީ އަދި އިޖްތިމާޢީ ހަމަހަމަކަމާއި އިތުރުވުން
- ކުރުމުއްދަތުގެ އަމާޒުތަކާއި ސިއްހަތުތަކަށް ސަރުކާރުން އިސްކަންދިނުން
- ސަރުކާރުގެ ސިއްހަތުތަކުގައި ސިއްޙަތު ކުރިއެރުވުމަށް ދޭ ސަމާލުކަން ކުޑަވުން
- ޓެކްނޮލޮޖީއާއި ގުޅުންހުރި ނުރައްކާތަށް
- އާއިލާތަކާއި ކޮމިޔުނިޓީތަކުގެ އިޖްތިމާޢީ ދިރިއުޅުމުގެ ޝަކުލު ބަދަލުވުމުގެ ސަބަބުން މުޖުތަމަޢުގެ ތަފާތުތައް
- އިޖްތިމާޢީ ތަނަވަސްކަމުގެ އަސަރު މުޖުތަމަޢު ދަށްވުން
- ރާއްޖޭގެ ދަރަނިތަކާއި ދުނިޔޭގެ އިޖްތިމާޢީ ނިޒާމު ހަމަޖެހުމަށް ހުރި ހުރަސްތައް

ރާއްޖޭގެ އާބާދީގެ ސިއްޙަތު ރައްކާތެރިކުރުމަށް ބޭނުންވާ ސިއްޙީ ހިދުމަތް ދިނުމަށް ފައިސާއާއި ތަކެތީގެ ފެންނަ މުއްސަނދިކަމާއި ބަޖެޓުތަކުގެ ތަނަވަސްކަމެއް ނެތުމާއި ވަޒީފާތަކުގެ އުފެއްދުންތައް ސީދާ އަސަރެއް ކުރާނެއެވެ. އެހެންކަމުން ރާއްޖޭގެ ސިއްހީ އަދި އިޖްތިމާޢީ މަސައްކަތް އަންނަމުންދާ ބަދަލުތަކާއި، ސިއްޙީ ނިޒާމުގެ ތެރޭގައި ޓެކްނޮލޮޖީ ގެނެސް ކަނޑު، ދާއިރާގެ ތަމްރީނުވެފައިވާ ފަންނީ މީހުން ބަހާލާ ދާއިރާގެ ހިދުމަތް ގެނެސްފައިވާތީ، ރާއްޖޭގެ އާބާދީގެ ސިއްހަތަށް ސިއްޙީ ހިދުމަތް ކުރިއަށް ޚިދުމަތްތަކުން ކުރިއަރާ ފަހިވާ ކުރިމަތިވެފައިވާ ފެނިގެންދާނެއެވެ. އެހެންކަމުން މިފަދަ މައްސަލަތަކުގައި ކުރިމަތިވާން

ބެހެއް ގެންދެވެންތިބެނީ އެކަށީގެންވާ ހިދުމަތް ފޯކަސްކުރެވިގެންވާ ތަރައްޤީގެ ސިއްހީ ނިޒާމު އޮތީ ތައްޔާރުކޮށް ކުރަމުން ނުބެލެވެއެވެ.

ހެއްބަ ސަލާމަތުކަމުގައި ދެނެގަނެވޭ ޚިދުމަތްދޭ އާބާދީގެ ދިމާވާ ޚިދުމަތްދޭގައި، އާންމުކުރުމުން އަންނަ ބަލިތަކަށް އެކަށީގެންވާ ފަރުވާ ފޯކަސްކުރެވިފައިވާ، ސިއްހީ ދާއިރާގެ ބައިވެރިވުމާއި ފަންނީ ހިދުމަތްދޭ ފަރާތްތަކުން ދޭ ގެންދެވުމަށް ކަނޑައަޅައެވެ. މިކަންކަން ރައްކާ ކުރުމަށްޓަކައި ސިޔާސީ އެއްބަސްވުމާއި ވިސްނުމުގެ މަސްދަރުތަކާއި ހާލަތު އަތޮޅުތަކަށް ސިއްހަތުގެ ކަނޑައެޅުމާއި، ކުރަންޖެހި ދީނަ ކަންތައްތަކަށް ތަފާ ސިއްހަތުގެ އާބާދީ ސިއްހީ ފަރުވާ ކުރަނީ ހިދުމަތްތަކަށް އިސްކަންދީގެން ވިސްނުންތެރިކަމާއި ސިއްހަތުތަކާއި ޕްރޮގްރާމްތަކާއި ތަރި ތަސައްވުރުތަކާއި އެކަށައެޅުން މިހިންގެވެ.

ތަސައްވަރު

ފުރިހަމަ ސިއްހަތަކާ ދިރި ޤައުމު އެކުގައި.

އަމާޒު

ދިވެހިރާއްޖޭގައި ސިއްހީ ގޮތުން ދުރުގެރަ އާބާދީއެއް އެކު ތަޢުލީމާއި، ހަމަހަމަކަމާއި، ހަރުދަނާ ރައްކާތެރިކަމާއި، ފުރުސަތު ބަރޮބަރު ތަޤާނާލުން ރައްޔިތުންނަށް ވަސީލަތްތަކަށް ފުރިހަމަ ސިއްހީ ހިދުމަތް، އެންމެހާ ބައިވެރިވުމާއި ފޯކަސްކުރެވޭ ކަރަތަރުހުން.

އަސާސީ މިންތައް

މި ތަސައްވުރު ހާސިލުކުރުމަށް ފުރިހަމަ މިންތަކަކީ:

1. އިންސާނީ ހައްގުތައް- ސިއްހީ ސިޔާސަތުތަކާއި، ޕްރޮގްރާމްތަކާއި ހިދުމަތްތަކުގައި ސިއްހަތަކީ އިންސާނީ ހައްގެއްކަން ދެނެގަނެ ކުރިއަށްދިއުން.
2. ހަމަހަމަކަން – ސިއްހީ ހިދުމަތް ފޯކަސްކުރުމުގައި އުމުރާއި ޖިންސު އަދި އިޖުތިމާއީ-އިޤްތިޞާދީ ޙާލަތަށް ބަލާއި ތަފާތުކުރުމެއްނެތި އެންމެ އެކަށީގެންވާ ހިދުމަތް ލިބޭނެ ތަނުން ހަމަޖެހުން.
3. އެންމެންގެ ބައިވެރިވުން – އާބާދީގެ ހުރިހާ ދިރިއުޅޭ ފަރާތްތަކުން ސިއްހީ ހިދުމަތް ފޯކަސްކުރުމުގައި ކަރަތަރުކުރުމަށް ހުރިހާ ފަރާތެއް ގުޅިގެން މަސައްކަތްކުރުން.
4. ޖިންސާއިރުވުން – ސިއްހީ ގޮތުން އެންމެ ރަނގަޅު ނަތީޖާ ހާސިލުކުރުމަށް ކަނޑައަޅާ ކަންތައްތައް ދުވުން ފެންނަ ގޮތަށް، ލިބެން ހުރި މަސްދަރުތަކުގެ އަތުގައި ނިންމުން.
5. ދެމެހެއްޓުން – އާބާދީގެ ސިއްހަތާއި ހާލަތުގެ ބައި މަޢުލޫމާތު، އެކަށީގެންވާ ގޮތަށް ސިއްހަތުގައި ބައްޓަންކުރި ވަސީލަތްތަކާގެ އިސްތިއުމާލު ކުރެވޭނެ އެންމެ ރަނގަޅު ސިއްހީ ދިރުމަށް މަސައްކަތްކުރުން.
6. ފަންނުވެރިކަން – ސިއްހީ ހިދުމަތްތެރިންނަކީ މަސައްކަތުގައި ފުރިހަމަ ކަނޑައެޅިފައިވާ ސުލޫކީ މިންގަނޑުތަކާ ތަބާވެ ސިއްހަތަށް ބަހައްޓައި ކަރަތަރުކުރެވިފައިން.

ޕްލޭންގައި ހިމެނިފައިވާ މިސްޓްރެޓަޖީތަކަށް ކަނޑައެޅުމުގައި ބަޖެޓުކުރި ޚަރަދުތައް

މި ޕްލޭންގެ މިސްޓްރެޓަޖީތަކަށް ކަނޑައަޅާފައި މިވަނީ ރައްޔިތުންގެ ފެންވަރު އަސާސީ އާއި ފާސްޓްރެކާއި ރައްޔިތުން ޖެނެރޭޓްކުރާ ބިޒްނަސް ކްލަސްޓަރު ބިޒްނަސްގެ ޕްރޮސެސް ކުރެވޭ މާލީ ދަތިތަކާއި، ބަޖެޓްގެ ޕްރޮޕޯޒަލް، ފުދުނުވަތަ ރަޖިސްޓްރީ ކުރެވޭ ބަޖެޓްތަކުގެ ވަސީލަތްތައް (ސަސްޓެއިނަބަލް ޑިވެލޮޕްމަންޓް ގޯލްސް) ރިޢާޔަތްކޮށްގެން. އަދި އާބާދީގެ ސިއްޙަތާއި ހުރިހާ ބައިތަކަށް ބަޖެޓް ކުރުމަށް ފަންޑު ޓާރގެޓް ސިއްޙީ ހާލަތު އަސާސީ ޚިދުމަތް ޓްރެކިންގ ކުރެވޭނެ ޕްރޮސެސްތަކެއް ރައްޔިތުންނަށް (ޕަބްލިކް ހެލްތު އޮފް ހެލްތު) ސިއްޙީ ނިޒާމު ބިނާކުރުމުގެ ރައްޔިތުންގެ (ހެލްތު ސިސްޓަމް ބިލްޑިންގ ބްލޮކްސް) ރިޢާޔަތްކޮށްގެންނެވެ.

މަޤްސަދު (ގޯލް) ފަންޑުރައިޒިންގ ސްޓްރެޓަޖީ

މަޤްސަދު (ގޯލް): ދިވެހިރާއްޖޭގެ ރައްޔިތުންގެ ސިއްޙަތުގެ ދަރަޖަ ކުރިއަރުވުން.

މި ޕްލޭން އެކުލަވާލުމުގައި މަގުސަދު އަމާޒުގެ ބައިގައި ބަޔާންކޮށްފައިވާ "ދިވެހިރާއްޖޭގެ ރައްޔިތުންގެ ސިއްޙަތުގެ ދަރަޖަ ކުރިއަރުވުން" މިއަށެވެ. މިއަމާޒަށް ދަތިތަކުރުމަށް ދިވެހިރާއްޖޭގެ ސަރުކާރުގެ ސިއްޙީ ދާއިރާގެ ބައިވެރިންގެ މަސައްކަތްތަކުގެ 3 ސްޓްރެޓަޖީއަކަށް ސަމާލުކަން ދިނުން ކުރުން މުހިންމެވެ. މިވީން ސްޓްރެޓަޖީ ބަދަލުކުރެވިފައިވާ ކުރިއަށްއޮތް 10 އަހަރަށް، ސިއްޙީ ދާއިރާގެ މިހާރުގެ ހާލަތަށާއި ޒިންމާ ދާރުކުރުމާ ދުނިޔޭގެ ގޮތަށާއި އިޤްތިޞާދީ-އިޖުތިމާޢީ އަދި ސިޔާސީ ގޮތުން އަންނަނިވި ބަދަލުތަކަށް ރިޢާޔަތްކޮށްގެން. މިވީން ސްޓްރެޓަޖީއަކީ:

ސްޓްރެޓަޖީ 1: ފުޅާ ސިއްޙީ ނިޒާމަކުން ރައްޔިތުންގެ އިޖުތިމާޢީ އެފޯޓްދިނުން.

ސްޓްރެޓަޖީ 2: އާބާދީގެ ބަލިމަޑުކަމާއި ނުރައްކާތެރިކަމަކުން ދަށްކުރުން.

ސްޓްރެޓަޖީ 3: ސިއްޙީ ޚިދުމަތާއި ބޭސްފަރުވާގެ ވަސީލަތްތަކަށް އާންމުންނަށް ލިބުމުގައި ހުރި ތަފާތުތައް ކުޑަކުރުން.

ފުޅާ ފެންވަރުގައި ހާސިލް ކުރަން ބޭނުންވާ ނަތީޖާތައް

މިޕްލޭންގެ އަމާޒާއި ސްޓްރެޓަޖީތައް ހާސިލްކުރުމަށްފަހު ނަތީޖާތަކެއް ފެނުމަށް މިޕްލޭންގެ މުއްދަތުގައި ނުކުތުމެއްނުވެ. މިޕްލޭންގެ ނަތީޖާތައް ކަމަށް ފާހަގަކޮށްފައި މިވާ ކަންތައްތަކަކީ ގެދޮރާއި ޖިސްމާނީ ފައިވާ ކަންތައްތައްކަމުން،ހާސިލްކުރެވޭ އެއް ނަތީޖާއެއް އަންނަ ނަތީޖާއަކީ އަސަރުކުރާނެކަން ފާހަގަކޮށްފައިވެ. ހާސިލް ކުރަން ބޭނުންވާ ނަތީޖާ ތަކަކީ:

1. ހުރިތަކެއްގައި ފެންނީ މިންގަނޑުތަކަށް ބިނާކޮށް ސިއްޙަތަށް ފައިދާކުރާނެ ގޮތަށް ސިއްޙީ ދާއިރާގެ ސިޔާސަތުތައް އެކުލަވާލުން.
2. ސިއްޙަތު ކުރިއެރުވުމަށް ސަރުކާރާއި ސިވިލް ޖަމްޢިއްޔާތައް ދަރުމަވެރި ފަރާތްތަކާއި (ޑޯނަރުން) ފަރާތްތަކާއި މަދަނީ ޖަމާޢަތްތަކާއި ދުވެލި އެކުގައި މަސައްކަތް ކުރުމަށް ކުރުން.
3. ސިއްޙީ ނިޒާމާއި ސިއްޙީ ޚިދުމަތަށް ހަރަދު ކުރާ މާލީ ނިޒާމު ދުލުޙަޖްހިލު ގޮތުގައި ތަރައްޤީކުރުން
4. ސިއްޙަތާ ގުޅުންހުރި ގާނޫނުތައް ތަންފީޒުކުރުން ހަރުދަނާކުރުން.

5. ތަފާސްކުރުމަށް ތަނަވަސްކަން ދިނުމުގެ ގޮތުގައި ތަކެއްޗާ ހަރުދަނާ ކަންކަމުގައި ހިނގާ ބަދަލުތަކާ ގުޅިގެން ބަދަލުތަކެއް ގެނައުން.
6. ދާނގަ ބަލި ފެތުރުމުގެ ކުރިންވެ ހުރިހާ ބަލިކުރާ ދަނޑުވެރިންނަށް ކުލަ ދިނުން.
7. ތަކެއްޗާ ގުޅުންހުރި ބަލިތަކުގެ ލައިސަންސް ދިނުން ހުއްޓާ ލުމާ ގުޅިގެން ކަންކަމުގައި ބަދަލުތަކެއް ގެނައުން.
8. ކާނާ ބަދަލުކުރާ ފަރާތްތަކާ ގުޅިގެން ބަލި ފެތުރުން ހުއްޓާ ލުމަށް ބަލަހައްޓަން.
9. ބަލި ދިފާއީ ބަދަލުތަކުގައި ހިންގަންޖެހޭ ކަންކަން ގަބޫލުކުރުން.
10. ބަލި ތަކެއްޓަކީ ބަލި ދިފާއީ ބަދަލުތަކުގައި ހިންގަންޖެހޭ ކަންކަން ގަބޫލުކުރުން.
11. ކުރީގައި ވަބާއެއްތަކެއް، ބައްލަ ވެސް ބަލި ދިފާއީ ބަދަލުތަކުގައި ބަލަހައްޓަން.
12. ބަލި ދިފާއީ ބަދަލުތަކުގައި ތަރުޔަތު ބަލަހައްޓާ ބަލި ދިފާ ބަދަލުތަކުގައި ގަބޫލުކުރުން.

ތަރައްގީ ކުރަންޖެހޭ ކަންކަމާ ގުޅޭ ބަދަލުތަކެއް ގެނައުމަށް ފަރުދީ ތަނަވަސްކަން ދިނުން

ލިޔެކިޔުންތަކުގެ ދަށުން ތަރައްގީ ކުރަންޖެހޭ ކަންކަމާ ގުޅޭ ބަދަލުތަކެއް ގެނައުމަށް ފަރުދީ ތަނަވަސްކަން ދިނުން. ތަފާސްކުރުން:

- ކާނާ ބަދަލުކުރާ ތަނުގައި (ކެފޭ ތަކެއް)
- ދާނގަ ކުލަ ދިނުމުގެ ކުރިންވެ
- ބަލި ދިފާއީ ގުޅިގެން ބަލަހައްޓަން.

ލ ތަކެއް ފަރާތަކަށް ގުޅިގެންވާ ތަކެއް ތަފާސްކުރުމުގައި ތަކެއް ފަރާތަކުން ކަންކަން ކުރުމުގައި ތަކެއް ގެނައުމުގެ ކުރިން ގުޅުން ހިންގާ ފަރާތްތަކާ ގުޅިގެން ބަދަލުތަކެއް ގެނައުން. ލ ތަކެއް ފަރާތަކުން ކަންކަން ކުރުމުގައި ތަކެއް ގެނައުމުގެ ކުރިންވެ ކާނާ ބަދަލުކުރާ ތަނުގައި ތަކެއް ގެނައުން.

ކާނާ ބަދަލުކުރާ ތަނުގައި (ކެފޭ ތަކެއް)

1. ދާދި ތަކެއް ގެނައުމާ (ހަލުވާ) ގުޅިގެން ބަލި ފެތުރުން ހުއްޓާ ލުމަށް ބަލަހައްޓަން.
2. ބަދަލުކުރާ ތަނުގައި ތަކެއް ގެނައުމާ ގުޅިގެން، ކަންކަމުގައި ހަނދާންތެރި ކަންކަން ބަލަހައްޓަން ތަކެއް ގެނައުމާ ގުޅިގެން ބަލަހައްޓަން.
3. ބަދަލު ގެނައުމާ ގުޅިގެންވާ ތަކެއް ބަލިވެ ބަދަލުކުރާ ބަދަލުކުރާ ގުޅިގެންވާ ކަންކަން ދިނުމުގެ ކުރިންވެ ތަކެއް ގެނައުން.

4. ސިއްޙީ ޚިދުމަތުގެ ނިޒާމާއި އިންތިޒާމީ ސިއްޙީ އިންޝުއަރަންސްގެ ނިޒާމަކީ މާލީގޮތުން ދެމެހެއްޓެނިވި ނިޒާމަކަށް ހެދުން.

5. މި ޤައުމީ ޕްރޮގްރާމްގެ އަމާޒާއި ލަނޑުދަނޑިތަކާއި، ބައިނަލް އަޤްވާމީ ދެމެހެއްޓެނިވި ތަރައްޤީގެ ލަނޑުދަނޑިތައް ހާސިލްކުރުމަށް ސިއްޙީ ދާއިރާގެ ފަރާތްތަކުގެ އެއްބާރުލުން ހޯދުން.

އާންމު ސިއްޙަތު ތަރައްޤީކުރުން

6. އިންސާނާގެ ހަޔާތުގެ ފެށުމުގެ ދުވަސްވަރުން މަގުފަހިކޮށްދިނުމުގެ ގޮތުން، ދަރިމައިވުމުގެ ސިއްޙަތާއި މައިންނާއި ކުޑަކުދިންގެ ސިއްޙީ ޚިދުމަތްތައް ހަރުދަނާކަމާއެކު ފޯރުކޮށްދިނުން.

7. ގައިންގަޔަށް ނުފެތުރޭ ބަލިތައް މަދުކޮށް، ރައްކާތެރިކަމުގެ ނަފްސާނީ ދުޅަހެޔޮކަން ކުރިއެރުވުން.

8. ގައިންގަޔަށް އަރާ ބަލިތައް ކޮންޓްރޯލް ކުރުމުގައި ދިވެހިރާއްޖެ ކާމިޔާބުވެފައިވާ ދަމަހައްޓާ، އާ ބަލިތަކާއި އަލުން ފެތުރޭ ގައިންގަޔަށް އަރާ ބަލިތައް ފެތުރުމުން ކޮންޓްރޯލްކުރުން.

9. ފަރުދުންގެ ކުދިންނާއި ޒުވާނުންގެ ދުނިޔެގައި ދަރިމައިވުމާއި ޖިންސީ ގޮތުން ތަރައްޤީ ސިއްޙީ އާދަކާތް އަނަގަނޑުވައި، ސިއްޙީ ދިރިއުޅުމުގައި ހުރުމަތުގެ ބޭނުންވާ ކުސްކުރެއް ހުއްޓުވުމާއި މަގުފަހިކުރުން.

10. އުމުރުން ދުވަސްވީ މީހުންނާއި ނުކުޅެދުންތެރިކަން ހުންނަ މީހުންނާއި ދިމާވާ މައްސަލަތަކުގެ ބަލަހައްޓާ އުޅޭ މީހުން ދިރިއުޅުން ރަނގަޅުކުރުމަށް މަގުފަހިކުރުން.

11. އާބާދީގެ ބަދަލާ ގެންދިޔަކަން އަމާޒުކޮށް ސިއްޙަތު ކުރިއެރުވުމާއި ސިއްޙީ ހާލަތުތަކަން އިތުރުކުރުން.

12. ބަލިތައް ފެތުރުމާއި، ހިސާބުތަކާއި މަޢުލޫމާތު ސިއްޙަތުގެ ތަރައްޤީގެ ގޮތުގެ ހާމަކުރުމުގެ މަގުފަހިކޮށްދިނުމަށް ސާފު، ތަރައްޤީގެ މަރުޙަލާއަށް ގެއިދިޔުން.

ސިއްޙީ ޚިދުމަތް ފޯރުކޮށްދިނުން

13. އާބާދުވެފައިވާ ކޮންމެ ރަށެއްގައި ސަރުކާރުން އިބްތިދާއީ ސިއްޙީ ޚިދުމަތް ފޯރުކޮށްދޭކަން ކަށަވަރުކުރުން.

14. ސަރުކާރާއި އަމިއްލަ ފަރާތްތަކާއި ދަރުމަވެރި ޖަމްޢިއްޔާ ޖަމާޢަތްތަކުގެ ގުޅުމުން ވިލަރެސް ކުރާ ނިޒާމުގެ ދަށުން އެކި ލެވެލްގެ (ޕްރައިމަރީ އާއި ސެކަންޑަރީ އަދި ޓާރޝަރީ) ސިއްޙީ ޚިދުމަތް އާންމުންނަށް ފޯރުކޮށްދިނުން.

15. އެކަށީގެންވާ ވަގުތުގައި ބަލިމީހުން ފޮނުވާ ގޮތުގެ އިންތިޒާމުތަކާއި، ވީ މަރުކަޒުގެ ރެފެރަލްސިސްޓަމާއި އާބާދީގެ ސިއްޙަތަށް އަސަރުކުރާ އިންތިޒާމީ ކަންކަން، ސިއްޙީ ރެފެރަލްސިސްޓަމް ދިރާސާގެ ރޭވުން ހަރުދަނާކުރުން.

16. ސިއްޙީ ޚިދުމަތަށް ބޭނުންވާ ތަކެތީގެ ފަރުވާދޭ އަސާސީ (އެސެންޝިއަލް) ބޭސާއި ވެކްސިނާއި، އެހެނިހެން މެޑިކަލް ތަކެއްޗާއި ޓެކްނޮލޮޖީތައް ދުރުނުކުރެ ފޯރުކޮށްދެވޭކަން ކަށަވަރުކުރުން.

17. ސިއްޙީ ދާއިރާއަށް ބޭނުންވާ އެކިފަންނީގެ ފަންނީ މީހުން ބިނާކޮށް ފަންނީ އަދި ސުލޫކީ މިންގަނޑެއް ހިފެހެއްޓި ސިއްޙީ ޚިދުމަތްތެރިން ވަޒީފާގައި ދެމިތިބުމަށް ބާރުއެޅުން.

18. ކުއްލި ހާލަތްތަކާއި ކާރިސާތަކުގައި ބޭނުންވާ ސިއްޙީ ޚިދުމަތްދިނުމުގެ ޤާބިލުކަން ސިއްޙީ ނިޒާމުގެ ތެރޭގައި ޤާއިމްކުރުން.

މިނަތީޖާތައް ހާސިލުކުރުމަށްޓަކައި ފޯކަސްކުރެވޭނީ މުހިންމު ޚިދުމަތްތަކާއި، ޕްރޮގްރާމްތަކާއި ބަދަލުތަކަށް ކުރުގޮތަކަށް މިޕްލޭނުގެ ތަފްސީލު އިސްޓްރެޓެޖީ ޕްލޭނުގައި ބަޔާންކޮށްފައިވާނެއެވެ. އަދި މަސައްކަތް އަމާޒުކުރާ ފަރާތްތަކާއިގުޅޭ މިންގަނޑުތަކާއި (އިންޑިކޭޓަރސް)، ފަދަ ބޭސްލައިން ހިސާބު (ޓާގެޓްސް) ވެސް މިޕްލޭނުގެ އިސްޓްރެޓެޖީ ތަފްސީލު ބަޔާންކުރާ ހިއްސާގައި ހިމެނިފައިވާނެއެވެ.

ޕްލޭން ތަންފީޛުކުރުން

މި ޕްލޭންގައި ފާހަގަކޮށްފައިވާ މުހިންމު ކަންތައްތައް ތަންފީޛުކުރުމުގައި ސިއްޙީ ނިޒާމުގެ ހުރިހާ ބައިވެރިން ގުޅިގެން މަސައްކަތްކޮށްގެން، ސަރުކާރާއި ވިޔަފާރިގެ ގޮތުގައާއި ހިލޭ ސާބަހަށް މަސައްކަތްކުރާ އަމިއްލަ ފަރާތްތަކާއި ޖަމްޢިއްޔާތަކުން ސިވިލްސޮސައިޓީ ހޮދަކުން، ސިއްޙަތަށް އަންނަ ޖާގައިން ވުރެ ޒިންމާދާރުވާނެ ގޮތަކަށް ބަލަހައްޓައިގެންނެވެ. މީގެ އިތުރުން މި ޕްލޭނުގެ ނަތީޖާތައް ހާސިލުކުރުމަށް ސިޔާސީ އެއްބާރުލުން ލިބޭ މިންވަރަކީ، ސިޔާސަތުތައް މައްޗަށް ހެޔޮ އަދިގަމުގައި ކަންތައްތައް މިންވަރަކީ، ސިއްޙީ ޚިދުމަތް ނުދޭ އަސަރުކުރާ ސިޔާސަތުތަކާއި ޕްރޮގްރާމްތަކަށް ސަރުކާރުން އެއްބާރުލުންދޭ ނުވަތަ މިންވަރު ވަރަށް ބޮޑެވެ. އަދި ސިއްޙީ ނިޒާމަށް ކުރަނީ ބަދަލުތަކަށް ނަގާނި ގޮތަށް ބައްޓަން ކުރުމާއި، ސިއްޙީ ކަންކަމަށް ކުރާކަނޑު ދުވަހުގެ ކަމަށް މިޕްލޭން ޒިންމާދޭ ފަސޭހަކުރުމަށް ހާސިލުކުރުމަށް އިސްކަންދިނުމަކީ މިޕްލޭން ތަންފީޛުކުރުމަށް މުހިންމު ކަމެކެވެ.

މިހެންކަމުން ސްޓެއްކްހޯލްޑަރުން ކުރިޔަށް ނިސްބަތުން އެކު ހެދުމުގެ ބަދަލުތަކަށް އެކަށައަޅައިދިނުމެވެ. މި ކުރިޔަށް ގެންދާ ސިއްޙީ ފަރާތުގެ ބައިވެރިން ޕްލޭންތައް އެކަށައަޅާ ދުވަހު މި ގޮތުގައި ޕްލޭނަށް ހިއްސާވާ ގޮތަށް ޕްރޮގްރާމްތަކާއި ހަރަކާތްތައް ރާވައިގެން ތަފާތު ދާއިރާތަކުގެ ފަރާތްތަކުގެ ގުޅުމެއް ކުރިއަށް ކުރާނީ، މިޕްލޭން ހިންގުމުގެ ކަމާގުޅޭ އަދަދު ބަލާ ނަތީޖާ ހާސިލުކުރުމަށް ތަފާތުކުރެވޭނެ.

ނަތީޖާ ހާސިލުކުރުމުގެ ބާރުން

މިޕްލޭނުގެ ނަތީޖާ ހާސިލުކުރުމަށް ބާރުކުރުމަށްޓަކައި ވަސީލަތްތަކާއި މަސައްކަތް އަމާޒުކުރަނީ ފަރާތްތަކުން ތަން ބޭނުންވާ ހިސާބަށް ދަނޑިވަޅު ބާރުކުރުމަށް އެ ފަރާތުގެ ކުރާ ވާސިލު މިންގަނޑުތަކާއި ބަލައިގެން ވަކި މިންގަނޑުތަކާއި ބައިވެރިވުމަށް ބަލަހައްޓާފައިވާ ބަލިތަކުގެ ވަކި ފަރާތުން އެހެން މިންގަނޑު ގެންނަމުންދާ ބަދަލެއް މިހެންނެވެ. އަދި ހާސިލުކުރި ނަތީޖާތަކާ ބެހޭ، ޕްލޭނަށް އެއްވެސް ބަދަލެއް ގެންނަންޖެހޭ ގޮތުގެ މަޢުލޫމާތު އެއްކުރުމަށް ގެންނަންޖެހޭނެއެވެ. އަދި ޕްލޭނުގެ މުއްދަތުގެ ހަމަވާ އަހަރު ސިއްޙީ ނިޒާމު ބައިވެރިންނާއެކު މަސައްކަތުގެ ފަރާތްތަކުގެ ކުރިއަށް ކަންތައްތައް ބަލާ ކަނޑައަޅާފައިވާ ނަތީޖާތައް ހާސިލުވެދާނެ ގޮތުގެ މަޝްވަރާ ޕްލޭނާއި އެކަށައަޅާފައިވާ ކަމަށް ދުވަހު ދުވަހު މަސައްކަތްކުރެވޭނެ.