3 GOOD HEALTH AND WELL-BEING

2017

HEALTH
SDG PROFILE

MINISTRY OF HEALTH
REPUBLIC OF MALDIVES

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List of Abbreviations

ADL	Approved Drug List
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Care
ARI	Acute Respiratory Infection
ARV	Antiretroviral
BBS	Biological and Behavioural Survey
BMI	Body Mass Index
CDC	Centre for Disease Control and Prevention
CPR	Contraceptive Prevalence Rate
CSC	Civil Service Commission
CVDs	Cardiovascular diseases
EML	Essential Medicine List
FCTC	Framework Convention on Tobacco Control
GHWA	Global Health Workforce Alliance
GoM	Government of Maldives
HIV	Human Immunodeficiency Virus
HPA	Health Protection Agency
HMP	Health Master Plan
HR	Human resource
HRH	Human resources for health
ICT	Immuno-Chromatographic Test
ICT	Information Communications Technology
IGMH	Indira Gandhi Memorial Hospital
INSSP	Integrated National Nutrition Strategic Plan
IYCF	Infant and Young Children Feeding
LECReD	Low Emission Climate Resilient Development
LF	Lymphatic Filariasis
MCCM	Multi-Country Coordination Mechanism
MDGs	Millennium Development Goals
MDHS	Maldives Demographic Health Survey
MDR-TB	Multi-Drug-Resistant Tuberculosis
MEE	Ministry of Environment and Energy
MFDA	Maldives Food and Drug Authority
MH	Mental health
MMR	Maternal Mortality Ratio
MNS	Micronutrient Survey
MoH	Ministry of Health
MPMMRC	Maternal and Paternal Morbidity and Mortality Review Committee
MVR	Maldivian Rufiyaa
NDA	National Drug Agency
NCD	Non-Communicable Diseases
NCR	National Cancer Registry

NGO	Non-Governmental Organisation
NHA	National Health Accounts
NMP	Neonatal Mortality Rate
NTP	National TB Control Program
PEN	Package of Essential Non-Communicable Disease
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-exposure prophylaxis
SDGs	Sustainable Development Goals
SEAR	WHO South-East Asia Region
SEARO	South East Asia Regional Organisation
SIDS	Small Island Development State
STI	Sexually Transmitted Infections
STO	State Trading Organisation Plc.
TB	Tuberculosis
TRIPS	The Agreement on Trade-Related Aspects of Intellectual Property Rights
UHC	Universal Health Coverage
UHIS	Universal Health Insurance Scheme
UN	The United Nations
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
WOG	Whole-of-Government

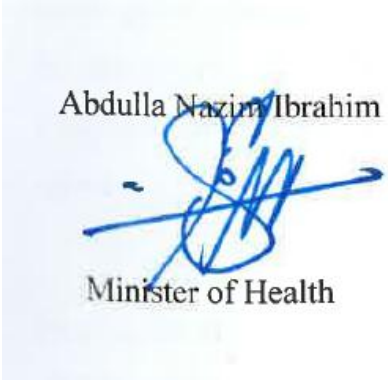
Foreword

The Sustainable Development Goals (SDGs) comes into replace the Millennium Development Goals (MDGs) as the broader developmental agenda of the world that calls for actions to end poverty, protect the planet and ensure that all people enjoy peace and prosperity.

The health related SDG aims to achieve 13 broad targets supporting health beyond health. Maldives is working towards achieving these goals, with the priority health related SDGs being part of the National Health Master Plan 2016-2025. This has meant the availability of stronger communication platforms for coordination and implementation, with a health system designed towards achieving sustainability through long term development practices which impacts positively on the health and well-being of the citizens of Maldives.

The main objective of this SDG health profile is to monitor SDG Goal 3 and other health related SDGs regularly by considering the global and national targets. The SDG 'Technical Coordination Committee formed on 12th January 2016 collaboratively works to implement and monitor health related SDGs in Maldives.

I look forward to witnessing these new developments as all sectors respond to the health related SDGs through their national plans and policies, The SDGs require priority action from all government institutions, private parties, NGOs, UN agencies, other developmental partners and individuals and I welcome the support that these parties provide to accelerate the transition to a healthier Maldives.



Executive Summary

The year 2015 saw the establishment of the Sustainable Development Goals (SDGs) by the United Nations (UN), to lead the global development agenda up till the year 2030. The SDGs are comprised of 17 global goals, with a total of 169 targets.

Of all the 17 SDGs, the health goal, ensuring healthy lives and promoting wellbeing for all ages, i.e. SDG 3 has the largest number of indicators. With the emergence of SDGs, every member country has embarked on aligning country developmental goals and plans with that of the SDGs.

Similarly, in the Maldives, as with other agencies and stakeholders within the government, the Ministry of Health (MoH) is working towards meeting the targets of the global agenda in the process of improving the health services provided to citizens scattered geographically across swathes of ocean, which in itself poses challenges.

This report duly focuses on the work that is being undertaken at the island, atoll, and country level in terms of meeting the targets of SDGs, the progress that has been made, the milestones achieved, and the challenges that remain as MoH forges ahead with its plans and policies to translate these goals into reality on the ground.

As there exists interdependence and inter-linkages between the goals, this report also looks into SDG 2 which deals with ending hunger and achieving food security for improved nutrition, which in a large way translates into healthy lives and promoting wellbeing.

The main focus of the report however, is made on the goals within the goal of SDG 3. It takes an in-depth look into areas such as the work that is currently being done to put an end to preventable deaths of new-borns and children under five years of age, to ending the epidemics of AIDS, tuberculosis etc. to ensuring healthy lifestyles to prevent the rise of non-communicable diseases (NCDs) that have become prevalent and are in a large way the leading cause of deaths in modern societies.

Amidst all this, due attention is given to challenges faced in terms of hiring and retaining adequately trained local human capital in the sector, the geographical challenges owing to the fact that Maldives is a small island state, the lack of robust

mechanisms in handling data that can be relied on to drive policies to forge ahead, and the need for increased stakeholder engagements when achieving milestones as SDGs themselves are multi-dimensional in nature.

The future lies in finding ways to overcome the barriers to progress identified, and using a whole-of-government (WOG) approach in some cases, if not all, to achieve the SDGs in question.

Reports in the future will look into broadening the scope, by including other health related SDGs not specifically grouped under SDG 3, but yet contribute in a large way towards bridging the gaps and bringing the health-related goals full circle.

Introduction

Maldives is a Small Island Developing State (SIDS) with a population of 407,660 sparsely spread across approximately 200 inhabited islands (National Bureau of Statistics, 2017). The tourism industry, compounded with sustained investments in social sectors transformed the country's developmental process in the form of increased access to education, health, and social services for the geographically isolated, small populations. However, as a SID, Maldives faces several constraints owing to the structural characteristics of the country.

Following the adoption of 2030 SDGs in September 2015, important steps were taken to address the SDG agenda for the Maldives including national dialogues, public awareness, and the setup of an institutional mechanism to coordinate SDGs by the Ministry of Environment and Energy (MEE) in 2016. This also resulted in MoH aligning the 10 Year Strategic Health Master Plan (HMP) with health-related SDGs. The HMP is an important document which outlines the principles and the national health goals, providing strategic guidance and direction to the public and partners in health to further develop programs and business plans to improve the health of the population and develop the health system of the country (Health Master Plan, 2016-2025). This alignment would mean that the prioritized health SDGs are also a part of the Health Sector Monitoring and Evaluation Framework.

This report explores the implementation of the health-related SDGs, especially related to goal two on ending hunger, and goal three on ensuring healthy lives and promoting wellbeing of all ages. It is a compilation of records from all relevant departments and agencies related to the previously highlighted SDGs. It also explores the challenges faced by Maldives as a SIDS due tothe geographical isolation, small size, limited natural resources, and small population. These geographical challenges compounded with increased turnover in the health workforce and limited human resource in the health sector needs attention when addressing the SDGs.

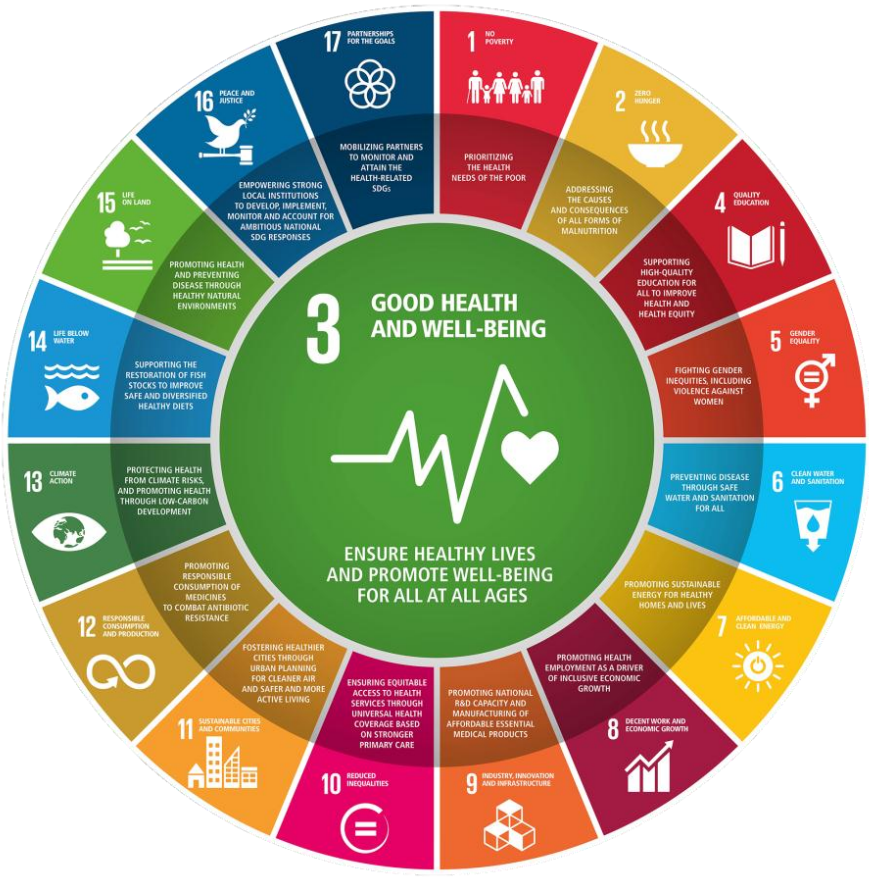


Figure 1: Sustainable Development Goals

Updates on the Health-Related SDGs in the Maldives

Goal 2: End hunger, achieve food security and improved nutrition, and promote sustainable agriculture.

There is more than enough food produced in the world today to feed everyone, yet around 815 million people are chronically undernourished and one in three people on the planet suffer from malnutrition (World Food Program, 2017).

Goal two focuses on targets that can be achieved by transforming food and agriculture systems, shifting to more sustainable and diversified consumption and production, improving governance and securing the political will to act.

To achieve zero hunger, improved food security and nutrition, all partners in both government and private sector must act to enhance food security, nutrition, and sustainable agriculture through public policies and programs.

2.2 By 2030 end all forms of malnutrition, including achieving by 2025 the internationally agreed targets on stunting and wasting in children under five years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women, and older persons.

Malnutrition in all its forms threatens human development. Micronutrient deficiencies, under nutrition, and being overweight and obese throughout the life-course are public health problems in many countries and Maldives is no exception. Economic growth and investments, demographic changes, globalization and social and health development have altered the nutrition profile and its determinants across the country.

Maldives has made significant progress in improving the nutritional status of the country over the past three decades. However, malnutrition persists in the Maldives at a high level. Maldives Demographic Health Survey (MDHS) 2009 and Micro Nutrient Survey (MNS) 2007 indicate that the nutrition situation in the country ranges from under nutrition among children, overweight and obesity among adults with micronutrient deficiency among all age groups.

According to MDHS (2009), wasting is observed among 10 per cent of children under the age of five, 17.3 per cent underweight and 18.9 per cent are chronically malnourished or stunted. Furthermore, results show that six per cent of children under the age of five in Maldives are overweight with respect to their age. The micronutrient survey conducted in 2007 showed that more than half the children between the ages of six months to five years are vitamin A deficient (5.1 per cent severely and 50.1 per cent moderately deficient). Anaemia prevalence among children of the same age category was found to be at 26 per cent, with more than half the children (57 per cent) suffering from iron deficiency. Similarly, recent findings from school health screenings (2015) showed 41 per cent of students to be within the normal weight range. Additionally, while 21 per cent of children observed were overweight and obese, 37 per cent showed to be underweight.

Malnutrition among reproductive aged women also continues to be of concern. MDHS 2009 showed that 46 per cent of women between 15-49 years are overweight or obese and eight per cent are too thin with BMI less than 18.5. While overweight and obesity prevalence is high, micronutrient deficiencies are also high in this age group. This co-existence of under nutrition, micronutrient deficiencies, and over nutrition exemplified by obesity and non-communicable and chronic disease contributes to multiple burdens of malnutrition.

MoH with the support of partner government institutions, donor agencies and non-governmental agencies is taking several steps to create an enabling environment to promote nutrition through a life-course approach. A combination of institutional strengthening efforts within a life-course approach, capacity building of service providers to deliver interventions and key messages, micronutrient nutrient supplementation programs to address micronutrient deficiencies, enacting of relevant regulations and social behaviour change, and communication interventions are core program areas to promote positive outcomes.

An integrated and comprehensive National Reproductive Health Strategy 2014-2018 hasbeen endorsed and is being implemented. HPA in collaboration with health facilities and UN organisations established the Adolescent Friendly Health Services (AFHS). National standards have been developed followed by plans to expand to all government facilities.

Maldives endorsed and rolled out the Integrated National Nutrition Strategic Plan (INSSP) 2013-2017. This multi-sectoral strategic plan contains policy goals and targets to improve child health and nutrition situation of the country and interventions carried out based on the priority areas focused in the strategy.

To reduce micronutrient deficiencies, Iron-Folic acid supplementation is provided to all pregnant mothers by the government free of charge and Vitamin A/deworming of children through schools and growth monitoring services.

In this line, national standards on Infant and Young Children Feeding (IYCF) growth monitoring promotion protocols and resources with integration of early childhood development components have been developed. Emphasis on first 1000 days since birth and early years is a key priority area to break the cycle of malnutrition.

A national conference on nutrition with theme of “First 1000 Days” was conducted for policy makers and technical level staff from various sectors with the aim of raising the profile and creating value around the first 1000 days of life. Evidence shows that communication alone is not sufficient in terms of improving breastfeeding and complementary feeding practices and needs to be complemented with counselling and support by skilled workers at the community and health system levels. Health workers are key agents in improving the nutrition situation of children; hence several programs on capacity building of healthcare providers on nutrition have been conducted. IYCF trainings were conducted in a total of 10 atolls in the last year. These include trainings on maternal nutrition, infant and young child nutrition, breastfeeding counselling, growth monitoring and promotion, and orientation on BMS regulation and trainings on adolescent youth friendly health etc. to give tailored and adolescent friendly services including nutrition interventions.

Multifaceted interventions aiming to support breastfeeding and infant feeding is required to bring positive behavioural changes. Some key programs underway include; development of a mobile application on maternal and child nutrition; designing of a social behaviour change communication strategy on the first 1000 days of life, with emphasis on breast feeding; optimal feeding practices; stimulation and care in this early period.

Promotion of health and nutrition in school settings is also an important area that needs specific focus. School health screenings are conducted to identify nutritional issues among school aged children. Nutrition awareness sessions to students and workshops targeting Parent-Teacher Association (PTA), parents and school teachers are on-going. Maldives has initiated the development of Nutrition Policy for Schools and School Canteen Guidelines too.

Maldives Food and Drug Authority (MFDA), under the purview of MoH developed and endorsed a Food Safety Policy in 2017. Additionally, a number of interventions are on-going which helps to ensure that the quality of food grown and imported to the country remains acceptable in terms of safety and other such requirements.

Goal 3: Ensure healthy lives and promote well-being for all ages

Goal 3 specifically relates to health which seeks to implement the health and wellbeing of all people across the world at every stage of life. This goal addresses all major health priorities, including reproductive, maternal, and child health; communicable, non-communicable, and environmental diseases; universal health coverage; and access to safe, effective, quality, and affordable medicines and vaccines. It also calls for more research and development, increased health financing, and strengthened capacity of all countries in health risk reduction.

3.2 By 2030, end preventable deaths of new-borns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births.

Maldives achieved the fourth and fifth goal of the Millennium Development Goals (MDGs), which aimed at reducing by two-thirds the mortality rate. However, sustaining the achievements and meeting the targets of SDGs related to health of children require more work. During the period of 2006-2015, infant mortality rate decreased from 16 to 9 per 1000 live births and under-five mortality rate decreased from 18 to 11 per 1000 live births (Ministry of Health, 2016). Neonatal Mortality Rates (NMR) also decreased substantially during this period from 11.5 to 5.3 per 1000 live births (Health Master Plan 2016-2025).

Maldives had a high Maternal Mortality Ratio (MMR) of 259 per 100,000 live births in the year 1997. MMR fell steadily since the beginning of the last decade. Although an increasing trend was seen from 2007 to 2010, MMR has fallen to the rate of 68 per 100,000 live births in 2016 (Ministry of Health, 2016). It should be noted that fluctuations are prominent due to the small population of the Maldives that causes the MMR to vary widely from year to year as a change by one death also causes a significant change in the ratio.

The Maternal and Prenatal Morbidity and Mortality Review Committee (MPMMRC) fulfil a vital role in helping to improve the quality and safety of prenatal maternal care in Maldives. Since its inception in the 1990's, changes have been made to the functions of the committee in order to meet the evolving needs. An in-depth review of maternal deaths was initiated in 1997 to identify and focus interventions in reducing maternal deaths. As the number of maternal deaths in a year is only a few, a review of each maternal and prenatal death by the MPMMRC is critical for understanding the contributing factors of these maternal deaths. These would lead to specific actions to prevent future maternal deaths because of similar problems. Emergency obstetric care at atoll level was strengthened and institutional deliveries were widely promoted.

The coverage of antenatal care (ANC) was 97 per cent in 2009 (MDHS, 2009), with the majority of women (90 per cent) having their first ANC visit in the first trimester of pregnancy.

The coverage of all basic maternal health services in health facility is higher than 90 per cent, which corresponds to the low level of MMR. However, Maldives is unique in that about 54 per cent of deliveries occur at IGMH in Male', while there are six regional hospitals and 14 atoll hospitals with many of them staffed by one or more obstetricians and paediatricians. Further, most normal deliveries are assisted by an obstetrician, while there are sufficient numbers of nurse-midwives/midwives working in the health facilities. Majority of the specialists in the outer atolls are expatriates from neighbouring countries, whereas majority are Maldivians at the tertiary care hospital in central level i.e. Male'.

A greater challenge for further reduction in infant mortality now lies with reducing neonatal death rate. In 2014, neonatal deaths accounted for 63 per cent of infant

deaths (Maldives Health Profile 2016). More importantly in 2014, 89 per cent of the neonatal deaths took place within the first week of life. It is important to note that many of these cases are contributed by premature births and babies born with birth defects including congenital heart defects and neural tube defects.

Postnatal care is combined with postpartum care for mothers and its coverage has reached 94 per cent. In summary, Neonatal Mortality Rate is low, which corresponds to the low MMR. Prematurity needs more attention, as it relates to survival and quality of life of premature babies in the future. Birth defect is also a growing issue all over the world and a concern for Maldives; thus, the existing data needs to be analysed for further interventions and preventive measures. Hence data entry of birth defects into World Health Organisation (WHO) South East Asia Regional Organisation (SEARO)'s national birth defects database initiated since 2015 with the focal point at Indira Gandhi Memorial Hospital (IGMH).

3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.

a) Malaria and Lymphatic Filariasis

Maldives was certified by WHO to have eliminated malaria and lymphatic Filariasis (LF) as a public health problem in 2015 and 2016 respectively. Both malaria and LF had been endemic in Maldives, but sustained efforts to reduce the vector and diagnosing and managing cases had significantly reduced the disease burden. The last indigenous case of malaria was recorded in 1984 and LF in 2003. Antigen prevalence survey for LF using Immuno-Chromatographic Test (ICT) is on-going with 100 per cent coverage in all atolls except two, with a plan in place to cover the whole country. In addition, malaria prophylaxis is provided to all travellers to malaria-endemic areas and for imported cases that get diagnosed. The challenge now lies in remaining malaria and LF free, especially given that LF vector is present and both the diseases are endemic in neighbouring countries with there existinga high chance of importation. Further strengthening vector surveillance and monitoring, combined with empowering patients with LF-related disabilities for self-care are planned.

b) Tuberculosis (TB)

TB is one of the Regional Flagship Priority areas of WHO-SEARO with accelerating efforts to end TB by 2030.

Maldives is a low-burden country for TB and therefore, is currently working towards TB elimination. Currently TB control activities are coordinated by the National TB Control Program (NTP). All patients with TB diagnosis are provided treatment by the NTP and are closely monitored. TB is one of the diseases screened in migrants in their annual health screening program. In addition, periodic screening activities are conducted for high risk populations.

MoH designed a strategic plan to eliminate TB by 2022. This plan has components to strengthen patient monitoring, improve case detection rates, and build up diagnostic capacity in the country. This plan has been costed and is currently in the process of procuring funds from various sources. Challenges in terms of TB elimination include a large migrant population from high-burden countries, especially countries where Multi-Drug-Resistant Tuberculosis (MDR-TB) burden is high. In addition, misinformation about TB still exists along with considerable stigma faced by patients in the community.

c) Hepatitis B

Routine immunization of infants with hepatitis B vaccine was introduced in 1993. Since then, immunization coverage has been consistently above 95 per cent. Currently a birth-dose with hepatitis B vaccine and three doses of pentavalent, which include hepatitis B vaccine as one component is provided to all eligible infants. A blood safety program is fully implemented nationally, with all donors screened for risk, and all donated blood screened for blood-borne viruses including hepatitis B. Screening for hepatitis B in antenatal care clinics and pre-surgery is also routine in the healthcare system. In addition, hepatitis B immunoglobulin is provided for infants born to mothers with hepatitis B. Ad hoc programs to prevent blood-borne diseases or sexually transmitted infections (STIs) have also addressed hepatitis B prevention over the years, usually tied to Human Immunodeficiency Virus (HIV) prevention.

However, Maldives has yet to develop and implement a specific program for hepatitis B control. There is incomplete surveillance data, and hence no national estimates of prevalence, but there are sources of data such as blood screening registries and lab records that can be used for some estimates. Anecdotally, there are pockets of high prevalence in some areas. In addition, treatment is still not widely available in the country.

HPA and MFDA are working with the State Trading Organisation (STO), a state-owned company, and *Aasandha*, a state-owned Universal Health Insurance Scheme, to ensure availability of treatment throughout the country. In addition, prevention in healthcare settings is being prioritized, with all health facilities directed to ensure their staffs is immunized. Development of infection prevention and control policies in the healthcare setting are also key to this.

With the current regional and global focus on controlling and eliminating viral hepatitis, Maldives will also be working towards the development of a strategic plan for hepatitis B control.

d) HIV/AIDS

Maldives is a low-prevalent country for HIV. The first case of HIV in the Maldives was reported in 1991, and by the end of 2016, cumulative number of HIV cases remained at 23. Of this nine were living with HIV and were on Antiretroviral (ARV) treatment.

All treatment and care of HIV/AIDS patients are covered by the Government of Maldives (GoM), and treatment is only available through the national program.

Targeted interventions for HIV/STI prevention in people who inject drugs are carried out, with a drop-in centre at two sites with higher concentration of the risk population. Interventions include provision of information, free-anonymous testing for HIV, outreach programs for the community, oral opioid substitution therapy and provision of preventive commodities through these set-ups. A Biological and Behavioural Survey (BBS) was first conducted in 2008, with the second round of data collection currently ongoing, which will help establish knowledge, risk behaviours, and HIV/STI prevalence among key populations. Awareness programs for public, especially for youth take place regularly, in the form of information

sessions, presentations at different forums, and an "*Engeytha" App* has also been developed to provide information. 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.

Maldives has been following a test-and-treat policy before WHO recommendations. Diagnosis and treatment is provided free of cost. Social support needed by patient is also provided. Maldives is initiating Pre-exposure prophylaxis (PrEP) of HIV for serodiscordant couples. Maldives has never seen a case of mother-to-child transmission of HIV, even with high levels of antenatal care and antenatal testing which makes Maldives eligible for WHO certification in having eliminated mother-to-child transmission of HIV.

WHO South-East Asia Region (SEAR) countries have agreed to establish a Multi-Country Coordination Mechanism (MCCM) to allow timely application for Global Fund multi-country proposals to work on controlling HIV/AIDS at a regional level.

e) Communicable Diseases

Dengue, diarrheal diseases, and Acute Respiratory Infections (ARI) continue to cause significant morbidity among children and adults. In 2012, ARI, viral fever, and diarrheal diseases had the highest incidence, amounting to 4,748, 2,130 and 694 per 100,000 populations respectively (Ministry of Health and Family, 2012). Diseases such as scrub typhus and toxoplasmosis also continue to be endemic. Although significant improvements in access to safe water and improved toilet facilities have been achieved, 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. New surveillance and diagnostic system for influenza has been established, with assistance from Centre for Disease Control and Prevention (CDC), USA.

Leprosy is below the elimination threshold, though not yet certified, and any diagnosed cases are treated free of cost.

Waste management is especially a significant problem and is one factor that contributes to the rapid spread of dengue during dengue season. New environmentally responsible and safe approaches that ensure health of the population are needed.

3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.

f) Non-Communicable Diseases

Over the past few decades, the sustained community level interventions by a resilient health workforce, ensuring high immunization coverage, coupled with advances in medicine, have brought down the spread of communicable diseases to a manageable level.

On the other hand, the advent of unhealthy foods and beverages and sedentary lifestyles have resulted in a sharp rise in major NCDs, becoming the most daunting public health challenge as well as the main cause of mortality and morbidity. Current estimates put mortality due to NCDs at an all-time high, with 81 per cent of all deaths attributed towards NCDs.

This high incidence of death and disability mirror the rise in associated risk factors; prevalence of tobacco use (34.7 per cent and 3.4 per cent male to female respectively), low intake of fruits and vegetables (only 6.4 per cent takes the recommended daily quantity), sedentary lifestyle (only 6.2 per cent engage in physical activities as per recommendation) and 37.1 per cent people are overweight (STEPS Survey 2011).

To slow down the rise of NCDs, Maldives has joined the efforts undertaken at a global level through actions taken at a local level. The Multi-sectoral Action Plan for the Prevention and Control of NCDs in Maldives (2016-2020) is aligned with the NCD global targets, and its implementation is overseen by a high-level steering committee comprising of members from other relevant sectors.

Furthermore, a national NCD campaign has been launched with the aim to raise awareness on healthy behaviour for the prevention of NCDs (specifically for Cardiovascular diseases (CVDs), cancer, diabetes, chronic lung diseases), and reduction of the risk factors that contribute to them among children and adults. Food Based Dietary Guideline promoting healthy diet and prevention of NCDs has also been finalized with plans for dissemination in progress.

Recently, Maldives adopted the Package of Essential Non-communicable (PEN) Disease Interventions for primary healthcare by WHO. This has been implemented in two regions with plans in place to expand to other regions. This package looks at interventions for early screening, treatment, and other preventative measures for NCDs.A National Cancer Registry (NCR) is in the process of being established and information collected from two tertiary hospitals (IGMH and ADK) in Male', and review of the process is currently underway to identify a way forward for expanding the registry nationwide.

In terms of combating use of tobacco in various forms, a national tobacco cessation clinic has been established at Dhamanaveshi (Urban Primary Healthcare Centre) in Male'. Additionally, one private tertiary facility (ADK Hospital) now offers cessation services. A National Toolkit for Brief Cessation Interventions at all healthcare facilities has been implemented to expand the services across the country.

Early screening and awareness are regularly conducted through NCD clinics. High quality curative services are available at main hospitals for all major chronic diseases, including treatment for cancers. Curative and cessation services and medicines are covered under Aasandha scheme, making them affordable and equitable.

To facilitate physical activity, more parks and open public spaces are being created, especially in urban settings. Some of these places are equipped with outdoor gyms which are becoming more popular. Under an initiative between GoM and WHO, 10 more outdoor gyms are slated to be installed across the country.

Hefty taxes have been imposed on energy drinks, soft drinks, and tobacco, followed by banning of energy drinks at educational and health facilities. To discourage and

curb the use of unhealthy foods and beverages, additional legislative and health promotion measures are being considered. These include taxes on a wide range of sugar sweetened beverages, restrictions on marketing of unhealthy foods and beverages, guidelines for school canteens, and healthy public events.

In September of 2017, a National Healthy Lifestyles campaign "25BY25" was initiated with the aim of bringing a relative reduction of 25 per cent in the prevalence of NCDs by 2025. The one year campaign which would run throughout 2018 is expected to provide renewed impetus to current efforts and contribute towards achieving the targets set out in the National NCD Action Plan as well as those of the related SDGs.

g) Mental Health

GoM recognizes mental health (MH) as being an integral element of the "health equation", and accordingly gives equal importance towards ensuring the mental wellbeing of Maldivians, akin to the focus on that of physical health.

While psychiatric services are available at some government and private hospitals, and psychiatric medicines are covered under the universal health insurance scheme "*Husnuvaa Aasandha*", the government acknowledges that a number of challenges continue to exist in this area. The limited number of psychiatrists and other professionals working in this arena in the country, coupled with high cost of services offered at private facilities currently not covered under "*Husnuvaa Aasandha*" make mental health services less accessible to the people. Similarly, while government pharmacies are established on all islands, the procurement, supply, and dispensing of psychiatric medicines continue to be a challenge, including frequent stock outs.

Taking into account these challenges, MoH put in place the National Mental Health Policy 2015-2025, and developed a Mental Health Strategic Planto achieve the goals of the Mental Health policy. A bill for a Mental Health Act is being developed with the aim of further consolidating and strengthening mental health services, and ensuring the rights of those suffering from mental illnesses. Meanwhile, efforts are being made to expand mental health across the country, including the availability of psychiatrists at regional and atoll hospitals.

3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.

Consumption of alcohol is prohibited for locals on religious grounds, and alcohol may not be served even to foreigners within local communities. The importation, storage, and sale of alcohol is strictly regulated through a licensing mechanism, and sold only at resorts, exclusive tourist vessels, and at duty free outlets. Despite these measures, there is evidence of consumption by locals including those of school-going age. There are also reports of illegal sales and illegal brewing.

Although Maldives has not developed a specific strategy to control alcohol and prevent harmful consumption, in line with the Global Strategy, Maldives has incorporated relevant elements of the global strategy into existing local plans and strategies of NCD control, drug control, and mental health.

Drug Control Act (17/2011) was ratified in 2011 and the work is on-going to implement the policies and regulations under this act.

National Drug Agency (NDA) is the authority coordinating the treatment of substance abuse including narcotic drug abuse. NDA provides drug treatment, detoxification, opioid replacement treatment, and community services through their facilities (Male', Addu, and Fuvahmulah City and K. Himmafushi).

Table 1: Treatment of substance abuse services

Drug treatment and detoxification centres	Community service centres	Methadone replacement centre
Gn.Fuvahmulah City	Male' City	Male' City
K.Himmafushi	Addu City	

Some non-governmental organisations (NGO) such as Journey, which focuses on HIV and drug prevention in the community, provides primary care for drug addicts, referrals to other service providers, outreach services to the atolls, crisis intervention services, home visits to assess family situation and support services, case management for drug addicts as well as legal services according to their needs.

3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents.

Maldives identifies road traffic injuries as a major public health burden with significant consequences in terms ofdisability, mortality, and socioeconomic costs. From 2012 to 2016 reported cases of accidents has increased by 75 per cent due to the increase in population within the capital city, together with the development of roads and highways in different parts of Maldives. Over the years there has been a dramatic increase in vehicle registration in Maldives, with 75 per cent of vehicles registered being used in Male' City. Fatal accidents with loss of lives have also increased over the years. To meet the global targets the Maldives Multi-sectoral Road Safety Action Plan has been developed including the 5 Road Safety Pillars in the Global Decade of Action on Road Safety 2011-2020. To strengthen injury surveillance, training programs have been conducted to build capacity among health care workers.

Furthermore, awareness campaigns in the south of Maldives were carried out to promote the use of helmets and similar campaigns are to follow in the central region. However, additional effort needs to be put in place in collaboration with the stakeholders to have a major impact with new and innovative ideas.

There is an urgency to revise and improve the existing legislations and regulations. Effective enforcement of the laws is required and review of safety standards is vital. It is also of utmost importance to strengthen the injury surveillance system in the country.

Noting the increase in fatal accidents and loss of lives in the country, establishing a mechanism for effective post-crash response and integrating trauma care in the existing emergency services in all the hospitals, especially in the high-risk areas of Maldives is crucial.

3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

While their perception and understanding about sexuality may not be adequate, adolescents and youth are the most vulnerable groups for risky sexual behaviours as they go through a challenging period of puberty and become sexually active. In Maldives, an estimated 52 per cent of its population is younger than 25 years. For these reasons, adolescents and youth deserve special attention when it comes to promoting sexual health.

Reproductive health practices are another area that has not seen significant progress and is in need of special attention. Most young women in Maldives have their first sexual intercourse after they turn 18. The proportion of women who have sex before they turn 18 is high among women who live in urban areas and in Male' (eight per cent) compared to those living in the atolls (Ministry of Health and Family and ICF Macro, 2009). The median age at first intercourse has increased from 17.0 years among women aged 45-49 to 21.8 years among women aged 25-29 years. Very few teenagers have begun childbearing at age 18; while seven per cent have started at age 19 (Ministry of Health and Family and ICF Macro, 2009).

The rate of young women having sexual intercourse by age 18 decreases rapidly by their degree of education, from 14 per cent among women with primary education to five per cent among women with secondary education (Ministry of Health and Family and ICF Macro, 2009).

Premarital sexual activity was found among 11.6 per cent youth of 18-24 year olds. About 36 per cent 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 aged 15-24 to 2.9 among men aged 40-49. The mean number of lifetime sexual partners is highest among men who are divorced, separated or widowed (3.9).

The results of MDHS showed that contraceptive prevalence rate for all methods decreased, by four per cent from 2006 to 2009. Although the use of condoms

increased from six per cent to nine per cent (1999-2009), the use of oral pills decreased from 13 per cent to only five per cent during this period (Ministry of Health and Family and ICF Macro, 2009). Proportion of married women who used sterilization for family planning declined from 10 per cent to seven per cent in 2004 but reverted to 10 per cent in 2009. Current MDHS which is underway will show the recent trend in terms of use of sterilization for family planning by married women.

Among the reasons for the discontinuation of all methods were; wanting to become pregnant (28.3 per cent), became pregnant while using contraceptives (13.8 per cent), and family planning side effects (10.4 per cent). The situation is, however, unique in Maldives in that while it has a low Contraceptive Prevalence Rate (CPR) (27 per centfor modern methods) and a high unmet need (29 per cent), the total fertility rate remains low (2.5) (Ministry of Health and Family and ICF Macro, 2009).

Possible reasons for this might be owing to the very high divorce rate in the country, termination of pregnancies, infertility, and use of traditional contraceptive methods. Insufficient knowledge about the fertile is also evident in young women as well as young men: 51 per cent among women and 53 per cent among men with only 16 per cent of women and 11 per cent of men giving the correct response. However, knowledge about contraceptive methods remains high between both genders with 94 per cent among women and 93 per cent among men (Ministry of Health and Family and ICF Macro, 2009).

The quality of care for family planning 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. Ministry of Youth and Sports initiated a Youth Health Café 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 which was piloted in IGMH. 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 underutilized as young people find these services stigmatizing.

There has been marked progress in reducing infant mortality rates and maternal mortality rates. There are number of programs carried out with objective of improving the overall reproductive health of women including sexual and reproductive health of adolescents including family planning information to unmarried youth and young adults.

Given the sensitive nature of services related to sexual and reproductive health the government regularly collaborates with civil society organisations to deliver information on sexual and reproductive health. Broadcast media is often utilized in a systematic manner to spread awareness, via video spots, interviews and public health messages.

Various additional programs have been conducted to provide information on reproductive and maternal health including family planning to unmarried youths and young adults.

Additionally, the National Family Planning Guideline is non-discriminatory and facilitates easy access to services. Its programs are devised to ensure that services are within reach to all individuals who need them. A range of contraceptives are available in all islands and a coordination mechanism exists to guarantee proper management of contraceptive dissemination throughout the country.

Finally, prevention of mother to child transmission (PMTCT) of HIV infection is given a special attention. The target in 2016 was to ensure that 90 per cent of pregnant women visiting ANC clinics have comprehensive knowledge on HIV infection and prevention and access to PMTCT programme. In addition, Voluntary Counselling and Testing (VCT) centres have been established and a review meeting for members of VCT facilities conducted.

3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

The universal health insurance scheme was implemented in January 2012 following the enactment of the National Social Health Insurance Act in December 2011, which provided a legal framework for establishing a universal health care financing scheme for all citizens. The Act formally mandates the National Social Protection Agency (NSPA) to oversee the administration of the National Social Health Insurance Scheme. In 2012, "*Madhana*" was replaced by a universal health insurance scheme named "*Aasandha*", where the government paid its full contribution (premium) on behalf of all the citizens. There were some caps for key areas such as a limit of MVR l00, 000 (USD 6,485) for outpatient services. "A*asandha*" also covered foreign health facilities empanelled in the scheme including hospitals in Sri Lanka and India. In 2014 "*Aasandha*" scheme was again re-named to "*Husnuvaa Aasandha*" (translates into a health insurance scheme without a price ceiling) administered by Aasandha Company Pvt Ltd of the government, which allowed unlimited coverage for all necessary healthcare services."*Husnuvaa* Aasandha" scheme is the universal health insurance scheme operating under the National Social Health Insurance Act (l5/20ll) by the state. Health care, sickness, and injuries are the branches of social security covered by this scheme. In addition to this, NSPA provides child and family support via single parent allowance, foster parent allowance, and food subsidy allowance for those living in poverty, under the Social Protection Act (2/2014), together with disability allowance for the disabled, under the Disability Act (8/2010).

The current health master plan 2016-2025 enables the implementation of SDGs by aligning these with global and regional health agenda making progress in terms of universal health coverage. This allows for the improvement of access to needed service including a robust healthcare workforce that can deliver those services with increased accessibility to affordable medicines, in terms of strategies to protect people from impoverishment owing to healthcare costs.

Current GoM is committed to providing medicines to all citizens through STO pharmacies under an agreement with STO. MFDA records show that there are 359 pharmacies in the private sector and 187 STO pharmacies across all locations with the greatest number (80) in Male' (MFDA, 2017).

Furthermore, interventions focused on improving the quality of healthcare are assured through relevant health regulations by licensing healthcare facilities, pharmacies, healthcare professionals, and the registration of medicines and vaccines.In addition to this, 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 consistency in the use of standard guidelines and protocols becomes a challenge. As major reforms continue 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.

3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.

In the Maldives, cases of communicable diseases that can be spread by water such as typhoid are uncommon. If any cases are reported, they are investigated by testing the water and required corrective actions taken, together with public awareness.

HPA represents national stakeholder forums in addressing these issues to achieve the global targets. Additionally, the Environmental and Occupational Health Division focuses on developing strategies, and guidelines with a component on awareness. Currently, a pilot project with support from WHO LECReD is on-going in Laamu Atoll, which focuses on addressing hazardous chemical waste which results from improper healthcare waste management.

3.a Strengthen the implementation of the WHO Framework Convention on Tobacco Control in all countries, as appropriate.

The Tobacco Control Act (15/2010) enabled the enactment of "One Regulation" in 2011, which helped establish smoking and non-smoking zones. MoH is currently working on two more regulations to appropriately monitor and control the import and use of tobacco in the Maldives.

Maldives implemented tobacco control measures in the 70's, before the birth of the Framework Convention on Tobacco Control (FCTC), halving the prevalence in 2001, from a high of approximately 57 per cent and 37 per cent to 27 per cent and 15 per cent respectively for males and females. Maldives signed and ratified the FCTC in 2004, heralding a new era for tobacco control by joining the global movement for effective tobacco control across the globe.

However, a long delay in introducing measures under the FCTC and a period of lax enforcement of existing measures ensued. This, coupled with a heightened effort in marketing tobacco products by the industry resulted in an increase in consumption to 34.7 per cent for males, while the prevalence for females continued to drop, at 3.4 per cent (STEPS Survey 2011). Prevalence for school age children (13-15 years) remained high at 15.2 per cent for boys and 6.7 per cent for girls (Global Youth Tobacco Survey 2011). Cigarette imports continued to increase at a rate of 462 million sticks per year, and new products like shisha, flavoured tobacco, vape, and other e-cigarette products have made inroads and are becoming popular among the younger generations. Meanwhile the youngest age of initiation has dropped to age eight (Global Youth Tobacco Survey 2011).

The enabling legislation for FCTC, the Tobacco Control Act (15/2010) came into existence in late 2010, and to date only a handful of measures has been enacted in relation to the obligations under FCTC. These include the formulation of an enabling local legislation, a multisectoral coordinating body, regulations requiring 30 per cent textual health warning, and regulations banning or restricting smoking in selected public places.

Since assuming office, the current government has made various efforts to further strengthen existing tobacco control measures and to put in place new policy initiatives. These include the reinstatement of the national multi-sectoral statutory body, the tobacco control board, boosting quit efforts by establishing the National Cessation Clinic and expanding the services to all healthcare facilities by developing and implementing the Brief Interventions Cessation Toolkit as well as covering both the cessation services and medication under the universal health coverage. Tax on tobacco has been raised twice over the past three years. The combined outcome has seen a threefold increase in quit rates. New legislative measures including regulations banning the sale of single cigarettes and requirement for graphic health warnings have been developed and are undergoing policy discussions (Global Youth Tobacco Survey 2011).

Tobacco control measures continue to be hampered and challenged by weak enforcement and increased activism by the tobacco industry. While new tobacco control measures are in the pipeline, products like shisha, vapes and e-cigarettes add to the challenge requiring constant legislative and policy updates. Shisha lounges have also mushroomed across the country and are largely unregulated.

It is anticipated that the renewed efforts and activities under the Tobacco Control Act, as well as the national multi-sectoral NCD Action Plan will galvanize tobacco control measures, contributing to Maldives achieving the stated targets under SDG 3.10.

3.b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.

All medicines imported, distributed, sold, and used in Maldives are registered under a set criterion and approved before import. The registration system is based on the systematic document review mechanism. This system has been in place since 2000. The registration system is periodically reviewed to ensure the quality, safety, and efficacy of medicines. Once the medicines are registered and approved, it is uploaded into the Approved Drug List (ADL). This list is updated every month. For medical devices, there is a voluntary registration system.

Currently, a childhood immunization program is in place which provides WHO prequalified vaccines free of cost. Preventable diseases for which vaccination is provided free of charge include, TB, diphtheria, pertussis (whooping cough), tetanus, polio, hepatitis B, haemophilus influenza B, measles, mumps, and rubella. In addition, vaccination for influenza is available at a small cost, and vaccines for cholera, polio, yellow fever, and meningitis are provided at cost for travellers to specific areas. Immunization for infants is available at every inhabited island through the hospital, urban primary healthcare centre or health centre. Trainings are conducted regularly for staff providing immunization and those involved in storage and transport of vaccines. Software is used for vaccine stock management, and WHO-approved guidelines are used to ensure cold-chain maintenance. Additionally, WHO reviews immunization programs periodically.

TB, HIV/STIs, and diseases under elimination (leprosy, malaria, Filariasis and Measles) have specific programs which coordinate preventive activities, awareness programs and patient diagnosis and treatment.

For some diseases such as TB and HIV, diagnosis and treatment are provided free of cost (this is not included in *Husnuvaa Aasandha*) for both locals and foreigners who are working in the country. For TB, contact screening is also undertaken. In addition, screening along with disease information is provided to incarcerated populations and those in institutions regularly. Currently the country is working with WHO and other partners to start a TB elimination program.

3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States.

h) Health Financing

Maldives National Health Accounts 2014 (NHA 2014) provides a detailed overview of resource flows in the Maldivian healthcare system. This report takes into account the expenditure on healthcare in the country by the government, private organisations and institutions, international organisations, and donor agencies.

In 2014, a total of MVR 4,287 million (USD 278 million) was spent on healthcare in the country, about two-thirds of which was contributed by the GoM (NHA 2014). This accounts for a 40 per cent increase in total spending in terms of healthcare in comparison to 2011.

The high priority that is given to improving healthcare and related services by the GoM through increased expenditure is evidenced by the commendable health improvements that Maldives has achieved. Maldivians enjoy high life expectancies, very low infant and maternal death ratios, and Maldives has seen control and elimination of many communicable diseases along the way.

Based on the positive outcomes as outlined, together with the high priority that the GoM places on the health sector, the government will continue to spend on improving access to quality health services for all Maldivians throughout the country.

i) Recruitment, development, training, and retention of the health workforce

Human resources for health (HRH) is a crucial component and pillar of a health system. HRH of an adequate quantity and skill mix are required, that of which are equitably distributed, well-supported, and sufficiently motivated in order to provide the entire population with access to quality and efficient services.

The First Global Forum on HRH, convened by the Global Health Workforce Alliance (GHWA), agreed on the Kampala Declaration and Agenda for Global Action to provide guidance to countries through six interacting strategies focusing on all stages of health workers' careers from entry to health training, from job recruitment through to retirement.

In recent years, challenges in HRH have prompted MoH to put greater focus and emphasis on the health workforce. By achieving better HRH management and development, MoH expects to ensure that all Maldivians have equitable access to comprehensive healthservices provided by a competent and professional health workforce.

In line with adopting the best practices of other SEAR countries, and to strengthen the information supply and demand for health workforce, the two phases of the National Health Workforce registry have been completed, which are yet to undergo the implementation phase. During the past decade, MoH made attempts to solve HRH issues by implementing the National Human Resources for Health Plan (2001–2010). In addition to this, MoH has also in place, a four-year National Health Workforce Strategic Plan (2014-2018).

MoH has made significant progress in expanding and upgrading regional, atoll, and island level health facilities, and in increasing the number of local and expatriate HRH as planned. However, important HRH issues persist. Since challenges associated with HRH concern a wide range of stakeholders, solving such complex issues requires a well thought out strategic plan resulting from intense policy dialogue among all related actors, following the country coordination and facilitation approach delineated by the Global Health Workforce Alliance (GHWA).

Consequently, MoH developed a structured approach to analyse the HRH situation and put together the National Health Workforce Strategic Plan 2014–2018 based on the findings of this analysis. The strategic plan is set to: a) guide MoH action in securing support for HRH development; b) provide a framework for making consistent decisions for planning HRH and their capacity-building; c) help monitor MoH action on HRH development and management; d) identify gaps in the system that needs to be addressed; and e) help estimate the costs of human resource training and deployment and assess the sustainability of the existing workforce by modelling different scenarios. In turn, the HRH strategic plan will help secure better finances from the national budget by prioritizing HRH as a critical area with documented evidence. National Health Workforce Strategic Plan 2014–2018 is also planned to be revised with the help of WHO.

MoH has developed 21 job structures with the help of local human resource (HR) consultant to create career and professional development for health professionals, currently awaiting the approval of the Civil Service Commission (CSC). In 2014 the new job and salary structures for doctors were approved and implemented, which encompassed attractive salary packages putting more focus on rural retention. It is believed that the new job structures which include salary, promotion, and career path development would encourage retention of local staff.

Moreover, new job structures come equipped with attractive salary packages for those employees that work in the outlying islands. A new job and salary structure for nurses remains at the stage of acquiring budget approval. In addition, a new recruitment policy and toolkit, promotion policy for new job structures, employee migration policy for the new job structure are also being developed with the help of the HR consultant.

From 2014 onwards 52 doctors for specialization, 139 doctors for MBBS have been sent to abroad (MoH, 2018).

Similarly, training opportunities are provided for employees enrolled in local programs, by providing them with paid or no-pay leave. In order to improve management skills of hospital managers and administrators, in-service training workshops on hospital management were conducted for 30 participants with the help of WHO.

General Challenges in the Implementation of Health SDGs in the Maldives

Although Maldives has made significant advancements in terms of health outcomes and managed to achieve all health related MDGs, there are challenges that persists. These challenges need to be duly addressed when the focus is turned towards achieving the much broader SDGs.

a) Geographical Challenges

The geography of Maldives, consisting of small islands scattered over a large area, presents significant challenges when it comes to providing health service to the entire population. The majority of island communities are small, with less than 1,000 persons in some islands. Providing basic health services, including both curative and preventive services to each and every community is a costly undertaking, resulting in higher than average spending on health by the country when compared to other nations with similar health outcomes. Being a small nation-state in terms of overall population and owing to the scattered distribution, itposes difficulties in achieving economies of scale when procuring resources for providing health service. Furthermore, the lack of a robust transportation system in place adds onto the cost of providing services.

b) Human Resources

It is the geographical features of Maldives that contributes towards the need for a higher than average requirement in terms of human resources when it comes to servicing the health sector. There are areas in the health system that remains understaffed, and compounding this issue is the fact that shortages exist when it comes to local staff with adequate and required training which results in an overreliance on expatriates to fill in the vacuum. In the peripheries, this issue is further exacerbated due to the high turnover.

As staff recruited are from diverse cultural backgrounds with varied levels of experience and exposure to the common health issues in the country, there is a need for refresher trainings. Though improvements are being made, the lack of an adequate number of training facilities to address this need, together with the unavailability of certain types of trainings itself poses challenges.

However, one of the core issues remain, whereby challenges persist when it comes to hiring and retaining local staff with adequate training. This is an area that requires further scrutiny so that solutions sought are geared towards addressing the root causes of the problems identified. One reason behind this could be the fact that there exists a lack of continued professional in-service trainings and career development opportunities.

Overdependence on expatriates to fill in the gaps also has its fair share of problems. There are difficulties in terms of attracting and retaining proficient HRH at the atoll levels which leads to high turnover and vacancy rates owing to this very issue. Budget constraints adds on, together with the fact that there are difficulties in binding staff legally to service bonds after they have been trained. Even though the training requirement is developed for the sector as a whole, MoH's abilities are tested when it comes to identifying the gaps in terms of training needs.

Furthermore, weak HRH leadership and management at all levels remains a major challenge, which needs to be addressed through proper analysis of data available, and finding ways to train, attract, and legally retain people for service in the long term.

c) Information Systems

Information systems are an important part of any health system. In Maldives there currently exists multiple, fragmented systems with varying levels of quality when it comes to data collection. Moreover, current systems are not designed to collect some of the required data that are needed to monitor some of the SDGs.

The capacity for information collection, collation, analysis and reporting also varies widely throughout the system, with an urgent need in some areas to improve and upgrade capacity. The well-developed national ICT infrastructure needs to be better utilized, and new technologies need to be integrated into the information system to gather data more easily.

d) Emerging Health Issues

Some emerging health issues such as NCDs also pose a challenge to achieving SDGs. Maldives has some of the highest risk factors for developing NCDs in the

SEAR and NCDs account for a significant proportion of the disease burden in the country. As these risk factors are lifestyle-related, and most of the risk factors are influenced by elements external to the health sector, such as urban planning, availability and affordability of healthy food and marketing etc., controlling NCDs needs multi-sectoral engagement, which includes the involvement of the private sector.

e) Demographic Factors

Increase in life expectancy correspondingly gives rise to the numbers of elderly population. This increases numbers of those suffering from chronic medical conditions which requires that the health system adapt to the changing requirements accordingly. In addition, there are large groups of adolescents and youth, who have multiple behavioural risk factors that need to be addressed, with multi-sectoral action.

f) Vulnerable Populations

In addition to the youth and elderly, there are a number of other vulnerable populations in the community whose risks, health needs, and access to preventive and curative services need to be addressed and improved. These include, but are not limited to, disabled populations, those with mental health conditions, and other at-risk groups such as drug users and the migrant population. Stigma, legal issues, and lack of services accessible and tailored towards the specific needs of the marginalized groups inhibit improvement of public health issues in these communities.

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Annexes

Annex 1: Other Health Related SDGs

Goal 2: Zero hunger

2.1 By 2030 end hunger and ensure access by all people, in particular the poor and people in vulnerable situations including infants, to safe, nutritious, and sufficient food all year round.

2.4 By 2030 ensure sustainable food production systems and implement resilient agricultural practices that increase productivity and production, that help maintain ecosystems, that strengthen capacity for adaptation to climate change, extreme weather, drought, flooding and other disasters, and that progressively improve land and soil quality.

2.5 By 2020 maintain genetic diversity of seeds, cultivated plants, farmed and domesticated animals and their related wild species, including through soundly managed and diversified seed and plant banks at national, regional and international levels, and ensure access to and fair and equitable sharing of benefits arising from the utilization of genetic resources and associated traditional knowledge as internationally agreed.

2.b. Correct and prevent trade restrictions and distortions in world agricultural markets including by the parallel elimination of all forms of agricultural export subsidies and all export measures with equivalent effect, in accordance with the mandate of the Doha Development Round.

Goal 3: Ensure healthy lives and promote well-being for all at all ages

3.d. Strengthen the capacity of all countries, particularly developing countries, for early warning, risk reduction, and management of national and global health risks.

Goal 6: Clean Water and sanitation

6.1 By 2030, achieve universal and equitable access to safe and affordable drinking water for all.

6.1.1 Proportion of population using safely managed drinking water services.

6.2 By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations.

6.2.1 Proportion of population using safely managed sanitation services, including a hand-washing facility with soap and water.

6.3.2 Proportion of bodies of water with good ambient water quality.

6.a. By 2030, expand international cooperation and capacity-building support to developing countries in water- and sanitation-related activities and programmes, including water harvesting, desalination, water efficiency, wastewater treatment, recycling and reuse technologies.

6.a.1 Amount of water- and sanitation-related official development assistance that is part of a government-coordinated spending plan.

6.bSupport and strengthen the participation of local communities in improving water and sanitation management

6.b.1 Proportion of local administrative units with established and operational policies and procedures for participation of local communities in water and sanitation management

Goal 12: Responsible consumption and production

12.4 By 2020, achieve the environmentally sound management of chemicals and all wastes throughout their life cycle, in accordance with agreed international frameworks, and significantly reduce their release to air, water and soil in order to minimize their adverse impacts on human health and the environment.

12.4.1 Number of parties to international multilateral environmental agreements on hazardous waste, and other chemicals that meet their commitments and obligations in transmitting information as required by each relevant agreement

12.4.2 Hazardous waste generated per capita and proportion of hazardous waste treated, by type of treatment

12.aSupport developing countries to strengthen their scientific and technological capacity to move towards more sustainable patterns of consumption and production

12.a.1 Amount of support to developing countries on research and development for sustainable consumption and production and environmentally sound technologies.

Annex 2: Health SDGs baseline statistics for Maldives, 2016

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verification**	**Priority ***	**Targets**			**Lead Agency for Implementation**	**Other Contributing Agencies**
							2020	**2025**	**2030**		
		2.11	Prevalence of underweight (weight-for-age) in children <5 years of age (%)	17.3 (2009)	MDHS	1		Reduce to 15% and maintain below 15%			
		2.11	Prevalence of wasting children <5 years (weight for height below-2SD)	10.6 (2009)	MDHS	1		Reduce by1/3 and Maintain			
1	Target 1.3 Implement	1.3.1	(Proxy, Proportion of the population covered by	100%(2016)	NHA, Aasandha Records, NSPA	1	Maintain at 100%	Maintain at 100%	Maintain at 100%	NSPA	Islamic Ministry, MoH, MoED,

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priorit y ***	**Targets**			**Lead Agency for**	**Other Contributi**
	nationall y appropri ate social protecti on systems and measure s for all, includin g floors, and by 2030 achieve substant ial coverag e of the poor and the		social protection floors/systems bysocial health insurance scheme).		Records						MoGF

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
	vulnerable.										
1	Target 1.a Ensure significant mobilization of resources from a variety of sources, including enhanced development	1.a.2	Proportion of total government spending on essential services (education, health and social protection) (Proxy, Proportion of total government spending on healthcare.)	9.5(2011)	MoFT (National Accounts)	1	Maintain 9 % and above	Maintain 9 % and above	Maintain 9 % and above	MOFT	Ministry of Health

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priorit y ***	**Targets**			**Lead Agency for**	**Other Contributi**
	cooperat ion, in order to provide adequat e and predicta ble means for developi ng countrie s, in particul ar least develop ed countrie s, to implem ent										

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
	programmes and policies to end poverty in all its dimensions.										
2	Target 2.1 By 2030, end hunger and ensure access by all people, in particular the	2.1.1	Prevalence of undernourishment.	MDHS	18.9 (2009)	2	Stunting: Reduce by 1/3rd and maintain Wasting: Reduce by 1/3rd and Maintain Underweight: Reduce to 15% and maintain below 15%	Stunting: Reduce by 1/3rd and maintain Wasting: Reduce by 1/3rd and Maintain Underweight: Reduce to 15% and maintain below 15%	Stunting: Reduce by 1/3rd and maintain Wasting: Reduce by 1/3rd and Maintain Underweight: Reduce to 15% and maintain below 15%	MoH	

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
	poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round.										
2	Target 2.2 By 2030,	2.2.1	Prevalence of stunting (height for age <-2 SD from the	MDHS	18.9 (2009)	2	Reduce by 1/3rd and Maintain	Reduce by 1/3rd and maintain	Reduce by 1/3rd and maintain	HPA	

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priorit y ***	**Targets**			**Lead Agency for**	**Other Contributi**
	end all forms of malnutri tion, includin g achievin g, by 2025, the internati onally agreed targets on stunting and wasting in children under 5 years of		median of the WHO Child Growth Standards) among children under five years of age.								

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
	age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons.										
2	Additional	2.2.2	Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of	MDHS	5.9 (2009)	2	Reduce by 1/3rd and maintain	Reduce by 1/3rd and Maintain	Reduce 1/3rd and maintain	MoH	MoGF/ MoE

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
			the WHO Child Growth Standards) among children under 5, disaggregated by type (wasting and overweight)								
2		2.11	Prevalence of underweight (weight-for-age) in children <5 years of age (%)	17.3 (2009)	MDHS	1		Reduce to 15% and maintain below 15%			
2		2.11	Prevalence of wasting in children <5 years (weight for height below-2SD)	10.6 (2009)	MDHS	1		Reduce by1/3 and Maintain			

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priorit y ***	**Targets**			**Lead Agency for**	**Other Contributi**
3	Target 3.1 By 2030, reduce the global materna l mortalit y ratio to less than 70 per 100,000 live births.	3.1.1	Maternal mortality ratio	VRS	41 (2014)	2	maintain below 70/100,000 live births	maintain below 60/100,000 live births	maintain below 55/100,000 live births	MoH	DNR and NCIT

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
		3.1.b	% of children aged 12 to 23 months who received all basic vaccinations (EPI vaccine coverage)	MDHS, HPA programme records	92.9(2009						
3		3.1.2	Proportion of births attended by skilled health personnel	VRS/MDHS	95.58 (2014)	2	maintain above 95%	maintain above 95%	maintain above 95%	MoH	
3	Target 3.2 By 2030, end preventable deaths	3.2.1	Under-five mortality rate	VRS	10 (2014)	1	maintain equal or less than 11	maintain equal or less than 11	maintain equal or less than 11	MoH - HPA	DNR and NCIT

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priorit y ***	**Targets**			**Lead Agency for**	**Other Contributi**
	of newbor ns and children under 5 years of age, with all countrie s aiming to reduce neonatal mortalit y to at least as low as 12 per 1,000 live births and										

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
	under-5 mortality to at least as low as 25 per 1,000 live births.										
3		3.2.2	Neonatal mortality rate	VRS	5.11 (2014)	1	maintain below 06	maintain below 06	maintain below 06	MoH (Including HFs and HPA)	DNR and NCIT
3	Target 3.3 By 2030, end the epidemics of AIDS,	3.3.1	Number of new HIV infections per 1,000 uninfected population (by age, sex, and key populations)	Disease Surveillance System – HPA	0.01 (2014)	1	maintain below 0.05	maintain below 0.05	maintain below 0.05	HPA	

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
	tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.										
3		3.3.2	TB incidence per 1,000	TB Control	41 (2015)	1	Decrease to below	Maintain below	Maintain below	TB Control	

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
			population	Program – HPA			10/100'000 population	10/100'000 population	10/100'000 population.	Program-HPA	
3		3.3.3	Malaria incidence per 1,000 population	Elimination Disease Unit-HPA	Elimination Certified in 2015	3	Maintain elimination status of Malaria (<0.01%)	Maintain elimination status of Malaria (<0.01%)	Maintain elimination status of Malaria (<0.01%)	Elimination Disease Unit-HPA	
3		3.3.4	Hepatitis B incidence per 1,000 population	Disease Surveillance System – HPA	Not Available	2	Minimize incidence	eliminate	maintain elimination	HPA	SHE, Island Health Centers, Atoll Hospitals, NSPA, Aasandha, Immigration, Labour Relations Authority
3		3.3.5	Number of people requiring	Disease Surveillance System	Not Available	3	Reduce the number of cases	Reduce the number of cases	Reduce the number of cases	HPA	MoFA, MoEE, Immigratio

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
			interventions against neglected tropical diseases	– HPA			requiring intervention for these cases	requiring intervention for these cases	requiring intervention for these cases		n, relevant CSOs
3	Target 3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through preventi	3.4.1	Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease	VRS	2.77% (2014)	1	Maintain Below 15	Maintain Below 13	Maintain Below 10	MoH (including HPA)	Relevant CSOs, Hospitals

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
	on and treatment and promote mental health and wellbeing.										
3		3.4.2	Suicide mortality rate	Police, VRS	4.32 (2015)	1	Maintain Below 4	Maintain below 4	Maintain below 4	Ministry of Gender and Family	Police, MOH, Relevant CSOs, MoIA
3	Target 3.5 Strengthen the prevention and treatme	3.5.1	Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation	National Drug Agency	0.038% (2012)	1	Increase availability of treatment interventions	Increase availability of treatment interventions	ensure availability of treatment interventions	NDA	MoH, MoH, Police, relevant courts, relevant CSOs, MoIA, HPA

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priorit y ***	**Targets**			**Lead Agency for**	**Other Contributi**
	nt of substanc e abuse, includin g narcotic drug abuse and harmful use of alcohol		and aftercare services) for substance use disorders								
3		3.5.2	Harmful use of alcohol defined according to the national context as alcohol per capita (15+ years old) consumption within a calendar year in	Police	Not Available	3	To be set once baseline available	To be set once baseline available	To be set once baseline available	Police	MoH, Police, relevant courts, relevant CSOs, MoIA,

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
			liters of pure alcohol								
3	Target 3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents	3.6.1	Death rate due to road traffic injuries			1	maintain at current levels	maintain at current levels	maintain at current levels	Police, Transport Authority	MoH (HPA)
3	Target 3.7	3.7.1	Proportion of women of	MDHS	34.7% (2009)	2				MOH(HPA)	SHE

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priorit y ***	**Targets**			**Lead Agency for**	**Other Contributi**
	By 2030, ensure universa l access to sexual and reprodu ctive health-care services, includin g for family plannin g, informat ion and educatio n, and		reproductive age (15-49 years) who have their need for family planning satisfied with modern methods.								

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
	the integration of reproductive health into national strategies and programmes.										
3		3.7.2	Adolescent birth rate (10-14; 15-19) per 1,000 women in that age group	VRS	0% (2014)	2	reduce to 10 and maintain (for 15-19 age group) maintain below 5 (for 10-14 years)	maintain at 10 or below (for 15-19 age group) maintain below 5 (for 10-14 years)	maintain at 10 or below (for 15-19 age group) maintain below 5 (for 10-14 years)	MoH (HPA)	

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
3	Target 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access	3.8.1	Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases and service capacity and access, among the	QARS Records, RAHS Records	Not Available	1	Target to be set once data is available	Target to be set once data is available	Target to be set once data is available	Aasandha/ NSPA/ MoH (including QARD and RAHS)	

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
	to safe, effective, quality and affordable essential medicines and vaccines for all		general and the most disadvantaged population)								
3		3.8.2	Lack of financial protection coverage in health	NBS, NSPA	Not Available	1	Maintain at 1000	Maintain at 1000	Maintain at 1000	NSPA/ Aasandha	
3	Target 3.9 By 2030,	3.9.1	Mortality rate attributed to household and ambient air	VRS	0	3	Maintain below 1	Maintain below 1	Maintain below 1	Ministry of Environment and Energy (EPA)	Ministry of Health (Including HPA)

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priorit y ***	**Targets**			**Lead Agency for**	**Other Contributi**
	substant ially reduce the number of deaths and illnesses from hazardo us chemica ls and air, water and soil pollutio n and contami nation		pollution								

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
3		3.9.2	Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe WASH services)	VRS	0	1	Maintain at same level	Maintain at same level	Maintain at same level	Ministry of Environment and Energy	Ministry of Health/ Ministry of Education, local councils
3	Target 3.9 By 2030, substantially reduce the number of deaths and illnesses	3.9.3	Mortality rate attributed to unintentional poisoning	Police, VRS	0	3	Maintain at same level	Maintain at same level	Maintain at same level	Ministry of Health	MoFA, MEE (EPA,), Housing, MED, POLICE

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
	from hazardous chemicals and air, water and soil pollution and contamination										
3	Target 3.a Strengthen the implementation of the World Health Organis	3.a.1	Age-standardized prevalence of current tobacco use among persons aged 15 years and older			1	Reduce by 30% and maintain	Reduce by 40% and maintain	Reduce by 50% and maintain	Ministry of Health (HPA)	MED, Customs, Finance, Parliament, Police, Agriculture,

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
	ation Framework Convention on Tobacco Control in all countries, as appropriate.										
3	Target 3.b Support the research and development of vaccines and	3.b.1	Proportion of the population with access to affordable medicines and vaccines on a sustainable basis	MFDA Records	Not Available	1	99% coverage and maintain	99% coverage and maintain	99% coverage and maintain	MoH (MFDA, HPA)	Min of Education, Island Councils (local governments), Ministry of Health (HPA, PIH

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priorit y ***	**Targets**			**Lead Agency for**	**Other Contributi**
	medicin es for the commu nicable and non- commu nicable diseases that primaril y affect developi ng countrie s, provide access to affordab le										and RAS)

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priorit y ***	**Targets**			**Lead Agency for**	**Other Contributi**
	essential medicin es and vaccines , in accorda nce with the Doha Declarat ion on the TRIPS Agreem ent and Public Health, which affirms the right of developi										

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
	ng countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect										

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priorit y ***	**Targets**			**Lead Agency for**	**Other Contributi**
	public health, and, in particul ar, provide access to medicin es for all.										
3		3.b.2	Total net official development assistance to medical research and basic health sectors	NHA	3.3 (2011)	1	Increase to 5% and maintain above 5%	Increase to 5% and maintain above 5%	Increase to 5% and maintain above 5%	Ministry of Health	MNU
3	Target 3.c	3.c.1	Health worker density and	HI Records	126 (Estimated	1	Increase by 25% and	Increase by 35% and	Increase by 50% and	Ministry of Health	MOE,

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priorit y ***	**Targets**			**Lead Agency for**	**Other Contributi**
	Substant ially increase health financin g and the recruitm ent, develop ment, training and retentio n of the health workfor ce in developi ng countrie s,		distribution		Figure)		maintain.	maintain.	maintain.		DHE, MED, CSC, MNU, Labour relations Authority, PO, Pay Commissio n, MOFT

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
	especially in least developed countries and small island developing States.										
3	Target 3.d Strengthen the capacity of all countries, in particular	3.d.1	International Health Regulations (IHR) capacity and health emergency preparedness	IHR-HPA	Annually Reported	1	Can be determined only after establishing a base line	Can be determined only after establishing a base line	Can be determined only after establishing a base line	HPA/MOH	

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
	developing countries, for early warning, risk reduction and management of national and global health risks.										
4	Target 4.2 By 2030, ensure that all	4.2.1	Per centage of children under 5 years of age who are developmentally on track in	Ministry of Education, HPA	Not Available	1	Can be determined only after establishing a base	Can be determined only after establishing a base	Can be determined only after establishing a base	MOE	MoH, LGA

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
	girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education.		health, learning and psychosocial well-being				line	line	line		

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
5	Target 5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of	5.6.1	Proportion of women (aged 15-49) who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care	MDHS	35 (2009)	1	Can be determined only after establishing a base line	Can be determined only after establishing a base line	Can be determined only after establishing a base line	HPA (MOH)	Hospitals (pvt and public), HFs

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
	Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review confere										

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
	nces.										
5		5.6.2	Number of countries with laws and regulations that guarantee women aged 15-49 years access to sexual and reproductive health care, information and education	Legal Records	0 (2017)	1				HPA	MoGF, FPA, AG
6	Target 6.1 By 2030, achieve universal and	6.1.1	Proportion of population using safely managed drinking water services	MDHS, Census	97.7 (2009)	1			100%	MEE	MoH, Local Councils, HPA

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
	equitable access to safe and affordable drinking water for all.										
16	Proportion of children under 5 years of age whose births have been registered with a civil	16.9.1		MDHS, VRS	92.5% (2011)						

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
	authority, by age (% of births registered – Proxy Indicator))										
5	Proportion of time spent on unpaid domestic and care work, by sex, age and location	5.4.1		HIES 2015/2016	Not Available						

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
6	Proportion of wastewater safely treated	6.3.1		Ministry of Environment and Energy	Not Available						
6	Proportion of bodies of water with good ambient water quality	6.3.2		Ministry of Environment and Energy	Not Available						
6	Target 6.2 By 2030, achieve access	6.2.1	Proportion of population using safely managed sanitation services,	MDHS, Census	94.5 (2009)	1			100%	MHI	MEE, HPA, MoH, Local Councils

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
	to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in		including a hand- washing facility with soap and water								

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
	vulnerable situations.										
6	Target 6.3 By 2030, improve water quality by reducing pollution, eliminating dumping and minimizing	6.3.2	Proportion of bodies of water with good ambient water quality	Ministry of Environment & Energy	Not Available	2	50%	80%	100%	MEE / MFDA/ HPA	Local Councils, HPA

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priorit y ***	**Targets**			**Lead Agency for**	**Other Contributi**
	release of hazardo us chemica ls and material s, halving the proporti on of untreate d wastewa ter and substant ially increasi ng recyclin g and										

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
	safe reuse globally.										
8	Target 8.8 Protect labor rights and promote safe and secure working environments for all workers, including migrant workers,	8.8.1	Frequency rates of fatal and non-fatal occupational injuries, by sex and migrant status	VRS, Injury Surveillance Reports	Not Available	2			Reduce 50% of fatal occupational injuries by 2030	MED	Immigration, LRA

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
	in particular women migrants, and those in precarious employment										
8	Target 8.b By 2020, develop and operationalize a global strategy for	8.b.1	Total government spending in social protection and employment programmes as per centage of the national budgets and	Ministry of Finance and Treasury, NHA	Not Available	1				MoYS/ NSPA/ Economic Development	LRA

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
	youth employment and implement the Global Jobs Pact of the International Labour Organisation		GDP								
16	Target 16.1 Significantly reduce all forms of	16.1.1	Number of victims of intentional homicide per 100,000 population, by			2				Police	MoH

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
	violence and related death rates everywhere		sex and age								
16	Target 16.1 Significantly reduce all forms of violence and related death rates everywhere	16.1.2	Conflict-related deaths per 100,000 population, by sex, age and cause			2				Police	

SDG INDICATORS AND TARGETS RELATED TO HEALTH											
Goal No.	**Target**		**Indicator**	**Baseline**	**Means of Verificati**	**Priority ***	**Targets**			**Lead Agency for**	**Other Contributi**
16	Target 16.9 By 2030, provide legal identity for all, including birth registration	16.9.1	Proportion of children under 5 years of age whose births have been registered with a civil authority, by age			1			It's a basic right so to discuss with DNR and target to reach 100% coverage as soon as possible	DNR	MoH, Hospitals

Annex 3: SDGs in Dhivehi

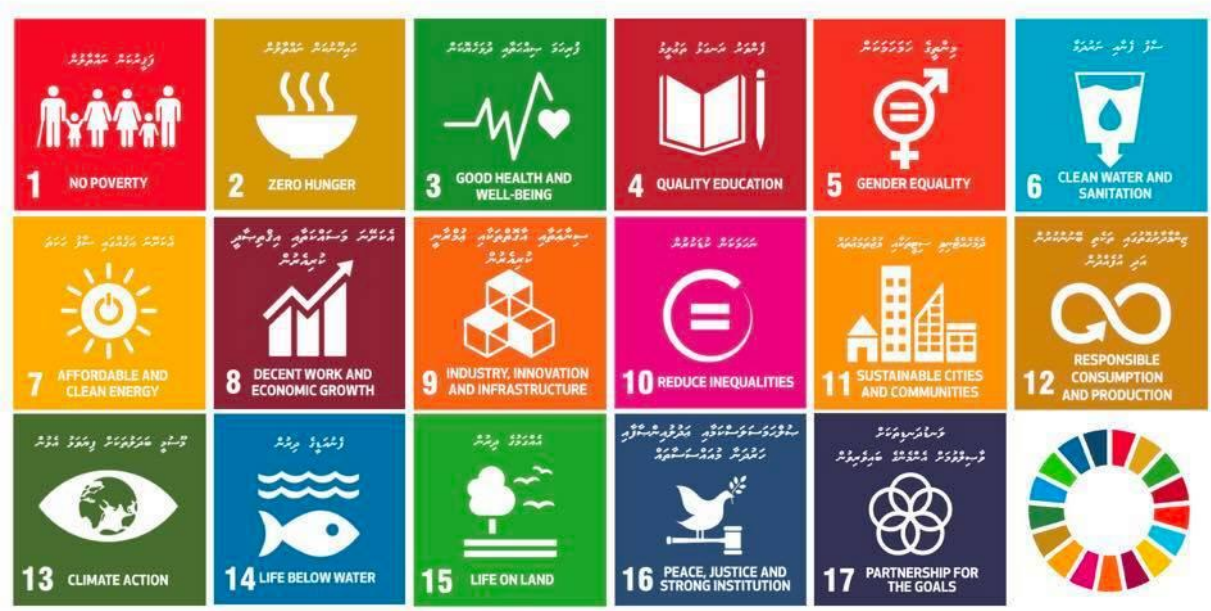

Figure 2: Sustainable Development Goals in Dhivehi

ދުނިޔޭގެ ތަރައްޤީގެ ގޯލްތައް

1. ފަޤީރުކަން ނެތްކުރުން
2. ހާރުކަން ނެތްކުރުން
3. ފުދުގަދަ ژިވުމާއި ހެޔޮކަން
4. ފުންމަތި ތަޢުލީމު ލިބުން
5. ޖިންސީ ހަގަނޑުބާވުން
6. ސާފު ފޮނި ފެނާއި ސެނިޓޭޝަން
7. ކަށަވަރު ތަކެއްގައި ސާފު ކަންކަން
8. ކަށަވަރު ދަށްނަގާ ތަރައްޤީ ހިންގުން
9. ތަރައްޤީ ވާންދެން ގާތްގަނޑަށް ބަދަލުތައް ގެނައުން
10. ތަފާތުކަން ދުރުކުރުން
11. ދަށްނުވާ ތަންތަނާއި ދަށ ދަށ ދިރިއުޅުން
12. ދެމިހުރެ ދަށ ދަށ ބޭނުންކުރުން ތަނަށް ވާނެ ގޮތް ހަދައިގަތުން
13. ދުނިޔެ ހަގަނޑުބާވުން ހުއްޓާލުން
14. ފުންމަތީ ދިރުން
15. ބިންމަތީ ދިރުން
16. ހޯދުގެ ދަށުން ތަރައްޤީ ހަގަނޑުހަމަ ކުރުން
17. ދަށ ދަށ ތަރައްޤީ ވާންދެން ގާތްގަނޑަށް ތަރައްޤީ ހިންގުން

Annex 4: Technical Coordinating Committee for Health SDGs

a) Objective of the Committee:

The objective of Technical Coordinating **Committee for Health SDG** is to coordinate the implementation, monitoring and reporting work of health related SDG goals and indicators at a national level.

b) Representations of the Committee

Technical Coordinating Committee for Health SDG	
Name	**Organization**
Khadeeja Abdul Samad Abdulla	Ministry of Health
Fathmath Limya	Quality Assurance & Regulations Division
Shareefa Adam Manik	Maldives Food & Drug Authority
Dr.Mariyam Jenyfa	Health Protection Agency
Ahmed Shakir	Regional and Atoll Health Services
Nayaz Ahmed	Maldivian Blood Services
Aishath Samiya	Policy Planning & International Health Division
Dr. Aminath Huda	National Social Protection Agency
Aishath Saadh	Ministry of Environment and Energy
Samaha Ali Mohamed	Ministry of Environment and Energy
Hassan Azhar	Ministry of Environment and Energy
Ilham Atho Mohamed	Ministry of Environment and Energy
Ahmed Mujuthaba	Ministry of Finance and Treasury
Fathimath Azza	Ministry of Education
Mariyam Sidhmeen	Ministry of Gender and Family
Ahmed Migdhah	Ministry of Economic Development
Shamhooza Ahmed	Ministry of Housing and Infrastructure
Khadheeja Moosa	Maldives Customs Service
Ikrisha Abdul Wahid	National Bureau of Statistics
Mohamed Shujau	Maldives Police Service
Ibrahim Sahugee	Department of National Registration
Dr.AbdulMalik	Indira Gandhi Memorial Hospital
Fathimath Hudha	WHO
Aishath Shahula Ahmed	UNICEF
Shadhiya Ibrahim	UNFPA