Maldives
COVID-19 RESPONSE
A SUMMARY

Health Protection Agency

Ministry of Health
Republic of Maldives

1 . Preparedness and Response Coordination

Health Protection Agency and Ministry of Health's emergency response mechanism was activated when WHO informed through IHR mechanism about cases of pneumonia of unknown cause. The response was guided by the Health Emergency Operations Plan and informed by updates from WHO as well as from the experience of other countries. Covid-19 Pandemic presented a unique challenge for response, as its effects were felt beyond the health sector and almost brought society to a halt, requiring input of multiple stakeholders across government and society.

The Health Emergency Coordination Committee was activated in the beginning of the response. As the threat level evolved, the coordination of response was shifted from Ministry of Health to the National Emergency Operations Centre in Dharubaaruge, led by the National Disaster Management Authority and Health Protection Agency.

In the Atolls and inhabited islands, local level Covid-19 Taskforces were formed, led jointly by the atoll/island council president and the head of the health facility. Other members of the Taskforce included representatives from relevant agencies in the island as well as any community-based organisations.

Once the first wave of Covid ended and response mechanisms were in place, the response was led by the Health Emergency Operations Centre, which expanded or downgraded over the course of the pandemic according to need.

A Technical Advisory Group (TAG) was formed at the outset, to provide technical guidance to the Covid-19 National Taskforce. Decisions on the control measures were taken by this Taskforce which was chaired by HE President and constituted of Cabinet Ministers and leaders of relevant national agencies.

The measures taken to address Covid-19 were pursuant to the Public Health Act 7/2012. A Public Health Emergency was declared on 12th March 2020 and remained in force until it was revoked on 13th March 2022.

The initial strategy was to prevent importation of the virus to the country and to contain any clusters. However, as imported cases were found and then community transmission established in Greater Male' Area, the strategy evolved to preventing transmission to islands. The measures

taken to control Covid-19 were some of the most socially restrictive measures seen in our lifetime. This was necessary as little was known about the virus and its long-term effects and only non-pharmaceutical interventions were the tools available at the outset. Health system capacity was also limited to attend to a rise in cases while maintaining essential health services. As vaccination coverage increased, the restrictive measures in place were loosened.

2 . Health system capacity development

With Covid-19 transmission, it was essential to have health facilities for treatment of Covid-19 patients in isolation, and quarantine facilities for contacts and those who arrived from abroad. Over the course of the pandemic, criteria for isolation at a facility changed from isolating all positives at facilities to only high-risk people and then only those who require hospital admission.

In March 2020, with the borders closed and tourism shut down, resorts and guest houses were used as quarantine facilities, until home quarantine was introduced. One resort was continued as a quarantine and isolation facility for tourists who needed a place for quarantine or community isolation.

Designated inpatient Isolation facilities were developed in Greater Male' area as well as Atolls as temporary arrangements to cater to the caseload. A more permanent facility, the Infectious Disease Management Centre (IDMC) was developed in Hulhumale.

Region	Facility	Capacity (Beds)
Region-1	Ha. Ihavandhoo COVID-19 Facility	3
	Sh. Funadhoo COVID-19 Facility	4
Region-2	B. Eydhafushi COVID-19 Facility	45
Region-3	L. Gan COVID-19 Facility	17
Region-4	Ga. Villigilli COVID-19 Facility	3
	GDh. Thinadhoo COVID-19 Facility	7
Region-5	Gn.Fuvahmulah COVID-19 Facility	3
	S. Hithadhoo COVID-19 Facility	30
GMR	Dharumavantha Hospital (DH11)	9
	Dharumavantha Hospital (DH16)	14
	Hulhumale Medical Facility	240
	Farukolhufuhsi COVID Facility	120

Table 1. COVID-19 management facilities established in Maldives

Construction and renovation work of these facilities were undertaken by the Ministry of Planning, Housing and Infrastructure, the Housing Development Corporation (HDC) along with other government SOEs and utility companies facilitating operational readiness of the facilities.

Covid-19 response was resource intensive in terms of medical equipment and consumables. Based on projected scenarios of transmission, forecasts for medical equipment and consumables needed were produced regularly. Technical guidance was provided on the specifications for the equipment and other medical supplies based on global standards. At the outset of the pandemic, global supply shortages and travel shutdowns impacted the supply of critical equipment and consumables. Supply was replenished by purchase from the government as well as by donations from friendly governments and private parties.

Logistic requirements, such as for patient and sample transport, delivery of medicines and consumables and for other operational purposes was also a challenge. Government agencies, state-owned enterprises and private companies assisted the National Emergency Operation Centre and the Health Emergency Operation Centre by lending their vehicles and staff for these operations.

Management of data was another important component of the response. Initially, the WHO Go Data system was used for epidemiological purposes. However, as the response operation expanded, a more task-oriented system was needed. A system called ‘Outbreak’ was developed, with a connected portal for labs and RRT teams to enter data of samples collected and tested. The development of this system enabled HEOC to manage data of cases, contacts and their legal notices. A portal for this system called ‘Haalubelun’ was introduced which the public could use to view their own test results and access quarantine/isolation notices. When vaccination was introduced, a Covid-19 vaccine database ‘Dhifaau’ was developed and later linked to ‘Outbreak’. Vaccination centres used the system to register vaccinees and enter their vaccine information, and public could use the linked ‘Covid-safe’ portal to view their vaccine data and generate electronic vaccine certificates.

3 . Testing and Surveillance

Expansive testing, isolation of cases and stringent contact tracing with quarantine of contacts were the cornerstones of Maldives’ Covid-19 response.

Adequate testing capacity with quick turn-around times was a pre-requisite to effective control of the epidemic. PCR testing for COVID-19 was established in February 2020 at IGMH, with the capacity to test only a few samples initially. Over the pandemic, testing capacity was expanded in the government sector and private sector, with investment from government as well as private companies and donors. By January 2022 when the Omicron wave began, the country had capacity to perform more than 9000 PCR tests per day.

Period	Testing capacity
Wave 1	200 – 300 tests
Wave 2	3000 tests
Wave 3 & 4	+9000 test

Table 2. Daily national PCR testing capacity

In addition to the time and resource intensive RT-PCR testing, GeneXpert (Point of care testing) and rapid antigen testing became a part of the case identification and confirmation tests. This further strengthened surveillance.

The Private Sector, including the tourism industry partners contributed to improving lab capacity, especially facilitating testing for traveler needs.

When genetic sequencing was recommended for countries to monitor the evolution of the outbreak, supported by WHO, Maldives sent batches of samples abroad for sequencing based on a contextualized sampling strategy. Data from sequencing is used to monitor the prevalent variants and subvariants and inform response.

In December 2022, in a collaboration with Institute of Genomics and Integrative Biology (IGIB), India, genetic sequencing capacity for Covid-19 was established at the National Health Laboratory of Maldives Food and Drug Authority.

Flu clinics were established in all inhabited islands and in the Greater Male' Region to cater to symptomatic persons. During the height of the pandemic, temporary sampling centers were set up in Greater Male' Region for those who require testing for release from quarantine or for travel purposes. In addition, mobile Rapid Response Teams were activated to take samples at homes or at active surveillance locations.

Maldives employed a broad sampling strategy during the pandemic. In addition to testing symptomatic cases fitting the case definition, active surveillance was conducted. Positivity among symptomatic cases, active surveillance positivity and overall sample positivity formed an important part of response monitoring. Epidemiological investigation of clusters was conducted to find the source of the outbreak, especially when cases were introduced into islands and tourist resorts.

Timely and comprehensive contact tracing was key to breaking the chain of transmission. The target was to complete contact tracing of 80% of cases within 24 hours of a positive result.

When a positive case was entered into the system, contact tracing cluster initiated the first call to the patient, where they are informed of the result, collected information on symptoms and comorbidities and obtained detailed information of contacts. Isolation notices for the case and quarantine notices for contacts were generated. During the initial waves, information of contacts who were high risk for Covid-19 disease was routed to the RRT cluster to prioritize sampling.

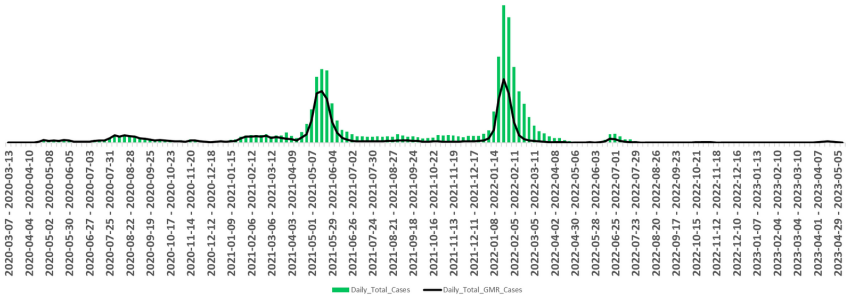

Figure 1. Weekly COVID-19 positive numbers

Until a majority of the eligible population was vaccinated, quarantine duration for contacts remained 14 days, with a test done at the end of quarantine. Given the reduced severity of the circulating variant and high population vaccine coverage, contact quarantine guidelines were revised for those who were vaccinated during the Omicron wave.

Due to the high load of cases, active contact tracing was temporarily discontinued during the height of the Delta and Omicron wave. However, a mechanism for self-declaration and reporting to HEOC was established.

The contact tracing team at HEOC also did epidemiological investigations of clusters, sometimes visiting inhabited/industrial islands and tourist establishments for this purpose.

4 . Clinical Management

A key challenge faced during the preparedness to respond to COVID-19 was the limited capacity of the health system to isolate and provide adequate care for the sick and vulnerable people during a surge in cases. Several measures were taken to implement early case detection and establish appropriate care pathways to manage all types of cases, including those with mild, moderate, severe and critical COVID-19 cases.

SOPs and clinical management guidelines were developed, and the workforce trained for the clinical management of cases. The Clinical Management Team (CMAT) based at IGMH advised clinicians in island health facilities for management of cases and guided in the referral of patients for further treatment and care.

Initially, all cases were isolated at facilities. Over time, facility-based isolation criteria were revised to reflect the capacity to triage and manage mild cases at home, and vaccination coverage. The isolation period changed from 14 days (for mild cases) to 7 days amidst Omicron wave case height, based on the reduced severity observed, high number of cases and evolving evidence about the disease.

The Mobile Medical Response Team (MMRT) based at NEOC facilitated the provision of community medical care for the Greater Male' Area during the lockdown. This cluster was comprised of volunteer health professionals and included medical students who came back temporarily during Covid-19. The MMRT also established a medical clinic in Thilafushi and conducted medical camps in Greater Male' Area for migrants. MMRT functions at HEOC were handed over to Dhamanaveshi (DMMRT) in July 2020. This team provided medical assistance to those in quarantine or isolation at home, providing guidance over the phone as well as by mobile teams.

During the Delta and Omicron waves, when the number of cases were rising rapidly in the Greater Male' Area, outpatient clinics were established. At these clinics, Covid-19 patients were triaged and were able to consult doctors and investigations were done. Those who required admission were referred to Covid-19 facilities.

5 . Human Resources

Manpower for the response was scaled up and down depending on the evolving situation of COVID-19 pandemic and was based on projections for HR requirement. The HR cluster was responsible for monitoring staff and volunteers involved in the response as well as ensuring mandatory training was conducted for new volunteers.

As part of the preparedness and response to the pandemic, priority was given to upscale the human resources, both for the response operations as well as for clinical management. In the initial response phase from January-February 2020, staff from HPA and MOH supported the Emergency Operations Centre. When NEOC was operationalized in March 2020, staff from NDMA, MNDF, Police, Local Government Authority and other relevant agencies and some volunteer-based organisations worked in the central response centre. As the operation expanded, HR requirement increased, and volunteer mobilization played a significant role in the response operations. In addition, staff from the government and private sector were mobilized to boost the HR capacity of operations, both at national and atolls/island levels.

For the medical response, students studying in Male' and repatriated from other countries were mobilized. Retired healthcare workers and those who worked in the private sector also assisted.

Trainings were conducted on IPC, clinical management and epidemiology, sampling and testing for healthcare workers across the country. Staff from Maldives National University and the main tertiary hospitals conducted the trainings which included some hands-on components. Trainings on contact tracing, isolation and other epidemiological aspects was covered by HPA.

Volunteers who worked in different clusters were trained on the functions of the specific cluster.

During the early phase of the response, under close bilateral relations, a team of health professionals from Bangladesh, which included doctors, paramedics and nurses served in the response operation. The HR gained from this arrangement was utilized in the RRTs, EMS and facility management.

On 7 May 2020, the government announced the decision to grant an allowance for the volunteers as an incentive for their contribution towards the response operations. The allowance set by the government was classified into three categories based on the level of risk and the operation functions performed.

6 . Legal Aspects

All control measures taken during Covid-19 response were pursuant to Public Health Act (7/2012). The provisions in the Act enabled the declaration of a Public Health Emergency for the first time and authorized the Director General of Public Health to implement measures such as quarantine, isolation, movement and travel restrictions. Legal notices were issued under this provision to quarantine, isolate or to put buildings and islands under monitoring. Society-wide measures such as movement and travel restrictions were also implemented under these provisions. In September 2020, the government enacted the sunset law 'Public Health Emergency Act 20/2020', with provisions addressing areas affected by Covid-19 including employment, housing, social welfare, tax payments, courts and tribunals and other matters such as electronic documents and financial statements and annual reports.

7 . Implementing Control Measures

A Covid-19 outbreak monitoring system was developed and modified over the course of the pandemic. This constituted indicators and thresholds for action for each indicator. They were developed based on WHO guidance for implementing public health and social measures and the country context. Surveillance indicators (such as sample positivity rates), disease severity indicators (hospitalization rate) and operational indicators (occupied isolation facility beds) were monitored at national level, for Greater Male' Area and Atolls separately and for tourist establishments. Projections were also made for the different waves using mathematical modelling.

	Indicator Type	Indicator	Description	Location	26 May - 1 Jun	2 - 8 Jun	9 - 15 Jun	16 - 22 Jun	23 - 29 Jun	30 June - 6 July	7-13 July	Threshold 1	Threshold 2	Threshold 3	Threshold 3	Baseline
1_NAT	EPIDEMIOLOGICAL INDICATOR	Sample Positive Rate (PCR Positive)	Number of new positives for the given week (a)	National	6819	3708	2025	1397	1366	925	747	<3%	3-4%	5-10%	>10%	
			Total Number of samples tested (excluding repeat sample of positive person) for the given week (b)		35343	33585	32174	31057	35852	33519	42454					
			(a/b)*100		19%	11%	6%	4%	4%	3%	2%					1%

Table 3. Monitoring of weekly indicators

The technical group (TAG and MoH technical team) met weekly (or more frequently according to the situation) to assess the situation, as shown by indicators and projections, and to recommend implementing additional control measures or easing of measures. When making recommendations, the group also looked at the experience of other countries, emerging evidence on virus characteristics, recommendations of WHO and the country context and operational capacity.

The recommendations from the technical team were presented to the National Covid-19 Taskforce. Factors such as economic and social impacts were taken into consideration when finalizing measures to implement.

The decisions were operationalized under the Public Health Act 7/2012 by signed orders from the Director General of Public Health.

Police, local councils and other relevant sectors were legally mandated to enforce the measures in place.

A range of control measures were applied depending on the level of the outbreak, including:

- Closure of borders
- Movement restrictions at certain times of the day
- Restriction on vehicles at certain times
- Full lockdown
- Closure of schools
- Closure of all workplaces that were non-essential
- Closure of restaurants
- Closure of gyms, cinemas
- Stopping congregational prayers
- Schools and workplaces opened with physical distancing and other measures
- Mosques reopened with physical distancing
- Reopening of international border with requirements for PCR testing prior to travel and later vaccination
- Restriction of travel from Greater Male' Area to islands (travel allowed only with a negative PCR and post-travel 'furabandhu' quarantine)

- Closure of all tourist establishments
- Restrictions on travel from resorts to inhabited islands
- Restriction on travel from islands where outbreaks occurred

Given the high vaccination coverage of the population and the reduced disease severity observed, the Public Health Emergency in place was revoked in March 2022. However, the Covid-19 response continues under a scaled-down Health Emergency Operations Centre.

8 . Risk communication and Community Engagement (RCCE)

The government's approach to curbing the spread of Covid-19 involved maintaining public trust through sharing timely information about the disease and its spread, communicating clearly about required behaviors for controlling the epidemic, rationale for policy decisions, and making timely calls for action. In March 2020, the Risk Communication and Community Engagement (RCCE) Plan was developed identifying key messages for different target audiences. To increase inclusivity, multi-lingual messaging for migrant workers were disseminated, sign language interpreters were engaged, and closed captioning on video communication materials was used. A specific branding used for Covid-19 response and vaccination (Dhifaau) helped to create a campaign identity that the public can easily recognize and relate to as the response effort for Covid-19. This helps provide a pathway for accurate information from the correct sources.

An official website for COVID-19 (www.COVID-19.health.gov.mv) was launched in early March 2020 to provide case updates, guidelines, SOPs, and public announcements.

Social media monitoring was extensively carried out for the first time in the country to gauge public needs, concerns, attitudes, and perceptions and to generate evidence-based, targeted messages to be utilized in all communication channels. These included press conferences, messaging on social media, TV and radio programs, and interviews. 255 press conferences were held throughout the public health emergency to keep the public informed about the latest case updates, government preparedness, and call for preventive action. A key feature of the press conferences was that all agencies involved in the response participated in

these according to need. Social Media channels used include Twitter, Facebook and- later on in the response- TikTok was used to reach certain audiences. Given that a large proportion of the population used Viber, an official "HPA - COVID-19 Updates" community Viber group was established and quickly became a trusted source of information for people living in the Maldives and beyond, with over 90,000 members by May 2020. Messages featuring graphics, animations, videos of healthcare workers, trusted community members and testimonials from public were used. To increase visibility and reach, public service announcements, dramas, TV and radio programs featuring HEOC cluster representatives and stakeholders were also used. Innovative methods such as including preventive messaging in Dhivehi and Bengali before every call for prayer were used. Leaflets, posters, and banners in multiple languages were developed and distributed to all inhabited islands in the country. Video spots were also broadcast on large displays in health facilities and other public areas.

The toll-free 1676 COVID-19 Hotline was established for the public to get into contact with queries related to COVID-19 during the pandemic. The call centre load and type of queries were monitored daily to ensure good response and identify areas where public was facing difficulties. Whenever changes were brought to public-related guidelines, call centre staff were informed before announcement of changes.

From the time cases were detected in Maldives, daily case data updates were made public at 10pm every night, until the end of the Public Health Emergency in March 2022. Since then, case updates were made public weekly.

In preparation for Covid-19 vaccination, the communications cluster worked with UNICEF and WHO to develop a vaccine communications strategy. A comprehensive vaccine communication campaign was conducted, which employed all the channels that were being used for Covid-19 communications. A branding similar to the Covid-19 branding was used. The effectiveness of the campaign was a crucial factor in the success of the vaccination drive.

Risk communication and reach out of public messages were meticulously supported by the communications officials at the President's Office.

9 . COVID19 Vaccination

Covid-19 vaccination was one of the most challenging vaccination campaigns to plan and execute in recent history. In 2020, it was unclear when the country would be able to access vaccines, in what quantity and which vaccines would be available. However, planning for vaccination started in October-November 2020 under guidance from WHO.

A National Covid-19 Vaccination Steering Committee was formed in November 2020 to coordinate planning and implementation of Covid-19 vaccination. Sub-groups were formed to oversee logistics, data management and communications. Maldives Technical Advisory Group on Immunization provided technical guidance to the National Immunization Program and the National Covid-19 Vaccination Steering Committee throughout.

Covid-19 vaccination campaign was implemented according to the National Vaccine Deployment Plan (NVDP), which was first developed in late 2020. Anticipating constrained global supply of vaccines when they first become available, an allocation framework was developed by the Maldives Technical Group on Immunization, to determine groups that would be prioritized for vaccination.

Cold-chain capacity was strengthened across the country in preparation for Covid-19 vaccination, with assistance from donor agencies and donor countries. This included establishing ultra-cold chain capacity at central level and at regional centres. Vaccine logistics was very complex as multiple vaccines were used and required storage at different temperatures; for some vaccines, the storage temperature at different levels was different. Vaccine transport while ensuring cold chain was managed with assistance from STO, MNDF and domestic airlines.

By December 2020, vaccine doses were not yet secured. Therefore, the government negotiated a purchase agreement with AstraZeneca to purchase 700,000 doses of vaccines. In addition, vaccines were received from the Covax Facility and as donations from friendly governments. Some of the donations were made through the Covax Facility.

Extensive trainings were held for healthcare workers in preparation for vaccination and continued throughout the campaign including introduction to Covid-19 vaccines, vaccine handling and cold-chain management, AEFI management and reporting and vaccine data management.

Vaccination began on 1st February 2021 for healthcare workers and elderly high-risk groups as per the Allocation Framework. The campaign was launched with vaccination of a frontline healthcare worker who worked in the main Covid-19 facility and HE President Ibrahim Mohamed Solih and other senior members of the government who fulfilled the criteria for the first priority group. When the first priority groups were vaccinated and vaccine supply improved, vaccination extended to those working in essential sectors and then to entire population above 18 years. By end of August 2021, 2nd dose coverage for above 18-years population was 85%. On 15th August 2021, vaccination was started for children aged 12-17 years. This was extended to 5–11-year age group on 15th February 2022.

Vaccination began in temporary mass vaccination centres in major population hubs such as Greater Male' Region. In smaller islands, vaccination was conducted within health facility premises. In resorts, vaccination teams from nearby health facilities conducted vaccination camps. By July 2021, vaccination for adults was transferred to routine vaccination centres. However, for vaccination of 12–17-year age group, mass vaccination centres were set up again temporarily. Vaccination for this age group was coordinated through Ministry of Education. Mobile vaccination teams were deployed to vaccinate bed-bound people and those with reduced mobility.

		1st Dose	2nd Dose	3rd Dose (Booster)
MALDIVES	Total population	73.16%	70.56%	30.73%
	Eligible Population (12+)	88.18%	85.06%	37.04%
	5-11 Year Population	0.13%		

Table 4. COVID 19 Vaccination update

AEFI management was a key component of the vaccine response. Guided by the National AEFI committee, AEFI guideline was produced for Covid-19 vaccination and healthcare workers were trained to manage AEFIs. Data for AEFIs was reported to the National Immunization Program. At vaccination centres, AEFI kits or emergency carts were in place as well as flow-charts to manage anaphylaxis. Dedicated healthcare workers were placed in all vaccination centres to manage AEFIs. AEFI data were analysed and causality assessments were done for severe AEFIs.

Individual counselling was arranged for those who were hesitant to get vaccinated due to pre-existing conditions such as allergies or as they were on medication. This helped to increase vaccine coverage in potentially high-risk populations.

A comprehensive vaccine communication campaign was conducted just before vaccine introduction and continued during vaccination campaigns. This is one of the key reasons for the high vaccination coverage.

10 . Structure of Emergency Operations

The operational functions of the NEOC/HEOC were categorized into several clusters to ensure the efficient implementation of the decisions taken by the HECC.

The Planning and Coordination Cluster was responsible for operational and contingency planning, information management, donor coordination and facilitation of coordination between stakeholders.

Administration, Budget and Procurement Cluster was mainly responsible to facilitate administrational arrangements of the operations Centre and ensure the continuous supply of required medical and other supplies are procured in line with the budgetary regulations.

Human Resource Planning and Coordination Cluster ensured the human resource requirements and capacities of the operations are met throughout based on the projections and planning.

Legal Cluster The Legal Cluster ensured implementation and compliance with legal requirements, generating legal notices and provided guidance and authorizations to public and health facilities regarding exemptions from guidelines in place for emergencies.

Facility Management Cluster oversaw the development and use of isolation and quarantine facilities, including their staffing and other resources. Maintaining patient and case flow records and coordinating movement to, from and between the isolation and quarantine facilities were efficiently managed by the cluster in close coordination with the medical team, RRT and EMS.

Rapid Response Team (RRT) Cluster was equipped and trained with the capacity to rapidly deploy to perform field response operations efficiently and effectively, including sample collection, disinfection, patient transfer and conducting field investigations jointly with contact tracing team.

Atoll Preparedness and Coordination Cluster facilitated and coordinated all operational tasks to island/atoll level, empowering the island/atoll task forces to implement the response operations efficiently and timely. They also provided guidance to atoll/island staff working on the response.

Mental Health and Psychological Support Cluster (MHPSS) focused on aligning MHPSS component into all stages of response operations to minimize distress resulting from the COVID-19 pandemic, promote mental health and wellbeing and support recovery and resilience.

Mobile Medical Response Team (MMRT) Cluster was the community based medical support function for the provision of medical support and other healthcare services for those under home quarantine or isolation, online medical support to quarantine facilities, medical assistance to resorts under travel restrictions, and deliver accurate medical information to queries.

Laboratory Coordination Cluster coordinated with laboratories and health facilities conducting Covid-19 tests and provided guidance.

Monitoring Cluster oversaw the health of isolated or quarantined individuals, with a focus on high-risk and vulnerable individuals. The cluster also provided guidance and assistance to international arrivals to be in compliance with guidelines in effect.

Emergency Medical Services (EMS) cluster facilitated transfer of medical emergency cases (positive cases and quarantined contacts) to medical facilities.

Contact Tracing Cluster was mainly responsible for identifying, assessing, and managing contacts who have been exposed to a positive case. This cluster was also responsible for informing positive cases of their results and referring high-risk cases and contacts for monitoring, testing or clinical management as required.

Risk Communication and Community Engagement Cluster was engaged in providing timely and accurate information regarding the disease and the updates of the response operation to the community using all kinds of media.

Medical Supply Cluster is responsible for the timely procurement and provision of medical supplies for the entire response, including isolation facilities and other health facilities.

Information Technology Cluster facilitated development of ICT tools such as software and applications to assist the smooth functioning of the response.

Mass Inspection Cluster conducted inspections of all public service providers and establishments to monitor the compliance with COVID 19 measures and guidelines in Greater Male' Region and guided taskforces in islands to conduct the same.

Complaints Cluster was formed to address grievances and complaints of the general public with regards to the response operations.

Vaccine Cluster managed planning and implementation of the Covid-19 vaccine campaign.

Data Management Cluster was established to address all IT and data management issues of the COVID19 vaccination campaign.

Call Center was the point of contact for the public to reach NEOC/HEOC for all Covid-19 queries.

Security Cluster was engaged in providing security for HEOC, vaccination centers, sample collections centers and facilities.

11 . Multisector Engagement and Response

COVID-19 response in the Maldives was a multisectoral effort. Multiple Ministries, government agencies, private entities, state-owned enterprises, UN agencies, NGOs, volunteer organisations and groups representing major industries were important partners of the response.

Due to the changing COVID-19 situation globally, the preparedness and response operations for COVID-19 in the Maldives was also escalated to a national level response. With this, the National Emergency Operations Center was activated, with NDMA leading the whole response. NDMA took the lead role in the multi-agency coordination efforts, while MOH/HPA continued to oversee and manage the health sector response.

Maldives National Defense Force (MNDF) played an important role in leading and managing several critical functions during the COVID-19 response. Managing isolation/quarantine facilities and transport of cases and contacts to these facilities was a key role. MNDF also contributed to the construction of quarantine and isolation facilities in GMA and other regional facilities and operated the flu clinic at Senahiya Military Hospital (SMH). Another area of logistics that MNDF involved in was vaccine transport.

The Tourism Sector was one of the most affected in the Covid-19 pandemic and the economic reliance on tourism made it imperative that the industry resumed as early as possible. The collaboration between Ministry of Tourism, the tourism industry and the technical team of health resulted in Maldives being one of the first countries to open their borders for tourism. This was achieved in a stepwise manner, with an extensive guideline in place that was grounded in scientific evidence of transmission and the Maldivian context. When borders opened, the collaboration extended to managing cases and contacts among tourists.

Ministry of Gender, Family and Social Services (MoGFSS) played an important role in the COVID-19 response operations in several areas. MoGFSS involved in helping individuals who are in need due to COVID-19. Especially by providing services to residents at Fiyavathi, Kudakudhinge Hiya, and Home for People with Special Needs in K.Guraidhoo Island. MoGFSS also assisted immensely in providing social care for individuals, who came to Male' for short-term and got stuck during lockdown, giving a focus to the vulnerable groups.

The Education Sector is one of the main areas which was affected greatly by the global pandemic. The closure of schools and higher education institutes had affected the students on a larger scale. However, with challenges, the Education Sector was able to develop plans and support the schools and other institutes to continue the education of the students through Tele class and online medium. The Ministry of Education also supported the response in numerous ways largely contributing human resource capacity for the functions of the emergency operations center. They also extensively conducted risk communication to school children and parents regarding COVID safety measures and vaccination.

Maldives Police Service ensured the enforcement of legal orders related to the response within the community. MPS led the Security and Enforcement Cluster at NEOC and HEOC while providing security for all the missions, tasks and activities conducted the NEOC/HEOC operations and by the all-other organizations and stakeholders. The police forensic laboratory was one of the first labs established for the COVDI-19 testing and provided support in taking up a huge load of testing. The police teams also worked closely with the contact tracing teams in tracing and tracking down unreachable contacts till the end of Delta wave. While MPS enforced movement restriction orders, managed vehicle permits and grocery shopping in greater Male' area. MPS also played a significant role in leading and supporting inspections of service providers.

STO is an important stakeholder in the health service delivery sector. It has established pharmacies in all inhabited island to provide required medicines consumables. STO is the largest supplier of pharmaceuticals and medical equipment to the government hospitals and healthcare facilities under established MoUs. During the COVID-19 pandemic, STO continued to supply medical consumables required for the national health emergency operations.

The Local Government Authority played a prominent role in supporting local authorities to implement guidelines and legal orders imposed during the public health emergency, especially during the lock down and when islands were placed under monitoring. Local councils were co-leads of local Covid-19 taskforces and were responsible for community support and monitoring of arrivals and departures.

The World Health Organization (WHO) is the main technical partner who provided continuous technical advice and guidance throughout the pandemic. In addition to the technical support, WHO supported the national response in building health sector capacity, supporting training of healthcare workers, establishment of laboratory capacity, including support to procure and supply essential medical equipment, medicines and other consumables. Guidelines and SOPs developed during Covid-19 were mainly based on the recommendations and guidance of WHO. WHO also supported the introduction of Covid-19 vaccines, assisting in training of healthcare workers and upgrading cold-chain capacity.

UNICEF is one of the main UN organizations that supported the national Covid-19 response. One area of UNICEF involvement was with education and other sectors on minimizing the negative impact of Covid-19 on children. A key role of UNICEF was in supporting risk communication and community engagement for the response. In addition, UNICEF had an important role in the vaccine campaign, especially in delivery of vaccines and consumables as well as improving cold-chain capacity.

Maldives Red Crescent (MRC) was a close partner in all aspects of the national level operation to mitigate the spread of COVID-19 in the Maldives. From the beginning, MRC took the lead in the provision of psychosocial support and supported risk communication, especially engagement with migrants. MRC volunteers also provided support in transport of patients to facilities and samples to the assigned labs

12 . Resilience and Recovery

Maldives closed its air and sea borders to tourist arrivals from March 27 to July 15. In mid-April 2020, the World Bank projected that Maldives would be the worst-hit economy in the South Asian region due to the pandemic. It was estimated that Maldives' economy would face severe repercussions as a result of the pandemic.

The government took measures with a few significant financial packages to cope with some of the economic impact being felt, especially in the services sector. Some utility service providers and telecom companies reduced the cost of many services and provided attractive data packages. Essential services like banking, household provisioning and filling prescriptions were made online.

The COVID-19 Recovery Loan Scheme introduced by the government provided financing for large businesses, SMEs, self-employed and freelance individuals affected by the COVID-19 pandemic. On 20 March 2020, Maldives government announced an Economic Recovery Plan of 2.5 billion rufiyaa to minimize the impact on the people of the Maldives due to the COVID-19 – 19 pandemics.

Economic Recovery support provided include:

- Arrangement of working capital for businesses through banks.
- Subsidizing 40 % from electricity bill for the month of April and May 2020
- Subsidizing 30 % from water bill for the month of April and May 2020
- Deferment of interest on loan repayments to BML by 6 months to businesses and people who have been impacted by the pandemic

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MALDIVES

COVID-19 RESPONSE

A SUMMARY

11 May 2023

Health Protection Agency

Ministry of Health

Republic of Maldives