Ministry of Health
Republic of Maldives

Health Protection Agency

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Maldives

Maldives National Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Strategy and Action Plan (2020-2025)

Forward

I am pleased to introduce the Maldives National Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) Strategy and Action Plan 2020-2025. This is the Maldives' first combined RMNCAH Strategy and Action Plan, and it replaces the National Reproductive Health Strategy 2014-2018 and the Child Health Strategy and Every Newborn Action Plan 2016-2020.

This Strategy and Action Plan provides detailed direction for improving RMNCAH over the next five years, and will contribute to achievement of the Strategic Action Plan (SAP) 2019-2023, the Health Master Plan 2016-2025, and the Sustainable Development Goals (SDGs). The Strategy has seven strategic areas - Reproductive Health, Maternal Health, Newborn Health, Child Health, Adolescent Health, Cross-Cutting Areas and the Enabling Environment – and is intended to guide actions related to RMNCAH by the Ministry of Health and the Health Protection Agency, the private sector, non-governmental organizations (NGOs), and partners.

I greatly appreciate the active involvement of a wide variety of stakeholders in development of this new strategy and action plan, and look forward to jointly monitoring progress in the years ahead.

Sincerely,

Minister of Health
Ahmed Naseem

Acknowledgements

This National Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Strategy and Action Plan 2020-2025 was developed through a participatory and collaborative process that involved the Ministry of Health, the Health Protection Agency, non-governmental organizations, UN agencies, and other national and international stakeholders. We would like to thank all stakeholders for their willingness to participate and their active involvement in this process.

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Acronyms and Abbreviations

ANC	Antenatal Care
CHW	Community Health Worker
C-Section	Cesarean Section
DHS	Demographic and Health Survey
DP	Development Partner
DVPA	Domestic Violence Protection Act
FHW	Family Health Worker
FP	Family Planning
GBV	Gender Based Violence
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HMP	Health Master Plan
HPA	Health Protection Agency
HPV	Human Papilloma Virus
IEC	Information Education and Communication
IUD	Intra-Uterine Device
KII	Key Informant Interview
LARC	Long-Acting Reversible Contraceptive
LSE	Life Skills Education
MBS	Maldivian Blood Services
mCPR	Modern Contraceptive Prevalence Rate
MFDA	Maldives Food and Drug Administration
MISP	Minimum Initial Service Package
MMR	Maternal Mortality Ratio
MOE	Ministry of Education
MOGFSS	Ministry of Gender, Family and Social Services
MoH	Ministry of Health
NDA	National Drug Agency
NDMA	National Disaster Management Authority
NMR	Neonatal Mortality Rate
OB/Gyn	Obstetrician/Gynecologist
PCOS	Polycystic Ovary Syndrome

PH	Public Health
PNC	Postnatal Care
PWD	People with Disabilities
RH	Reproductive Health
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
ROM	Republic of Maldives
SAP	Strategic Action Plan
SBA	Skilled Birth Attendant
SHE	Society for Health Education
SIDS	Small Island Developing States
STI	Sexually Transmitted Infection
STO	State Trading Organization
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VIA	Visual Inspection with Ascetic Acid
WHO	World Health Organization

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Introduction

Background and Context

The Republic of Maldives is an archipelago consisting of 1192 coral islands that form a chain stretching 820 km in the Indian Ocean. In recent years, the country has experienced rapid economic growth, and as of 2017, the Maldives' Human Development Index (HDI) was 0.717, which places the country in the high human development category. This figure puts the Maldives above the average value of 0.684 for Small Island Developing States (SIDS), and above the average value of 0.638 for countries in South Asia.[1]

As of 2014, the country had a total population of 407,660 with 84% of the population classified as Maldivians, and 16% classified as foreigners - with a majority of these foreigners being men in the 18-35 year old age group.[2] While fertility is decreasing, the country grew at an average annual rate of 1.65% between 2006 and 2014, and the country has a relatively young population. As of 2014, 43% of the population was under the age of 25[3].

By 2015, the Maldives had achieved 5 out of the 8 Millennium Development Goals (MDGs), and its maternal mortality ratio was one of the lowest in the South Asian region. However, despite these achievements, challenges remain. Studies show that the Maldives has one of the world's highest carrier rates for Thalassemia (16–18 % of the population are β-thalassemia carriers)[4], religious conservatism is increasing, and socio-cultural norms, particularly amongst young people, are changing.

In recent years, the health sector has become highly medicalized, with specialist care seen as the preferred form of care, and the country is highly dependent on foreign health professionals to provide health services, especially outside of the capital, Malè. Work is currently on-going to upgrade five regional hospitals to tertiary hospitals, and the preference for hospital based, specialist care has led the country to spending > 10% of its gross domestic product (GDP) on health which is the highest level in WHO's South East Asia Region.[5] However, the current government is expanding funding and support for public health services, and a Public Health forum was recently held in November 2019.

[1] Government of Maldives; Strategic Action Plan 2019-2023; 2019.
[2] Maldives National Bureau of Statistics; Maldives Population and Housing Census 2014 – Statistical Release 1: Population and Households; 2015:6
[3] Maldives National Bureau of Statistics; Maldives Population and Housing Census 2014 – Statistical Release 1: Population and Households; 2015.
[4] Waheed, F., Fischer, C., Awofeso, A.N. and Stanley, D., Carrier Screening for Beta-Thalassemia in the Maldives; Journal of Community Genetics 7: 243-253; 2016.
[5] Presentation by the Maldives Ministry of Health; National Health Accounts Maldives: 2015-2017.

The country's current key health-related challenges and priorities are laid out in its new Strategic Action Plan (SAP) 2019-2023, and the third Health Master Plan (HMP) 2016-2025. Both plans highlight the importance of reproductive, maternal, newborn, child and adolescent health (RMNCAH), and the need for further work in these areas. Key policy priorities in the government's new SAP include, "promoting and advocating a healthy lifestyle with a key focus on primary healthcare and preventive care, strengthening safe motherhood and child health and nutrition programmes, enforcing an appropriate quality assurance and regulatory framework to ensure patient and provider safety, provide access to affordable, all-inclusive and quality health care services, and strengthen health care management and modernize services through ICT and strengthen health sector response in emergencies."[6]

The Government of the Maldives is committed to improving RMNCAH has decided to do this through developing a comprehensive Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Strategy and Action Plan for 2020 to 2025. This strategy and action plan are aligned with and informed by key national documents and processes, such as the SAP and the HMP noted above, and the new Child Health Policy and the 2018 Review of the National RH Strategy. The Strategy and Action Plan are also aligned with, and support achievement and reporting for, the SDGs, the Global Strategy for Women's, Children's and Adolescents' Health 2016-2030, and other global and regional strategies related to RMNCAH.

While, in the past, RMNCAH issues and priorities in the Maldives were addressed through separate strategies and action plans, the Ministry of Health (MoH) and the Health Protection Agency (HPA) decided to address these issues through developing one comprehensive RMNCAH strategy. Having a comprehensive strategy and action plan will promote a continuum of care in line with what is in the Global Strategy for Women's, Children's and Adolescents' Health, and what is seen in RMNCAH strategies in countries such as India, Afghanistan, Lao PDR, Vanuatu, Tanzania, Sierra Leone and Uganda. It will also promote alignment of partners and resource mobilization across the RMNCAH spectrum, and minimize overlap and gaps between the various sub-sectoral areas per what occurred in the previous National RH Strategy and the National CH Strategy and Every Newborn Action Plan (ENAP) 2016-2020.

Methodology

This strategy was developed between October 2019 and February 2020, and the development process was overseen by the National RMNCAH Coordinating Committee and supported by two international consultants. Financial support for the work was provided by the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA).

Work to develop this strategy was divided into 5 Phases. Phase 1, the inception phase, included a review of background documents and preparation of an Inception Report. Phase 2 involved in-country field work, key informant interviews and stakeholder consultation. Phase 3 involved development of the overall framework for the strategy and

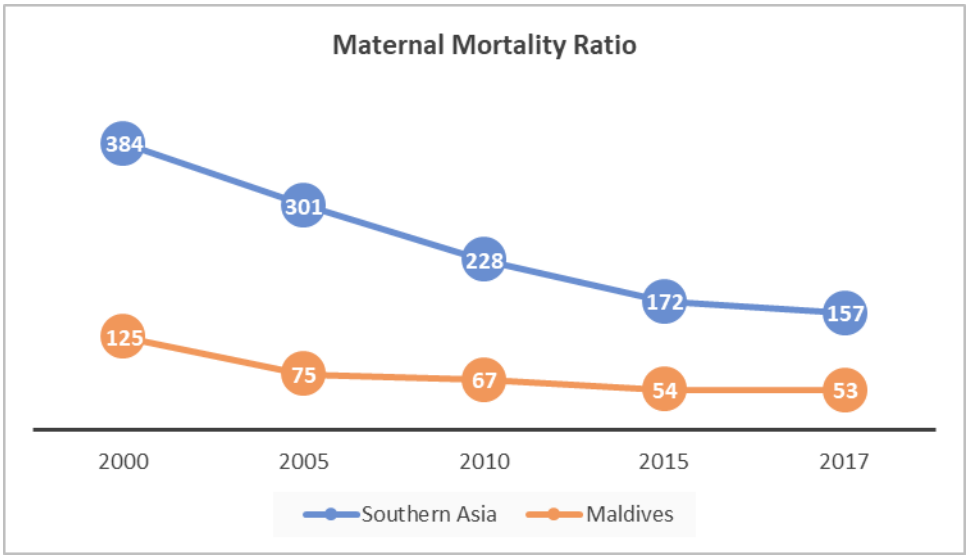
[6] Government of Maldives; Strategic Action Plan 2019-2023; 2019.

action plan. Phase 4 involved in-country validation and action planning, and Phase 5 included drafting and finalization of the strategy and action plan.

Situation Analysis

RMNCAH outcomes have improved significantly in the Maldives since 1990, and its maternal, neonatal and under-five mortality figures are now amongst the lowest in the South Asia Region. However, with SDG's much work needs to be still done. While the Total Fertility Rate decreased from 2.5 in 2009 to 2.1 in 2016/17[7], and the maternal mortality is estimated to have decreased from 67 to 53 maternal deaths per 100,000 live births between 2010 and 2017[8], the country does not appear to have fully achieved its maternal mortality targets of < 50 maternal deaths per 100,000 live births by 2018.

Graph 1: Maternal Mortality Trends in the Maldives and the Southern Asia Region[9]



Source: WHO, UNICEF, UNFPA, WB Group, UN Pop. Division; Trends in maternal mortality: 2000 to 2017; 2019.

In recent years, the rates of reduction of neonatal and under-five morality rates also slowed , and the neonatal mortality rate is estimated to have decreased from 9.1 deaths per 1000 live births in 2008 to 4.8 in 2018, and the under-five mortality rate is estimated to have decreased from 16.2 deaths per 1000 live births to 8.6 over the same time period.[10] As of 2017, neonatal mortality was estimated to account for 56% of under 5 deaths, and as of 2015, the main causes of neonatal mortality were prematurity (40%) and congenital anomalies (30%). (For more detailed information and graphs on newborn and under five mortality, please see the newborn and child mortality sub-section under Newborn Health).

[7] Maldives MoH and The DHS Program ICF; Maldives Demographic and Health Survey 2016-17; 2018.
[8] WHO, UNICEF, UNFPA, WB Group, UN Pop. Division; Trends in maternal mortality: 2000 to 2017; 2019.
[9] The Southern Asia Region (per the UN Population Division) includes the following countries: Afghanistan, Bangladesh, Bhutan, India, Iran, Maldives, Nepal, Pakistan and Sri Lanka.
[10] UNICEF, https://data.unicef.org, data retrieved January 2020.

Reproductive Health

Family Planning

The use of modern family planning (FP) methods is the best way to reduce unintended pregnancies and the risks associated with pregnancies and childbirth. In the Maldives the use of contraceptives is decreasing, and the country did not achieve its 2018 target for overall contraceptive prevalence amongst married women of 39%.

Overall, the modern contraceptive prevalence rate (mCPR) amongst married women decreased from 27% in 2009 to 14.9% in 2016/17, and, as of 2016/17 the mCPR was lowest in the Southern Region (10.1%). However, there was no real correlation between mCPR and education or wealth groups. Demand for contraception also decreased during this period, but unmet need went from 28.1% in 2009 to 31.4% in 2016/17.[11] Unmet need is lower among all women than among currently married women (23% versus 31%, respectively); however, it is extremely high among the small number of sexually active unmarried women (89%).[12]

As of 2016/17, the proportion of demand satisfied with modern methods amongst married women was 29.8%, and was lowest amongst adolescents 15-19 years old (9.5%), and amongst women in the Southern Region (21%). Interestingly, no real correlation was found between increasing demand satisfied and increasing education or wealth groups.[13]

High unmet need for modern contraception and low demand satisfied are likely to be at least partly due to low levels of exposure of WRA to information on contraception. The most often cited source of information on family planning messages reported by women and men age 15-49 in the past few months is newspapers, and magazines and leaflets (26% and 29%, respectively). Other sources include television (20% for women and 22% for men) and radio (15% for women and 12% for men), the 2016/17 Demographic and Health Survey (DHS) found that 59.6% of WRA had not been exposed to any family planning information (on radio or television, in a newspaper or magazine, or via mobile phone) over the last few months, and only 6.3% of female non-contraceptive users had discussed family planning with a field worker or in a health facility over the last 12 months.[14] Other factors limiting use of family planning methods are likely to include fear of the long-term effects of hormonal methods, increasing use of traditional methods (particularly the rhythm method), personal beliefs, limited fertility due to high reported levels of Polycystic Ovarian Syndrome (PCOS) and endometriosis, the split between public health and curative care services and low funding for public health services.

The contraceptive method mix has shifted slightly away from permanent methods since 2009, and as of 2016/17, the most commonly used contraceptive methods were the male condom (6.5%), female sterilization (4.4%), and the pill (2.2%). While Implanon has been introduced in the country, at present, it is only available in Malè, and awareness of

[11] Maldives MoH and The DHS Program ICF; Maldives Demographic and Health Survey 2016-17; 2018.
[12] Maldives MoH and The DHS Program ICF; Maldives Demographic and Health Survey 2016-17; 2018.
[13] Maldives MoH and The DHS Program ICF; Maldives Demographic and Health Survey 2016-17; 2018.
[14] Maldives MoH and The DHS Program ICF; Maldives Demographic and Health Survey 2016-17; 2018.

Emergency Contraception is reported to be limited.[15] Particularly striking about the current situation in the Maldives is that the decrease in contraceptive usage and demand satisfied by modern contraceptive methods, and the corresponding increase in unmet need, happened at the same time that the total fertility rate (TFR) was declining.

Where people get contraceptive methods is also changing, and more people are getting their contraceptives from the private sector than in the past. As of 2009, 31% of individuals reporting getting contraceptive from the private sector compared to 39% in 2016/17, and the proportion of individuals getting contraceptives from the public sector decreased from 63.1% to 49.3% during the same time period.[16,17]

Abortion

Until recently, Maldives permits abortion under two conditions – to save a woman's life and to preserve a woman's physical health. Abortion is permitted up to 120 days of gestational age where thalassaemia is diagnosed and for cases where major congenital anomalies are reported. However, in 2013, the Ministry of Islamic Affairs Fiqh Academy on 11th December 2013, released a fatwa which expanded the conditions allowing abortion. The fatwa outlines the following conditions:

1. Under the circumstance where a mahram (kin with whom marriage is unlawful) man commits forceful adultery with his kin – the termination of the consequent fetus within 120 days of gestation;

2. Under the circumstance where a non-mahram (a person with whom marriage is lawful) man commits forceful adultery with a woman – the termination of the consequent fetus within 120 days of gestation;

3. Under the circumstance where a man commits forceful adultery with a physically weak or under aged girl – the termination of the consequent fetus within 120 days of gestation;

4. Under the circumstance where in a lawful marriage, the conceived fetus is believed to be a thalassemic major, sickle cell major or the fetus is believed to be physically or mentally deformed at the time of its birth and that it will not be cured by any means – the termination of the fetus within 120 days of gestation;

5. Under the circumstance where the life of a pregnant woman is in danger – the termination of the fetus or administration of an induced abortion even after 120 days of gestation.

This has been implemented in the country the procedure has to be certified by Doctors. However, stakeholders suggest that some women do not approach the health facility or approach the health facility late or opt for risky methods by self with some travelling abroad.[18]

[15] Maldives MoH and The DHS Program ICF; Maldives Demographic and Health Survey 2016-17; 2018.
[16] Maldives Ministry of Health and Family and ICF Macro; Maldives Demographic and Health Survey 2009; 2010.
[17] Maldives MoH and The DHS Program ICF; Maldives Demographic and Health Survey 2016-17; 2018.
[18] ARROW; Country Profile on Universal Access to Sexual and Reproductive Rights: Maldives; 2017.

Sexually Transmitted Infections (STI) and Human Immunodeficiency Virus (HIV)

The prevalence of HIV is less than 1% in the Maldives, and by the end of 2017, 25 HIV-positive cases had been reported among Maldivians (21 males, 4 female), and more than 415 cases had been reported among expatriates. At present, there are 13 people living with HIV in the Maldives and 11 are on Anti-Retroviral Treatment (ART).[19]

However, the Maldives is considered to have high vulnerability, risk and epidemic potential due to low levels of HIV knowledge and condom use, and relatively high levels of unsafe and harmful practices as were seen in the 2008 Behavioural and Biological Survey (BBS) of key affected populations. These unsafe and harmful practices include unprotected sex, commercial sex work, men having sex with men and needle sharing among injecting drug users.[20]

In the Maldives, all pregnant women are routinely tested for HIV, Hepatitis B and Syphilis during antenatal care (ANC), and the Ministry of Health (MoH) reported 0 pregnant women testing positive for HIV in 2015[21], and 0 pregnant women testing positive for syphilis during either 2015 or 2016.[22] And, as of July 2019, WHO certified the Maldives as having eliminated Mother-to-Child Transmission of HIV and Syphilis.

However, limited information is available on the incidence of other STIs. Genital warts were reported to be common, but Chlamydia and Gonorrhea testing available in limited number of locations, and non-specialists have limited capacity to screen and test for STIs.

In 2020, MoH/HPA plans to develop new comprehensive strategies for HIV/Tuberculosis/STI/Hepatitis B and C , and for Migrant Health, which would address areas related to high risk and vulnerable populations along with relevant stakeholders (e.g. drug users, sex workers, prisoners, migrants, individuals with mental health issues)

Cervical Cancer

Cervical cancer is one of the most common cancers in the Maldives, and is currently the second most common cancer amongst women.[23] As of 2018, it is estimated to have an age standardized incidence rate of 23.2 cases per 100,000 women per year, and an age standardized mortality rate of 13.4 per 100,000 women per year.[24]

In recent years, the country developed a National Cervical Cancer Screening Program, and, in 2019, included Human Papilloma Virus (HPV) in the national vaccination schedule and introduced Human Papilloma Virus (HPV) vaccination for girls aged 10-14 years of age. The goal of the screening program is to screen all women aged 30-50 every five years using visual inspection with acetic acid (VIA) as the primary screening test.

However, cervical cancer prevention and screening in the country are still at early stages of implementation, and the National Cervical Cancer screening programme pre-dates the development of WHO's new Draft Global Strategy for Elimination of Cervical Cancer which is expected to be released in 2020. HPA, Society for Health Education (SHE) and

[19] Maldives Health Protection Agency: Epidemiological Report 2018; 2018.
[20] Maldives Ministry of Health; Maldives HIV/AIDS Country Progress Report; 2016.
[21] Maldives Ministry of Health; Maldives HIV/AIDS Country Progress Report; 2016.
[22] Maldives Ministry of Health; Maldives Health Statistics 2015-16; 2019.
[23] Global Cancer Observatory, WHO/International Agency for Research on Cancer; Maldives Cancer Factsheet; 2018.
[24] Global Cancer Observatory, WHO/International Agency for Research on Cancer; Maldives Cancer Factsheet; 2018.

the Cancer society of Maldives have undertaken cervical cancer screening camps to increase awareness and access to screening services. Screening is done in the tertiary heath facilities and as outreach camps at atoll health facilities. As of 2019, screening is still being done in an opportunistic rather than a routine manner, and, at present, there is no way to ensure that all woman in the target group are screened every three to five years. Human Papilloma Virus (HPV) vaccination has been introduced into the national vaccination schedule

Infertility and Reproductive Health Morbidities

Limited data is available on infertility and related RH morbidities, but stakeholders noted that PCOS and endometriosis are quite common amongst WRA in the Maldives. These conditions are usually chronic, and can lead to irregular and painful menstruation, limited fertility and other complications amongst affected women. However, as these conditions are currently classified as infertility by the national health insurance system, Aasanda, the treatment is currently not covered or included in the insurance benefit package.

Maternal Health

Antenatal Care

Antenatal Care (ANC) is nearly universal in the Maldives at 99%, and, as of 2016/17, the vast majority, 89.4%, was conducted by an Obstetrician/Gynecologist (Ob/Gyn). Ninety five percent of pregnant women had an ANC visit during their first trimester, and the quality of ANC was also relatively high with 99% of pregnant women having their blood pressure measured and urine and blood samples taken during ANC. However, only 75% of pregnant women received counselling about birth preparedness during their ANC visits, and there was no change in this figure between 2009 and 2016/17.

The proportion of women receiving at least 4 ANC visits in the Maldives decreased from 85% in 2009 to 82% in 2016/17, and the country did not achieve its target of > 95% coverage of quality ANC by 2018. It is not exactly clear why ANC4+ is decreasing, but women in Malè region (84%) are slightly more likely than women in other regions (80%) to receive at least 4 ANC visits.[25]

The World Health Organization (WHO) published updated ANC recommendations in 2016, and the MOH/HPA is currently developing new national minimum standard ANC and PNC guidelines that should be available by 2020.

Intrapartum Care

Delivery by skilled health personnel is now universal in the Maldives and increased from 95% in 2009 to 100% in 2016/17. As of 2016/17, 75% of deliveries were attended by obstetricians/gynecologists (OB/Gyn), and this appears to be expected by health professionals and community members, and is reimbursed by health insurance. Given this situation, the role of midwives in many health centers, and atoll and regional hospitals, appears to be limited to assisting obstetricians/gynecologists, rather than managing normal ANC, deliveries, and PNC.

[25] Maldives MoH and The DHS Program ICF; Maldives Demographic and Health Survey 2016-17; 2018.

The proportion of women delivering in a health facility was also high (95%), although there was no change in between 2009 and 2016/17, and the country only partially achieved its target of > 95% deliveries in health facilities by 2018. Interestingly, the groups with the highest levels of home births were women in the highest income quintile (1.9%) and women in Malè (1.3%).[26]

Blood transfusion is an essential component of comprehensive emergency obstetric care. Blood banking services are available in Malè, , 3 regional hospitals, 1 atoll hospital and there is reliance on patients to provide their own blood donors, and this has the potential to limit access to life-saving services, especially in the case of an emergency. National Blood Policy is a step to ensure provision of safe, adequate and accessible supply of high-quality blood and blood products to all patients in need of a transfusion. Work is ongoing towards strengthening blood banks throughout the country and increasing blood banks in the atoll to widen the accessibility.

Overall, approximately 15% of deliveries are expected to be complicated and to require some form of Emergency Obstetric Care (EmOC).[27] In the Maldives, the proportion of women delivering by cesarean section (c-section) increased from 32% in 2009 to 40% in 2016/17,[28] and the country did not achieve its target of < 10% of deliveries by c-section by 2018. The c-section rate was highest in the southern region (48.9%) and lowest in the Central Region (31.6%), but limited differences were seen in the prevalence of c-sections between women in different education and wealth quintiles.[29] This increase in c-sections appears to be driven by a fear of pain and complications during normal delivery, preference of community members (and to some extent specialists), and the costs of c-sections being reimbursed by the national health insurance system regardless of whether the procedure was medically indicated.

The WHO Statement on Cesarean Section Rates states that, "At population level, caesarean section rates higher than 10% are not associated with reductions in maternal and newborn mortality rates."[30] Given this, the Maldives can be considered to have an un-necessarily high prevalence of c-sections, and this is of concern given the risks that c-sections pose to both the mother and the child.

Postnatal Care

Early postnatal care (PNC) for mothers (within 2 days of birth) is increasing in the Maldives and went from 67% in 2009 to 80% in 2016/17,[31] but the country did not achieve its target of > 95% coverage of quality PNC by 2018. PNC coverage was lowest (72%) in the North Central Region, and was slightly lower in the lower education and wealth groups when compared to higher income and wealth groups. However, no data was available on the quality of PNC for mothers.

The World Health Organization (WHO) published updated PNC recommendations in 2013, and the MOH/HPA is currently developing new national minimum standards ANC and PNC guidelines which should be available in 2020.

[26] Maldives MoH and The DHS Program ICF; Maldives Demographic and Health Survey 2016-17; 2018.
[27] WHO, WHO Statement on Cesarean Section Rates; 2015.
[28] Maldives MoH and The DHS Program ICF; Maldives Demographic and Health Survey 2016-17; 2018.
[29] Maldives MoH and The DHS Program ICF; Maldives Demographic and Health Survey 2016-17; 2018.
[30] WHO, WHO Statement on Cesarean Section Rates; 2015.
[31] Maldives MoH and The DHS Program ICF; Maldives Demographic and Health Survey 2016-17; 2018

Nutrition amongst Women of Reproductive Age

The proportion of WRA who are overweight or obese increased from 45.5% in 2009 to 49.3% in 2016/17 and the risk of diet-related non-communicable diseases is increasing in the country. As of 2016/17, the highest levels of overweight and obesity were seen outside of Malè (52.1%), amongst WRA with no education (70%), and amongst those in the lowest income quintile (51.9%).[32,33] Undernutrition amongst WRA also continues to be a challenge, and 11% of WRA are considered to be thin (body mass index <18.5 kg/m2), and 8% of WRA are short (<145 cm tall).[34]

Anemia is also a significant problem in the country, and as of 2016/17, 63% of WRA were anemic. This situation is exacerbated by a high prevalence of Thalassemia and poor diet, and as the overall prevalence rate for anemia is over 40%, the country is classified as having severe public health significance according to WHO.[35]Anemia amongst WRA was highest in Malè region (73.4%) and amongst those in the highest income (71.1%) and education quintiles (69.7%), and the country does not appear to have met its 2018 target for anemia amongst pregnant women of 15%. While iron supplements are commonly given to pregnant women during ANC, only 46% of pregnant women actually consumed iron supplements for at least 90 days during their most recent pregnancy, and 8% took none.[36]

Newborn Health

Low birth weight

Between 2009 and 2016/17 there was an increase in the proportion of newborns with LBW (< 2,500 g) from 10.5% to 12.9%. In 2016/17, the proportion of LBW is high among mothers below 20 years of age (20.6%), mothers with more than 6 children (26.4%), women with primary education (17.6%), and women from the lowest wealth quintile (17.0 %). Similar to the situation with perinatal mortality rates, low birth weight was more frequently found in the South and Central regions.[37,38]

Healthy Newborns

The first 48 hours of life is a critical phase in the lives of newborn babies and a period in which many neonatal deaths occur. Approximately 82% of newborns had a postnatal check-up by a medical doctor (69%) or a nurse or midwife (13%) within the first 2 days after birth, while 7% received no postnatal check-up and no information was available for the remaining 11%. Almost all newborns were weighed at birth or within first 48 hours (98.8%), the umbilical cord was examined in 90% and body temperature was measured in 89% of newborns. Approximately 73% of mothers had a counselling session on breastfeeding and direct observation of breastfeeding, while a considerably smaller percentage of mothers were counselled on danger signs (58%) and newborn feeding practices (48%).[39]

[32] Maldives Ministry of Health and Family and ICF Macro; Maldives Demographic and Health Survey 2009; 2010.
[33] Maldives MoH and The DHS Program ICF; Maldives Demographic and Health Survey 2016-17; 2018.
[34] Maldives MoH and The DHS Program ICF; Maldives Demographic and Health Survey 2016-17; 2018.
[35] WHO; Haemoglobin concentrations for the diagnosis of anaemia and assessment of severity; 2011.
[36] Maldives MoH and The DHS Program ICF; Maldives Demographic and Health Survey 2016-17; 2018.
[37] Maldives Demographic and Health Survey 2009; 2010
[38] Maldives Demographic and Health Survey 2016-17; 2018
[39] Maldives Demographic and Health Survey 2016-17; 2018

Between 2009 and 2016-2017, the overall prevalence of ever breastfed children was stable (98%), and considerable improvements were seen in exclusive breastfeeding rates. For example, the exclusive breastfeeding rate amongst infants 0-5 months increased from 47.8% in 2009 to 63.5% in 2016/17. There was also a slight increase in the early breastfeeding initiation rate within 1 hour of birth from 64.3% to 66.5% during the same time period. However, the overall breastfeeding initiation rate within the first 24 hours of life decreased from 92% to 88.8%. Unfortunately, the prevalence of prelacteal feeding, a nutritional malpractice, a barrier for implementation of exclusive breastfeeding, and a risk factor for neonatal infections, also increased from 11.7% in 2009 to 14.2% in 2016/17.[40,41]

The national immunization calendar includes birth doses of BCG and Hepatitis B vaccines.[42] Despite the fact that 99% of all deliveries take place in health facilities, there has been a decrease in vaccination coverage with both antigens. Between 2009 and 2016-2017, BCG and Hepatitis B vaccination rates decreased from 99.4% to 91.8%, and from 99% to 91.5%, respectively.[43,44]

Small and Sick Newborns

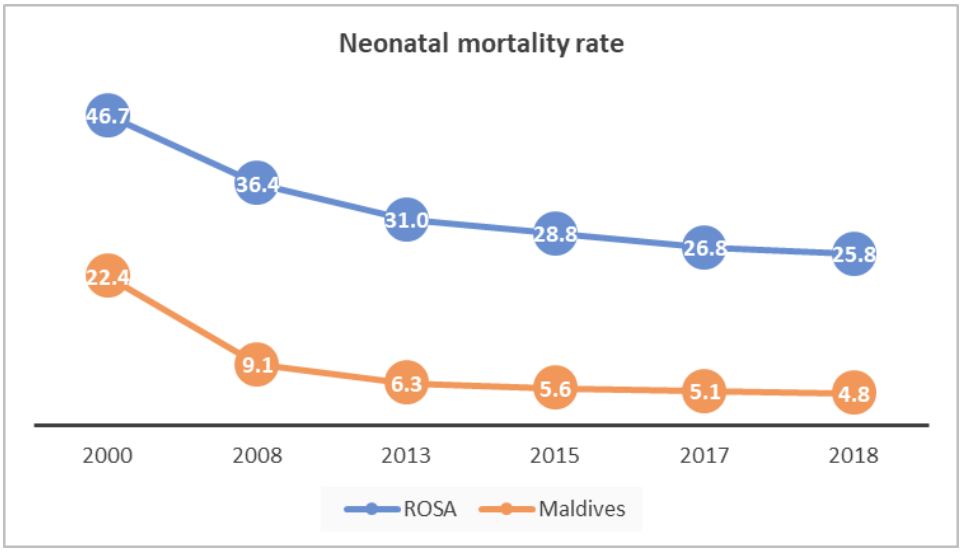
In 2016, there were 6,797 total births, of which 6,756 (99.4%) were live births. Approximately 63% of all live births took place in Malè, 32% in atolls and 5% abroad.[45] Stillbirths and early neonatal deaths are decreasing, but figures differ by data source. Between 2009 and 2016/2017, there was a decrease in the number of stillbirths from 34 to 9, in early neonatal deaths from 35 to 24, and in perinatal mortality rate from 18 to 12 per 1,000 total births. The highest perinatal mortality rates were recorded in women below 20 years of age, primiparous women, women from the lowest wealth quintile, and women without formal or with primary education. Furthermore, perinatal mortality was considerably higher in South, South Central, Central and North Central regions.[46,47]

Newborn and Child Mortality

Newborn and child mortality rates have improved significantly over the last 18 years, and the Maldives achieved the Sustainable Development Goal (SDG) targets for newborn and child mortality (12 and 25 per 1,000 live births, respectively) by 2008. Between 2000 and 2018, the Maldives had a higher percentage decrease in newborn mortality (78.6% vs. 44.8%) and child mortality (78.1% vs.55.2%) than the average for the UNICEF South Asia Region[48]

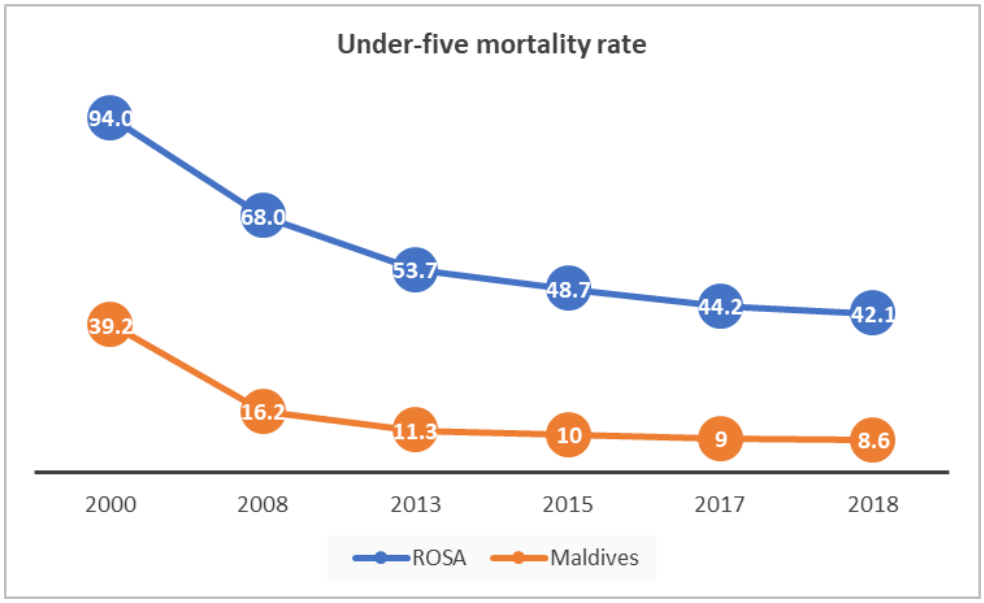
Graph 2: Comparative trend in newborn mortality rates in the Maldives and the South Asia Region

[40] Maldives Demographic and Health Survey 2009; 2010
[41] Maldives Demographic and Health Survey 2016-17; 2018
[42] Immunization Policy of Maldives, 2019
[43] Maldives Demographic and Health Survey 2016-17; 2018
[44] Maldives Demographic and Health Survey 2009; 2010
[45] Maldives Health Statistics 2015-2016, Ministry of Health, 2019
[46] Maldives Demographic and Health Survey 2009; 2010
[47] Maldives Demographic and Health Survey 2016-17; 2018
[48] UNICEF Region for South Asia (ROSA) includes: Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka



Source: UNICEF; https://data.unicef.org, data retrieved in January 2020.

Graph 3: Comparative trend in child mortality rates in the Maldives and the South Asia Region



Source: UNICEF; https://data.unicef.org, data retrieved in January 2020.

Similarly, between 2000 and 2015, the average annual reduction rates (AARR) for both indicators in the Maldives were the highest compared to the South Asia Region (8.8% vs. 3.2% for the newborn mortality rate and 8.7% vs. 4.3% for the child mortality rate). However, the AARR declined between 2015 and 2018 - 5.0% vs. 3.6% for the newborn mortality rate, and 4.9% vs. 4.7% for the child mortality rate – and this can be explained by a changing pattern in the causes of newborn and child mortality.

While mortality due to pneumonia decreased from 10% to 0% between 2000 and 2015, birth defects as a cause of newborn deaths increased from 10% to 30%. Complications of prematurity are the leading cause of newborn deaths (40%), and this figure has been stable since 2008. The underlying causes of preterm birth and low birth weight are

likely to be related to social, economic and cultural factors, inadequate antenatal care, maternal nutrition and high prevalence of anemia among women of reproductive age.[49] Other direct causes of newborn deaths in the Maldives are birth asphyxia (10%), neonatal infections including sepsis (10%) and unclassified causes (10%).[50] Since 2010, there is a persistent pattern of most newborn deaths, approximately 78%, occurring during the early neonatal period (0-6 days).[51] Considering the causes of newborn mortality, the concentration of deaths in the first week of life indicates that there are gaps in lifestyle modifications for a healthy pregnancy, quality of care during pregnancy, care during childbirth and in the early postnatal period.

The main direct causes of under-five deaths in the Maldives are neonatal causes, including prematurity, birth asphyxia and neonatal infections (38%), birth defects (30%), injuries (5%), pneumonia (7%), diarrhea (2%) and other causes (18%). It is notable that there has been a sharp decrease in the incidence of pneumonia (-56%) and diarrhea (-67%) as causes of under-five deaths between 2000 and 2015.[52]

Birth Defects

Birth defects accounted for approximately 30% of newborn deaths in 2015, and, since 2008, are the second leading cause of neonatal mortality after prematurity (40%).[53] A hospital-based birth defects surveillance system and register were established at Indira Gandhi Memorial Hospital (IGMH) in 2008, and A national hospital-based birth defects surveillance system supported by WHO SEARO has been rolled out to the hospitals in Greater Male' and Atolls by MoH/HPA with support from IGMH and two prospective studies on the incidence, types and associated risk factors of birth defects were carried out by IGMH in 2008-2014 and 2016-2018.[54,55] These studies found that there was a sharp increase (+296%) in the incidence of birth defects, from 16 per 1000 live births in 2008-2014 to 63.4 per 1,000 live births in 2016-2018, but that the associated mortality rate was relatively stable at 2.5-2.7 per 1,000 live births since 2008-2014. While most birth defects were non-fatal, they put a heavy burden on the national health care system and families in terms of direct and indirect costs of managing complications of birth defects.

Comparative analysis of the 2008-2018 data shows that the most common conditions were defects of the cardiovascular system, followed by musculoskeletal, urogenital and gastrointestinal systems. Furthermore, there was a significant, almost three-fold, upward trend in the incidence of these 4 groups of birth defects over this time period.

[49] WHO, Regional Office for South-East Asia, Improving Newborn and Child Health: A Strategic Framework (2018–2022)
[50] Global Health Observatory data repository, http://apps.who.int/gho/data/node.main.ChildMortCTRY3002015?lang=en, 2015 data retrieved in November 2019
[51] Maldives Health Statistics 2015-2016, Ministry of Health, 2019
[52] WHO Global Health Observatory data repository, http://apps.who.int/gho/data/node.main.ChildMortCTRY3002015?lang=en, 2015 data retrieved in November 2019
[53] WHO Global Health Observatory data repository, http://apps.who.int/gho/data/node.main.ChildMortCTRY3002015?lang=en, data retrieved in November 2019
[54] Birth Defects Report January 2008 - September 2014, IGMH 2014
[55] Birth Defects in Government Referral Hospital of Maldives 2016 – 2018, IGMH 2019

The 2014 study analyzed various risk factors for birth defects such as maternal age, geographical residence, gestational age at birth and newborn weight.[56] Approximately 55% of cases with birth defects in 2008 – 2014 originated from 6 atolls (Haa Alifu (9%), Haa Daalu (6.8%), Kaafu (6.8%), Seenu (6.8%), Noonu (6.2%), and Laviyani (5.3%)) and the city of Malè (14.6%). These six atolls were characterized by a higher ratio of birth defects to population, which potentially suggests a higher frequency of close interrelated marriages. Incidence of birth defects was also found to be highest in mothers > 40 years of age, 13.4 and 17.0 per 1,000 live births in 2008 – 2014 and 2016 – 2018, respectively, while gestational age at birth and newborn weight did not have a significant effect.

In 2016, the country adopted a National Birth Defects Prevention and Control Plan 2015 – 2018. This plan set four strategic goals including reducing the prevalence of the neural tube defects by 14%, reducing the number of thalassemia births by 20% and eliminating congenital rubella and syphilis.[57] Neural tube defects, which contribute to a large proportion of congenital anomalies of the central nervous and cardiovascular systems, can be prevented through folic acid supplementation in the peri-conceptual period.[58,59,60,61] Folic acid supplementation is a routine ANC practice in the country and folic acid intake among pregnant women increased from 50% in 1999 to 87% in 2004.[62]

Commercial fortification of staple foods, e.g. flour and rice, with iron-folate premix is another effective and cost-effective strategy for reduction of neural tube defects, and global evidence demonstrates that adopting appropriate national policies and legislation to address micronutrient deficiencies can lead to a sizeable decrease in the incidence of neural tube defects and prevention of neonatal mortality. [63,64] However, as of 2018 no food fortification programs or legislation exist in the country[65], although discussions with the Maldives State Trading Organization (STO) to introduce an appropriate legislation are ongoing since 2017.

Ultrasonography screening for early identification of birth defects is available in all atoll/ regional hospitals and referral is in place with other health facilities, however, further testing and expertise for prenatal diagnosis of birth defects is limited. Similarly, fetal echocardiography is not widely used and referral to tertiary level hospitals is relied on which prevents timely response and preparedness for management of serious congenital anomalies of the cardiovascular system.[66] TORCH (Toxoplasmosis, Other (including Syphilis), Rubella, Cytomegalovirus and Herpes Simplex) and STI screening tests, are used as another approach to reduce the incidence of birth defects, and are routinely carried out

[56] Birth Defects Report January 2008 - September 2014, IGMH 2014
[57] National Birth Defects Prevention and Control Plan 2015 – 2018, Plan/23/MoH/2016/06, Ministry of Health, 2016
[58] Standards for Integrated Management of Pregnancy and Childbirth (IMPAC) "Prevention of neural tube defects", WHO 2007
[59] Helga V. Toriello, Genet Med 2011:13(6):593–596. Policy statement on folic acid and neural tube defects, The American College of Medical Genetics
[60] Folic Acid Supplementation for the Prevention of Neural Tube Defects, US Preventive Services Task Force Recommendation Statement, JAMA. 2017;317(2):183-189. doi:10.1001/jama.2016.19438
[61] Prevention and Control of Birth Defects in South-East Asia Region, Strategic Framework for 2013–2017, WHO, 2013
[62] National Micronutrient Survey, Ministry of Health, 2007
[63] Flour fortification: reporting accomplishments Report of a joint WHO/UNICEF/MI intercountry technical review meeting on flour fortification Cairo, Egypt, 17-19 July 2001, WHO 2003
[64] Crider, K. S., Bailey, L. B. and Berry, R. J. (2011). 'Folic acid food fortification: Its history, effect, concerns, and future directions', Nutrients, 3(3), pp. 370–84.
[65] Birth Defects in Government Referral Hospital of Maldives 2016 – 2018, IGMH 2019
[66] Birth Defects Report January 2008 - September 2014, IGMH 2014

as a part of ANC. Rubella vaccination, administered as MMR vaccine at 18 months of age, has been introduced into the national EPI calendar and rubella has also been formally included in the HPA list of notifiable diseases since 2007.

Thalassemia

Thalassemia is one of the most common genetic disorders in the Maldives. The country has one of the highest carrier rates of thalassemia in the world, including β-thalassemia (16-18%), α-thalassemia (12%) and other minor variants (3-4%).[67]

Since the 1990s, The Maldivian Government has identified thalassemia as a national problem, and has undertaken substantial efforts to provide awareness raising campaigns, health education, preventive and curative care, including establishing the Maldivian Blood Services (MBS) in 2012. The MBS consists of Thalassemia and Other Haemoglobinopathies Centre (TOHC) and the Central Blood Bank (CBB). TOHC was formed under Thalassemia Control Act (4/2012) and is mandated with prevention and management of patients with thalassemia and other haemoglobinopathies across the country.[68,69]

A national register of thalassemia patients was established in 1990, and, as of 2019, there are 857 patients in the register resulting in a cumulative prevalence rate in the range of 2.3-2.6 per 1,000 population. As of 2019, 228 out of 857 patients have died, which results in a case fatality rate of 27%. Between 1990 and 2019, the overall mortality rate increased from 0.5 to 3.0 per 100,000 population, with the average age of death being approximately 12 years.

The majority of thalassemia cases in the Maldives (80%) are due to β-thalassemia major followed by HbE β-thalassemia (12%). Most patients are from Malè Atoll (28%), while 8 Atolls (Haa Dhaal, Noonu, Raa, Laamu, Haa Alif, Thaa, Addu and Shaviyani) account for half of all cases in the country.[70] However, between 1992 and 2014 there was a gradual downward trend in the incidence rate from 15.1 to 3.7 per 1,000 live births. The introduction of the Thalassemia Control Act in 2012, and genetic screening and counselling for couples at risk in 2017 are likely to have further contributed to the significant two-fold decrease in the incidence rate from 3.7 to 1.6 per 1,000 live births between 2014 and 2019.[71]

As of 2019, only around 300 patients (47%) receive blood transfusion and iron chelation therapy at MBS in Malè, while the remaining patients appear to seek treatment at atoll and regional hospitals[72]. Although thalassemia treatment is free of charge in the country, many patients from other atolls have difficulties in accessing MBS services due to indirect costs and distance.[73] Available evidence suggests differences in the quality of care for patients living in and near Malè

[67] Thalassemia International Federation: The Maldives WHO Mission, 2014
[68] Shanooha M et al, 2018, 'A Descriptive Study on Quality of Life among Adolescents with Beta-Thalassemia Major in the Maldives', International Medical Journal Vol. 25, No. 4, pp. 211 - 214
[69] Situation of Thalassemia in the Maldives 2020, Ministry of Health
[70] Situation of Thalassemia in the Maldives 2020, Ministry of Health
[71] Situation of Thalassemia in the Maldives 2020, Ministry of Health; National Bureau of Statistics; Ministry of Planning
[72] Situation of Thalassemia in the Maldives 2020, Ministry of Health
[73] Waheed F et al, 2016, 'Carrier screening for beta-thalassemia in the Maldives: perceptions of parents of affected children who did not take part in screening and its consequences', J Community Genet, 7:243–253

compared to those in the atolls. These differences include the continuity of drugs and consumable materials, availability of donors, and the clinical competencies of health workers, mainly expatriates, at atoll and regional hospitals in the management of thalassemia patients. Specialized cardiological, gastroenterological, endocrinological and psychological care is also very limited at atoll level.[74]

Primary prevention interventions for thalassemia focus on health education and mass screening, which are carried out by SHE and MBS which are both based in Malè. The screening services and health education for people living in other atolls are provided by the mobile teams of SHE. Available evidence suggests that there is a degree of hesitancy to undertake testing for thalassemia before or after marriage due to poor awareness, social, cultural, and a lack of understanding of the possible consequences of having a β-thalassemic child. This in turn might indicate that awareness programs, primarily centered in Malè, are not fully reaching the population in other atolls. [75] Prenatal diagnosis, as secondary prevention, is not available in the Maldives and couples have to travel abroad to access the service.[76,77]

Child Health

Vaccination

Immunization against vaccine preventable diseases is a top priority in the Maldives. A new national immunization policy was developed by HPA with technical support of WHO in 2018. The new policy considers immunization as a basic right of every child to receive quality, timely and free vaccination. As of 2018, there were 10 antigens in the national vaccination schedule which was updated based on the latest scientific evidence and international recommendations.[78]

Since the introduction of the Expanded Program of Immunization in 1982, the Maldives has achieved substantial progress with vaccination coverage and control of vaccine preventable diseases including the elimination of poliomyelitis, neonatal tetanus, pertussis and diphtheria. As of 2009, approximately 93% of children between 12-23 months of age received all basic vaccinations, and the coverage for BCG, three doses of polio, DPT vaccine and measles was almost universal.[79]

Despite these achievements, there were several negative trends in vaccination coverage between 2009 and 2016-2017. There were serious issues with the data quality and record keeping for vaccination coverage, and the percentage of children with a vaccination card decreased from 89% to 81%.[80,81] The percentage of children fully vaccinated with

[74] Thalassemia International Federation: The Maldives WHO Mission, 2014
[75] Waheed F et al, 2016, 'Carrier screening for beta-thalassemia in the Maldives: perceptions of parents of affected children who did not take part in screening and its consequences', J Community Genet, 7:243–253
[76] Waheed F, 2016, 'Thalassemia prevention in Maldives: effectiveness of primary, secondary and tertiary prevention interventions', PHD Thesis
[77] Situation of Thalassemia in the Maldives 2020, Ministry of Health
[78] Immunization Policy of Maldives, HPA, 2019
[79] Situation of Newborn and Child Health in South-East Asia: Progress towards MDG 4, RO for South-East Asia, WHO, 2014
[80] Maldives Demographic and Health Survey 2009; 2010
[81] Maldives Demographic and Health Survey 2016-17; 2018

BCG, Penta-3, Polio-3 and Measles-1 at 12-23 months of age also decreased from 92.9% to 76.7% during this period, and the percentage of children with no vaccinations increased from 1% to 8%.

Furthermore, the continuity of coverage with Measles vaccine in children 24-35 months of age decreased from 89.1% to 75.3%, and coverage with Polio vaccine in children 12-23 months of age decreased from 91.4% to 81.8% among 512 children born in the 3 years preceding the DHS 2016/17 survey.[82] This is particularly concerning as WHO recommends to maintain national measles vaccination coverage above 90% to prevent establishment or re-establishment of endemic transmission.[83] As there were 2 confirmed cases of measles, both imported, in 2017 and 2018[84], and the epidemiological situation in the Region and globally continues to deteriorate[85], Maldives' measles- and polio-free status is potentially at risk if current trends continue. A recent measles outbreak in January 2020 with 12 confirmed cases as of mid-February 2020 is a direct consequence of increasing gaps in measles vaccination coverage and resultant decrease in herd immunity.

The most important challenges and problems with the immunization program and its supply chain system have been identified by UNICEF and HPA. These, in addition to incomplete reporting and data quality, include insufficient managerial capacity at central level, inadequate infrastructure for vaccine storage at national vaccine store, inefficient transportation system for vaccines and sub-optimal cold chain maintenance, including temperature control along the cold chain. In the last 3-4 years, vaccine hesitancy and refusal were also on the rise, and neither existing IEC strategies or capacity of health workers and vaccinators, especially at atoll level, are sufficient to deal with this emerging issue.[86,87]

Nutrition

Between 2009 and 2016-2017, there were improvements in the main anthropometric indices related to nutrition of children under 5 years of age. For example, the overall prevalence of stunting (height-for-age <-2 SD) decreased from 19% to 15%, and the prevalence of severe stunting (height-for-age <-3 SD) decreased from 6% to 4% during this time period. Prevalence of wasting (weight-for-height <-2 SD), underweight (weight-for-age <-2 SD) and overweight (weight-for-height >+2SD) also decreased during this period, and went from 11% to 9%, from 17% to 15% and from 6% to 5%, respectively. Between 2009 and 2016/17, there was also an increase in stunting and underweight amongst children below 6 months of age. Stunting in this age group increased from 14.8% to 22.4%, and underweight increased from 17.2% to 18.9%, while there was a moderate decrease in all other age groups for both indicators.

At the national level, underweight women (BMI <18.5 kg/m^2) were more likely to have children who were stunted (23.2% vs. 15%), wasted (14.2% vs. 9%) or underweight (28.7% vs. 15%), which may partly be due to the slight rise in

[82] Maldives Demographic and Health Survey 2016-17; 2018
[83] Global eradication of measles, Report by the Secretariat, Sixty-third World Health Assembly,2010
[84] Epidemiological report 2018, HPA
[85] UNICEF/ROSA, https://www.unicef.org/rosa/press-releases/alarming-global-surge-measles-cases-growing-threat-children-unicef
[86] Immunization – Technical Support by UNICEF Regional Office for South Asia, 2016
[87] Immunization Policy of Maldives, HPA, 2019

the LBW during this period. For all indicators, disparities in nutritional status related to residence status, maternal education, sex of a child and wealth decreased between 2009 and 2016/17. However, stunting and underweight rates continue to be higher than national average in North (17% and 16.1%) and North Central (19.8% and 18.5%) Regions.[88,89] The prevalence of overweight is highest in South Central (7.1%) and North (6%) Regions, more common in boys than girls (6.7% vs. 3%) and tends to increase with the household wealth.[90]

Between 2009 and 2016/17, there were also substantial improvements in complementary feeding at 6-23 months of age in breastfed and non-breastfed children:

- intake of other fruits and vegetables increased from 31.8% to 51.5% and from 42.9% to 51.5%;
- intake of roots and tubers increased from 19.9% to 32.0% and from 21.3% to 32.0%.

Despite such improvements, between 2009 and 2016/17 the proportion of children 6-23 months (breastfed and non-breastfed) who have the minimum acceptable diet has slightly decreased and is only 51.2%, with a slight difference in the rate between breastfed (52.2%) and non-breastfed (47.6%) children.[91] There are also notable regional differences: South and South Central Regions have the lowest rates, 35.2% and 43.4%, in comparison to Malè (59%) and North Central Region (58.3%). The proportion of children who have the minimum acceptable diet is considerably lower in the households in the lowest wealth quintile, 38% vs. 58% in the highest wealth quintiles.[92]

Between 2009 and 2016/17, there was a moderate increase in the proportion of children 6-23 months who consumed foods rich in vitamin A from 82.1% to 90.6% and iron from 65.8% to 72%.[93,94] Despite improved intake of iron-rich foods, the prevalence of anemia (<11 g/dl) in children 6-59 months remains very high, 49.7%.[95] The prevalence is highest in children 6-8 months (65.3%) and 9-11 months (56.3%), which suggests considerable gaps in appropriate practices for complementary feeding. Anemia is most common in Malè (65.1%) and Central Region (66.4%) and the prevalence increases with the household wealth (70% in the wealthiest quintile).[96]

During the same time period, intervention coverage for both vitamin A supplementation and deworming for under-five children increased from 48.1% to 74.7% and from 68.6% to 85.8%, respectively. The similar coverage for the two interventions was expected as they are both implemented via vertical campaigns.[97]

[88] Maldives Demographic and Health Survey 2009; 2010
[89] Maldives Demographic and Health Survey 2016-17; 2018
[90] Maldives Demographic and Health Survey 2016-17; 2018
[91] Maldives Demographic and Health Survey 2016-17; 2018
[92] Maldives Demographic and Health Survey 2016-17; 2018
[93] Maldives Demographic and Health Survey 2009; 2010
[94] Maldives Demographic and Health Survey 2016-17; 2018
[95] Maldives Demographic and Health Survey 2016-17; 2018
[96] Maldives Demographic and Health Survey 2016-17; 2018
[97] Maldives Demographic and Health Survey 2016-17; 2018

Common Communicable and Non-communicable Childhood Illnesses

Population-based disaggregated data on the prevalence and incidence of major communicable and non-communicable childhood illnesses are very limited, therefore much of this analysis is based on hospital admission data for 2016.[98] However, available summary statistics suggests that there was an increase in the number of cases of acute respiratory and diarrheal diseases (all ages) between 2017 and 2018, and that the number of dengue cases tripled from 996 (2017) to 3,404 (2018) with approximately 36% of dengue cases diagnosed amongst children 0-14 years of age.[99]

Country-wide, there were a total of 1,878 admissions to tertiary level hospitals due to communicable diseases in 2016, of which 53% (n=997) were children aged 0-14 years. The most common reasons for pediatric hospitalization were respiratory infections[100] (n=380, or 38%), and other infectious and parasitic diseases[101] (n=617, or 62%). Admissions due to non-communicable diseases were considerably higher, 6,412 cases, of which only 13% (n=819) were children aged 0-14 years. The most common diseases were genitourinal[102] (17%), gastrointestinal (16%), respiratory[103] (14%), endocrine (14%) and other diseases.

As most of these conditions can normally be managed at primary healthcare level, and there is no indication as to whether these cases were complicated, it is difficult to estimate the percentage of unjustified hospitalizations. However, available evidence from the field visits and discussions with HPA suggests that there is a growing trend for over-medicalization of pediatric care. This is in part, driven by people going directly to higher level hospitals for care, and universal insurance coverage which guarantees hospital-based treatment free of charge. However, it is also driven by lower level providers commonly referring upwards, and the variable capacity of these providers to manage cases. To a great extent, the latter appears to be explained by poor knowledge and compliance with existing HPA clinical protocols and guidelines, including IMCI, which clearly outline diagnostic procedures, referral criteria and clinical case management approaches at outpatient and hospital levels.

Adolescent Health

Nutrition

There were some positive and negative changes to adolescent nutrition between 2009 and 2014. The percentage of adolescents aged 13-17 years who ate fruits and vegetables three or more times per day and ate breakfast always or most of the time increased from 12.9% to 17.3%, and from 46.5% to 61%, respectively.[104,105] However, as a reflection of changing dietary patterns, the proportion of adolescents in the same age group who consumed carbonated drinks

[98] Maldives Ministry of Health, Maldives Health Statistics 2015-16, 2019
[99] Epidemiological Report 2018, HPA
[100] Upper and lower respiratory tract infections and otitis media
[101] Dengue, diarrheal infections, tuberculosis, meningitis, hepatitis B and other
[102] Nephritis, nephrosis and other
[103] Asthma, chronic obstructive pulmonary disease and other
[104] Global school-based student health survey, 2009
[105] Global school-based student health survey, 2014

increased from 33% to 60%, and the proportion who ate foods from fast food restaurants two or more times during the 7 days before the survey, increased from 16% to 36.7%.[106,107] Findings of a nation-wide school screening survey amongst Grade 7 students (n=4,238) suggest that only 54% of boys and 45% of girls had a normal BMI. Approximately 16% of boys and 30% of girls were underweight, and 25% of boys and 21% of girls were overweight or obese. Anemia was also found to be high, and was 28% amongst boys and 45% amongst girls.[108]

Mental Health

In line with the national mental health policy, the MoH/HPA has significantly expanded mental health services, however, no systematically collected data is yet available. Based on the findings of the Global School-based Student Health Surveys, there is a high prevalence of adolescent mental health-related issues, with all rates significantly higher in atoll areas. Almost 14% of students in these surveys seriously considered attempting suicide, and a high percentage of students self-reported signs of anxiety (15.1%, mostly caused by bullying at schools), depression (35%) and loneliness (16.5%)[109,110]. At the same time, only 26% of students reported that they had been taught effective stress management techniques in schools or elsewhere.

Results related to violence and injuries showed that more than one-third of students reported that they had experienced bullying, physical fights, and serious injuries one or more times. Approximately 23% of students did not go to school because they felt unsafe on their way to or from school, and around 25% of students experienced stealing or deliberate damage to their property. The prevalence of reported sexual abuse and physical coercion to have sexual intercourse was alarmingly high for both female (16.1%) and male students (17.8%).[111] Increasingly, adolescents appear to be unsupervised and exposed to unsafe environments, and the percentage of adolescents who missed classes or school without permission increased from 30.3% to 36.3% between 2009 and 2014. Another alarming finding was that almost 12% of schoolchildren had carried a weapon on school property.[112]

Substance Abuse

The global student-based health survey also found an estimated prevalence of lifetime drug of 5.4%. Among students who ever had tried drugs, 67.7% were 13 years old or younger when they first tried drugs. Around 10% of respondents reported being involved in drug selling or buying, and drug-related crime rates involving children below the age of 16 years, and amongst those in the 16-24 age group, had increased significantly since 2001.[113]

Among students who ever drank alcohol or smoked cigarettes, 73% had their first drink of alcohol before the age of 14 years, while 60.5% of students had their first cigarette before the age of 14 years.[114] Overall, 36.0% of students had

[106] Global school-based student health survey, 2009
[107] Global school-based student health survey, 2014
[108] Adolescent Health Screening Report, HPA, 2015
[109] Global school-based student health survey, 2009
[110] Global school-based student health survey, 2014
[111] Global school-based student health survey, 2009
[112] Maldives Ministry of Education; Global school-based student health survey-Maldives Country Report, 2014
[113] Maldives Ministry of Education; Global school-based student health survey-Maldives Country Report. 2009.
[114] Maldives Ministry of Education; Global school-based student health survey-Maldives Country Report . 2014.

a parent or guardian who used any form of tobacco, and 5.5% of students had a parent or guardian who used alcohol.[115]

Adolescent and Youth Friendly Information and Services

Adolescent Sexual and Reproductive Health (ASHR) is a growing concern in the Maldives, and this is associated with changing socio-cultural norms, increasing age of marriage, and increasing pre-marital sexual activity. As of 2009, 11.6% of youth aged 18-24 reported engaging in premarital sexual activity[116], and, as noted above, reported sexual abuse and coerced sexual practices amongst students in grades 8-10 was very high. [117] As of 2016/17, 5.2% of young women and 15% of young men aged 15-24 reported having sexual intercourse before the age of 18,[118] and more recent qualitative studies suggest that figures are even higher. [119]

However, contraceptive knowledge and use amongst young people remain low as does the comprehensive knowledge of AIDS. While over 90% of ever-married women aged 15-24 know about condoms, less than 50% know about Long-Acting Reversible Contraceptives (LARCs), such as implants and Intra-Uterine Devices (IUDs), or emergency contraception.[120] Similarly, only 35% of ever-married women aged 15-24 have a comprehensive knowledge of AIDS.[121,122] The Gender Equality Act prohibits direct or indirect discrimination based on the circumstances.[123]

In recent years, the Ministry of Education has worked to address the needs of young people through its school health program and its Life Skills, Health and Physical Education courses, and the Ministry of Health/ HPA has worked to address young people's reproductive health needs through establishing adolescent and youth friendly health services, and through developing National Standards for Adolescent and Youth Friendly Health Services for All Young People (2015). The health promoting school policy was developed in 2011, and this was a key step toward providing adolescents with information on healthy practices through Life Skills, Health and Physical Education courses. The school health program also aims at making a child- and adolescent-friendly school environments to promote healthy lifestyles, physical and mental health, and to improve sanitary and hygienic conditions in schools, including proper water supply and sanitation facilities.[124]

The MOE initiated an extra-curricular Life Skills Education (LSE) Program for secondary school students and out of school children in 2004. This program evolved over the years, and, in recent years, attention was given to

[115] Maldives Ministry of Education; Global school-based student health survey-Maldives Country Report . 2009.
[116] Maldives Ministry of Health and Family and ICF Macro; Maldives Demographic and Health Survey 2009; 2010.
[117] Maldives Ministry of Education; Global School Based Student Health Survey – Maldives Country Report; 2009.
[118] Maldives MoH and The DHS Program ICF; Maldives Demographic and Health Survey 2016-17; 2018.
[119] Abdulghafoor H.; Qualitative Assessment on challenges to access SRH/R among young people in the Maldives with a focus on unplanned teenage pregnancy; 2020.
[120] UNFPA Maldives; Reproductive Health Knowledge and Behavior of Young Unmarried Women in Maldives; 2011.
[121] Comprehensive knowledge means knowing that consistent use of a condom during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting the AIDS virus, knowing that a healthy-looking person can have the AIDS virus, and rejecting the two most common local misconceptions about AIDS transmission or prevention.
[122] Maldives Ministry of Health and Family and ICF Macro; Maldives Demographic and Health Survey 2009; 2010.
[123] Gender Equality Act (18/2016), Article 9(b)
[124] Ministry of Education and Ministry of Health and Family; School Health Policy; 2011.

institutionalizing the LSE program and integrating it into the new National Education Curriculum, and the roll out of the new National Education Curriculum is expected to be finished in 2019. [125]

No new data is available on the roll-out of the integrated LSE program, although interviews suggest that teachers and schools continue to face challenges delivering some of the more sensitive, knowledge-based subjects such as sexual and reproductive health. This doesn't appear to be a new issue, and when UNICEF conducted a review of the former LSE program in 2015, it found that the LSE program had only been implemented in certain schools in a limited fashion and in an inconsistent manner. The main reasons for this were reported to be an absence of clear guidelines for implementation at the school level; limited capacity building for LSE facilitators, and the absence of regular monitoring and evaluation systems.[126]

Development of youth friendly health services started in 2004, at nearly the same time as the initiation of the LSE program, and this involved establishing a Youth Health Café at the Social Centre under the Ministry of Youth and Sports. However, these services were discontinued in 2008 when there was a change in government. In 2014-2015, the MoH developed National Standards for Adolescent and Youth Friendly Health Services (NSAYFHS), and the Ministry subsequently piloted adolescent health clinics at Dhamanaveshi Community Health Center in Malè, Kulhudhuffushi Regional Hospital and Eydhafushi Hospital. The new Health Master Plan 2016-2025 reported that 3 government health facilities were providing youth friendly health services as of 2016, and that non-governmental organizations (NGOs) were also providing youth-friendly health services. However, as of 2017, the AYFHS in Kulhudhuffushi and Eydhafushi were no longer fully functional. Many of the elements of the prescribed AYFHS package were missing in Eydhafushi Hospital, and the Kulhudhuffushi Hospital had been privatized with all public health facilities and functions removed from the hospital mandate.[127] Interviews suggest that very few government service providers are aware of the 2015 Standards for AYFSH, and, as of 2019, it appears that only one NGO, the Society for Health Education (SHE), is providing fully-functional AYFHS. SHE is the International Planned Parenthood Federation's (IPPF) local affiliate, and it is currently providing a full complement of AYFHS in its clinic, and it also supports a youth kiosk, a monthly youth safe space and an AYFHS mobile app called Siththaa. However, while SHE does provide periodic outreach sessions to the islands, the majority of the AYFHS services they provide are only available in Malè, and the organization's only clinic is in the capital city.

Cross-Cutting Areas

Gender Based Violence and Child Abuse

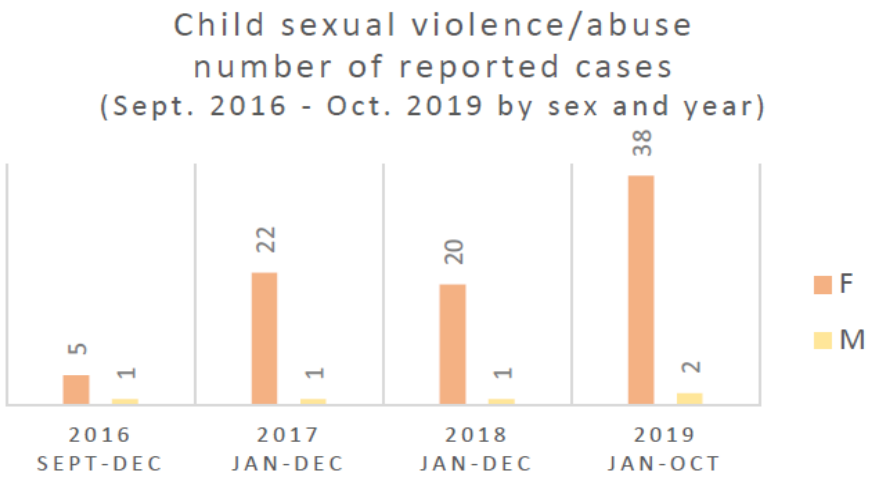
Gender Based Violence (GBV) and Child Abuse are serious concerns in the Maldives. The 2007 Study on Women's Health and Life Experiences found that approximately 6.4% of WRA had experienced physical or sexual violence, and 12.3% had experienced emotional violence, by an intimate partner over the last 12 months. This study also found that

[125] UNICEF Maldives; Review of the Life-Skills Education Programme: Maldives; 2015.
[126] UNICEF Maldives; Review of the Life-Skills Education Programme: Maldives; 2015.
[127] UNFPA Maldives; A brief situation analysis on ASRH Services; 2018.

6.2% of WRA had experienced sexual violence by a non-intimate partner since the age of 15.[128] Data from the recent Demographic and Health Survey (DHS) suggests that limited change has occurred since that time, and as of 2016/17, 5.6% of WRA reported physical or sexual violence, and 14.1% of WRA reported emotional violence, by an intimate partner over the last 12 months.[129]

There is also a steady increase in reported cases of child abuse and rape of children in recent years. Available data from the Ministry of Gender, Family and Social Services (MOGFSS) shows that reported violence and rape of girls is much higher than reported violence and rape amongst boys.[130]

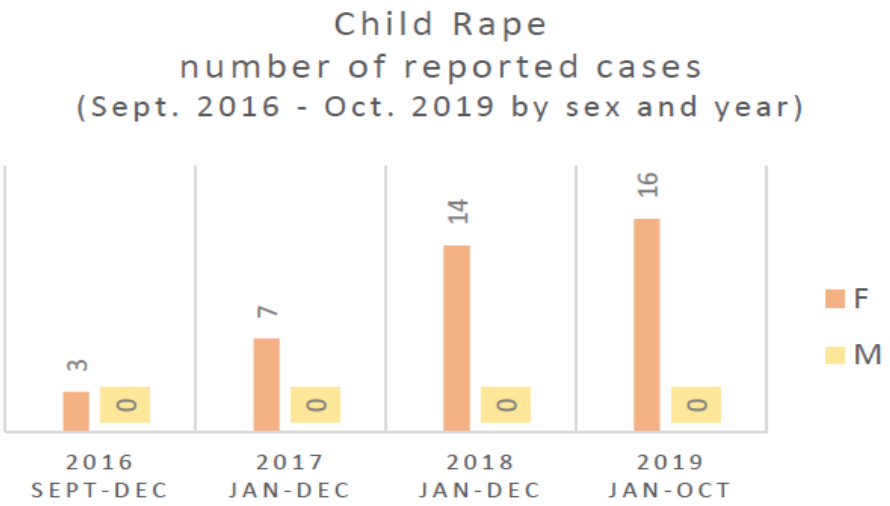
Graph 4: Child Abuse Cases 2016-2019



Source: MOGFSS, 2019.

Graph 5: Child Rape Cases 2016-2019

[128] Maldives Ministry of Gender and Families; The Maldives Study on Women's Health and Life Experiences; 2007.
[129] Maldives MoH and The DHS Program ICF; Maldives Demographic and Health Survey 2016-17; 2018.
[130] Abdulghafoor H.; Qualitative Assessment on challenges to access SRH/R among young people in the Maldives with a focus on unplanned teenage pregnancy; 2020.



Source: MOGFSS, 2019.

The government of the Maldives is working to address these issues, and the Domestic Violence Protection Act (DVPA) was passed in 2012, and a Child Rights Act is currently being developed. The Family Protection Authority was established in response to the DVPA, and, in 2013, the Ministry of Health/Health Protection Agency (HPA) developed the Health Sector Response to GBV - National Guidelines on Providing Care and Prevention for Health Care Providers. These guidelines are based on WHO standards, and were developed in order to improve the health sector's response to GBV, and to fulfill the MOH's obligations under the DVPA. A Plan of Action for the Health Sector was subsequently developed by the MOH and the Ministry of Gender and Family in June 2013, and this was complemented by the Family Protection Authority's training of health staff on the DVPA, and development of an online training course for government health staff on the Health Sector Response to GBV.

However, key informant interviews undertaken in 2018/19 found that GBV reporting from the health sector continues to be low, and very few health staff are aware of or following the new GBV guidelines. For example, while 2712 cases of domestic violence were reported in the Maldives between 2013 and 2018, only 59 (or 2% of) cases were reported by the MOH. This situation was also noted in the Health Master Plan 2016-2025 which stated that the health sector roll-out of the coordinated system of medical examination and health care for victims of GBV had been slow, and that efforts to establish early detection of GBV cases had achieved limited success due to factors such as the lack of space for privacy, and frequent changes of focal points in response teams.[131]

Female Circumcision

According to DHS 2016/17, 13% of Maldivian WRA were circumcised. However, the prevalence of female circumcision increases with age, from only 1% amongst women aged 15-19 to 38% among women aged 45-49, suggesting that female circumcision has decreased significantly over the last 50 years. Anecdotal evidence suggests that in the Maldives, female circumcision mainly falls into the Type 4 category, consisting mostly of small cuts to the genitals. As of 2016/17, there was little difference in the prevalence of female circumcision between regions or wealth groups, but less educated women were far more likely to be circumcised than women with more education. For example, 30.8%

[131] Maldives Ministry of Health; Health Master Plan 2016-2025; 2016.

of women with no education were circumcised compared to 11.6% amongst those with more than a secondary education. Traditional forms of female circumcision have decreased significantly.[132]

However, according to key informants more radical forms of female circumcision had been introduced in recent years, yet according to the the MDHS 2016/17 the prevalence of female circumcision was only 1% amongst women aged 15-19 suggesting that female circumcision has decreased significantly over the last 50 years. Female circumcision/FGM, is now internationally recognized as a violation of the human rights of girls and women; it constitutes an extreme form of discrimination against women, and can cause severe bleeding, problems urinating, infections, as well as later complications in childbirth and increased risk of newborn deaths.[133]

RMNCAH in Emergencies

Some progress has been made in terms of RMNCAH in emergency situations. In 2018, UNFPA and the Society for Health Education (SHE) supported the government of the Maldives to adapt the Minimum Initial Service Package (MISP) for reproductive health, maternal and newborn health, HIV and GBV to the Maldivian context, and to integrate it into national emergency preparedness and response plans. As of late 2019, work is still on-going to formally incorporate/operationalize MISP in the Health Emergency Operational Plan and the National Emergency Preparedness and Response Plan, and work is also ongoing to include social protection and inclusion into these plans.

Enabling Environment

As has been noted, the Maldives is currently implementing a highly medicalized model of health care, and service delivery is often verticalized. The country is dependent on expatriate health professionals to deliver services, especially medical and specialist services outside of Malè. Health insurance is paying for specialist care, regardless of whether it is medically indicated, and these features are driving up the proportion of GDP spent on health care.

Observations made during field visits undertaken as part of this strategy development process point to the fact that foreign specialists at lower levels of care are not fully aware of, or following, national guidelines or standards; they have very low case-loads and are seeing cases that could be managed by nurses, midwives or general practitioners. For example, pediatricians are commonly reporting that they see children with the common cold, and Ob/Gyns are commonly reporting that they do all ANC and deliveries in their respective facilities.

There is also a clear de-link between public health and clinical care services, and low levels of funding for public health services. There is no systematic sharing of patient information between doctors and community health workers (CHWs) or family health workers (FHWs), and difficulties in tracking of patients. There is a clear need for HMIS/DHIS for harmonizing the public health and clinical services area data for decision making. Funding for public health services in recent years has been very low, and in 2018/19 public health staff consistently reported that they had very limited/no budget for outreach or for supervision. Encouragingly, a high-level public health forum was held in November 2019, and the MOH has now committed itself to increasing funding and support to public health care.

[132] Maldives MoH and The DHS Program ICF; Maldives Demographic and Health Survey 2016-17; 2018.
[133] WHO, Factsheet on Female Genital Mutilation; 2018.

However, in order to reduce the heavy case-loads and long wait times for the tertiary hospitals in Malè, the MOH/HPA are simultaneously working to upgrade five regional hospitals to tertiary hospitals, and it is unclear to what extent resources will be available to both further expand public health care and to further expand tertiary hospital services.

Strategy and Action Plan

This RMNCAH strategy builds on achievements of previous NRHS 2005 – 2007, 2008- 2010 and 2014- 2018. The Strategy and action plan will also contribute to achievement of the SDGs, the Health Master Plan 2016-2025 and the Strategic Action Plan 2019-2023.

The Strategy and Action Plan 2020-2025 has one overarching goal, and six strategic areas – Reproductive Health, Maternal Health; Newborn Health; Child Health; Adolescent Health and Cross Cutting Issues. Each Strategic Area is comprised of a number of sub-areas and each of these sub-areas is comprised of an objective and key interventions. For ease of reference, key interventions are divided into three categories: Governance/Enabling Environment; Supply Side and Demand Side.

The strategy's goal, principles, strategic areas, objectives and key interventions are described below, and more detailed information on indicators and targets can be found in Annex 1 – RMNCAH Strategy Monitoring Framework. Additional information on the timing and responsibility for key interventions can be found in Annex 2- the RMNCAH Action Plan.

Principles

The RMNCAH Strategy and Action Plan 2020-2025 are based on a human rights-based approach, and reinforce the rights of women, children and adolescents, both girls and boys. The strategy and action plan reinforce equity, universal health coverage, and leaving no one behind, and is comprised of evidence-based interventions that build on previous experience, and international best practices.

Goal

Improve the health, nutritional status and well-being of women, newborns, children, and adolescents.

Strategic Area 1: Reproductive Health

Objective 1.1: Family Planning

By 2025, reduce unmet need and unintended pregnancies, and increase demand satisfied by modern family planning methods, through increasing awareness, availability and access to quality FP information and services.

Key Issues to be Addressed

- Contraceptive prevalence rate appears to have significantly reduced while unmet need has increased and total fertility rate has decreased.
- There are likely to be many reasons for this situation, less involvement of community and religious leaders, the split between clinical and public health services are likely to have contributed to this decrease in contraceptive prevalence.
- Low levels of exposure to information on contraceptives, apprehension of the long-term effects of hormonal methods, increasing use of traditional methods (particularly the rhythm method), whether there is increasing infertility due to PCOS and endometriosis or whether there is increasing use of abortion.
- Method mix skewed toward male condoms (6.5%), and female sterilization (4.4%) and people increasingly accessing contraceptives from the private sector.
- Implanon is mainly available in greater Malè area as it requires trained health care personal for insertion and removal.
- It is not clear how mCPR and demand satisfied by modern contraceptive methods declines, while the TFR also declines.

Key Interventions

Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)

- Finalize and disseminate new FP standards.

Supply Side

- Use existing knowledge and data to address identified obstacles to contraceptive use:
    - Ensure all FP methods (including Implanon and LARCs) are consistently available at different service delivery levels/facilities per new standards;
    - Ensure appropriate space is available for counseling and providing FP at different service delivery levels/facilities;
    - Train nurses, midwives, health careworkers, and other staff, as relevant, on LARCs;
    - Assess/supervise FP service providers;
- Expand collaboration with NGOs and the private sector for provision of FP info and services (e.g. hospitals, clinics and pharmacies);

Demand Side

- Increase awareness of individuals/couples and religious and community leaders on family planning including how FP promotes the health of women and children and increases the well-being and prosperity of families and communities, available methods (including EC and male

sterilization), where services are available, and dispel mis-information about hormonal methods and explain risks of traditional methods

- Mass Media- TV spots;
- Social Media;
- Print Materials for use in health facilities;
- Inter-personal communication during consultation, outreach, ANC, and PNC;

Objective 1.2: Abortion

By 2025, ensure that health facilities are aware of and continue to provide comprehensive abortion care, and that reflects to according to the fatwa.

Key Issues to be Addressed

- Not all facilities are providing abortion even if allowed under the fatwa;
- Align country policy with the current WHO recommendation to use the combined regimen of misoprostol and mifepristone once.

Key Interventions

Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)

- Update the abortion protocol and essential drug and drug import list to include the WHO recommended combined regimen of misoprostol and mifepristone in accordance with WHO recommendations for medical abortion;
- Policy discussions regarding the legal barriers to implementing fatwa on abortion, and consider including provisions in the fatwa for people with disabilities;

Supply Side

- Disseminate and provide training to health staff in tertiary, regional and atoll hospitals on updated abortion protocol;
- Reinforce and monitor that health facilities providing abortion services to ensure they are providing services according to the fatwa and updated protocol;
- Train midwives in provision of abortion care;

Demand Side

- Increase awareness according to fatwa through mass media;
- Promote FP and that every child should be a wanted child.

Objective 1.3: STIs and HIV

By 2025, maintain zero mother to child transmission of HIV and Syphilis and decrease STI incidence and morbidity through promoting awareness and prevention, and increasing availability and access to quality STI information and services.

Key Issues to be Addressed

- High vulnerability, risk and epidemic potential due to low levels of HIV/STI knowledge and condom use;
- Increase awareness of available information/services for high-risk and vulnerable groups.
- Increase availability of information and services for high risk/vulnerable groups (potentially through online info/service delivery platforms e.g. expanding Siththaa)
- Genital warts are reported to be common;
- HIV/STI program needs to be further strengthened. Limited information on the incidence of STIs other than HIV and Syphilis due to:
    - Limited availability of chlamydia and gonorrhea testing;
    - Limited knowledge and capacity of non-specialists to do STI screening and testing.

Key Interventions

Governance/Enabling Environment (Policies, Guidelines, Standards and Research)

- Increase collection and availability of STI data;

Supply Side

- Continue to provide routine testing for HIV and Syphilis during ANC, and provide appropriate anti-retroviral treatment for mother/child, as necessary;
- Move away from the syndromic approach for STIs, and move toward disease specific testing and treatment (particularly for gonorrhea and chlamydia) in tertiary, regional and atoll hospitals. This will involve:
    - Increasing lab capacity in tertiary, regional and atoll hospitals, and
    - Increasing knowledge and capacity of GPs, OB/Gyn to do STI screening and testing;

Demand Side

- Promote awareness and prevention of STIs, particularly amongst high-risk and vulnerable groups, and provide information on where information and services are available;
- Promote information on availability and access to condoms for prevention of STIs.

Objective 1.4: Cervical Cancer

Decrease mortality due to cervical cancer through increasing HPV coverage for girls aged 10-13, and increasing cervical cancer screening for women aged 30-50.

Key Issues to be Addressed

- Initial coverage and continuity of cervical cancer screening is limited;
- Screening is opportunistic rather than routine and there is limited ability to track screening status;

Key Interventions

Governance and Enabling Environment (Policies, Guidelines, Standards and Research)

- Add HPV vaccination and cervical cancer screening information to children's vaccination cards and/or mother's cards to enable better tracking;
- Maintain E- cancer register;
- Establish cervical cancer screening recall system;
- Update national cervical cancer screening programme in line with new WHO strategy for elimination of cervical cancer;

Supply Side

- Introduce and train staff on updated national cervical cancer screening programme and monitor its implementation;
- Introduce HPV screening in line with new WHO and national strategy;
- Expand geographic availability of cervical cancer screening particularly in islands and atolls;
- Promote the importance of routine screening of women amongst health workers;
- Continue annual HPV vaccination for girls:
    - Collaborate with schools and provide the first vaccine at school, if appropriate;
    - Establish and advertise annual time/place for HPV vaccination;
    - Follow-up girls who do not return for the second vaccination;

Demand Side

- Increase awareness amongst the general population, and particularly amongst WRA, and religious and community leaders of cervical cancer and the importance of prevention and early detection and treatment, including HPV vaccination and routine cervical cancer screening;
- Provide information to parents of 10-year-old girls on the benefits of HPV vaccination, the need for 2 vaccines and potential side effects.

Objective 1.5: Infertility and RH Morbidities

By 2025, increase availability and access to care for RH morbidities such as PCOS and endometriosis.

Key Issues to be Addressed

- There is limited information and awareness of RH morbidities, although PCOS and endometriosis are reported to be common;
- Care for PCOS and endometriosis is limited and is not covered by the national insurance system.

Key Interventions

Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)

- Undertake research to:
    - Understand how the fertility rate continues to decline despite decreasing contraceptive prevalence, and to
    - Identify the prevalence of key reproductive RH morbidities; the availability and cost of existing services; the impact these morbidities are having on the lives of those affected, and the challenges these individuals face;
- Use the results of the above research to advocate for inclusion of care for RH morbidities (e.g. PCOS and endometriosis) and infertility treatment and services (e.g. fertility testing and in-utero insemination/IVF) in the national health insurance benefit package;

Supply Side

- Increase availability and quality of care for RH morbidities and infertility including:
    - Ensure all regional and tertiary hospitals can diagnose and manage PCOS;
    - Ensure all central/tertiary hospitals can manage more complex cases such as endometriosis;
    - Introduce IUI and IVF services in the country;

Demand Side

- Disseminate and publicize the results of the above research to increase community awareness of RH morbidities (e.g. PCOS and endometriosis) and infertility; and how these issues are affecting people's lives.

Strategic Area 2: Maternal Health

Objective 2.1: Antenatal and Postnatal Care

By 2025, increase the proportion of pregnant women receiving adequate, timely, high quality ANC and PNC.

Key Issues to be Addressed

- 2018 targets for ANC and PNC were not achieved;
- Recent WHO ANC and PNC recommendations needs to be incorporated into local service delivery standards/practices; and
- Package and timing of services varies between facilities, and limited quality and content of counselling.

Key Interventions

Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)

- Finalize and disseminate national minimum standards for ANC/PNC:
    - Incorporate new WHO ANC/PNC recommendations into these standards;
    - Reinforce comprehensive counselling during ANC;
    - Introduce child-birth training workshops during ANC where pain management options and the risks of c-sections are clearly explained, and
    - Introduce midwifery led model of care;
- Strengthen supervision/monitoring mechanisms at central level
- Digitalize records within an integrated HMIS/DHIS2 system for easy access for program interventions and policy decisions.

Supply Side

- Train midwives and OB/Gyns on national minimum standards for ANC/PNC, counselling, child birth training workshops and midwifery led model of care;
- Orient new recruits on national minimum standards for ANC/PNC (can be combined with overall orientation of new recruits on national standards and guidelines);
- Undertake supportive supervision to reinforce usage of the national standards and to increase quality of care;
- Monitor implementation of the national minimum standards by regulatory authority at Ministry of Health;

Demand Side

- Increase community awareness of:
    - The importance of 8+ ANC and 4 PNC visits with a comprehensive service package,
    - Midwifery led care for normal ANC and PNC (Consider combining with other demand side community awareness interventions for intrapartum care and nutrition amongst WRA).

Objective 2.2: Intrapartum Care

By 2025, increase the quality of intrapartum care, achieve universal coverage of deliveries in health facilities, and reduce the provision of non-medically indicated c-sections.

Key Issues to be Addressed

- 95% of women are delivering in a health facility, this figure remains the same between 2009 and 2016/17;
- Quality of care is variable;
- Blood stocks/blood banks are limited only available in Malè and in 3 regional and 1 atoll hospital, and patients are often expected to supply their own donors, and
- The c-section rate is inappropriately high (40%) and increasing.

Key Interventions

Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)

- Develop and disseminate national intrapartum care standards that incorporate: a) recent WHO recommendations for MH, intrapartum care, PPH and eclampsia, and b) reinforce the role of midwives in managing normal deliveries;
- Develop and disseminate clinical practice standards for C-sections which include some of the WHO/FIGO recommendations for reducing un-necessary c-sections such as:
    - Use a uniform classification system for c-sections (Robson/WHO classification)
    - Undertake audits of all c-sections;
    - Get mandatory second opinions for all c-sections;
    - Publish hospital c-section rates;
- Develop (or incorporate MH/intrapartum care into) supervision/monitoring mechanisms at central level and introduce systems for periodic auditing of partographs and routine auditing of c-sections by regulatory body at Ministry of Health;
- Study availability and usage of blood supplies throughout the country;
- Meet with the national health insurance authority and request that the benefit package is revised and that national health insurance only pays 100% for c-sections when medically indicated;

Supply Side

- Train providers on national minimum standards of intrapartum care, and clinical practice standards for C-sections;

- Orient new recruits on intrapartum care standards and clinical practice standards for C-sections (can be combined with overall orientation of new recruits on national standards and guidelines);
- Undertake supportive supervision to reinforce usage of the national standards and to increase quality of care;
- Monitor implementation of the national minimum standards and conduct periodic auditing of partographs and routine auditing of c-sections;
- Increase availability of blood supplies throughout the country, prioritizing high use locations outside of Malè identified through the above research, and locations where a large number of deliveries are taking place;
- Ensure essential obstetric care services with trained birth attendants and primary care providers are available at all levels of the health system;
- Strengthen implementation of the maternal and perinatal death surveillance and response system by regulatory authority of Ministry of Health;

Demand Side

- Increase awareness of community members of the importance of delivering in a health facility, the benefits of midwifery led care, and the pros and cons of c-section vs. normal delivery (Can combine with other demand side community awareness interventions for ANC/PNC and nutrition amongst WRA).

Objective 2.3: Nutrition amongst Women of Reproductive Age

By 2025, increase the proportion of women with adequate and appropriate nutrition and micronutrient intake, and who receive adequate, timely and high-quality nutrition care and support.

Key Issues to be Addressed

- Nearly half of all WRA in the Maldives (49%) are now overweight or obese and this has negative consequences for the mother and child;
- 63% of WRA are anemic and this is considered to be of severe public health significance according to WHO;
- Maternal undernutrition continues to be a challenge and 11% of WRA are considered to be thin (body mass index <18.5 kg/m2); and 8% of WRA are considered to be short (<145 cm tall);
- Iron folic acid (IFA) supplementation is provided to all pregnant women during ANC first trimester, but compliance is limited
- There is no large-scale food fortification with iron/folic acid and fortified foods not currently available in the Maldives.

Key Interventions

Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)

- Integrate latest WHO preconception, pregnancy and post-partum nutrition recommendations on healthy eating, micronutrient supplementation (iron-folic acid or multiple micronutrients, and calcium), deworming prophylaxis, weight gain monitoring, and physical activity for pregnant women into national ANC/PNC standards and training packages (combine with activity related to finalizing ANC/PNC standards under ANC and PNC objective);
- Coordinate with the State Trading Organization (STO), and the Ministries of Economic Development and Finance to improve access to nutritious, safe and affordable diets for women through large-scale food fortification:
    - Fortify foods (flour and or rice) with iron and folic acid (for prevention of iron-deficiency anemia amongst WRA, children and adolescents, and prevention of birth defects);
    - Potentially subsidize the costs of these fortified foods to incentivize use by the general population and ensure access by vulnerable groups (combine with same child and adolescent health intervention);
- Conduct nutrition related research to guide public health policy and programme interventions:
    - Determine the prevalence, types and determinants of anemia in WRA, and evaluate modifiable and nonmodifiable factors (combine with same child health intervention);
    - Determine implementation bottlenecks and optimal approaches to drive improvements in the coverage, quality and equity of maternal nutrition interventions;
- Strengthen the monitoring and tracking of key maternal child nutrition coverage indicators (through household surveys, health information systems, DHIS2 and programme monitoring and reporting systems);

Supply Side

- Strengthen counselling on dietary intake and healthy lifestyle during ANC, PNC and FP, and during healthy pregnancy home visits;
- Train midwives and OB/Gyns and health workers on updated national minimum standards for ANC/PNC including delivery of a comprehensive maternal nutrition package (combine with similar activity under ANC/PNC);
- Undertake supportive supervision, mentoring, and action-oriented feedback to increase quality of care in provision of maternal nutrition services as part of ANC, FP, and healthy pregnancy home visits (combine with similar activity under FP and ANC/PNC);

Demand Side

- Increase community and family awareness of the importance of a healthy lifestyle and nutritious and safe diets for women; the negative effects of overweight, obesity, and anemia, and the benefits of prenatal iron/folic acid supplementation and iron/folic acid fortification (if taking place) using a variety of approaches including healthy mother campaigns, and the Yagooth mobile application

  (Can combine with other demand side community awareness initiatives for ANC/PNC and intrapartum care).

Strategic Area 3: Newborn Health

Objective 3.1: Birth Defects

By 2025, strengthen prevention, early detection, treatment and rehabilitation of birth defects, including thalassemia.

Key Issues to be Addressed

- Birth defects is the second largest cause contributing to neonatal mortality (30%);
- Increase community and family awareness of the importance of a healthy lifestyle
- Limited success in prevention, early detection (including ultrasonographic examination) and rehabilitation of patients with birth defects;

Key Interventions

Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)

- Continue discussions with the State Trading Organization (STO), and the Ministries of Economic Development and Finance to improve access to nutritious, safe and affordable diets through large-scale food fortification:
  - fortify foods (flour and or rice) with iron and folic acid (for prevention of iron-deficiency anemia amongst WRA, children and adolescents, and prevention of birth defects);
  - potentially subsidize the costs of these fortified foods to incentivize use by the general population and ensure access by vulnerable groups;
- Include regional and private hospitals in the national birth defects surveillance system;
- Expand the national surveillance system for early identification of country-specific genetic metabolic disorders;
- Update/develop and disseminate protocols for clinical, instrumental and laboratory neonatal screening and case management for birth defects, metabolic disorders and sensory deficits, including universal neonatal hearing screening;
- Include birth defects prevention in new national strategies for the control of non-communicable diseases and HIV, STIs and Hepatitis B and C;

- Develop diagnostic protocol for the use of chorionic villus sampling test (CVS) for early detection of thalassemia;

Supply Side

- Improve quality of antenatal screening for early detection of birth defects, including fetal ultrasonography, genetic and biochemical screening at tertiary hospitals;
- Strengthen pre-marital counselling for thalassemia risk assessment;
- Improve referral of high-risk pregnancies (women +35 years, known family history of birth defects, gestational diabetes, epilepsy etc.) to tertiary hospitals;
- Strengthen laboratory diagnostic services for detection of TORCH infections;
- Introduce CVS test for early detection of thalassemia in tertiary and Regional hospitals;
- Expand availability of care (clinical management and rehabilitative services) for birth defects, including thalassemia and early referral;

Demand Side

- Increase community awareness of most common birth defects, including causes and risk factors, prevention, detection, treatment and care in the country and abroad.

Objective 3.2: Small and Sick Newborns

By 2025, reduce the proportion of low birthweight and pre-term births and stillbirths and improve quality of care for small and sick newborns.

Key Issues to be Addressed

- Prematurity is the leading cause of neonatal mortality (40%);
- High proportion of very small or smaller than average newborns (13%);
- Increase in the proportion of low birth weight newborns (13%);
- Need to expand capacity in advanced newborn care at Regional and Atoll levels;

Key Interventions

Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)

- Update and disseminate clinical protocols and minimum standards of care for the management of small and sick newborns at all levels of care;
- Disseminate new ANC minimum standards (combine with the same activity under Maternal Health);
- Conduct a feasibility study for the use of BABIES matrix to improve registration of perinatal deaths and improve quality of care;
- Scale up perinatal death auditing as part of the Maternal and Perinatal Death Surveillance and Response System by the regulatory authority at Ministry of Health;
- Provisions for emergency transportation and evacuation of high-risk newborns with main national airline carriers;

- Develop criteria and standard operating procedures for medical evacuation and retrieval of high-risk newborns through Aasandha;

Supply Side

- Continue to train healthcare providers in the management of small and sick preterm newborns at Regional and Atoll Hospitals;
- Ensure that equipment and medical commodities in Regional hospitals are appropriate to provide advanced newborn care;
- Conduct regular supportive supervision of Regional and Atoll Hospitals;
- Strengthen routine ANC system with emphasis on women at risk (gestational diabetes, gestational intermittent hypoxia, substance abuse, malnutrition etc.) (combine with ANC interventions under Maternal Health);
- Improve referral system to tertiary hospitals for women at risk of pre-term labor through Aasandha;

Demand Side

- Increase community awareness on risk factors and prevention of preterm births and low birth weight (combine with communication strategy for the prevention and control of birth defects as most risk factors are the same).

Objective 3.3: Healthy Newborns

By 2025, improve quality of essential newborn care, including promotion and support of breastfeeding (early initiation of breastfeeding and exclusive breastfeeding), timely administration of birth dose vaccines, and appropriate home-based care for newborns and infants.

Key Issues to be Addressed

- Early initiation of breastfeeding and exclusive breastfeeding rates and its continuity are still low;
- Essential newborn care needs to be reinforced in all health facilities;
- Coverage of basic vaccinations were seen to decrease in MDHS2016-17;

Key Interventions

Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)

- Update and disseminate clinical protocols and standards for essential newborn care at all levels of care;
- Roll out the social and behavior change communication strategy for the first 1000 days;
- Strengthen the enforcement of national legislation on the International Code of Marketing of Breast-milk Substitutes and related WHA resolutions

- Disseminate operational and clinical guidelines on the Baby Friendly Hospital Initiative and develop certification/re-certification system (or include BFHI in larger hospital accreditation system);
- Monitor compliance with national legislation on the marketing of breastmilk substitutes, including online advertisement of breast milk substitutes, targeted to infants (combine with similar advocacy activity under Child Health);
- Disseminate Vaccination Policy of Maldives;
- Establish National Vaccination Surveillance System (including maternal, child and nutrition indicators);
- Introduction of 6 months maternity leave (combine with same activity in Maternal Health);

Supply Side

- Continue to refresh and train healthcare providers in the essential newborn care at Regional and Atoll Hospitals;
- Conduct regular supportive supervision of Regional and Atoll Hospitals (and Island Hospitals performing deliveries and providing newborn care);
- Implement Baby Friendly Hospital Initiative in all atoll, regional and tertiary hospitals; conduct regular monitoring and supportive supervision visits and implement certification/re-certification system
- Train/re-train healthcare workers on healthy feeding practices for infants, and counseling and interpersonal communication skills (combine with the same activity under Child Health);
- Provide IYCF counselling for caregivers and families (combine with the same activity under Child Health);

Demand Side

- Increase community awareness on the importance of early initiation of breastfeeding, exclusive breastfeeding and optimal home-based newborn and infant care (use the First 1000 Days Communication Strategy);
- Conduct health education sessions for mothers and caregivers on danger signs in the neonatal period.

Strategic Area 4: Child Health

Objective 4.1: Routine Childhood Vaccination

By 2025, increase coverage with age-appropriate vaccinations and reduce vaccine hesitancy and vaccine refusal.

Key Issues to be Addressed

- Vaccination coverage and completeness rates are decreasing;
- National EPI supply chain and cold chain needs constant monitoring and optimization;
- Surveillance for vaccine-preventable diseases needs to be reinforced;

Key Interventions

Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)

- Disseminate Immunization Policy of Maldives;
- Strengthen national surveillance and diagnostics system for vaccine preventable diseases (EPI), including sample collection, laboratory confirmation and response mechanisms;
- Strengthen national surveillance system for Adverse Events Following Immunization;
- Integrate immunization coverage data into DHIS/Online Database;
- Conduct research on bottlenecks and challenges in vaccination coverage, including vaccine hesitancy and refusal;

Supply Side

- Provide refresher trainings to health providers on vaccine communication, AEFI, vaccine administration, including temperature control, minimization of vaccine wastage, health education and counselling, especially for vaccine hesitancy and refusal;
- Promote team approach between public health, clinical and general staff to increase vaccination coverage and reduce missed opportunities;
- Strengthen infrastructure and logistics for vaccine storage, transportation and maintenance of cold chain at all levels, including implementing recommendations of the EVM Study;
- Strengthen follow-up mechanism on immunization;
- Publish the research on vaccine hesitancy and refusal and implement the recommendations;
- Develop and implement targeted interventions to increase access and coverage of vulnerable groups with immunization;

Demand Side

- Increase community awareness on immunization, including through ANC, PNC and pre-marital counselling;
- Implement UNICEF Vaccine Communication and Demand Generation Strategy
- Increase civil society participation on vaccination awareness at community level.

Objective 4.2: Child Nutrition

By 2025, increase the proportion of children who have adequate and appropriate nutrition and micronutrient intake, and who receive adequate, timely and high-quality nutrition care and support.

Key Issues to be Addressed

- Prevalence of stunting (15%), wasting (9%) and obesity (5%), and very high prevalence of anemia (49%);
- The feeding practices of only half of children age 6-23 months (51%) in the Maldives meet the minimum acceptable diet;
- Concerns on increasing consumption of unhealthy foods and beverages high in energy, sugar, fat, and salt;

Key Interventions

Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)

- Strengthen the enforcement of national legislation on the International Code of Marketing of Breast-milk Substitutes and related WHA resolutions;
- Advocate for maternity protection and breastfeeding support policies in the workplace;
- Strengthen the adoption and enforcement of legislation to regulate the promotion of foods for young children;
- Strengthen the food environment and advocate for a ban on the advertisement and sponsorship of unhealthy food products targeted to children, including junk food, sugary and carbonated drinks;
- Advocate for enhancing the transparency of nutritional information through front-of-package food labelling in English and Dhivehi;
- Disseminate and implement the SBCC First 1000 Days Communication Strategy and strengthen linkages with ECD to promote and support breastfeeding and complementary feeding (combine with same activity under Newborn health);
- Continue discussions with the State Trading Organization (STO), and the Ministries of Trade and Finance to improve access to age appropriate fortified complementary foods for children aged 6-23 months and other fortified foods that meet quality standards:
    - fortify foods (flour and or rice) with iron and folic acid (for prevention of iron-deficiency anemia amongst WRA, children and adolescents, and prevention of birth defects);
    - potentially subsidize the costs of these fortified complementary foods to incentivize use by the general population and ensure access by vulnerable groups (combine with same maternal and adolescent health interventions);
- Conduct relevant research to guide public policy and programme interventions:
    - Determine the prevalence, types and determinants of anemia in children and evaluate modifiable and nonmodifiable factors;
    - Determine implementation bottlenecks and optimal approaches to drive improvements in the coverage, quality and equity of child nutrition interventions;

(Combine with same maternal health interventions)

- Update and implement School Health Policy and Standards in all schools;
- Strengthen the monitoring and tracking of key child nutrition coverage indicators (through household surveys, health information systems and programme monitoring and reporting systems);

Supply Side

- Train/re-train health workers on healthy feeding practices for young children, and counseling and interpersonal communication skills through multi-channel social and behaviour change communication approaches;
- Enhance access and utilization of infant and young child nutrition counselling for caregivers and families and linkage with ECD;
- Promote access to diverse, nutritious, safe and locally available foods;
- Conduct laboratory screening for anemia in high-risk infants and children (signs of malnutrition, low birth weight, prematurity, signs and symptoms of anemia, chronic diseases etc.) and refer for treatment;
- Continue annual deworming campaigns in children 24-59 months;
- Continue biannual vitamin A supplementation campaigns in children 9-59 months;
- Strengthen supportive supervision, mentoring, and action-oriented feedback to increase quality of care in provision of child nutrition services including delivery of skilled counselling support;

Demand Side

- Increase social behavior change communication and community and family awareness on healthy nutrition, including through establishing collaboration with civil society and national media and promotion of messages on healthy nutrition focusing on priority infant and young child feeding behaviours (use the First 1000 Days Communication Strategy;
- Strengthen linkages with social protection and welfare programmes to reduce financial barriers at community and household level in accessing nutritious, safe and affordable diets for young children.

Objective 4.3: Care for Common Childhood Diseases

By 2025, improve diagnosis, treatment and care for common childhood (communicable and non-communicable) diseases, mental health issues and disabilities.

Key Issues to be Addressed

- Implementation of INMCI guidelines for the management of common childhood illnesses is weak;

Key Interventions

Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)

- Review, revise and disseminate adapted IMCI package for the primary health care facilities and WHO's Guidelines for Hospital Care for Children;
- Develop/update and disseminate clinical protocols and guidelines for childhood non-communicable diseases, including care for children with severe wasting, mental health issues, developmental delays and disabilities;
- Provide technical support to Aasandha to update hospitalization and referral guidelines/criteria for childhood illnesses including severely wasted children;
- Strengthen surveillance system on childhood NCDs (birth defects, cancer and injury);

Supply Side

- Conduct orientation and re-training programs for health professionals on clinical protocols and guidelines for management of childhood communicable and non-communicable diseases, including severely wasted children;
- Conduct regular supportive supervision to monitor implementation of IMCI guidelines and other protocols on child health, including nutritional support for severely wasted children;
- Conduct regular audit of hospital admissions at Regional and Atoll levels to ensure appropriateness of hospitalization and quality of pediatric care;
- Conduct regular patient audits to ensure compliance with protocols on child health including nutritional support for severely wasted children;

Demand Side

- Increase community awareness on causes and risk factors of childhood communicable and non-communicable diseases, including severe wasting in young children, mental health issues and disabilities;
- Conduct community awareness and education programs to promote healthy behavior and lifestyles.

Objective 4.4: Early Childhood Development

By 2025, promote interventions for early childhood development, including early stimulation and responsive feeding, and early detection, management and referral for disabilities, developmental delays and disorders.

Key Issues to be Addressed

- Current approaches related to ECD focus on physical growth monitoring and need to be reviewed to promote child well-being and holistic development;

Key Interventions

Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)

- Develop/update protocols and guidelines for early detection and intervention, and care for children with developmental delays and disorders;
- Develop/update referral mechanisms and guidelines for diagnosis, management and care of children with developmental disorders and disabilities;
- Conduct study on ECD practices and develop multi-sectoral ECD policy for children 0-3 years;
- Develop quality standards for public and private providers of ECD services;

Supply Side

- Reinforce the correct use of growth monitoring tools, focusing on emotional, cognitive and social development and early identification of disabilities, developmental delays and disorders;
- Train/re-train health providers in providing support to families and care-takers for early stimulation and responsive feeding;
- Train/re-train health providers in basic screening for early identification and referral and management of developmental delays and disorders;
- Develop capacity of pre-school teachers, social workers and health professionals on promoting ECD;
- Conduct regular joint monitoring of public and private providers of ECD services;
- Develop comprehensive awareness programs to empower parents on ECD;

Demand Side

- Increase community awareness on the importance of ECD; regular child growth monitoring with emphasis on emotional, cognitive and social development; early signs of common disabilities, developmental delays; and pathways to access specialized care (use the First 1000 Days Communication Strategy).

Objective 4.5: Mental Health

By 2025, promote mental health and well-being, and increase the availability and quality of mental health and psychosocial services for children.

Key Issues to be Addressed

- Increasing prevalence of mental health issues in children, especially Autism Spectrum of Diseases and Global Developmental Delay;[134]
- Increasing prevalence of school-based violence and bullying;
- Increasing prevalence of Attention deficit hyperactivity disorder, self-harm, depression and suicidal behavior;

Key Interventions

Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)

- Disseminate National Mental Health Policy 2015-2025 and National Mental Health Strategic Plan 2016-2021 to tertiary, Regional and Atoll hospitals (combine with the same activity under Adolescent Health);
- Finalize National Suicide Prevention Strategy and Mental Health Act (combine with the same activity under Adolescent Health);
- Develop a new National Mental Health Strategic Plan 2022-2027 which includes a focus on children (combine with the same activity under Adolescent Health);
- Conduct national mental health survey to identify common mental health issues amongst key target groups including children (combine with the same activity under Adolescent Health);
- Establish a system for early identification of common mental health issues in childhood and referral mechanisms;

Supply Side

- Increase access to mental health services for children through targeted and longer-term strategies to cover all the regions and atolls;
- Strengthen mental health support available, including referral mechanism, for children in schools and build the capacity of school counsellors;
- Ensure that every school has a licensed school counselor, and a system in place for training and supervision of school counsellors (combine with the same activity under Adolescent Health);

Demand Side

[134] Maldives Ministry of Health; Health Master Plan 2016-2025; 2016

- Increase community awareness on mental health issues with the objective of fighting against stigma on mental health.

Strategic Area 5: Adolescent Health

Objective 5.1: Adolescent Nutrition

By 2025, increase the proportion of adolescents and young people who have an adequate and appropriate nutrition and micronutrient intake, and who receive adequate, timely and high-quality nutrition care and support.

Key Issues to be Addressed

- High prevalence of underweight (21.4%), overweight and obesity (21.6%), and anemia (33.2%) amongst adolescents and young people;
- Concerns on increasing consumption of unhealthy foods and beverages high in energy, sugar, fat, and salt;
- Knowledge and skills gaps for good nutrition and active living amongst adolescents and young people;

Key Interventions

Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)

- Foster healthy food environment and advocate for a ban on the advertisement (including sports event sponsorships, school-related activities and billboards) of unhealthy food and beverage products targeted to adolescents, including junk food, processed meat, sugary and carbonated drinks, and carcinogenic products such as betel nut and its products (combine with the same activities under Newborn and Child Health);
- Develop food standards in school settings that make healthy food available and restrict the availability of unhealthy food;
- Continue discussions with the State Trading Organization (STO), and the Ministries of Economic Development and Finance to improve access to nutritious, safe and affordable diets for adolescents and young people through large-scale food fortification;
    - fortify foods (flour and or rice) with iron and folic acid (for prevention of iron-deficiency anemia amongst WRA, children and adolescents, and prevention of birth defects);
    - potentially subsidize the costs of these fortified foods to incentivize use by the general population and ensure access by vulnerable groups (combine with same maternal and child health interventions);

- Advocate for introduction of subsidies for wholegrain products, removal of subsidies for sugar and reduction of taxes and duties on fruits and vegetables;
- Advocate for removal of sugar sweetened drinks from meal packages in restaurants e.g. removing free high calorie sugary drinks e.g. coca cola with pizza package;
- Adapt STEPS instrument to the context of the Maldives, and include youth 17-24 years, and use survey findings to develop and implement targeted interventions and regular monitoring of status and coverage of adolescent nutrition interventions;

Supply Side

- Reinforce nutrition and physical education in secondary schools as a means of promoting healthy lifestyle, body image and diet and preventing overweight and obesity by:
    - increasing time for physical activity and sports within the curriculum;
    - ensuring school canteens do not provide unhealthy drinks and food, and promoting healthy food in school ceremonies and celebrations;
    - piloting a home science module in schools that are focused on healthy living (healthy food, active life);
- Increase the frequency and coverage of regular comprehensive health screening (nutrition, SRH, mental health) of school, college and university students;
- Train primary healthcare/public health workers and school health officers to provide nutrition/healthy lifestyle counselling and health check-up for adolescents and youth with underweight, overweight and obesity;
- Strengthen supportive supervision, mentoring, and action-oriented feedback to increase quality of provision of adolescent nutrition services;
- Incorporate health, healthy diets and well-being module in MEMIS;

Demand Side

- Increase community awareness on the causes, risk factors and consequences of underweight, overweight and obesity, anemia and folic acid deficiency and the value of a healthy lifestyle and diet;
- Use social networks, peer groups and influential persons to promote healthy eating, and physical activity;
- Increase awareness among adolescents and youth on health risks associated with food supplements e.g. protein shakes, protein bars and skin/hair supplements.

Objective 5.2: Mental Health

By 2025, promote mental health and well-being, and increase the availability and quality of mental health and psychosocial services for adolescents and youth.

Key Issues to be Addressed

- Incidence of mental health issues amongst adolescents and young people (depression, anxiety, self-harm and suicide) is increasing;

Key Interventions

Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)

- Disseminate National Mental Health Policy 2015-2025 and National Mental Health Strategic Plan 2016-2021 to tertiary, Regional and Atoll hospitals (combine with same activity under Child Health);
- Develop a new National Mental Health Strategic Plan 2022-2027 which includes a focus on adolescents and youth (combine with same activity under Child Health);
- Conduct national mental health survey to identify common mental health issues amongst key target groups including adolescents and youth (combine with same activity under Child Health);
- Establish a system for early identification of common mental health issues and referral mechanisms (combine with same activity under Child Health);
- Establish national protocol and guidelines for national media on reporting news on mental health issues e.g. suicide, substance abuse and school-based violence;
- Conduct mapping of mental health service providers to provide information, including through social networks, to help adolescents and youth locate mental health services;

Supply Side

- Provide mental health services (identification, treatment, advocacy and referral) including psychosocial counselling and mental well-being promotion in accordance with national plan to establish mental health services at Regional and Atoll levels;
- Train health providers on mental health policy and adapted protocols and the importance of early detection and referral of adolescents and youth with mental health issues;
- Provide training based on mhGAP for gatekeepers, including primary health care workers, school counsellors, school health officials, teachers, youth and social workers;
- Ensure that every school has a licensed school counselor, and a system in place for training and supervision of school counsellors;
- Establish safe spaces in community centers to provide youth development and health services e.g. skills building, life skills program for adolescents and youth;

Demand Side

- Pilot parenting project to increase awareness of parents, families and care-takers of special needs and challenges of adolescence and the importance of creating positive, safe and protective environments for adolescents at home, school and in the community;

- Increase awareness of adolescents and youth on mental health issues such as depression, anxiety, suicidal tendencies, stress management etc.;
- Increase awareness of adolescents and youth on social health issues such as building caring and trusting relationships, safe environment, positive behaviors, emotional resilience and self-esteem, problem solving and coping skills;
- Increase awareness of adolescents and youth on gaming and screen time addiction;
- Use electronic resources, including social networks and platforms, for self-help, peer-to-peer education and support groups;
- Promote awareness-raising campaigns to reduce stigma and promote care/help-seeking and access to mental health services.

Objective 5.3: Substance Abuse

By 2025, strengthen prevention of substance abuse, including narcotic drugs, alcohol, and tobacco and its products, amongst adolescents and youth.

Key Issues to be Addressed

- Incidence of substance abuse amongst adolescents and young people (narcotic drug abuse, alcohol tobacco and its products) is increasing;

Key Interventions

Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)

- Strengthen collaboration with National Drug Agency and relevant NGOs for prevention and treatment of substance abuse;

Supply Side

- Train healthcare providers at PHC level in early detection and referral of adolescents with suspected substance abuse (combine with the same activity under Adolescent Mental Health);
- Provide technical expertise to NDA in:
    - establishing detox and rehabilitation centers for adolescents and youth;
    - establishing different treatment modalities and protocols at detox and rehabilitation centers e.g. methadone treatment;
    - organizing and conducting training of service providers at detox and rehabilitation centers;
- Establish linkages with regional mental health programs and youth development programs to provide community services for adolescents and young people with substance use (e.g., vocational trainings, skills development, career opportunities);
- Pilot technology-based interventions for prevention and treatment of substance abuse (use research findings as a model);

Demand Side

- Conduct mass-media campaigns to raise awareness of the dangers of tobacco, vaping, sheesha, alcohol and illicit drugs and availability of services.

Objective 5.4: Adolescent Sexual and Reproductive Health

By 2025, increase availability and quality of SRH information and services that are responsive to the needs of adolescents and youth.

Key Issues to be Addressed

- ASHR is an area of concern an`d is associated with changing socio-cultural norms, increasing age of marriage, and increasing pre-marital sexual activity;
- Reported sexual abuse and coerced sexual practices amongst students in grades 8-10 is very high;
- Contraceptive knowledge and use amongst and comprehensive knowledge of AIDS amongst young people is low; and
- The availability of AYF information and services is very limited;

Key Interventions

Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)

- Review delivery of the integrated LSE program in the new curriculum, school health and PE curricula, with emphasis on SRH and other adolescent health issues, and update/revise as necessary;
- Ensure incorporation of LSE, CSE and STI prevention modules into teacher training curriculum at MNU and private colleges;
- Ensure SRH is incorporated into the Youth Act;
- Advocate for ways to tackle adolescent health issues in the community;

Supply Side

- Develop/expand innovative online AYF information and service delivery platforms e.g. expanding Siththaa and providing information on SRH for newlyweds;
- Support and expand provision of AYF information and services through NGOs and other service delivery platforms;
- Increase access and coverage with SRH services to vulnerable groups e.g. PWDs, substance users and migrants;
- Strengthen promotion of condom use for dual protection and ensure availability of emergency contraception;
- Strengthen collaboration with Ministry of Education and schools to ensure that integrated services (SRH and mental health) are provided to young mothers;

- Strengthen collaboration with the Ministry of Education and schools, and increase capacity of teachers and health workers for delivery of integrated LSE, school health and PE curricula, particularly the SRH and other adolescent health issues;

Demand Side

- Increase awareness of adolescents and youth, migrant population, community leaders, parents, teachers, PTAs, health service providers and religious leaders on the importance of SRH issues and the negative consequences of teen pregnancy and STIs, including HIV;
- Provide information, including through social networks, to help adolescents and youth locate providers for SRH information and services.

Strategic Area 6: Cross-Cutting Issues

Objective 6.1: Gender Based Violence, Domestic Violence and Child Abuse

By 2025, increase awareness, detection and reporting of GBV and DV in the health sector.

Key Issues to be Addressed

- GBV, DV and Child Abuse are serious concerns in the Maldives;
- There has been a steady increase in reported child abuse and rape cases in recent years, and there has been no decrease in the prevalence of GBV;
- Reporting and documentations of GBV/DV and child abuse cases from the health sector are areas that needs to be strengthened
- National Guidelines for the Health Sector Response to GBV in place yet healthcare providers needs to be constantly sensitized as its an ongoing process due to high turnover of the workforce especially doctors.
- GBV e-module in place for easy acquaintance to the guideline as it's based on the National Guidelines for the Health Sector Response to GBV which all healthcare professionals are advised to undertake which the health facility manager needs to ensure.

Key Interventions

Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)

- Update the National Guidelines for the Health Sector Response to GBV and update the Online Training Module by adding an annex to include responsibilities for child abuse (per the new child rights act and other relevant legislation);
- Establish/strengthen monitoring and accountability mechanisms for implementation of the national guidelines and ensure adequate human resources are in place for implementation;

- Develop an integrated data-entry and management system for reporting of GBV/DV/child abuse from the health sector with stratified levels of access to facilitate the generation of coherent and consistent data. (As far as possible, use or link to existing information systems such as the Geveshi Portal/MCPD/DHIS);

Supply Side

- Disseminate updated guidelines and information on the new data entry and reporting system, and reinforce that health staff and new recruits take the updated online training course;
- Undertake supportive supervision to reinforce implementation of the national guidelines and to increase appropriate reporting of GBV/DV/child abuse per the new reporting system;
- Monitor Health Facility GBV/DV and Child Abuse Reporting by regulatory authority on a monthly basis.

Objective 6.2: Female Circumcision/FGM

By 2025, further reduce the prevalence of female circumcision through increasing awareness that female circumcision/FGM is a harmful practice and a human rights violation.

Key Issues to be Addressed

- Traditional forms of female circumcision have decreased significantly.
- Anecdotal evidence suggests that in the Maldives, female circumcision mainly falls into the Type 4 category, consisting mostly of small cuts to the genitals.
- The prevalence of female circumcision increases steeply with age according to MDHS 2016-17, from only 1% among women age 15-19 to 38% among women age 45-49.

Key Interventions

Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)

- Develop policy to stop the promotion and public endorsement Female Circumcision/FGM;

Supply Side

- Increase awareness amongst the community and stakeholders that female circumcision is:
    - A harmful practice and a human rights violation;
    - Radical forms of female circumcision can cause severe health problems for women;

Demand Side

- Develop and launch a public awareness campaign to:

- Increase awareness amongst national, religious and community leaders and members that female circumcision is a harmful practice and a human rights violation and radical forms of female circumcision can cause severe health problems for women;
- Increase public support and encourage reporting

Objective 6.3: RMNCAH in Emergencies

By 2025, fully integrate and operationalize RMNCAH within Emergency Preparedness and Response Plans and initiatives.

Key Issues to be Addressed

- The MISP (for SRH, MNH, HIV and GBV) has been adapted to the Maldivian context, but has not yet been formally incorporated/operationalized in the National Emergency Preparedness and Response Plans and Health Emergency Operational Plan, and
- It is not yet clear whether child, adolescent health and nutrition have been fully incorporated into these plans.

Key Interventions

Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)

- Formally incorporate and operationalize MISP in the Health Emergency Operational Plan and the National Emergency Preparedness and Response Plans;
- Review the Health Emergency Operational Plan and the National Emergency Preparedness and Response plans and revise to incorporate child and adolescent health needs and nutrition, if necessary;

Supply Side

- Train and undertake practical drills with health staff on the operationalization of the updated MISP (and additional child health, adolescent health and nutrition elements, if added);
- Ensure every island has available service kits and human resources to provide MISP.

Strategic Area 7: Enabling Environment

Objective 7.1: Public Health

By 2025, significantly increase funding and staffing for critical public health services.

Key Issues to be Addressed

- There has been a decrease in the funding and functioning of public health (PH) services, and coverage of some key public health services (e.g. family planning and vaccination) is declining, and

- Service delivery is verticalized and there is a de-link between public health and curative care services.

Key Interventions

Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)

- Advocate with senior government officials/politicians regarding the importance of public health services (and increase their awareness of the issues associated with the current highly medicalized model of care);
- Increase government funding for PH services, especially for RMNCAH;
- Increase staffing/recruitment for PH services;
- Develop mechanism to monitor PH expenditure;
- Establish patient tracking/electronic medical records system and strengthen links between PH and curative care services;
- Create multi-sectoral coordination mechanism to implement RMNCAH strategy;

Supply Side

- Increase awareness amongst health staff and professional associations of the importance of public health services and the issues associated with the current highly medicalized model of care;
- Build capacity of staff on the patient tracking/electronic medical records system;

Demand Side

- Increase community awareness (to change public perception) of the importance of public health services; the issues associated with the current highly medicalized model of care, and empower the community to prioritize public health.

Objective 7.2: Primary Health Care

By 2025, re-introduce a primary health care-oriented service delivery model.

Key Issues to be Addressed

- The Maldives is implementing a very costly, highly medicalized model of care and is highly dependent on international health professionals to deliver services, especially outside of Malè, and
- Service delivery is verticalized, and specialists are providing the majority of care and are often being seen for basic health issues.

Key Interventions

Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)

- Advocate with senior government officials/politicians regarding the importance of a primary health care-oriented service delivery model (and increase their awareness of the issues associated with the current highly medicalized model of care);
- Re-introduce a primary health care (PHC) oriented service model where Community Health Workers (CHWs), Family Health Workers (FHWs), midwives, nurses and General Practitioners (GPs) manage normal/basic cases, and specialist care is accessible (and only fully covered by insurance) on referral;
- Introduce a patient centered approach to PHC – particularly for island and urban health centers
    - Provide comprehensive services to a mother-child pair (FP, counselling, growth monitoring, vaccination, nutrition information, etc.);
    - Consider providing visiting GP services);
- Develop a model and costed plan for developing additional urban health centers in Malè and get approval for implementation;

Supply Side

- Increase awareness amongst health staff and professional associations of the importance of a primary health care-oriented service delivery model; the issues associated with the current highly medicalized model of care, and the potential benefits of a patient centered approach to care);
- Work with academia, and professional associations to introduce and train staff on the new primary health care (PHC) oriented service model, and the patient centered approach to care;
- Review and revise service and staffing packages and rationalize the availability of specialist care, particularly at atoll and HC level;
- Expand training of Maldivian GPs with deployment to islands and atolls;
- Expand and develop additional urban community health centers in Malè;

Demand Side

- Increase community awareness of the benefits of the new primary health care-oriented service delivery model and the patient-centered approach to care;
- Promote and market the opening of new urban community health centers in Malè.

Overarching Risks and Mitigation Measures

The strategy faces a number of risks during implementation. These include: a) stagnant or decreasing government financing to the health sector; b) limited willingness or resources to strengthen public health and primary health care as agreed during the Public Health Forum in November 2019; c) limited capacity for implementation; d) vulnerability

to climate change and natural disasters, and e) religious context. Risk Mitigation measures are expected to include: a) advocacy for continued/increased government financing to the health sectors; b) advocacy for increased support to public health and primary health care; c) inclusion of capacity building and disaster preparedness and response interventions in the actual strategy, and e) cross-sectoral engagement and advocacy to mitigate religious context.

Monitoring and Evaluation

The RMNCH Strategy and Action Plan 2020-2025 will be monitored annually, and more formal reviews will be undertaken mid-way through implementation (e.g. in 2022) and towards the end of implementation (e.g. in 2025). The main basis for reviewing the RMNCAH Strategy and Action Plan will be the RMCAH Monitoring Framework found in Annex 1, and the RMNCAH Action Plan found in Annex 2. The RMNCAH coordinating committee will have responsibility for overseeing these monitoring and review processes, and relevant units in the MOH/HPA will be responsible for collecting relevant data and information.

Annual reviews of the Strategy and Action Plan will be used to inform MOH/HPA annual planning and budgeting processes, and these reviews will be used to monitor progress against key interventions in the action plan. These reviews will also be used to adjust future interventions as necessary, and to assess progress against the objectives, key indicators and targets, if data is available. The mid-term review should be a more strategic assessment of progress to date, and should also provide recommendations for making improvement in the remaining years of implementation, 2023-2025.

The final, external review of the strategy and action plan should look at progress over the full implementation period (e.g. 2020 to 2025). It should thoroughly assess progress in relation to the overall goal and specific objectives of the strategy, and should also provide recommendations for key issues to be addressed in the RMNCAH Strategy and Action Plan 2025-2030.

Annexes:

Annex 1. RMNCAH Strategy Monitoring Framework

	Indicators	Baseline	Objectives of existing strategy	Target						Source of Data
		2016-2018		2020	2021	2022	2023	2024	2025	
Goal										
Goal: Improve the health, nutritional status and well-being of women, newborns, children, and adolescents.	Maternal Mortality Ratio (SDG 3.1.1) (<2/3 reduction from 2010 baseline (87) by 2030 (29)	44 (MOH VSR 2016) 53 (Global Es. 2017)	Maintain MMR<50 per 100000						29.36	Global Estimate and MOH VSR
	# of Maternal Deaths per year	4 (2018)							2	MOH VSR
	Neonatal Mortality Rate (SDG 3.2.2)	4.8 (2018)							3.6	UNIGME
	< 5 Mortality Rate (SDG 3.2.1)	8.6 (2018)							6.5	UNIGME

	Indicators	Baseline	Objectives of existing strategy	Target						Source of Data
		2016-2018		2020	2021	2022	2023	2024	2025	
	Prevalence of stunting amongst children < 5 years (SDG 2.2.1)	19% (2009)							9.5%	DHS
	Prevalence of wasting amongst children < 5 years (SDG 2.2.2)	9% (2009)							< 5%	DHS
	Prevalence of overweight amongst children < 5 years (SDG 2.2.2)	6% (2009)							4.5%	DHS
	Prevalence of overweight and obesity amongst WRA	49.3%							< 49.3%	DHS
	Prevalence of anemia amongst WRA (World Health Assembly global nutrition indicator)	63%							20.5%	DHS
	Prevalence of anemia amongst children < 5 years	49.7% (2016/17)							44.7%	DHS

	Indicators	Baseline	Objectives of existing strategy	Target						Source of Data
		2016-2018		2020	2021	2022	2023	2024	2025	
	Adolescent Birth Rate (SDG 3.7.2)	1.6%							<1.6%	DHS
Strategic Area 1: Reproductive Health										
Objective 1.1: Family Planning By 2025, reduce unmet need, and increase demand satisfied by modern family planning methods through increasing awareness, availability and access to high-quality FP information and services.	Contraceptive Prevalence Rate (married women; modern methods)	14.9% (2016/17)	Increase in CPR to >39%						17.4%	DHS DHIS2
	% of married women with an unmet need for contraception	31.4% (2016/17)							28.9	DHS
	% of married women who have their demand/need for FP satisfied by modern methods	29.8% (2016/17)							32.3%	DHS
	% of WRA who have their demand/need for FP satisfied by modern methods (SDG 3.7.1)	29.4% (2016/17)							31.9%	DHS

	Indicators	Baseline	Objectives of existing strategy	Target						Source of Data
		2016-2018		2020	2021	2022	2023	2024	2025	
	Method Mix (married women)	condom (M) – 6.5% Sterilization (F) – 4.4% Pill -2.2% Traditional methods – 4% (2016/17)							Increased diversity of modern method usage and reduced traditional method usage	DHS DHIS2
Objective 1.2: Abortion By 2025, ensure that health facilities are aware of and continue to provide comprehensive abortion care, and that reflects to according to the fatwa.	% of tertiary (T), regional (R) and atoll (A) hospitals are aware of and continue to provide comprehensive abortion care, and that reflects to according to the fatwa.	TBC		T =100% R=20% A=0-5%	T =100% R=40% A=10%	T =100% R=60% A=25%	T =100% R=80% A=50%	T =100% R=100 % A=80%	T =100% R=100% A=100%	MOH/ QARD monitoring reports

	Indicators	Baseline	Objectives of existing strategy	Target						Source of Data
		2016-2018		2020	2021	2022	2023	2024	2025	
	% of tertiary(T), regional (R) and atoll (A) hospitals providing medical abortion using WHO recommended regimen of misoprostol AND mifepristone	T=0% R=0% A=0%							T=100% R=100% A=100%	MOH/QARD Monitoring Reports
Objective 1.3: STIs and HIV By 2025, maintain zero mother to child transmission of HIV and Syphilis, and decrease STI incidence and morbidity through increasing awareness, prevention, and availability and access to quality STI information and services.	# of reported cases of HIV and Syphilis transmitted from mother to child	HIV = 0 Syphilis = 0 (2018)		0 0	0 0	0 0	0 0	0 0	0 0	MOH Health Statistics
	Incidence of gonorrhea	NA							TBC once baseline determined	MOH Health Statistics
	# of tertiary (T), regional (R) and atoll (A) hospitals able to test for gonorrhea and chlamydia	T = 1 R = 0 A = 0		T = 2 R = 0 A = 0	T= 3 R = 2 A = 3	T= 4 R = 3 A =6	T = 4 R = 6 A=10	T = 5 R = 6 A= 13	T =5 (incl. Hulhumale & Equitorial) R = 6 A= 13	MOH Health Statistics/ HPA Reports

	Indicators	Baseline	Objectives of existing strategy	Target						Source of Data
		2016-2018		2020	2021	2022	2023	2024	2025	
Objective 1.4: Cervical Cancer By 2025, increasingly prevent and decrease mortality due to cervical cancer through increasing HPV coverage for girls aged 10-14, and increasing cervical cancer screening for women aged 30-50.	Age Standardized Mortality Rate for Cervical Cancer	13.4 (2018)		13.2	13	12.8	12.6	12.4	12	Global Cancer Observatory
	% HPV coverage for girls aged 10-14	TBC		75%	80%	80%	90%	95%	> 95%	HPV vaccination records
	% women aged 30-50 years who have been screened for cervical cancer	TBC		20%	35%	40%	50%	60%	70%	Facility or Hospital based Cervical Cancer Screening Program Registry/ MOH Health Statistics
Objective 1.5: Infertility and RH Morbidities By 2025, increase availability and access to	% of regional hospitals providing diagnosis and treatment of PCOS	TBC		75%	75%	90%	90%	100%	100%	MOH Health Statistics

	Indicators	Baseline	Objectives of existing strategy	Target						Source of Data
		2016-2018		2020	2021	2022	2023	2024	2025	
care for RH morbidities such as PCOS and endometriosis.	% of tertiary hospitals providing diagnosis and treatment of endometriosis and or unexplained infertility	TBC		75%	75%	75%	100 %	100 %	100%	MOH Health Statistics
	# of facilities in the country providing assisted reproductive medicine	0					1 IUI in Malè		1 IUI and 1 IVF in Malè	MOH Health Statistics
Strategic Area 2: Maternal Health										
Objective 2.1: ANC and PNC By 2025, increase the proportion of pregnant women receiving adequate, timely, high quality ANC and PNC.	% of pregnant women receiving at least 4 and 8 ANC checks	8 = TBC 4 = 82% (2016/17)				8 = 80% 4 = 100 %			8 = 85% 4 = 100%	DHS DHIS2 HMIS
	% of pregnant women who had an ANC check during the first trimester	95% (2016/17)				97%			99%	DHS

	Indicators	Baseline	Objectives of existing strategy	Target						Source of Data
		2016-2018		2020	2021	2022	2023	2024	2025	
	% of pregnant women counselled for birth preparedness	75% (2016/17)				80 %			85%	DHS
	% of women receiving PNC within 2 days of delivery	80% (2016/17)				85 %			90%	DHS
Objective 2.2: Intrapartum Care By 2025, increase the quality of intrapartum care, achieve universal coverage of deliveries in health facilities, and reduce the provision of non-medically indicated c-sections.	% of women delivering with a skilled health professional (SDG 3.1.2)	100% (2016/17)							100%	DHS, DHIS2 HMIS
	% of women delivering in a health facility	95% (2016/17)							100%	DHS DHIS2 HMIS
	% of audited partograms where births were managed correctly	NA							95%	Ministry of Health regulatory authority Partograph Audit Reports
	% of deliveries by c-section	40%							30%	DHS DHIS2 HMIS

	Indicators	Baseline	Objectives of existing strategy	Target						Source of Data
		2016-2018		2020	2021	2022	2023	2024	2025	
	% of audited c-sections that are determined to be medically indicated	NA							95%	Ministry of Health regulatory authority C-Section Audit reports
Objective 2.3: Nutrition amongst WRA By 2025, increase the proportion of WRA with adequate and appropriate nutrition and micronutrient intake, and who receive adequate, timely and high-quality nutrition care and support.	% of WRA who eat 5+ fruit or vegetables per day	15-24: 3.9% 25-34: 5.2% 35-44: 7.0% (2011)							15-24:7% 25-34:8% 35-44:10 %	STEPS survey - NCD Risk Factor Survey
	Proportion of mothers who took Iron supplements (tablets/syrup) during last pregnancy for 90+ days	46.3% (2016/17)							75%	DHS DHIS2 HMIS
	Availability of iron/folic acid fortified staple foods	No iron/folic acid				Iron /folic			Iron/folic acid fortified	MOH / MFDA Reports

	Indicators	Baseline	Objectives of existing strategy	Target						Source of Data
		2016-2018		2020	2021	2022	2023	2024	2025	
		fortified food available in the country				acid fortified foods widely available in the country			foods widely available in the country	
Strategic Area 3: Newborn Health										
Objective 3.1: Birth Defects By 2025, strengthen prevention, early	Prevalence rate of birth defects, by type, per 1,000 live births	Overall: 63.4							Overall: 60.2	National Birth Defects Surveillance Register

	Indicators	Baseline	Objectives of existing strategy	Target						Source of Data
		2016-2018		2020	2021	2022	2023	2024	2025	
detection, treatment and rehabilitation of birth defects, including thalassemia										integrated with HMIS
	Incidence rate of thalassemia, per 1,000 live births	1.6 (2019)							1.0	MBS
	% of thalassemia patients utilizing standard treatment (blood transfusion and iron chelation therapy)	47% (2019)							51.7%	MBS
Objective 3.2: Small and Sick Newborns By 2025, reduce the proportion of low birthweight and pre-term births and stillbirths and improve quality of care for small and sick newborns	% of newborns with low birth weight (<2,500g)	13% (2016/17)							10%	MOH Health Statistics DHS DHIS2 HMIS
	% of preterm newborns (<37 weeks of gestation)	12.0% (2019)							10%	MOH Health Statistics DHIS2 HMIS

	Indicators	Baseline	Objectives of existing strategy	Target						Source of Data
		2016-2018		2020	2021	2022	2023	2024	2025	
	Stillbirth rate, per 1,000 total births	6 (2016)[135]							4	MOH Health Statistics DHIS2 HMIS
	% of LBW newborns on health facility-initiated Kangaroo Mother Care	NA							TBD	MOH Health Statistics DHIS2 HMIS
	% of perinatal deaths for which perinatal mortality audit was conducted	11.75							TBD	MOH/ VRS
Objective 3.3: Healthy Newborns By 2025, improve quality of essential newborn care, including promotion and support of breastfeeding (early initiation of	% of newborns who had a postnatal check within the first 2 days after birth	82% (2016/17)							100%	DHS DHIS2 HMIS
	% of newborns who had birth dose of Hepatitis B vaccine	91.5% (2016/17)							100%	DHS DHIS2 HMIS

[135] Maldives Health Statistics, 2015-2016, Ministry of Health, 2019

	Indicators	Baseline	Objectives of existing strategy	Target						Source of Data
		2016-2018		2020	2021	2022	2023	2024	2025	
breastfeeding and exclusive breastfeeding), timely administration of birth dose vaccines, and appropriate home-based care for newborns and infants	% of newborns who had BCG vaccine	91.8% (2016/17)							100%	DHS DHIS2 HMIS
	% of infants 0-5 months who are exclusively breastfed	63.5% (2016/17)							70%	DHS DHIS2 HMIS
	% of newborns who were breastfed within 1 hour of birth	66.5% (2016/17)							75%	DHS DHIS2 HMIS
Strategic Area 4: Child Health										
Objective 4.1: Routine Childhood Vaccination By 2025, increase coverage with age-appropriate vaccinations and reduce vaccine hesitancy and vaccine refusal	% of children 12-23 months receiving all age-appropriate basic vaccinations	76.7% (2016/17)				90%			98%	HPA DHS DHIS2 HMIS
	% of children 12-23 months with no vaccination	8% (2016/17)							1%	HPA DHS DHIS2

	Indicators	Baseline	Objectives of existing strategy	Target						Source of Data
		2016-2018		2020	2021	2022	2023	2024	2025	
										HMIS
	% of children 12-23 months receiving 3 doses of Polio vaccine	81.8% (2016/17)				90%			98%	HPA DHS DHIS2 HMIS
	% of children 24-35 months receiving 2 doses of Measles vaccine	75.3% (2016/17)				90%			98%	HPA DHS DHIS2 HMIS
	% of boys 10-14 years receiving HPV	0% (2019)				90 %			> 95%	DHS HPA MOH
Objective 4.2: Child Nutrition By 2025, increase the proportion of children who have adequate and appropriate nutrition and micronutrient intake, and	% of children 6-23 months who receive a minimum acceptable diet	51.2%[136] (2016/17)							60%	DHS
	% of children 6-23 months who consumed foods rich in vitamin A in last 24 hours	90.6% (2016/17)							95%	DHS

[136] All children (breastfed and non-breastfed) 6-23 months

	Indicators	Baseline	Objectives of existing strategy	Target						Source of Data
		2016-2018		2020	2021	2022	2023	2024	2025	
who receive adequate, timely and high-quality nutrition care and support.	% of children aged 6-23 months who consumed foods rich in iron in the last 24 hours	72% (2016/17)							77%	DHS
	% of caregivers who received counselling on IYCF	NA							TBC	MOH HPA
Objective 4.3: Care for Common Childhood Diseases	% of appropriate pediatric hospitalizations	NA							TBC	MOH
By 2025, improve diagnosis, treatment and care for common childhood (communicable and non-communicable) diseases, mental health issues and disabilities	% of audited cases which were diagnosed and treated according to IMCI guidelines	NA							TBC	MOH
Objective 4.4: Early Childhood Development	% of children 36-59 months attending organized child education programs	78% (2016/17)							85.8%	DHS HMIS

	Indicators	Baseline	Objectives of existing strategy	Target						Source of Data
		2016-2018		2020	2021	2022	2023	2024	2025	
By 2025, promote interventions for early childhood development, including early stimulation and responsive feeding, and early detection, management and referral for disabilities, developmental delays and disorders										
	% of children 0-59 months with developmental delays or disability identified	NA							TBC	MOH HMIS
Objective 4.5: Mental Health By 2025, promote mental health and well-being, and increase the availability and quality of mental health and psychosocial services for children	% of children 6-12 years who attempted suicide	NA							TBC	MOH School surveys Police reports HMIS
	% of Regional Hospitals with mental health units	0%							100%	MOH
	% of schools providing basic mental health support	0%							100%	MOE MOH

	Indicators	Baseline	Objectives of existing strategy	Target						Source of Data
		2016-2018		2020	2021	2022	2023	2024	2025	
Strategic Area 5: Adolescent Health										
Objective 5.1: Nutrition By 2025, increase the proportion of adolescents and young people who have adequate and appropriate nutrition and micronutrient intake, and who receive adequate, timely and high-quality nutrition care and support	% of students aged 13-17 who usually drank carbonated soft drinks one or more times per day during the 30 days before the survey	33.6% M: 37.3% F: 30.1% (2014)							30.2% M=35.5% F=27%	GSHS
	% of students aged 13-17 who usually ate fruit three or more times per day during the 30 days before the survey	8.5% M=10.0% F=6.5% (2014)							9.4% M=11.0% F=7.2%	GSHS
	% of students aged 13-17 who described weight as slightly or very overweight	27.4% M=23.4% F=31.6%							24.6% M=21.1% F=28.4%	GSHS

	Indicators	Baseline	Objectives of existing strategy	Target						Source of Data
		2016-2018		2020	2021	2022	2023	2024	2025	
		(2014)								
Objective 5.2: Mental Health By 2025, promote mental health and well-being, and increase the availability and quality of mental health and psychosocial services for adolescents and youth	% of adolescents 13-17 years who attempted suicide	13.2% M=14.9% F=10.8% (2014)							11.8% M=13.4% F=9.7%	GSHS
	% of Regional Hospitals with mental health units	0%							60%	MOH
	% of schools providing basic mental health support	0%							70%	MOH MOE
	% of adolescents and youth with positive clinical outcomes following treatment or counselling (effectiveness of care)	NA							TBC	MOH/ CMH
	% of adolescents and youth who completed prescribed treatment/counselling sessions (continuity of care)	NA							TBC	MOH/CMH

	Indicators	Baseline	Objectives of existing strategy	Target						Source of Data
		2016-2018		2020	2021	2022	2023	2024	2025	
Objective 5.3: Substance Abuse By 2025, strengthen prevention of substance abuse, including narcotic drugs, alcohol, and tobacco and its products, amongst adolescents and youth	% of adolescents 13-17 years who currently smoke cigarettes	11.2% M=16% F=6.1% (2014)							10 % M=14% F=5%	GSHS
	% of adolescents 13-17 years who currently use other tobacco products	7.5% M=10.2% F=4.3% (2014)							6 % M=9% F=3%	GSHS
	% of adolescents 13-17 years who currently use marijuana	5.0% M=7.2% F=2.5% (2014)							4.5% M=6.4% F=2.2%	GSHS
	% of adolescents 13-17 years who used heroin	5.9% M=7.4% F=3.8% (2014)							5.3% M=6.6% F=3.4%	GSHS
	% of adolescents 13-17 years who used a prescription drug without a doctor's prescription	17.2% M=16.6% F=17.3%							15.4% M=14.9% F=15.5%	GSHS

	Indicators	Baseline	Objectives of existing strategy	Target						Source of Data
		2016-2018		2020	2021	2022	2023	2024	2025	
		(2014)								
Objective 5.4: Adolescent Sexual and Reproductive Health By 2025, increase availability and quality of SRH information and services that are responsive to the needs of adolescents and youth	% of adolescents 15-19 years who have comprehensive knowledge of HIV[137]	24.1% M=21.3% F=26.9% (2016/17)							26.5% M=23.4% F=29.5%	DHS
	Unmet need for contraception amongst adolescents and young people 15-24 (all; modern methods)	36.9% (2016/17)							27.6%	DHS
	Number of facilities (public, private, NGOs and online platforms) providing AYFHS in line with national guidelines	NA							TBC	MOH MoYS MoE NGO's
Strategic Area 6: Cross-Cutting Areas										

[137] Using condom every time they have sexual intercourse, limiting sexual intercourse to one uninfected partner, knowing that a healthy-looking person can have HIV, and rejecting most common misconceptions about HIV transmission or prevention (that HIV can be transmitted by mosquito bites, supernatural means, sharing food with HIV-infected person and protective power of religion)

	Indicators	Baseline	Objectives of existing strategy	Target						Source of Data
		2016-2018		2020	2021	2022	2023	2024	2025	
Objective 6.1: Gender Based Violence, Domestic Violence and Child Abuse By 2025, increase awareness, detection and reporting of GBV/DV/child abuse in the health sector.	% of health staff who have taken online GBV e-module on health sector response to GBV	TBC							95%	MoH (HR)
	# of child abuse/ under 18 marriage cases reported by health sector per year	NA							TBC	
	#/% of GBV/DV/abuse cases reported by the health sector per year	59/2712 or 2% (2013-2018)							25%	FPA
	% of health professionals whose job description/licensing/appraisal includes requirement to complete HSR-GBV module	0%							100%	MoH/CSC
Objective 6.2: Female Circumcision	% of WRA who have underdone FGM/cutting (SDG 5.3.2)	13%							< 10%	DHS

	Indicators	Baseline	Objectives of existing strategy	Target						Source of Data
		2016-2018		2020	2021	2022	2023	2024	2025	
By 2025, further reduce the prevalence of female circumcision through increasing awareness that female circumcision/FGM is a harmful practice and a human rights violation.	# of reported cases of FGM/C	NA							TBC once baseline figure available	MOGFSS
Objective 6.3: RMNCAH in Emergencies By 2025, fully integrate and operationalize RMNCAH within Emergency Preparedness and Response plans and initiatives.	Status of RMNCAH in Emergency Preparedness and Response Plans	MISP for SRH, MNH, HIV and GBV adapted to Maldivian context		MISP for SRH, MNH, HIV and GBV formally incorporated into Health Emergency Operational Plan and National Emergency Preparedness	MISP, Health Emergency Operational Plan and National Emergency Preparedness and Response Plan reviewed and Child, Adolescent Health and				RMNCAH fully incorporated and operationalized in the Health Operational and National Emergency Preparedne	Health Emergency Operational Plan National Emergency Preparedness and Response Plan

	Indicators	Baseline	Objectives of existing strategy	Target						Source of Data
		2016-2018		2020	2021	2022	2023	2024	2025	
				and Response Plan	Nutrition Needs incorporated, if necessary				ss and Response Plans	
	# of disaster/crisis incidents where MISP was activated	0							TBC	NDMA/MoH/ HPA/NGO
	# of awareness drills by NDMA or HPA where MISP was included	TBC							TBC	NDMA / HPA / SHE/NGO
Strategic Area 7: Enabling Environment										
Objective 7.1: Public Health: By 2025, significantly increase funding and staffing for critical public health services.	Amount of money (# / %) the government spends on PH	TBC (112 / 2% of health expenditure going to preventive care providers							TBC	National Health Accounts

	Indicators	Baseline	Objectives of existing strategy	Target						Source of Data
		2016-2018		2020	2021	2022	2023	2024	2025	
		–NHA 2017)								
	#/% of government health staff working in PH functions/areas	TBC							TBC	MoH Human Resources Division
Objective 7.2: Primary Health Care By 2025, re-introduce a primary health care-oriented service delivery model.	# of community health centers in Malè	1							4	MOH Reports
	# and % of atoll hospitals and health centers implementing PHC oriented service delivery model	Atoll = 0/0% Health Center = 0/0%							Atoll =TBC Health Center = TBC	MOH Reports
	Status of financing of specialist care by national health insurance	Specialist services reimbursed regardless of							Specialist services fully reimbursed when patient	National Health Insurance Benefit Package

	Indicators	Baseline	Objectives of existing strategy	Target						Source of Data
		2016-2018		2020	2021	2022	2023	2024	2025	
		whether patient referred							referred (partially reimbursed when not referred)	

Annex 2. RMNCAH Action Plan

STRATEGIC AREA 1: REPRODUCTIVE HEALTH

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regi-onal	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
OBJECTIVE 1.1: Family Planning												
Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)												
1.1.1. Finalize and disseminate new FP standards: • Include statement that people with mental disabilities can be provided contraceptives with parental consent after appropriate clinical evaluation and assessments.	HPA/MOH	X					X					
Supply Side												
1.1.2. Use existing knowledge and data to address identified obstacles to contraceptive use: • Ensure all FP methods (including Implanon and LARCs) are consistently available at different service delivery levels/facilities per new standards; • Ensure appropriate space is available for counseling and providing FP at different service delivery levels/facilities;	HPA/MOH	X	X	X	X	X	X	X	X	X	X	X

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regi-onal	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
• Train nurses, midwives, health officers and other health staff, as relevant, on LARCs; • Assess/supervise FP service providers. (SAP Action 1.5d)												
1.1.3. Expand collaboration with NGOs and the private sector for provision of FP info and services (e.g. hospitals, clinics and pharmacies) (SAP Action 1.5c)	HPA/MOH	X	X	X	X	X	X	X	X	X	X	X
1.1.4. Increase availability of information and services for high risk/vulnerable groups (potentially through online info/service delivery platforms e.g. expanding Siththaa) (SAP Action 1.5d)	HPA/MOH	X	X	X	X	X	X	X	X	X	X	X
Demand Side												
1.1.5. Increase awareness of individuals/couples and religious and community leaders on family planning including: how FP promotes the health of women and children and increases the well-being and prosperity of families and communities, available methods (including EC and male sterilization), where services are available, and dispel mis-information about hormonal methods and explain risks of traditional methods	HPA/MOH	X	X	X	X	X	X	X	X	X		

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regi-onal	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
• Mass Media- TV spots • Social Media • Print Materials for use in health facilities • Inter-personal communication during consultation, outreach, ANC, and PNC (SAP Action 1.5d)												
1.1.6. Increase awareness of available information/services for high-risk and vulnerable groups	HPA MOH MOGFSS NDA NGO	X	X	X	X	X	X	X	X	X	X	X
OBJECTIVE 1.2: Abortion												
Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)												
1.2.1. Update the abortion protocol and essential drug and drug import list to include the WHO recommended combined regimen of misoprostol and mifepristone in accordance with WHO recommendations for medical abortion	MOH MFDA	X						X				

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regi-onal	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
1.2.2. Remove barriers to implementing fatwa on abortion, and consider including provisions in the fatwa for people with disabilities	Fiqh academy/MOH/ MOGFSS/ Health facilities	X	X	X				X	X	X	X	X
1.2.3. Remove barriers to midwives providing abortion care	MOH Nursing/Midwifery Association	X						X	X			
Supply Side												
1.2.4. Disseminate and provide training to health staff in tertiary, regional and atoll hospitals on updated abortion protocol	MOH Tertiary Regional	X	X	X	X			X	X			
1.2.5. Reinforce and monitor that health facilities providing abortion services to ensure they are providing services according to the fatwa and updated protocol	MOH (QID) All Hospitals	X	X	X	X			X	X	X	X	X
1.2.6. Train midwives in provision of abortion care	MOH	X	X	X	X				X	X	X	X
Demand Side												
1.2.7. Increase awareness on abortions according to fatwa through mass media	Ministry of Islamic Affairs MOH MOGFSS	X					X	X	X	X	X	X
1.2.8. Promote FP and that every child should be a wanted child	MOH	X	X	X	X	X	X	X	X	X	X	X

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regi-onal	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
OBJECTIVE 1.3: STIs and HIV												
Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)												
1.3.1. Increase collection and availability of STI data	All health Institutions	X	X	X	X		X	X	X	X	X	X
Supply Side												
1.3.2. Continue to provide routine testing for HIV and Syphilis during ANC, and provide appropriate anti-retroviral treatment for mother/child, as necessary	All health institutions	X	X	X			X	X	X	X	X	X
1.3.3. Move away from the syndromic approach for STIs, and move toward disease specific testing and treatment (particularly for gonorrhea and chlamydia) in tertiary, regional and atoll hospitals by: • Increasing lab capacity in tertiary, regional and atoll hospitals, and • Increasing knowledge and capacity of GPs, OB/Gyn to do STI screening and testing	MOH All health institutions	X	X	X				X	X	X	X	X
Demand Side												
1.3.4. Promote awareness and prevention of STIs, particularly amongst high-risk and vulnerable groups, and provide	WDC NDA	X	X	X	X	X	X	X	X	X	X	X

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regi-onal	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
information on where information and services are available	HPA MOE (All schools) NGOs, Media											
1.3.5. Promote information on availability and access to condoms for prevention of STIs	MOH NDA All health institutions NGOs	X	X	X	X	X	X	X	X	X	X	X
OBJECTIVE: 1.4: Cervical Cancer												
Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)												
1.4.1. Add HPV vaccination and cervical cancer screening information to children's vaccination cards and/or mother's cards to enable better tracking	MOH All health institutions NGOs	X	X	X			X	X	X	X	X	X
1.4.2. Maintain E- cancer register	MOH All health institutions NGOs Aasandha	X	X	X			X	X	X	X	X	X
1.4.3. Establish cervical cancer screening recall system	MOH All health institutions Dhamanaveshi All health institutions	X	X	X			X	X	X	X	X	X

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regi-onal	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
	NGOs Aasandha											
1.4.4. Update national cervical cancer screening programme in line with new WHO strategy for elimination of cervical cancer	MOH HPA	X							X	X		
Supply Side												
1.4.5. Introduce and train staff on updated national cervical cancer screening programme (including the introduction of HPV screening) and monitor its implementation;	MOH HPA	X	X	X	X				X	X	X	
1.4.6. Increase geographic availability of cervical cancer screening particularly in islands and atolls(SAP Action 1.1f)	MOH All health institutions NGOs	X	X	X			X	X	X	X	X	X
1.4.7. Promote the importance of routine screening of women amongst health workers(SAP Action 1.1a)	MOH Dhamanaveshi All health institutions NGOs WDC	X	X	X	X	X	X	X	X	X	X	X
1.4.8. Continue annual HPV vaccination "campaign" for girls: • Collaborate with schools for HPV vaccine at school;	MOE (All schools) MOH Dhamanaveshi	X	X	X	X	X	X	X	X	X	X	X

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regi-onal	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
• Establish and advertise annual time/place for HPV vaccination; • Follow-up girls who do not return for the second vaccination	City councils and Island Councils All health institutions NGOs WDC											
Demand Side												
1.4.9. Increase awareness amongst the general population, and particularly amongst WRA, and religious and community leaders of cervical cancer and the importance of prevention and early detection and treatment, including HPV vaccination and routine cervical cancer screening	MOE (All school) MOH Dhamanaveshi NGOs WDC	X	X	X	X	X	X	X	X	X	X	X
1.4.10. Provide information to parents of 10-year-old girls on the benefits of HPV vaccination, the need for 2 vaccines and potential side effects	MOE (All school) MOH Dhamanaveshi City councils and Island Councils All health institutions NGOs WDC	X	X	X	X	X	X	X	X	X	X	X
OBJECTIVE: 1.5: Infertility and RH Morbidities												

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regi-onal	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)												
1.5.1. Undertake research to: 1) understand how the fertility rate continues to decline despite decreasing contraceptive prevalence and to 2) identify the prevalence of key reproductive RH morbidities; the availability and cost of existing services; the impact these morbidities are having on the lives of those affected, and the challenges these individuals face. (SAP Action 1.4b)	MOH MNU HPA	X					X	X				
1.5.2. Use the results of the above research to advocate for inclusion of care for RH morbidities (e.g. PCOS and endometriosis) and infertility treatment and services (e.g. fertility testing and in-utero insemination/IVF) in the national health insurance benefit package	MOH HPA	X						X	X			
Supply Side												
1.5.3. Increase availability and quality of care for RH morbidities and infertility including: • Ensure all regional and tertiary hospitals can diagnose and manage PCOS	MOH HPA Tertiary and Regional Hospitals	X	X	X			X	X	X	X	X	X

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regi-onal	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
• Ensure all central/tertiary hospitals can manage more complex cases such as endometriosis • Introduce IUI and IVF services in the country												
Demand Side												
1.5.4. Disseminate and publicize the results of the above research to increase community awareness of RH morbidities (e.g. PCOS and endometriosis) and infertility; and how these issues are affecting people's lives	MOH HPA	X						X	X			

STRATEGIC AREA 2: MATERNAL HEALTH

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regio n-al	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
OBJECTIVE 2.1: ANC and PNC												
Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)												

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regio n-al	Atoll	Island (HC)	Comm -unity	20	21	22	23	24	25
2.1.1. Finalize and disseminate national minimum standards for ANC/PNC: (SAP Action 1.5c) • Incorporate new WHO ANC/PNC recommendations into these standards; • Reinforce comprehensive counselling during ANC; • Introduce child-birth training workshops during ANC where pain management options and the risks of c-sections are clearly explained, and • Introduce midwifery led model of care	Relevant Depts/Divisions MOH HPA	X					X	X				
2.1.2. Develop (or incorporate ANC/PNC into) supervision/monitoring mechanisms at central level (SAP Action 1.1f)	MOH	X					X	X				
Supply Side												
2.1.3. Train midwives and OB/Gyns on national ANC/PNC standards, counselling, child birth training workshops and midwifery led model of care	MOH	X	X	X	X		X	X				

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regio n-al	Atoll	Island (HC)	Comm -unity	20	21	22	23	24	25
2.1.4. Orient new recruits on national ANC/PNC standards (can be combined with overall orientation of new recruits on national standards and guidelines)	MOH	X	X	X	X		X	X	X	X	X	X
2.1.5. Undertake supportive supervision to reinforce usage of the national standards and to increase quality of care	MOH	X	X	X	X		X	X	X	X	X	X
2.1.6. Monitor implementation of the national standards	MOH	X	X	X	X					X		X
Demand Side												
2.1.7. Increase community awareness of: • The importance of 8+ ANC and 4 PNC visits with a comprehensive service package, • Midwifery led care for normal ANC and PNC (Consider combining with other demand side community awareness interventions for intrapartum care and nutrition amongst WRA)	MOH HPA All Health Facilities	X	X	X	X			X	X	X		
OBJECTIVE 2.2: Intrapartum Care												
Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)												

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regio n-al	Atoll	Island (HC)	Comm -unity	20	21	22	23	24	25
2.2.1. Develop and disseminate national intrapartum care standards that: a) incorporate recent WHO recommendations for MH, intrapartum care, PPH and eclampsia, and b) reinforce the role of midwives in managing normal deliveries	MOH HPA	X					X	X				
2.2.2. Develop and disseminate clinical practice standards for C-sections which include some of the WHO/FIGO recommendations for reducing un-necessary c-sections such as: • Use a uniform classification system for c-sections (Robson/WHO classification) • Undertake audits of all c-sections; • Get mandatory second opinions for all c-sections; • Publish hospital c-section rates;	MOH HPA	X					X	X	X			
2.2.3. Develop (or incorporate MH/intrapartum care into) supervision/monitoring mechanisms at central level and introduce systems for periodic auditing of partographs and routine auditing of c-sections	MOH HPA	X					X	X				

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regio n-al	Atoll	Island (HC)	Comm -unity	20	21	22	23	24	25
2.2.4. Study availability and usage of blood supplies throughout the country	MOH MNU	X						X	X			
2.2.5. Meet with the national health insurance authority and request that the benefit package is revised and that national health insurance only pays 100% for c-sections when medically indicated	MOH	X					X	X				
Supply Side												
2.2.6. Train providers on national intrapartum care standards, and clinical practice standards for C-sections	MOH	X	X	X	X	X	X	X				
2.2.7. Orient new recruits on intrapartum care standards and clinical practice standards for C-sections (can be combined with overall orientation of new recruits on national standards and guidelines)	MOH	X	X	X	X	X	X	X	X	X	X	X
2.2.8. Undertake supportive supervision to reinforce usage of the national standards and to increase quality of care	MOH	X	X	X	X	X	X	X	X	X	X	X

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regio n-al	Atoll	Island (HC)	Comm -unity	20	21	22	23	24	25
2.2.9. Monitor implementation of the national standards including periodic auditing of partographs and routine auditing of c-sections	MOH	X	X	X	X	X	X	X	X	X	X	X
2.2.10. Increase availability of blood supplies throughout the country, prioritizing high use locations outside of Malè identified through the above research, and locations where a large number of deliveries are taking place	MOH	X	X	X				X	X	X	X	X
2.2.11. Ensure essential obstetric care services with trained birth attendants and primary care providers are available at all levels of the health system	MOH	X	X	X	X		X	X	X	X	X	X
2.2.12. Strengthen implementation of the maternal and perinatal death surveillance and response system (SAP Action 1.4g)	MOH	X	X	X			X	X	X	X	X	X
Demand Side												
2.2.13. Increase awareness of community members of the importance of delivering in a health facility, the benefits of midwifery led care, and the pros and cons of c-section vs.	MOH	X						X	X	X		

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regio n-al	Atoll	Island (HC)	Comm -unity	20	21	22	23	24	25
normal delivery (Can combine with other demand side community awareness interventions for ANC/PNC and nutrition amongst WRA)												
OBJECTIVE 2.3: Nutrition amongst WRA												
Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)												
2.3.1. Integrate latest WHO preconception, pregnancy and post-partum nutrition recommendations on healthy eating, micronutrient supplementation (iron-folic acid or multiple micronutrients, and calcium), deworming prophylaxis, weight gain monitoring, and physical activity for pregnant women into national ANC/PNC standards and training packages (combine with activity related to finalizing ANC/PNC standards under ANC and PNC objective);	MOH HPA	X					X	X				
2.3.2. Coordinate with the State Trading Organization (STO), and the Ministries of Trade and Finance to improve access to nutritious, safe and affordable diets for women through large-scale food fortification: • Fortify foods (flour and/or rice) with iron and folic acid (for prevention of iron-deficiency anemia	Ministries of Health, Economic Development and Finance, HPA,MFDA and STO	X					X	X	X			

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regio n-al	Atoll	Island (HC)	Comm -unity	20	21	22	23	24	25
amongst WRA, children and adolescents, and prevention of birth defects); • Potentially subsidize the costs of these fortified foods to incentivize use by the general population and ensure access by vulnerable groups; (Combine with same child and adolescent health intervention)												
2.3.3. Conduct nutrition related research to guide public health policy and programme interventions: • Determine the prevalence, types and determinants of anemia in WRA, and evaluate modifiable and nonmodifiable factors; (Combine with same child health intervention) • Determine implementation bottlenecks and optimal approaches to drive improvements in the coverage, quality and equity of maternal nutrition interventions;	MOH HPA MNU	X						X	X	X		
2.3.4. Strengthen the monitoring and tracking of key maternal nutrition coverage indicators (through household surveys,	MOH HPA	X						X	X	X		

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regio n-al	Atoll	Island (HC)	Comm -unity	20	21	22	23	24	25
health information systems and programme monitoring and reporting systems)												
Supply Side												
2.3.5. Strengthen counselling on dietary intake and healthy lifestyle during ANC, PNC and FP, and during healthy pregnancy home visits (SAP Action 1.4d)	MOH All Health Facilities	X	X	X	X	X	X	X	X	X	X	X
2.3.6. Train midwives and OB/Gyns on updated national minimum standards for ANC/PNC including delivery of a comprehensive maternal nutrition package (combine with similar activity under ANC/PNC);	MOH	X	X	X	X	X	X	X				
2.3.7. Undertake supportive supervision, mentoring, and action-oriented feedback to increase quality of care in provision of maternal nutrition services as part of ANC, FP, and healthy pregnancy home visits (combine with similar activity under FP and ANC/PNC)	MOH	X	X	X	X	X	X	X	X	X	X	X
Demand Side												

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regio n-al	Atoll	Island (HC)	Comm -unity	20	21	22	23	24	25
2.3.8. Increase community and family awareness of the importance of a healthy lifestyle and nutritious and safe diets for women; the negative effects of overweight, obesity, and anemia, and the benefits of prenatal iron/folic acid supplementation and iron/folic acid fortification (if taking place) using a variety of approaches including healthy mother campaigns, and the Yagooth mobile application (Can combine with other demand side community awareness initiatives for ANC/PNC and intrapartum care) (SAP Action 1.4d)	MOH	X					X	X	X	X	X	X

STRATEGIC AREA 3: NEWBORN HEALTH

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Region-al	Atoll	Island (HC)	Comm -unity	20	21	22	23	24	25
OBJECTIVE 3.1: Birth Defects												

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Region-al	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)												
3.1.1. Continue discussions with the State Trading Organization (STO), and the Ministries of Economic Development and Finance to improve access to nutritious, safe and affordable diets through large-scale food fortification: • fortify foods (flour and or rice) with iron and folic acid (for prevention of iron-deficiency anemia amongst WRA, children and adolescents, and prevention of birth defects); • potentially subsidize the costs of these fortified foods to incentivize use by the general population and ensure access by vulnerable groups (Combine with same Maternal and Adolescent Health interventions)	Ministries of Health, Economic Development and Finance, MFDA and STO	X					X	X	X			
3.1.2. Include regional and private hospitals in the national birth defects surveillance system and intergrate with HMIS	MOH HPA WHO RAHS	X	X	X			X	X				

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Region-al	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
3.1.3. Expand the national surveillance system for early identification of country-specific genetic metabolic disorders	MOH – HPA IGMH Private Hospitals	X	X				X	X	X			
3.1.4. Update/develop and disseminate protocols for clinical, instrumental and laboratory neonatal screening and case management for birth defects, metabolic disorders and sensory deficits, including universal neonatal hearing screening	MOH – QA/HPA RAHS WHO CSOs	X	X	X	X		X	X				
3.1.5. Include birth defects prevention in new national strategies for the control of non-communicable diseases and HIV, STIs and Hepatitis B and C	HPA	X					X					
3.1.6. Develop diagnostic protocol for the use of chorionic villus sampling test (CVS) for early detection of thalassemia	MOH MBS Tertiary Hospitals SHE	X	X				X	X				
Supply Side												

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Region-al	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
3.1.7. Improve quality of antenatal screening for early detection of birth defects, including fetal ultrasonography, genetic and biochemical screening at tertiary hospitals	MOH RAHS QA HPA Aasandha	X	X	X			X	X	X			
3.1.8. Strengthen pre-marital counselling for thalassemia risk assessment	Family court MBS MOH HPA MOGFSS	X	X	X	X		X	X	X	X	X	X
3.1.9. Improve referral of high-risk pregnancies (women +35 years, known family history of birth defects, gestational diabetes, epilepsy etc.) to tertiary hospitals	MOH RAHS Health Facilities	X	X	X	X		X	X	X			
3.1.10. Strengthen laboratory diagnostic services for detection of TORCH infections	MOH RAHS	X	X	X			X	X	X			
3.1.11. Introduce CVS test for early detection of thalassemia in tertiary and Regional hospitals	MOH IGMH Tertiary Hospitals	X	X				X	X				

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Region-al	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
3.1.12. Expand availability of care (clinical management and rehabilitative services) for birth defects, including thalassemia	MOH MBS Aasandha NSPA Tertiary Hospitals CSOs	X	X	X	X		X	X	X	X	X	X
Demand Side												
3.1.13. Increase community awareness of most common birth defects, including causes and risk factors, prevention, detection, treatment and care in the country and abroad (use WHO/SEARO communication strategy for the prevention and control of birth defects[138] and CDC toolkit[139] as a model)	MOH HPA MFDA Dhamanaveshi MBS IGMH CSOs	X	X	X	X	X	X	X	X	X	X	X
OBJECTIVE 3.2: Small and Sick Newborns												
Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)												

[138] https://apps.who.int/iris/bitstream/handle/10665/160757/Regional%20Communication%20strategy%20for%20the%20prevention%20and%20control%20of%20birth%20defects.pdf?sequence=1&isAllowed=y

[139] https://www.nbdpn.org/docs/2019_BDPM_Packet_FINAL.pdf

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Region-al	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
3.2.1. Update and disseminate clinical protocols and standards of care for the management of small and sick newborns at all levels of care (SAP Action 1.5c)	MOH UNICEF WHO Tertiary Hospitals	X	X	X			X	X				
3.2.2. Disseminate new minimum standards for ANC (SAP Action 1.5c) (Combine with the same activity under Maternal Health)	HPA RAHS Health Facilities	X	X	X			X	X				
3.2.3. Conduct a feasibility study for the use of BABIES matrix to improve registration of perinatal deaths and improve quality of care	MOH HPA IGMH	X					X	X				
3.2.4. Scale up perinatal death auditing as part of the Maternal and Perinatal Death Surveillance and Response System (SAP Action 1.4g)	MOH MPMMRC Health Facilities	X	X	X			X	X	X			
3.2.5. Provisions for emergency transportation and evacuation of high-risk newborns with main national airline carriers	MOH Aasandha NSPA Maldivian MNDF Sea/Air	X					X	X				

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Region-al	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
3.2.6. Develop criteria and standard operating procedures for medical evacuation and retrieval of high-risk newborns	MOH – QA Aasandha MNDF Sea/Air	X					X	X				
Supply Side												
3.2.7. Train health providers in the management of small and sick preterm newborns at Regional and Atoll Hospitals[140]	MOH – HPA RAHS UNICEF WHO Tertiary Hospitals	X	X	X				X	X			
3.2.8. Ensure that equipment and medical commodities in Regional hospitals are appropriate to provide advanced newborn care	MOH RAHS -CMSD QA	X	X	X			X	X	X			
3.2.9. Conduct regular supportive supervision of Regional and Atoll Hospitals	HPA RAHS QA	X	X	X			X	X	X	X	X	X
3.2.10. Strengthen routine ANC system with emphasis on women at risk (gestational diabetes, gestational intermittent hypoxia, substance abuse, malnutrition etc.)	HPA QA RAHS	X	X	X	X		X	X	X	X	X	X

[140] Special newborn care: thermal care; kangaroo mother care; pain and stress management; assisted feeding; administration of oxygen; prevention of apnoea; detection and management of neonatal infection, hypoglycemia, jaundice and seizures; detection and referral of newborns with birth defects; referral of high-risk newborns to intensive care

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Region-al	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
(Combine with ANC interventions under Maternal Health)	All Health Facilities											
3.2.11. Improve referral system to tertiary hospitals for women at risk of pre-term labor	MOH Aasandha Tertiary Hospitals	X	X	X	X		X	X	X	X	X	X
Demand Side												
3.2.12. Increase community awareness on risk factors and prevention of preterm births, stillbirths and low birth weight infants (Combine with communication strategy for the prevention and control of birth defects as most risk factors are the same)	MOH HPA All Health facilities NGOs CSOs	X	X	X	X	X	X	X	X	X	X	X
OBJECTIVE 3.3: Healthy Newborns												
Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)												
3.3.1. Update and disseminate clinical protocols and standards for essential newborn care at all levels of care	MOH UNICEF WHO	X	X	X			X	X				
3.3.2. Roll out the social and behavior change communication strategy for the first 1000 days (SAP Action 1.3d)	HPA UNICEF	X	X	X	X	X	X	X	X			

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Region-al	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
	All Health Facilities											
3.3.3. Strengthen the enforcement of national legislation on the International Code of Marketing of Breast-milk Substitutes and related WHA resolutions	MOH HPA MFDA	X					X	X	X			
3.3.4. Disseminate operational and clinical guidelines on the Baby Friendly Hospital Initiative and develop certification/re-certification system (or include BFHI in larger hospital accreditation system)	HPA Tertiary, Regional and Atoll Hospitals	X	X	X			X	X				
3.3.5. Monitor compliance with national legislation on the marketing of breastmilk substitutes , including online advertisement of breast milk substitutes, targeted to infants (combine with similar advocacy activity under Child Health)	HPA MFDA AG Office	X					X	X				
3.3.6. Disseminate Vaccination Policy of Maldives	HPA MOE	X	X	X	X		X					
3.3.7. Establish National Vaccination Surveillance System (including maternal, child and nutrition indicators)	MOH Ministry of Communication,	X					X					

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Region-al	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
	Science and Technology											
3.3.8. Advocate for introduction of 6 months maternity leave	MOH	X					X					
Supply Side												
3.3.9. Train health providers in the essential newborn care at Regional and Atoll Hospitals[141]	MOH – HPA RAHS UNICEF WHO Tertiary Hospitals	X	X	X			X	X	X			
3.3.10. Conduct regular supportive supervision of Regional and Atoll Hospitals (and Island Hospitals performing deliveries and providing newborn care)	RAHS QA HPA	X	X	X	X		X	X	X	X	X	X
3.3.11. Implement Baby Friendly Hospital Initiative in all atoll, regional and tertiary hospitals; conduct regular monitoring and supportive supervision visits and	HPA – QA RAHS	X	X	X			X	X	X	X	X	X

[141] Essential newborn care: immediate newborn care (drying, skin-to-skin contact, delayed cord clamping, hygienic cord care); neonatal resuscitation for those who need it; early initiation and support for exclusive breastfeeding; routine care (Vitamin K, eye care and vaccinations, weighing and clinical examinations); assessment, management and referral of bacterial infections, jaundice and diarrhea, feeding problems, birth defects and other problems; registration of newborns; postnatal/pre-discharge advice on mother and baby care and follow up

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Region-al	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
implement health facility certification/re-certification system												
3.3.12. Train/re-train health workers on healthy feeding practices for infants, and counseling and interpersonal communication skills (Combine with the same activity under Child Health)	HPA UNICEF	X	X	X	X		X	X	X			
3.3.13. Provide IYCF counselling for caregivers and families (Combine with the same activity under Child Health)	HPA Health Facilities	X	X	X	X	X	X	X	X	X	X	X
Demand Side												
3.3.14. Increase community awareness on the importance of exclusive breastfeeding, adequate complimentary feeding and optimal home-based newborn and infant care (use the First 1000 Days Communication Strategy)	HPA UNICEF Dhamanaveshi Health Facilities	X	X	X	X	X	X	X	X	X	X	X
3.3.15. Conduct health education sessions for mothers and caregivers on danger signs in the neonatal period	Health Facilities Public Health Units	X	X	X	X	X	X	X	X	X	X	X

STRATEGIC AREA 4: CHILD HEALTH

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
OBJECTIVE 4.1: Routine Childhood Vaccination												
Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)												
4.1.1. Disseminate Immunization Policy of Maldives	HPA	X	X	X	X		X					
4.1.2. Strengthen national surveillance and diagnostics system for vaccine preventable diseases (EPI), including sample	HPA	X	X	X	X		X	X	X	X	X	X

Key Interventions		Responsible Groups	Action Level					Timeframe					
			Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
	collection, laboratory confirmation and response mechanisms	National Reference Laboratory at IGMH											
4.1.3.	Strengthen national surveillance system for Adverse Events Following Immunization	HPA All Health Service Providers	X	X	X	X		X	X	X	X	X	X
4.1.4.	Integrate immunization coverage data into DHIS/Online Database/HMIS	MOH	X	X	X	X		X	X	X			
4.1.5.	Conduct research on bottlenecks and challenges in vaccination coverage, including vaccine hesitancy and refusal	HPA MNU	X	X	X	X		X	X				
Supply Side													
4.1.6.	Provide refresher trainings to health providers on vaccine communication, AEFI, vaccine administration, including temperature control, minimization of vaccine wastage, health education and counselling, especially for vaccine hesitancy and refusal	HPA Health Facilities	X	X	X	X		X	X	X	X	X	X

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
4.1.7. Promote team approach between public health, clinical and general staff to increase vaccination coverage and reduce missed opportunities	HPA Health Facilities Schools	X	X	X	X		X	X	X	X	X	X
4.1.8. Strengthen infrastructure and logistics for vaccine storage, transportation and maintenance of cold chain at all levels, including implementing recommendations of the EVM Study	HPA Health Facilities	X	X	X	X		X	X	X	X	X	X
4.1.9. Strengthen follow-up mechanism on immunization	HPA Health Facilities Schools	X	X	X	X		X	X	X	X	X	X
4.1.10. Publish the research on vaccine hesitancy and refusal and implement the recommendations	MOH HPA	X						X	X			
4.1.11. Develop and implement targeted interventions to increase access and coverage of vulnerable groups with immunization	HPA Health Facilities	X	X	X	X	X	X	X	X	X	X	X
Demand Side												
4.1.12. Increase community awareness on immunization	HPA Health Facilities CSOs	X				X	X	X	X	X	X	X

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
through ANC, PNC and pre-marital counselling (use CDC toolkit[142] as a model)												
4.1.13. Implement UNICEF Vaccine Communication and Demand Generation Strategy	HPA Health Facilities CSOs	X	X	X	X		X	X	X			
4.1.14. Increase civil society participation in vaccination awareness at community level	HPA Health Facilities CSOs	X	X	X			X	X	X	X	X	X
OBJECTIVE 4.2: Child Nutrition												
Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)												

[142] https://www.nbdpn.org/docs/2019_BDPM_Packet_FINAL.pdf

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
4.2.1. Strengthen the enforcement of national legislation on the International Code of Marketing of Breast-milk Substitutes and related WHA resolutions	MOH	X					X	X				
4.2.2. Advocate for maternity protection and breastfeeding support policies in the workplace	MOH	X					X	X				
4.2.3. Strengthen the adoption and enforcement of legislation to regulate the promotion of foods for young children	MOH	X					X	X				
4.2.1. Strengthen the food environment and advocate for a ban on the advertisement and sponsorship of unhealthy food products targeted to children, including junk food, sugary and carbonated drinks	HPA MED MOE	X					X					
4.2.2. Advocate for enhancing the transparency of nutritional information through front-of-package food labelling in English and Dhivehi	HPA MFDA MED MOE	X					X	X				
4.2.4. Disseminate and implement the SBCC First 1000 Days Communication Strategy and strengthen linkages with	HPA Health Facilities	X	X	X	X		X	X	X			

Key Interventions		Responsible Groups	Action Level					Timeframe					
			Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
	ECD to promote and support breastfeeding and complementary feeding (combine with same activity under Newborn health);												
4.2.5.	Continue discussions with the State Trading Organization (STO), and the Ministries of Economic Development and Finance to improve access to age appropriate fortified complementary foods for children aged 6-23 months and other fortified foods that meet quality standards: • Fortify foods (flour and or rice) with iron and folic acid (for prevention of iron-deficiency anemia amongst WRA, children and adolescents, and prevention of birth defects); • potentially subsidize the costs of these fortified complementary foods to incentivize use by the general population and ensure access by vulnerable groups (combine with same maternal and adolescent health interventions)	Ministries of Health, Economic Development and Finance, MFDA and STO	X					X	X	X			
4.2.1.	Conduct relevant research to guide public policy and programme interventions:	HPA MED MOE	X					X	X				

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
• Determine the prevalence, types and determinants of anemia in children and evaluate modifiable and nonmodifiable factors; • Determine implementation bottlenecks and optimal approaches to drive improvements in the coverage, quality and equity of child nutrition interventions; (Combine with same maternal health interventions)	MNU											
4.2.2. Update and implement School Health Policy and Standards in all schools	MOE MOH HPA MFDA	X					X	X	X	X	X	X
4.2.3. Strengthen the monitoring and tracking of child nutrition coverage indicators through household surveys, health information systems and programme monitoring and reporting systems	HPA	X					X	X	X	X	X	X

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
Supply Side												
4.2.4. Train/re-train health workers on healthy feeding practices for young children, and counseling and interpersonal communication skills through multi-channel social and behaviour change communication approaches (SAP Action 1.4)	HPA Health Facilities	X	X	X	X		X	X	X			
4.2.5. Enhance access and utilization of infant and young child nutrition counselling for caregivers and families and linkage with ECD	HPA Health Facilities CSOs	X	X	X	X	X	X	X	X	X	X	X
4.2.6. Promote access to diverse, nutritious, safe and locally available foods	Ministry of Economic Development HPA MFDA	X	X	X	X	X	X	X	X	X	X	X
4.2.7. Conduct laboratory screening[143] for anemia in high-risk infants and children (signs of malnutrition, low birth weight, prematurity, signs and symptoms of anemia, chronic diseases etc.) and refer for treatment	MOH Health Facilities	X	X	X	X		X	X	X	X	X	X

[143] At least measurement of hemoglobin level. Complete blood count, including hemoglobin, hematocrit, mean corpuscular volume (MCV), and red blood cell distribution width (RDW) is indicated for further investigation.

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
4.2.8. Continue annual deworming campaigns in children 24-59 months	HPA MoE Health Facilities	X	X	X	X	X	X	X	X	X	X	X
4.2.9. Continue biannual vitamin A supplementation campaigns in children 9-59 months	HPA MoE Health Facilities	X	X	X	X	X	X	X	X	X	X	X
4.2.10. Strengthen supportive supervision, mentoring, and action-oriented feedback to increase quality of care in provision of child nutrition services including delivery of skilled counselling support	HPA	X	X	X			X	X	X	X	X	X
Demand Side												
4.2.11. Increase social behavior change communication and community and family awareness on healthy nutrition, including through establishing collaboration with civil society and national media and promotion of messages on healthy nutrition focusing on priority infant and young child feeding behaviours (use the First 1000 Days Communication Strategy (SAP: Action 1.1d &Action 1.4)	HPA MOE CSOs	X	X	X	X	X	X	X	X	X	X	X

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
4.2.12. Strengthen linkages with social protection and welfare programmes to reduce financial barriers at community and household level in accessing nutritious, safe and affordable diets for young children	MOH MOFGSS	X					X	X	X			
OBJECTIVE 4.3: Care for Common Childhood Diseases												
Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)												
4.3.1. Review, revise and disseminate adapted IMCI package for the primary health care facilities and WHO's Guidelines for Hospital Care for Children	MOH HPA	X					X	X				
4.3.2. Develop/update and disseminate clinical protocols and guidelines for childhood non-communicable diseases, including care for children with severe wasting, mental health issues, developmental delays and disabilities	MOH HPA	X					X	X				
4.3.3. Provide technical support to Aasandha to update hospitalization and referral guidelines/criteria for childhood illnesses including and severely wasted children	MOH NSPA	X					X					

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
4.3.4. Strengthen surveillance system on common childhood NCDs (birth defects, cancer and injury)	MOH HPA Health facilities	X	X	X	X		X	X	X	X	X	X
Supply Side												
4.3.5. Conduct orientation and re-training programs for health professionals on clinical protocols and guidelines for management of childhood communicable and non-communicable diseases, including severely wasted children	MOH	X					X	X	X	X	X	X
4.3.6. Conduct regular supportive supervision to monitor implementation of IMCI guidelines and other protocols on child health, including nutritional support for severely wasted children	MOH	X	X	X	X		X	X	X	X	X	X
4.3.7. Conduct regular audit of hospital admissions at Regional and Atoll levels to ensure appropriateness of hospitalization and quality of pediatric care	MOH HPA	X	X	X	X		X	X	X	X	X	X

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
4.3.8. Conduct regular patient audits to ensure compliance with IMCI guidelines and other protocols on child health, including nutritional support for severely wasted children	MOH HPA	X	X	X	X		X	X	X	X	X	X
Demand Side												
4.3.9. Increase community awareness on causes and risk factors of childhood communicable and non-communicable diseases, including severe wasting in young children, mental health issues and disabilities	MOH Health Facilities CSOs					X	X	X	X	X	X	X
4.3.10. Conduct community awareness and education programs to promote healthy behavior and lifestyles for children	MOH Health Facilities Schools CSOs					X	X	X	X	X	X	X
OBJECTIVE 4.4: Early Childhood Development												
Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)												
4.4.1. Develop/update clinical protocols and guidelines for early detection and intervention, and care for children with developmental delays and disorders	MOH HPA	X					X	X				

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
4.4.2. Develop/update referral mechanisms and guidelines for diagnosis, management and care of children with developmental disorders and disabilities	MOH HPA	X					X	X				
4.4.3. Conduct study on ECD practices and develop multi-sectoral ECD policy for children 0-3 years	MOH MOGFSS MOE MNU	X					X	X				
4.4.4. Develop quality standards for public and private providers of ECD services	MOH MOGFSS MOE	X					X	X				
Supply Side												
4.4.5. Reinforce the correct use of growth monitoring tools, focusing on emotional, cognitive and social development and early identification of disabilities, developmental delays and disorders	HPA All Health Facilities	X	X	X	X		X	X				
4.4.6. Train/re-train health providers in providing support to families and care-takers for early stimulation and responsive feeding	HPA All Health Facilities	X	X	X	X		X	X	X			

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
4.4.7. Train/re-train health providers in basic screening for early identification and referral and management of developmental delays and disorders	HPA All Health Facilities	X	X	X	X		X	X				
4.4.8. Develop capacity of pre-school teachers, social workers and health professionals on promoting ECD	MOH MOGFSS MOE	X	X	X	X		X	X	X			
4.4.9. Conduct regular joint monitoring of public and private providers of ECD services	MOH MOGFSS MOE	X	X				X	X	X	X	X	X
4.4.10. Develop comprehensive awareness programs to empower parents on ECD	MOH MOGFSS MOE CSOs	X	X	X	X	X	X	X	X	X	X	X
Demand Side												
4.4.11. Increase community awareness on the importance of: • ECD; • regular child growth monitoring with emphasis on emotional, cognitive and social development;	MOH HPA Health Facilities MOGFSS MOE					X	X	X	X	X	X	X

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
• early signs of common disabilities, developmental delays; • pathways to access specialized care (use the First 1000 Days Communication Strategy)	CSOs											
OBJECTIVE 4.5: Mental Health												
Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)												
4.5.1. Disseminate National Mental Health Policy 2015-2025 and National Mental Health Strategic Plan 2016-2021 to tertiary, Regional and Atoll hospitals (Combine with the same activity under Adolescent Health)	MOH HPA	X	X	X	X		X	X				
4.5.2. Finalize National Suicide Prevention Strategy and Mental Health Act (Combine with the same activity under Adolescent Health)	MOH HPA CMH	X					X	X				
4.5.3. Develop a new National Mental Health Strategic Plan 2022-2027 which includes a focus on children (Combine with the same activity under Adolescent Health)	HPA CMH WHO	X						X	X			

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
4.5.4. Conduct national mental health survey to identify common mental health issues amongst key target groups including children (Combine with the same activity under Adolescent Health)	HPA WHO MNU	X						X				
4.5.5. Establish a system for early identification of common mental health issues in childhood and referral mechanisms	HPA CMH WHO	X					X	X				
Supply Side												
4.5.6. Increase access to mental health services for children through targeted and longer-term strategies to cover all the regions and atolls	MOH HPA Health Facilities	X	X	X	X		X	X	X	X	X	X
4.5.7. Strengthen mental health support available, including referral mechanism, for children in schools and build the capacity of school counsellors	MOH HPA MOE Schools	X	X	X	X		X	X	X	X	X	X
4.5.8. Ensure that every school has a licensed school counselor, and a system in place for training and supervision of school counsellors	MOE HPA	X	X	X	X		X	X	X	X	X	X
Demand Side												

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Community	20	21	22	23	24	25
4.5.9. Increase community awareness on mental health issues with the objective of fighting against stigma on mental health (SAP Action 8.1d)	MOH HPA CSOs MOGFSS MOE	X	X	X	X	X	X	X	X	X	X	X

STRATEGIC AREA 5: ADOLESCENT HEALTH

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Community	20	21	22	23	24	25
OBJECTIVE 5.1: Nutrition												
Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)												
5.1.1. Foster healthy food environment and advocate for a ban on the advertisement (including sports event sponsorships, school-related activities and billboards) of unhealthy food and beverage products targeted to adolescents, including junk food, processed meat, sugary	MOH HPA MFDA MOE MOYSCE Sports Associations	X					X	X				

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regio n- al	Atoll	Island (HC)	Comm -unity	20	21	22	23	24	25
and carbonated drinks, and carcinogenic products such as betel nut and its products (Combine with the same activities under Newborn and Child Health) (SAP Action 2.3a)	MBC MMC NCD Alliance											
5.1.2. Develop food standards in school settings that make healthy food available and restrict the availability of unhealthy food	MOH HPA MOE	X					X	X				
5.1.3. Continue discussions with the State Trading Organization (STO), and the Ministries of Economic Deveopment and Finance to improve access to nutritious, safe and affordable diets for adolescents and young people through large-scale food fortification: • Fortify foods (flour and or rice) with iron and folic acid (for prevention of iron-deficiency anemia amongst WRA, children and adolescents, and prevention of birth defects);	Ministries of Health, Economic Deveopment and Finance, MFDA and STO	X					X	X	X			

Key Interventions		Responsible Groups	Action Level					Timeframe					
			Central	Regio n- al	Atoll	Island (HC)	Comm -unity	20	21	22	23	24	25
	• potentially subsidize the costs of these fortified foods to incentivize use by the general population and ensure access by vulnerable groups (Combine with same maternal and child health interventions)												
5.1.4.	Advocate for introduction of subsidies for wholegrain products, removal of subsidies for sugar and reduction of taxes and duties on fruits and vegetables	MOH HPA MFDA MOED NCD Alliance	X					X	X				
5.1.5.	Advocate for removal of sugar sweetened drinks from meal packages in restaurants e.g. removing free high calorie sugary drinks e.g. coca cola with pizza package	MOH HPA MFDA MMC MBC NCD Alliance	X					X	X				
5.1.6.	Adapt STEPS instrument to the context of the Maldives, and include youth 17-24 years, and use survey findings to develop and implement targeted interventions and regular	MOH HPA WHO	X					X	X				

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regio n- al	Atoll	Island (HC)	Comm -unity	20	21	22	23	24	25
monitoring of status and coverage of adolescent nutrition interventions												
Supply Side												
5.1.7. Reinforce nutrition and physical education in secondary schools as a means of promoting healthy lifestyle, body image and diet and preventing overweight and obesity by: • increasing time for physical activity and sports within the curriculum; • ensuring school canteens do not provide unhealthy drinks and food • promoting healthy food in school ceremonies and celebrations; • piloting a home science module in schools that are focused on healthy living (healthy food, active life)	HPA MOE	X	X	X	X	X		X	X			
5.1.8. Increase the frequency and coverage of regular comprehensive health screening (nutrition, SRH, mental health) of school, college and university students	MOH HPA MOE MOHE	X	X	X	X			X	X	X	X	X

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regio n- al	Atoll	Island (HC)	Comm -unity	20	21	22	23	24	25
5.1.9. Train primary healthcare/public health workers and school health officers to provide nutrition/healthy lifestyle counselling and health check-up for adolescents and youth with underweight, overweight and obesity	MOH MOE	X	X	X	X			X	X	X		
5.1.10. Strengthen supportive supervision, mentoring, and action-oriented feedback to increase quality of provision of adolescent nutrition services	MOH MOE	X	X	X	X		X	X	X	X	X	X
5.1.11. Incorporate health, healthy diets and well-being module in MEMIS	MOH MOE UNICEF	X						X	X			
Demand Side												
5.1.12. Increase community awareness on the causes, risk factors and consequences of underweight, overweight and obesity, anemia and folic acid deficiency and the value of a healthy lifestyle and diet	HPA MOE MOIA LGA PO (Social Council) WDCs	X	X	X	X	X	X	X	X	X	X	X
5.1.13. Use social networks, peer groups and influential persons to promote healthy eating and physical activity	HPA MOE MOIA	X	X	X	X	X	X	X	X	X	X	X

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regio n- al	Atoll	Island (HC)	Comm -unity	20	21	22	23	24	25
	MMC MBC PO (Social Council) NGOs Fitness Centers											
5.1.14. Increase awareness among adolescents and youth on health risks associated with food supplements e.g. protein shakes, protein bars and skin/hair supplements	MOH MOE MOYSCE Sports Associations	X	X	X	X	X	X	X	X	X	X	X
OBJECTIVE 5.2: Mental Health												
Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)												
5.2.1 Disseminate National Mental Health Policy 2015-2025 and National Mental Health Strategic Plan 2016-2021 to tertiary, Regional and Atoll hospitals (SAP Action 8.2a)	MOH HPA WHO	X	X	X	X		X					
5.2.2. Develop a new National Mental Health Strategic Plan 2022-2027 which includes a focus on adolescents and youth (Combine with same activity under Child Health)	MOH HPA CMH WHO	X						X				

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regio n- al	Atoll	Island (HC)	Comm -unity	20	21	22	23	24	25
5.2.3. Conduct national mental health survey to identify common mental health issues amongst key target groups including adolescents and youth (Combine with same activity under Child Health)	HPA WHO	X						X				
5.2.4. Establish a system for early identification of common mental health issues and referral mechanisms (Combine with same activity under Child Health)	MOH HPA CMH WHO	X	X	X	X		X	X				
5.2.5. Establish national protocol and guidelines for national media on reporting news on mental health issues e.g. suicide, substance abuse and school-based violence	MOH HPA CMH MBC MMC	X					X	X				
5.2.6. Conduct mapping of mental health service providers to provide information, including through social networks, to help adolescents and youth locate mental health services	HPA	X					X	X				
Supply Side												
5.2.7. Provide mental health services (identification, treatment and advocacy) including psychosocial counselling and	MOH HPA	X	X	X			X	X	X	X	X	X

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regio n- al	Atoll	Island (HC)	Comm -unity	20	21	22	23	24	25
mental well-being promotion in accordance with national plan to establish mental health services at Regional and Atoll levels (SAP: Action 8.2a)	CMH											
5.2.8. Train health providers on mental health policy and adapted protocols and the importance of early detection and referral of adolescents and youth with mental health issues	MOH HPA CMH WHO	X	X	X	X		X	X	X			
5.2.9. Provide training based on mhGAP for gatekeepers, including primary health care workers, school counsellors, school health officials, teachers, youth and social workers. (SAP: Action 8.1d)	HPA MOE MOGFSS WHO	X	X	X	X		X	X	X			
5.2.10. Ensure that every school has a licensed school counselor, and a system in place for training and supervision of school counsellors	HPA MOE	X	X	X	X		X	X	X			
5.2.11. Establish safe spaces in community centers to provide youth development and health services e.g. skills building, life skills program for adolescents and youth	HPA MOYSCE PO (Social Council) WDCs	X				X	X	X	X			

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regio n- al	Atoll	Island (HC)	Comm -unity	20	21	22	23	24	25
Demand Side												
5.2.12. Pilot parenting project to increase awareness of parents, families and care-takers of special needs and challenges of adolescence and the importance of creating positive, safe and protective environments for adolescents at home, school and in the community	HPA MOYSCE MOE MOGFSS NGOs Private Clinics	X						X				
5.2.13. Increase awareness of adolescents and youth on mental health issues such as depression, anxiety, suicidal tendencies, stress management etc. (SAP Action 8.1d)	HPA MOE MOHE MOYSCE PO (Social Council) WDCs	X	X	X	X	X	X	X	X	X	X	X
5.2.14. Increase awareness of adolescents and youth on social health issues such as building caring and trusting relationships, safe environment, positive behaviors, emotional resilience and self-esteem, problem solving and coping skills (SAP: Action 8.1d)	HPA MOE MOHE MOYSCE PO (Social Council) WDCs	X	X	X	X	X	X	X	X	X	X	X

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regio n- al	Atoll	Island (HC)	Comm -unity	20	21	22	23	24	25
5.2.15. Increase awareness of adolescents and youth on gaming and screen time addiction	HPA CMH MOYSCE NGOs PO (Social Council) WDCs	X	X	X	X	X	X	X	X	X	X	X
5.2.16. Use electronic resources, including social networks and platforms, for self-help, peer-to-peer education and support groups	HPA MOE MOYSCE NGOs	X					X	X	X	X	X	X
5.2.17. Promote awareness-raising campaigns to reduce stigma and promote care/help-seeking and access to mental health services	HPA CMH MMC MBC NGOs	X	X	X	X	X	X	X	X	X	X	X

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regio n- al	Atoll	Island (HC)	Comm -unity	20	21	22	23	24	25
OBJECTIVE 5.3: SUBSTANCE ABUSE												
Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)												
5.3.1. Strengthen collaboration with National Drug Agency and relevant NGOs for prevention and treatment of substance abuse	MOGFSS NDA NGOs MOH HPA	X					X	X	X			
Supply Side												
5.3.2. Train health providers at PHC level in early detection and referral of adolescents with suspected substance abuse (Combine with the same activity under Adolescent Mental Health)	MOGFSS NDA MOH HPA Aasandha	X	X	X	X		X	X	X	X	X	X
5.3.3. Provide technical expertise to NDA in: • establishing detox and rehabilitation centers for adolescents and youth; • establishing different treatment modalities and protocols at detox and rehabilitation centers e.g. methadone treatment;	MOGFSS NDA MOH HPA WHO	X	X				X	X	X			

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regio n- al	Atoll	Island (HC)	Comm -unity	20	21	22	23	24	25
• organizing and conducting training of service providers at detox and rehabilitation centers												
5.3.4. Establish linkages with regional mental health programs and youth development programs to provide community services for adolescents and young people with substance use (e.g., vocational trainings, skills development, career opportunities)	NDA MOYSCE TVET Authority MOHE HPA MOH	X	X					X	X			
5.3.5. Pilot technology-based interventions for prevention and treatment of substance abuse (use research findings as a model[144])	MOGFSS NDA HPA IGMH	X						X				
Demand Side												
5.3.6. Conduct mass-media campaigns to raise awareness of the dangers of tobacco, vaping, sheesha, alcohol and illicit drugs and availability of services (SAP: Action 1.3c)	HPA NDA MOYSCE MOE MMC MBC	X					X	X	X	X	X	X

[144] Child Adolesc Psychiatr Clin N Am. 2016 October ; 25(4): 755–768. doi:10.1016/j.chc.2016.06.005.

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regio n- al	Atoll	Island (HC)	Comm -unity	20	21	22	23	24	25
OBJECTIVE 5.4: ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH												
Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)												
5.4.1. Review delivery of the integrated LSE program in the new curriculum, school health and PE curricula, with emphasis on SRH and other adolescent health issues, and update/revise as necessary	MOE ESQID MOH HPA	X					X	X	X			
5.4.2. Ensure incorporation of LSE, CSE and STI prevention modules into teacher training curriculum at MNU and private colleges	MOHE MOH HPA MOE	X						X	X			
5.4.3. Ensure SRH is incorporated into the Youth Act	MOH MOYSCE HPA UNFPA WHO UNICEF	X					X					
5.4.4. Advocate for breaking the taboo on ASRH in the community	HPA Dhamanveshi	X					X	X	X	X	X	X

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regio n- al	Atoll	Island (HC)	Comm -unity	20	21	22	23	24	25
	MOYSCE UNFPA WHO UNICEF NGOs WDCs Health faciilities											
Supply Side												
5.4.5. Develop/expand innovative online AYF information and service delivery platforms e.g. expanding Siththaa and providing information on SRH for newlyweds	HPA MOYSCE NGOs	X					X	X				
5.4.6. Support and expand provision of AYF information and services through NGOs and pharmacies	MOH HPA MOYSCE Community Centers STO NGOs	X	X	X	X		X	X	X			
5.4.7. Increase access and coverage with SRH services to vulnerable groups e.g. PWDs, substance users and migrants	MOH HPA MOGFSS	X	X	X	X		X	X	X	X	X	X

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regio n- al	Atoll	Island (HC)	Comm -unity	20	21	22	23	24	25
	NSPA Aasandha											
5.4.8. Strengthen promotion of condom use for dual protection and ensure availability of emergency contraception through community centers	HPA MOYSCE	X	X	X	X	X	X	X	X	X	X	X
5.4.9. Strengthen collaboration with Ministry of Education and schools to ensure that integrated services (SRH and mental health) are provided to young mothers	HPA MOE CMH MOGFSS	X					X	X	X			
5.4.10. Strengthen collaboration with the Ministry of Education and schools, and increase capacity of teachers and health workers for delivery of integrated LSE, school health and PE curricula, particularly the SRH and other adolescent health issues	HPA MOE NGO's	X					X	X	X			
Demand Side												
5.4.11. Increase awareness of adolescents and youth, migrant population, community leaders, parents, teachers, PTAs, health service providers and religious leaders on the	HPA MOYSCE MOIA MOE	X	X	X	X	X	X	X	X	X	X	X

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regio n- al	Atoll	Island (HC)	Comm -unity	20	21	22	23	24	25
importance of SRH issues and the negative consequences of teen pregnancy and STIs, including HIV	MOHE MOGFSS Islamic University MRC MNU MMC MBC SHE NGO's											
5.4.12. Provide information, including through social networks, to help adolescents and youth locate providers for SRH information and services	HPA MOYSCE SHE NGO's	X	X	X	X	X	X	X	X	X	X	X

STRATEGIC AREA 6: CROSS-CUTTING ISSUES

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
OBJECTIVE 6.1: GBV/DV/Child Abuse												
Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)												
6.1.1. Update the National Guidelines for the Health Sector Response to GBV and update the Online Training Module by adding an annex to include responsibilities for child abuse (per the new child rights act and other relevant legislation)	MOH FPA MOGFSS Police MMC	X					X	X	X			
6.1.2. Establish/strengthen monitoring and accountability mechanisms for implementation of the national guidelines and ensure adequate human resources are in place for implementation	MOH FPA MOGFSS MPS	X					X	X	X			
6.1.3. Develop an integrated data-entry and management system for reporting of GBV/DV/child abuse from the health sector with stratified levels of access to facilitate the generation of coherent and consistent data. (As far as	FPA MOH MOGFSS	X					X	X	X			

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
possible, use or link to existing information systems such as the Geveshi Portal/MCPD/DHIS)												
Supply Side												
6.1.4. Disseminate updated guidelines and information on the new data entry and reporting system, and reinforce that health staff and new recruits take the updated online GBV E-MODULE training.	MOH FPA	X	X	X	X	X		X	X	X	X	X
6.1.5. Undertake supportive supervision to reinforce implementation of the national guidelines and to increase appropriate reporting of GBV/DV/child abuse per the new reporting system	MOH	X	X	X	X	X		X	X	X	X	X
6.1.6. Monitor Health Facility GBV/DV and Child Abuse Reporting on a monthly basis	MOH HPA	X	X	X	X	X	X	X	X	X	X	X
OBJECTIVE 6.2: Female Circumcision												
Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)												
6.2.1. Develop policy to stop the promotion and public endorsement of FGM/C	MOGFSS MOIA	X						X	X			

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
	AG Office MOH											
Supply Side												
6.2.2. Increase awareness amongst community and healthcare providers that female circumcision is a harmful practice and a human rights violation and radical forms of female circumcision can cause severe health problems for women	MOGFSS MOIA MOH HPA NGO's	X	X	X	X	X		X	X	X		
Demand Side												
6.2.3. Develop public awareness to: • increase awareness amongst national, religious and community leaders and members that female circumcision is a harmful practice and a human rights violation and radical forms of female circumcision can cause severe health problems for women; • increase public support to stop FGM and encourage reporting	MOGFSS MOIA AG Office MOH NGO's	X							X	X	X	

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
OBJECTIVE 6.3: RMNCAH in Emergencies												
Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)												
6.3.1. Incorporate and operationalize MISP in the Health Emergency Operational Plan and the National Emergency Preparedness and Response Plans	NDMA MOH HPA	X					X	X	X			
6.3.2. Review the Health Emergency Operational Plan and the National Emergency Preparedness and Response plans and revise to incorporate child health, adolescent health and nutrition needs, if necessary	NDMA MOH HPA	X					X	X	X			
Supply Side												
6.3.3. Train and undertake practical drills with health staff on the operationalization of the updated MISP (and additional child health, adolescent health and nutrition elements, if added)	MOH HPA NDMA	X	X	X	X	X	X	X	X	X	X	
6.3.4. Ensure every island has available service kits and human resources to provide MISP	NDMA MOGFSS	X	X	X	X	X	X	X	X	X		

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
	MOH											

STRATEGIC AREA 7: ENABLING ENVIRONMENT

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
OBJECTIVE 7.1: Public Health												

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)												
7.1.1. Advocate with senior government officials/politicians regarding the importance of public health services (and increase their awareness of the issues associated with the current highly medicalized model of care);	MOH	X	X	X	X	X	X	X	X	X	X	X
7.1.2. Increase government funding for PH services, especially for RMNCAH)	MOH	X					X	X	X	X	X	X
7.1.3. Increase staffing/recruitment for PH services;	MOH	X					X	X	X	X	X	X
7.1.4. Develop mechanism to monitor PH expenditure	MOH	X					X	X				
7.1.5. Establish patient tracking/electronic medical records system and strengthen links between PH and curative care services	MOH IT	X	X	X	X	X		X	X	X	X	
7.1.6. Create multi-sectoral coordination mechanism to implement RMNCAH strategy.	MOH HPA	X					X	X				
Supply Side												

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
7.1.7. Increase awareness amongst health staff and professional associations of the importance of public health services, and the issues associated with the current highly medicalized model of care	MOH HR HPA RAHS	X	X	X	X		X	X	X	X		
7.1.8. Build capacity of staff on the patient tracking/electronic medical records system	MOH IT HR PIH HPA RAHS	X	X	X	X				X	X	X	X
Demand Side												
7.1.9. Increase community awareness (to change public perception) of the importance of public health services; the issues associated with the current highly medicalized model of care and empower the community to prioritize public health	HPA RAHS	X	X	X	X	X	X	X	X	X	X	
OBJECTIVE 7.2: PHC												
Governance/Enabling Environment (including Policies, Guidelines, Standards and Research)												

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
7.2.1. Advocate with senior government officials/politicians regarding the importance of a primary health care-oriented service delivery model (and increase their awareness of the issues associated with the current highly medicalized model of care) (Note: this intervention can be combined with intervention 7.1.1. above)	MOH HPA PO	X	X	X	X	X	X	X	X	X	X	X
7.2.2. Re-introduce a primary health care (PHC) oriented service model where Community Health Workers (CHWs), Family Health Workers (FHWs), midwives, nurses and General Practitioners (GPs) manage normal/basic cases, and specialist care is accessible (and fully covered by insurance) on referral	RAHS HR HPA QA	X	X	X	X	X	X	X	X	X	X	X
7.2.3. Introduce a patient centered approach to PHC – particularly for island and urban health centers: • Provide comprehensive services to a mother-child pair (FP, counselling, growth monitoring, vaccination, nutrition information, etc.), and • Consider providing visiting GP services	RAHS HR HPA QA	X	X	X	X	X	X	X	X	X	X	X

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
7.2.4. Revise the national health insurance scheme and update the benefit package to: • Include PH services, and • Ensure that specialist care is fully paid for if a patient is referred (and partially paid if a patient is not referred)	NSPA PO MOH PIH HPA	X					X	X	X			
7.2.5. Develop a model and costed plan for developing additional urban health centers in Malè and get approval for implementation and establish additional urban centers	HPA HR ADMIN RAHS	X					X	X				
Supply Side												
7.2.6. Increase awareness amongst health staff and professional associations of the importance of a primary health care-oriented service delivery model; the issues associated with the current highly medicalized model of care, and the potential benefits of a patient centered approach to care (Note: this intervention can be combined with intervention 7.1.6. above)	HPA RAHS HR	X	X	X	X	X	X	X	X			

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
7.2.7. Work with academia, and professional associations to introduce and train staff on the new primary health care (PHC) oriented service model, and the patient centered approach to care	MOH HPA HR Professional associations	X	X	X	X	X	X	X	X	X	X	X
7.2.8. Review and revise service and staffing packages and rationalize the availability of specialist care, particularly at atoll and HC level	HR RAHS	X		X	X	X			X	X	X	X
7.2.9. Expand training of Maldivian GPs with deployment to islands and atolls	MoH - HR	X					X	X	X	X	X	X
7.2.10. Expand and develop additional urban community health centers in Malè	MOH HPA	X						X	X	X	X	X
Demand Side												
7.2.11. Increase community awareness of the benefits of the new primary health care-oriented service delivery model and the patient-centered approach to care (Note: this intervention can be combined with intervention 7.1.10 above)	HPA	X	X	X	X	X		X	X	X	X	X

Key Interventions	Responsible Groups	Action Level					Timeframe					
		Central	Regional	Atoll	Island (HC)	Comm-unity	20	21	22	23	24	25
7.2.12. Promote and market opening of new urban community health centers in Malè	MOH HPA Media	X						X	X	X	X	X

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Signature:

Date: 22ndMarch 2021

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Date: 22ndMarch 2021