Maldives Health Profile 2010

Decision Support Division
Ministry of Health & Family
Republic of Maldives

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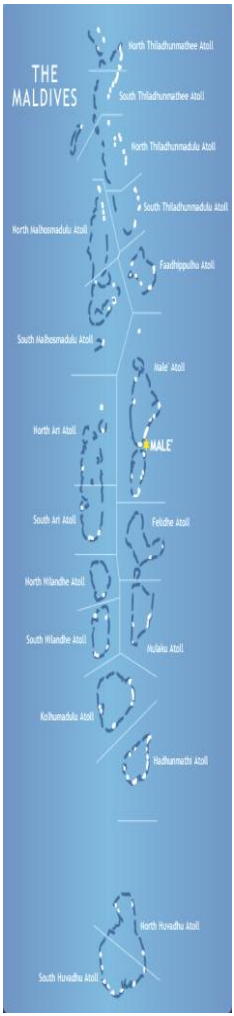
Introduction

The Maldives is an archipelago comprising of 1190 coral islands located in the Indian Ocean and covers a geographical area of approximately 90,000 square kilometers of which land area comprises of 300 square kilometers. The Maldives is divided into 7 provinces which consists of a total of 20 atolls. The population of Maldives is 298,968 (Census, 2006).



The health system of Maldives is based on a referral system with the island level health facilities referring patients to higher level health facilities in the atolls, regions and to central level depending upon the need. The government is committed to improving the health and well being of the people of Maldives through affordable and quality health services and by providing better access to health care. To achieve this goal continuous effort is put to provide better services through a decentralized service model with increased involvement of local people and development of an effective referral system and the role of private sector in the health service provision is encouraged.

The health status of Maldivians have shown improvements in some areas noticeably in reducing the Infant Mortality Rates, Maternal Mortality Rates and increased life expectancy. Most of the communicable diseases have been controlled. There have been no indigenous case of malaria since 1984 and vaccine preventable diseases have also been controlled to such an extent that diseases like polio, neonatal tetanus, whooping cough and diphtheria are nonexistent. However new emergent health problems like drug addiction, malnutrition, emerging diseases such as pandemic flu still imposes to be a threat to the health of the population.

This booklet intends to give a brief overview of the current health situation in the country with focus on government policy and commitments, trends in socio-

demographics, access to health care, reproductive health, child health & nutrition, mortality trends, and morbidity trends.

Commitment from Government towards achieving affordable and quality healthcare

The Strategic Action Plan of the government outlines the mission of the government to "provide affordable, accessible and quality health care for all" as a human right, by establishing internationally accepted standards of health care, by improving the quality of health services; establishing better referral systems and high quality regional health centres; assuring health care training opportunities to Maldivians; reducing the costs of health care; setting up an inclusive social health insurance system; and encouraging private sector participation in health.

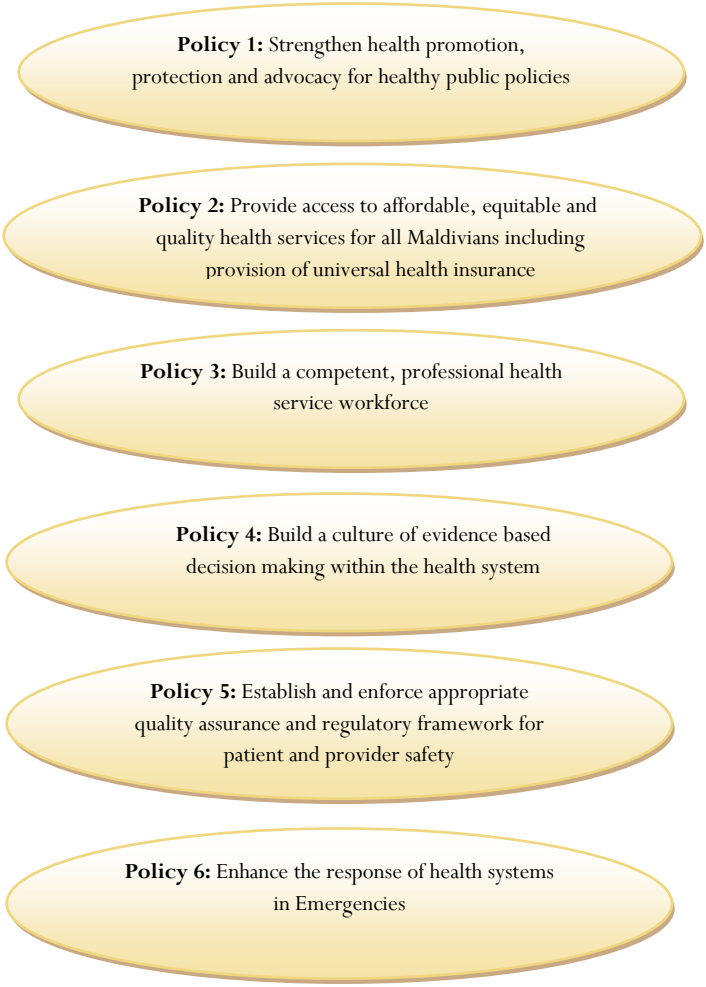
Goals & Objectives of Health Sector

- Ensure citizens have correct knowledge and enabling environment for practice of healthy lifestyles
- Ensure all citizens have equitable access to quality, affordable health services
- Ensure appropriately trained and competent professionals provide health services
- Ensure evidence-based decision-making in health policy formulation and health care reform
- Establish appropriate quality assurance and regulatory framework for client and provider safety
- Establish a nationally coordinated system for emergency medical services and public health emergencies

Health Sector key policies

The figure below illustrates the key policies of the health sector.

Figure 1: Government Health Sector Policies



Institutional Framework

Lead Agency for the Sector:

Ministry of Health and Family is responsible for developing national health policy of the country, public health protection, regulation and quality assurance of health services.

Regulatory Bodies:

- Maldives Medical Council/Maldives Nursing council/ Maldives Health Sciences Board: responsible for regulating the practice and conduct of the professionals in the relevant bodies
- Maldives Food and Drug Authority: responsible for quality and safety of medicines and food products and services
- Centre for Community Health and Disease Control: responsible for regulating aspects of public health provisions/ protection

Local Governance System

- Provincial Health Directorates of MOHF will monitor performance and quality of health services, overseen by the province office
- Provincial Health Service Cooperation: will ensure delivery of preventive, curative and rehabilitative services at atoll and island levels
- Ministry of Home Affairs, Province Offices: facilitates functioning of provincial health and family directorates.

- Atoll and island councils - local Health services and public health measures for municipal functions by atoll and island councils, as per the national standards.

Private (and civil society) Sector Involvement

Health services will be delivered through Private Public Partnership (PPP) approach and the establishment of legal frameworks will facilitate the environment for private investors. Health service corporations established at provincial levels will ensure delivery of these medical and public health services as per national standards and guidelines.

Cooperation with Other External Organizations

Numerous external organizations contribute and supports the development of the health sector in various ways. Some of the key contributors to the health sector are WHO, UNICEF, UNFPA, UNDP , UNAIDS, World Bank, IFRC, IDB, Kuwait Fund, Commonwealth and other International and Regional Health Care Institutions and Organizations and other donor agencies, International NGOs in the health field.

Legal Framework

A number of legislations need to be developed and enforced to facilitate achievement of affordable, safe and quality health care. It has become more important and urgent now that private sector investments in health service delivery will be the norm.

At present the tobacco bill is in the parliament. Health professionals bill and medicines bill is drafted. Health service bill, public health protection bill, health insurance bill and medical negligence bill are other key legislations that are in different stages of drafting.

Ensure other legislations in the economic sector do not limit/ or are not in conflict with public health protection and access to health care. For example Intellectual Property law should ensure there are flexibilities allowed for access to medicines and public health protection.

Cross-Cutting areas relevant to the sector

- **Human Rights:** protecting the health rights of clients, vulnerable groups (women, children, elderly, persons with disabilities) and the public.
- **Decentralization:** health service delivery is planned to be delivered by Health Service Corporations through PPPs at provincial levels and monitored through Directorates of Health and Family at provincial level. Local governance councils will have the authority to develop their local health service in alignment with national health policy and national standards.
- **Transport and connectivity:** transport network will assist in improving access to health care services including emergency and non-emergency referrals.
- **Gender:** mechanisms and processes will be established at health service facilities to respond to gender specific needs (as well as the needs of people with disabilities). Monitoring mechanisms will be instituted at provincial levels to monitor responsiveness of the health services to age, sex and disability needs of clients.
- **Social protection:** the provision of primary healthcare is pivotal in reducing risks and vulnerabilities of the population, especially of the poorer sections.
- **Environment:** adaptation to climate change and mitigation of the adverse human health effects arising from it are key actions to be

implemented in partnership with stakeholder agencies for climate change in the country.

- **Private Sector Partnership:** health services will be delivered in partnership with civil society organizations and private sector.

Socio-demographic trends

The most recent Population and Housing Census of Maldives conducted in 2006 indicate that the population of Maldives is 298,968 and the average annual population growth rate to be 1.69 percent (Ministry of Planning & National Development, 2006). Table below gives the population and its growth rate from the last four Censuses.

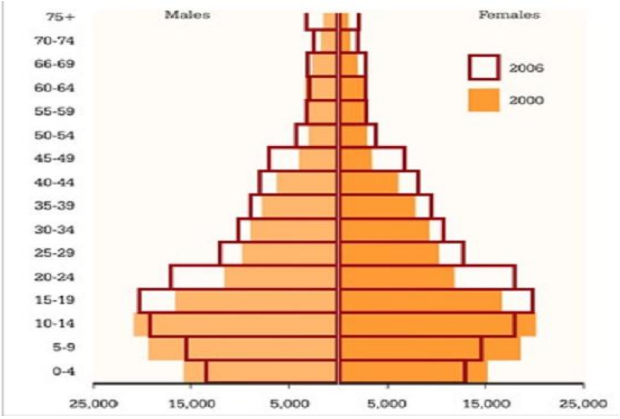
Table 1: Population trends from 1990-2006

	1990	1995	2000	2006
Population	213,215	244,814	270,101	298,968
Numerical Increase	33,127	31,599	25,287	28,867
Average Annual growth	3.43	2.73	1.96	1.69

(Source: Analytical Report of Census 2006)

It can be considered given the narrowing gap between births and deaths population growth pace may decrease, however, given the changes in fertility patterns it may also lead to increase in population growth. Health factors, population change, economic, social, political factors play a pivotal role in determining the demographic trends in the country.

Figure1: Population Pyramid 2006



(Source: Analytical Report of Census 2006)

The 2006 Census indicates that since 1920, Sex Ratio has been declining with minor fluctuations throughout. There were three percent (1531) more men than women in 2006, compared to twenty percent in 1931.

The general shape of the population pyramid indicates that the age and sex composition of the population is similar to other developing countries with relatively smaller proportion in the older age categories and larger proportion of the population in the less than 20 years of age categories. Furthermore, 28 percent of the population comprises of women in the reproductive age group (15-49 years) which may have an impact on the population growth due to potential baby boom years ahead.

The life expectancy trends in the population also show marked improvement which indicates improvement in the health status of the population. The life expectancy at birth has increased from 70.0 to 72.5 for males while it has increased from 70.1 to 74.1 for females from year 2000 to 2008 respectively. Several factors may have contribute to the increase in life expectancy such as improved accessibility of health services, improved diagnostic and other health services, and increased awareness within the population leading to healthy lifestyles. Table 2 below shows the trend in life expectancy for years 2000-2008.

Table 2: Life expectancy at birth from 1990-2006

Year	Male	Female

2000	70.0	70.1
2001	70.2	70.7
2002	70.0	70.9
2003	70.4	71.3
2004	71.1	72.1
2005	71.7	72.7
2006	72.0	73.2
2007	72.3	73.7
2008	72.5	74.1

(Source: Department of National Planning, 2009)

Access to health care

Despite the achievements in the health sector, it is a daunting challenge for Maldives to improve accessibility of health services equitably throughout the country. The delivery of services hampered by the geographical nature of the country with numerous islands scattered throughout and often the means of transport is by sea which can be affected by unfavourable weather. In terms of cost effectiveness and sustainment, it is not favourable to have hospitals or health centres in each island as the population in some islands reach up to few hundred only. Moreover, due to the limited public transport system, in many islands people are unable to travel or forced to pay for limited and over priced private transport services when seeking health care or other services. Considering these factors, health care services provision in Maldives is expensive.

It is envisaged that the new government policy of establishing a nationwide transport system will improve the accessibility of health services in the country. A sustainable marine transport network will increase accessibility and mobility of the people and is expected to increase economic regeneration at all levels through revitalization of the urban setting and land use.

Lack of adequately trained human resources is still a major concern in the health sector. A large expatriate workforce both in public and private sector contribute to delivery of health services.

In 2005, there were 379 medical doctors while in 2008 there were 615 doctors. In the year 2008, Population per hospital bed was 215 and population per practicing staff nurse stood at 176 while population per practicing doctor was 503.

Table 3: Doctors and Nurses working in the Maldives

Indicator	Year 2008
Population per hospital bed	215
Population per practicing nurse	176
Population per practicing doctor	503
Doctor / 10,000 population	19
Number of Doctors in Male'	260
Number of Doctors in Atolls	355

Large expatriate workforce presents difficulties in patient-doctor communication and interactions, especially at community level. It also means that there is a high staff turnover thus impacting on quality of services.

Table 4: Doctors, nurses and paramedical staff – expatriate and locals by atolls

	Republic			Male'			Atolls		
	Total	Local	Expat	Total	Local	Expat	Total	Local	Expat
Doctors	**615**	118	497	**260**	93	167	**355**	25	330
General Practitioners	**384**	68	316	**128**	43	85	**256**	25	231
Doctors (Specialists)	**231**	50	181	**132**	50	82	**99**	0	99
Nurses	**1760**	750	1010	**618**	226	392	**1142**	524	618
Paramedical	**595**	188	407	**319**	145	174	**276**	43	233

Note: Private clinics data and Community Health Personnel data not included (Source: MoHF)

In addition to the shortage of local skilled personnel, there is also skill-job mismatch of trained personnel in the health systems, which decreases efficiency and achievement of expected health outcomes, indicating the need for building country capacity for health system management.

Health care service by the government are provided within a 5-tier referral system through one tertiary care hospital (the IGMH) located in the capital, 6 Regional Hospitals with a number of specialities at strategic locations in the outer atolls, 14 Atoll Hospital providing closer access to emergency obstetric and newborn health, health centres in the rest of the island populations providing basic medical and nursing care. In addition to curative health care, these health care facilities carryout the public health functions of immunisation, maternal and child health, family planning, disease surveillance, health education and promotion.

The private sector in health in the Maldives, although small, is vigorous and distributed widely across the islands. In 1996 the first private hospital, ADK Hospital with 40 beds was opened in Male'. The ADK hospital is a tertiary facility offering outpatient, inpatient and diagnostic services. There are numerous, smaller private health clinics. A total of 62 clinics are distributed throughout the country of which 73% are located in Male'. All pharmacies in the country are in the private sector, including those located in public sector facilities. Owing to remote and small population in many islands, and the need to assure access to drugs, women or youth committees or NGO are supported by the government to establish community pharmacies.

Under the government's decentralization, corporatization and privatization policies, selected health services will be delivered through Public Private Partnerships and managed by corporate bodies at provincial levels. Efficiency benefits of the private sector are expected from competition, modernization, innovation, and new technology; along with lowering of infrastructure and administrative costs to the government. Capacity building at Ministry of Health and Family for oversight and performance monitoring needs to be addressed urgently ensure equitable access to quality care for all irrespective of age, sex and locality.

Primary Health care is to be revitalized by focusing on preventive health in national health policy; by empowerment of community to make decisions related to health services at island and atoll levels through political and administrative decentralization and supporting training of community based public health professionals. In the private sector, health care primarily covers outpatient and diagnostic services. The government depends heavily on external funding for capital investment and human resource development in the health sector.

The government's commitment for improving the health services is evident by the health expenditure by the government. The health expenditure has increased over the years and in the year 2008 the health expenditure as a percentage of national budget stood at 13 percent, representing a per capita expenditure of MRf 4056.

Table: 5 Government Health Expenditure

Indicator	Year 2008
Health Expenditure as a % of national budget	13
Public Health Expenditure as a % of total GDP	11.8
Per capita Health Expenditure as of National Budget (MRf)	4056
% of population covered by government social health insurance scheme *(Madhana)*	16.25%

(Source: Maldives Health Statistics, NSPA 2010)

The government recognizes that access to good quality health services is a right of each person. In this regard, while the government embarks on corporatization and public private partnerships in health services, the government's has introduces and opened up the social health insurance scheme *(Madhana)* for all people and improving the accessibility of quality medical services. At present the percentage of population covered by

Madhana is16.25%. Other private health insurance schemes cover approximately 20% of the population.

Reproductive Health

Government is committed to providing reproductive health services that are affordable have equity in access and quality corresponding to the needs of each individual, encompass the principles of primary health care, ensure privacy of the individual and are sensitive and responsive to the socio-cultural circumstances of the individual.

A lot of work has been undertaken to improve the reproductive health situation in the country. Different studies in the recent past have shown that there is almost universal coverage of antenatal care in Maldives. The Table below shows some of the RH related indicators from past surveys.

Table 6: Reproductive Health Related indicators from past surveys

Indicators	1999 RH Survey	2004 RH Survey	2007 Micronutrient Survey
	Percentage		
At least one ANC visit during pregnancy	88%	99%	99.9%

Four or more ANC visits during pregnancy	62%	91%	93.2%
Skilled Birth Attendance Rate	…	85%	…
Postnatal care coverage (contact with health care provider within six weeks following delivery)	…	60%	…
Contraceptive Prevalence Rate (All methods including traditional methods)	42%	39%	…
Contraceptive Prevalence Rate (Modern methods of contraception)	32%	34%	…
Unmet Need for Family Planning	42%	37%	…

In addition to survey data, data from the routine vital registration system indicates that 99 percent of deliveries are institutional deliveries. Number of birth attended by skilled health personnel (Doctors and nurses) is 98.25 percent.

Figure 2: Percentage of deliveries by type of birth attendant

The commitment to promote family planning has increased over the past years, however other challenges do exist with regard to contraceptive use and adopting family planning methods. Given the investments in the area, More qualitative research is needed to identify and explore in-depth RH related issues so that these can be better addressed in an evidence based manner.

Maldives Demographic and Health Survey (MDHS) 2009 shows that women in the Maldives demonstrate contraceptive use behaviour that is quite different from commonly occurring patterns. Contraceptive prevalence in the Maldives shows a decline with increasing education as evident in use of

modern methods declining from 36 percent among women with no education to 21 percent among women with more than secondary education. Most of the differential is due to the higher reliance on female sterilization among women with no education. Interestingly, while pill use declines with increasing education, male condom use increases with increasing education. Unlike many other countries, the differences in contraceptive prevalence by wealth status or urban-rural residence also are not substantial.

Anaemia among pregnant women continues to be a problem. The National Micronutrient Survey 2007 shows that overall, 15.4% women of reproductive age were anaemic to some degree: 0.3% severely anaemic and 15.1% moderately anaemic.

Child Health and Nutrition

Despite the improvements in many areas of health, nutrition situation in the country continues to be an area of public health concern. Past studies have shown that percentage of children under 5years who are underweight has gradually declined from 43% in 1996 to 17.3% in 2009. Similarly, stunting declined from 30% in 1996 to 18.9 % in 2009; wasting declined from 17% in 1996 to 10.6 % in 2009.

Table 7: Trends in nutritional status of children less than five years by sex

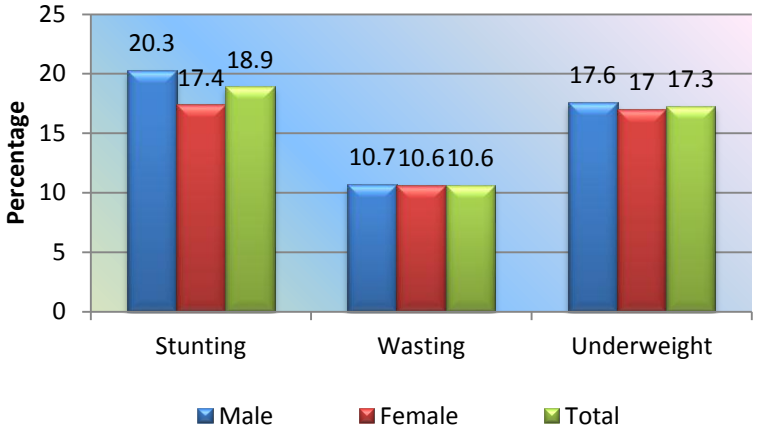
Indicators	1996 MICS I	2001 MICS II	2009 MDHS*
	Percentage of Under5 children		

Stunting	30	25	18.9
Wasting	17	13	10.6

Underweight	43	30	17.3

** preliminary results of MDHS*

Figure 3: Malnutrition status of under-five children



Source: MDHS, 2009 (Preliminary Results)

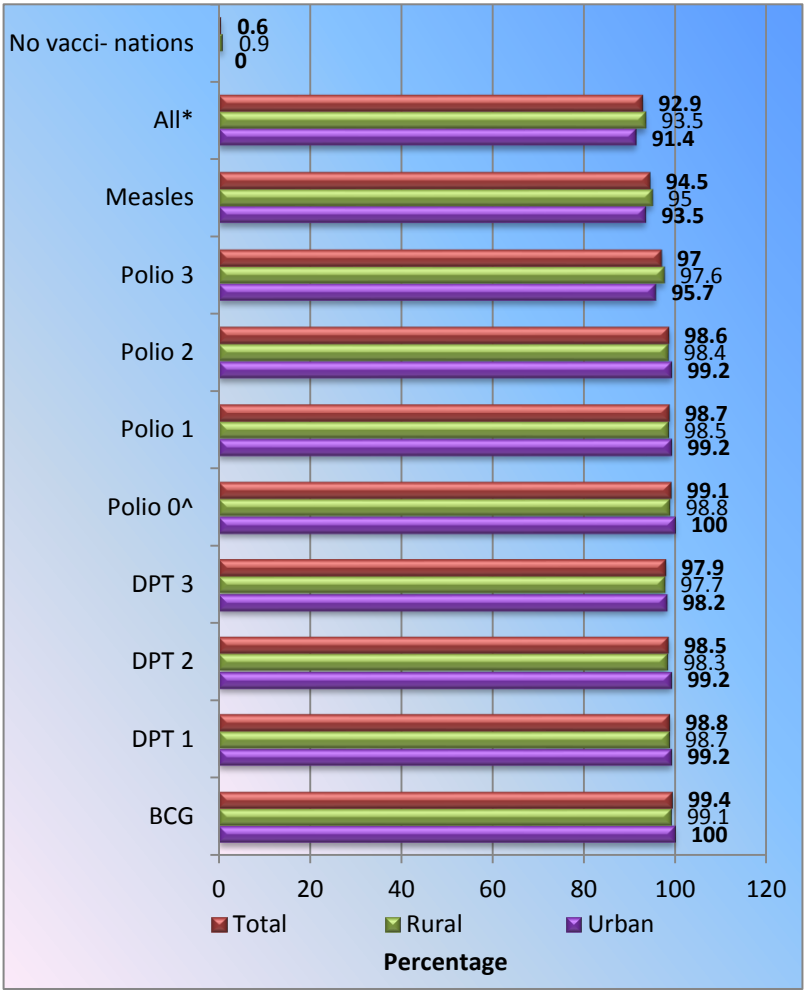
It was observed in the micronutrient survey of 2007, that the weaning and feeding and practices of infants and children is a major factor for the

continued malnutrition problem. The study also showed that micronutrient deficiencies, especially deficiencies in iron, zinc and Vitamin A are nutrition issues that need to be addresses in both children and reproductive aged women.

Breastfeeding is commonly practiced in the Maldives. However, the proportion of children being exclusive breastfed up to 6 months of age is seen to be low. Multiple Indicator Cluster Survey II (2001) showed a mere 10 percent of babies exclusively breastfed. As a result of promotion of exclusive breastfeeding practices through baby friendly hospital initiatives, as well as health awareness programs, this proportion has increased to 48 percent as shown from the 2009 MDHS.

Maldives has long maintained, the almost universal coverage in EPI. Since early 1990s, the coverage rate has been maintained over 90 percent for all vaccines. Percentage of children, 12 to 23 months fully immunised has increased from 85 percent in 2001 (MICS II) to 93 percent in 2009 (MDHS).

Figure 4: Immunisation Coverage



Source: MDHS, 2009 (Preliminary Results)

Note: ^ - Polio0 is the polio vaccination given at birth.

*All * - BCG, measles and three doses each of DPT and polio vaccine (excluding polio vaccine given at birth)*

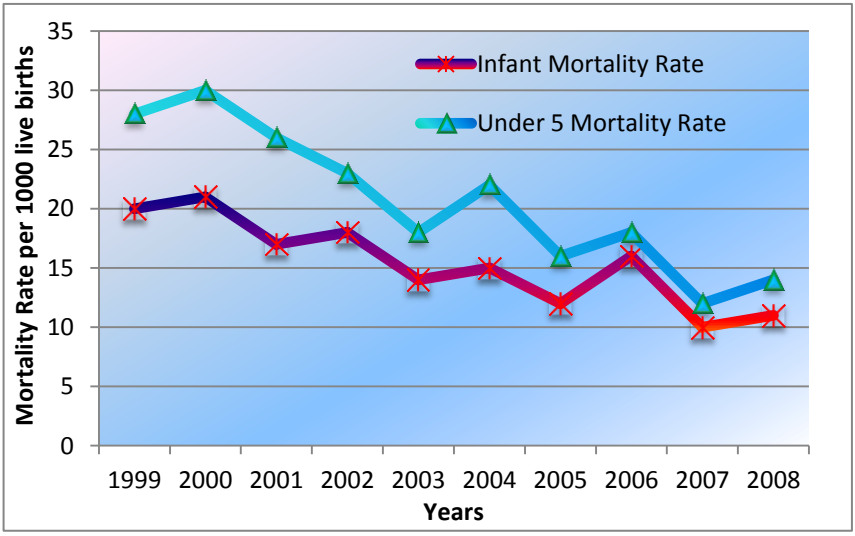
Mortality trends

Crude Death Rate (CDR) over the years had shown a steady decline and it has stabilized between 4 and 3 per 1000 population during the years of the last decade or so. The CDR which stood at 4 in 2006 and 2007 has reduced to 3 per 1000 population in 2008. Significant falls in CDR was seen to be mainly associated with the fall in the infant and child mortality rates over the last two decades. Access to better health care and expansion of health services to the atoll populations and effective immunization programs played a major role in the fall of death rates.

Infant and child Mortality

Infant and Child Mortality Rates had a steep fall during the 1980s and 1990s, thereafter the rate of fall was slower.

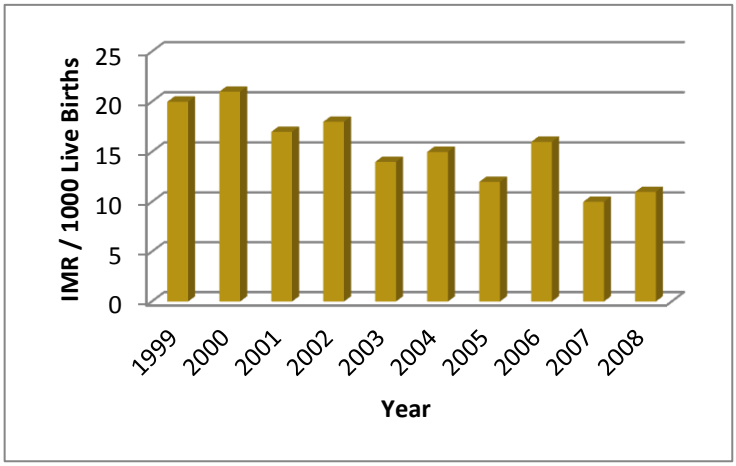
Figure 5: Comparison of IMR and Under five mortality



(Source: Vital Registration System, MoHF 2009)

Although there were fluctuations of IMR over the past years, generally IMR has reduced.

Figure 6: Infant Mortality Rates 1999-2008



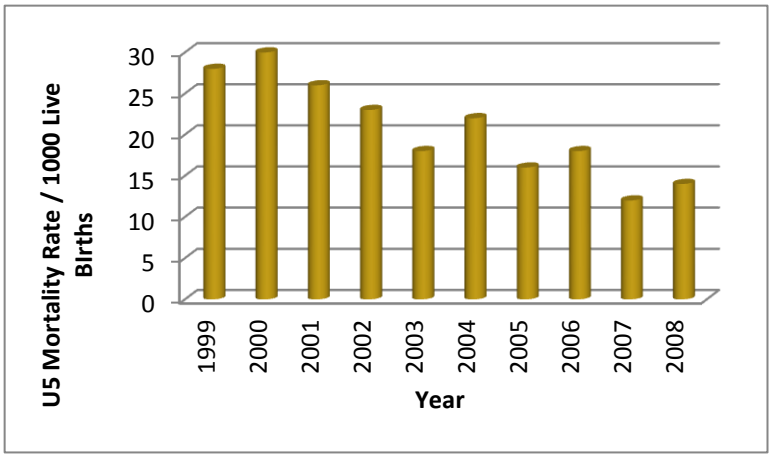
(Source: Vital Registration System, MoHF 2009)

Reduction in Child Mortality Rate is one of the goals of the Millennium Development Goals (MDGs) and utmost priority has been placed to reduce the Child Mortality Rate.

The baseline data of 1990 indicates that Under-Five Mortality Rate stood at 48 per 1000 live births in 1990 while IMR stood at 34 per 1000 live births. The MDG target for Maldives is to reduce Under Five Mortality to 16 per 1000 live births by the end of 2015. There is a significant improvement in Under Five Mortality Rate and Infant Mortality Rate as shown from the data of 2007 and 2008. In the year 2007, Under Five Mortality Rate was 12 per thousand live births while it increased to 14 per thousand live births in 2008. Similarly, Infant Mortality Rate for 2007 was 10 per 1000 live births while it increased to 11 per thousand live births in 2008. Although there are fluctuations, it can be expected that Maldives will sustain achievements in the MDG target of

reducing Under Five Mortality by two thirds between the baseline year of 1990 and 2015.

Figure 7: Under-five Mortality Rates 1999-2008



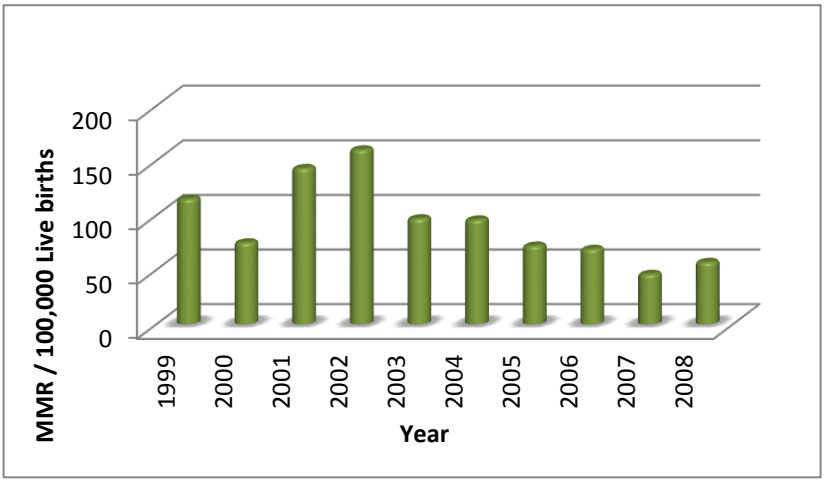
(Source: Vital Registration System, MoHF 2009)

However, consistent efforts have to be made towards improving the Infant Mortality Rate, Under- Five Mortality Rate and Child Mortality. A greater challenge for further reduction in infant mortality now lies with reducing neonatal death rate. More than 70% of infant deaths are neonatal deaths. It has to be noted that there is a large proportionate of premature births. Chances of survival of some of these premature infants may not be possible if an appropriate neonatal intensive care or resuscitation measures are not available in most of the health facilities. This large proportion of premature births among other factors, contribute to the increased neonatal death rate.

Maternal Mortality

Improvements in reducing Maternal Mortality is evident by the reduction of Maternal Mortality Ratio (MMR) over the past years, which may be mainly due to efforts such as auditing of maternal deaths and improved accessibility of health services in the islands. One of the targets of the Millennium Development Goals is to reduce the Maternal Mortality Ratio by three quarters between 1990 and 2015.

Figure 8: Maternal Mortality Rates 1999-2008



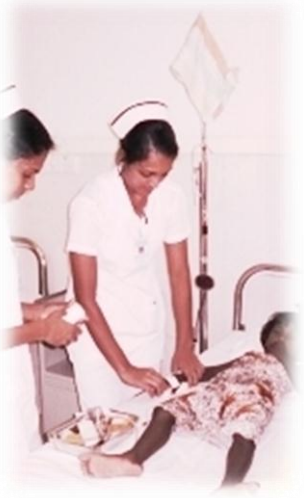
(Source: Vital Registration System, MoHF 2009)

When considering the baseline indicator of 1990, given the available data at that time, MMR was at 500 per 100,000 live births. As such it is targeted to reduce the maternal mortality ratio to 125 per 100,000 live births by year 2015. In the year 2007 MMR was 46 per 100,000 live births and it increased to 57 per 100,000 live births in 2008. Although reduction in MMR can be seen to be on track we have to be cautious as MMR is likely to fluctuate in the coming years. Also when interpreting the data, it has to be noted that due to the small population, even a single maternal death has a large effect on the MMR of the country.

Morbidity trends

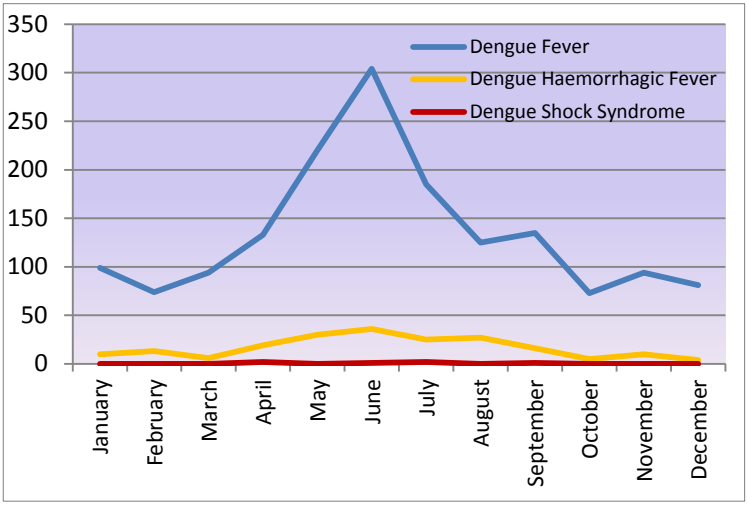
The main morbidity trend observed over the past decade is the transition from high burden of communicable diseases to a higher burden of non-communicable diseases.

Notable achievements have been made in the control of communicable diseases. There is no indigenous transmission of Malaria since 1984 and Maldives is maintaining it's malaria free status in the entire South East Asian Region. Only few imported cases (from 10 to 30) are being reported every year. Vaccine preventable diseases have also been controlled to such an extent that diseases like polio, neonatal tetanus, whooping cough and diphtheria are nonexistent. Filaria and Leprosy is progressing towards the elimination regional target. Although the country is on track to achieving MDG goal 6 of combat HIV/AIDS, malaria and other diseases, numerous challenges lie ahead.



Mortality due to diarrhoea and acute respiratory infections continue to cause significant morbidity among children and adults. Between 2007 and 2008, ARI and diarrhoea cases accounted for approximately 47% and 8% of reported cases of communicable diseases. Diseases such as dengue, chikungunya, scrub typhus, toxoplasmosis and leptospirosis have also emerged due to environmental and climate changes and continue to be endemic.

Figure 9: Number of cases of Dengue Fever, Dengue Haemorrhagic Fever & Dengue Shock Syndrome, 2008



(Source: CCHDC, 2009)

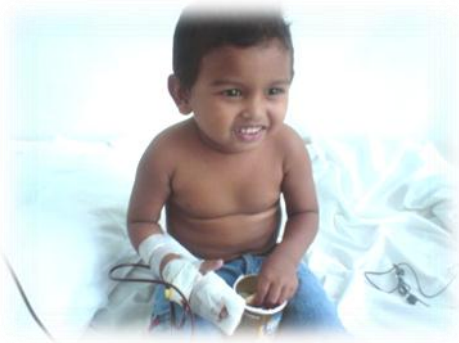
Added to this, are the increasing health risks of zoonoses and related public health emergencies of international concern. Access to safe drinking water and improved sanitation still remains a challenge, making the achievement of MDG goal 7 (*Ensuring environmental sustainability*) unlikely, leading to environment related health risks.

Tuberculosis though controlled, continues to persist and has a high risk of spread in Male' due to the overcrowding and poor housing condition and MDR-TB has emerged in the country increasing the risk and

challenge for control many fold. The 2008 behavioural and biological survey of at risk population groups indicates HIV risk and STIs are significant due to the practice of unsafe harmful practices such as unprotected sex among sex workers and young people and needle sharing among intravenous drug users indicating concerted efforts to limit the potential spread are imperative.

With the control of communicable diseases and lifestyle changes associated with development, chronic non communicable diseases have emerged as the main cause of morbidity and mortality in the country. Cardiovascular diseases, chronic respiratory diseases, accidents and injuries and cancers are the leading causes of death in the country. According to WHO estimates about 36% of all years of life lost in Maldives in 2002 were due to NCDs.

Thalassaemia is also an area of concern with a national prevalence of 20% and growing number of renal diseases are other common chronic diseases of concern. Added to these physical disease conditions is the issue of mental health and psychosocial wellbeing. Mental health survey in 2003 showed that 10% of the population suffers from mental health problems, with highest proportion of psychotic symptoms in the age group of 15-25 years. Women's health and life experiences survey of 2002 had showed the strong connection of gender based violence and child abuse with emotional distress and suicidal tendencies.



Constraints and emerging issues in the health sector

1. Lack of skilled local health professionals at all levels of the health system due to limited training opportunities in the country as well as abroad. At the same time, there is inadequate financial allocation for the training of health professionals taking into view the high cost of training medical specialists.
2. The provision of specialized health services at provincial and atoll levels with smaller populations requires huge investments which is not cost effective in the absence of a nation-wide affordable transport system. This continues to be a deterrent for private investments in health care in the atolls. At the same time, the skilled professionals have limited opportunity for application of their training and skills.
3. The focus on development of curative care has resulted in deterioration of delivery of Primary Health Care resulting in reduced community participation in preventive and protective health services and underutilization of the skills of trained community based public health workers.
4. The existing health care financing scheme is limited to limited number of providers and population groups resulting in inequity in access to health services.
5. Lack of appropriate laws to protect public health and the human right to health
6. Limited capacity and scope of mental health programmes resulting in increasing suicides, antisocial behaviour and violence
7. Emergence of communicable diseases such as dengue, chikungunya, scrub typhus, toxoplasmosis, leptospirosis and zoonoses due to climate change and human practices.
8. Tuberculosis including the MDR TB is re-emerging due to overcrowding and poor housing conditions in urban settings as well

as noncompliance to medical advice on diagnosis. There is also a high risk of spread of HIV due to increasing injecting drug use, with unsafe practices such as needle sharing and unprotected sex among the drug users and sex workers.

9. Chronic non communicable diseases such as cardiovascular diseases, chronic respiratory diseases and cancers have increased due to high prevalence of risk factors for non communicable diseases such as sedentary lifestyles, obesity, tobacco use
10. The problems of accidents and injuries are growing leading to death and disabilities, from road traffic accidents, occupational and worksite injuries due to the absence of regulatory framework with enforcement mechanism.
11. Inadequate reorganization of services and sensitization of health care professionals in pace with changes to the demographic profile of the country leading to inadequate services for newborns, adolescent and young people and elderly in general as well as specific services for concentrated population groups in urban and island settings caused by population migration
12. Absence of periodic research and analysis of health needs with the objective of reorienting health services to emerging health needs such as chronic diseases, mental health, accidents and injuries, gender-based violence and child abuse
13. Lack of a legal framework to protect the patients and providers is leading to mis-management of medico legal issues resulting in loss of trust and confidence in the health system both by the public and the providers as well as public health protection measures.
14. Lack of capacity for monitoring quality and evaluating health service provision and health system management needs to be addressed urgently to ensure safety and quality of health services delivered through Public Private Partnerships and by the private sector.

"Maldives will be a model society of socially protected, healthy individuals – its people are aware, value family ties and live healthy satisfying lives"

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