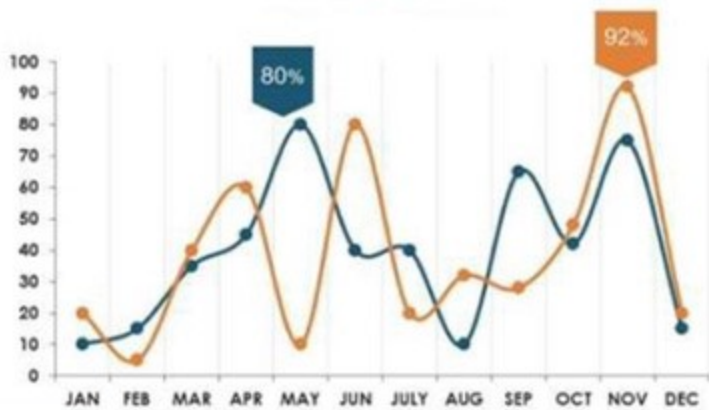


Maldives Health Profile

2019



MALDIVES HEALTH PROFILE 2019

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About

It presents some of the key findings and concepts from the main health statistics report, and directs readers to the relevant chapters in *Maldives Health Statistics 2017-19* should they require more information. The findings are drawn from a range of data sources—full details can be found in *Health Statistics 2017-19* and in the supplementary tables attached with the report.

On an average day in our health system

- 17 babies are born
- 9 live births are vaginal deliveries
- 8 live births are caesarian section deliveries
- 12 babies are born in Male'
- 3 people die
- 2 people die of a chronic condition (cardiovascular disease, chronic obstructor pulmonary disease, cancer and diabetes)
- 1 person die of cardiovascular disease
- 122 hospitalizations are made
- 95 hospitalizations are in public hospitals
- 27 hospitalizations are in private hospitals
- 48 hospitalizations are due to communicable, maternal, perinatal and nutritional conditions
- 39 hospitalizations are due to noncommunicable diseases
- 3.7 days was the duration of hospitalization in hospitals
- 6,561 outpatient visits were made to health facilities

Vision of Ministry of Health

To have a nation with a healthy population which are health literate and practice healthy lifestyles, and have easy and effective access to quality health services in the region where they reside which is covered by a health care financing mechanism.

Mission of Ministry of Health

Protect and promote health of the population with enabling policies, relevant modern ICT and healthy environments; provide social health insurance; develop an efficient, sustainable health system and provide need based, accessible, affordable and quality health services in partnership with private sector and community.

1. The Health System of Maldives

The public sector conforms to the largest share of the health system in Maldives. The public sector is supported by a number of private health care providers, mainly providing curative and diagnostic services, and medicines and medical products located within the country as well as in neighboring countries. Another key sector that forms part of the health system is the voluntary sector in the form of NGOs working on specific health issues. While the public system extends to all inhabited island, private and voluntary sector services are concentrated in Male'. The health system is also supported by external development partners.

Despite the achievements in the health sector, it is a daunting challenge for Maldives to sustain accessibility of health services equitably throughout the country. The delivery of services is 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 unfavorable weather. In terms of cost effectiveness and sustainability, it is not favorable to have hospitals or health centers in each island as the population in some islands reach up to a few hundred only.

1.1. The Healthcare Delivery System

The health care delivery system of Maldives is organized into a three-tier system with island level primary health centers, a higher level of health facilities with respect to provision of maternal, new born care and specialty care at an atoll/regional level and tertiary care at a central level. Depending on the grading of the hospital and health center, specialty care is provided.

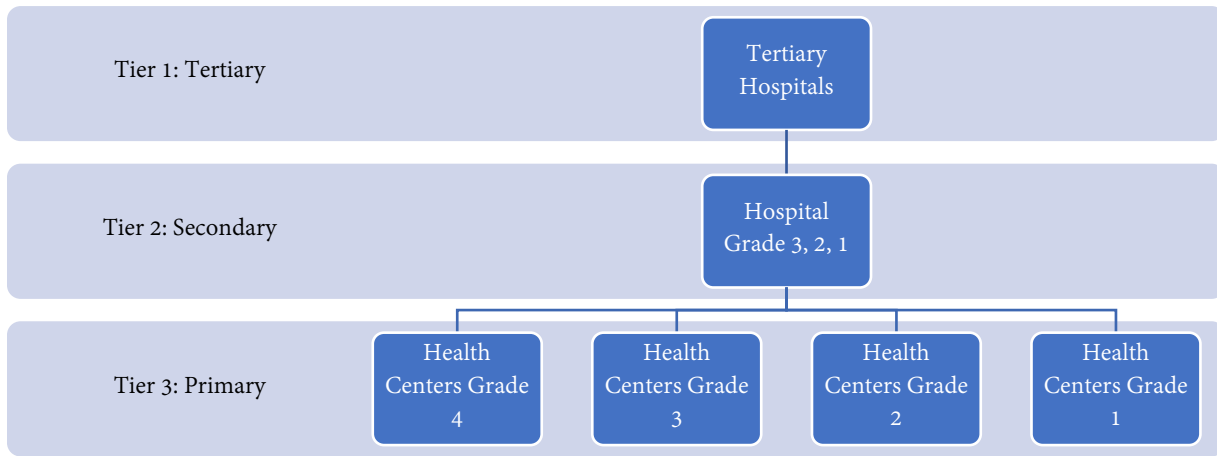
Health policies with regard to public service delivery include, establishing a public health facility either a hospital or health center in each inhabited island, for which the service level would be decided depending on the level of population, patient load, and distance to nearest hospital. Each atoll excluding K atoll, has a hospital catering to the population of that atoll. Even though hospitals are called regional or atoll hospitals, the grading criteria for hospitals, contains three levels. Administratively, the regional or atoll hospital in each atoll acts as the main coordinating body in providing primary and curative health care in that atoll and each atoll covers a population of 5,000 to 15,000 people. The following depicts gives the 3 tiers of Maldivian Health System.

Table 1-1: Number of health facilities by category

Category of health facility	Private	Public	Total	
a. Health Centre		164	164	
b. Atoll Hospital		13	13	
c. Hospital ¹	2	3	6	
d. Regional Hospital		6	6	
e. Tertiary Hospital		2	1	3
Total	5	187	192	

¹ Hospitals include Villimale', Hulhumale, Senahiya, IMDC and Medica Hospital.

Figure 1-1: Public healthcare delivery system of Maldives



1.2. Healthcare Resources

The limited and unreliable public transport system, people in many islands are unable to travel or have to pay high amounts to the private transport services to reach appropriate health care. Considering these factors, health care services provision in Maldives is a costly undertaking.

A systematically organized public transportation system is a necessary pre-requisite for the full utilization of health care delivery system. 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. One of such effort by the health sector is the introduction of the sea ambulance in the year 2014. By the end of 2016, coverage has been extended to all the atolls of Maldives with 26 sea-ambulance in operation.

Strategies to improve utilization of enabling platforms such as telemedicine, e-health programs and the initiatives for increased financial health protection are of importance. There is a need to strengthen the health care system to meet the increasing health care demands and the challenges of social determinants of health amidst financial and resource shortages.

Further, to overcome the shortage of medicine in smaller communities, the government entered into a partnership with the State Trading Organization (STO) in 2014 outsourcing the supply and management of medical supply system of the public health care delivery system. As such, STO is establishing pharmacies in smaller island, medical storage facilities among the atolls, establishing a biomedical service and medical supplies information system to guide effective supply of medicines, medical products and technology to all public health facilities. In this aspect the number of pharmacies has increased over the years.

1.3. Financial Resources

The government’s commitment for improving the health services is evident by the health expenditure by the government. After several attempts to provide the benefits of health insurance, all Maldivians now enjoy a universal health insurance scheme fully financed by the government. The following gives the introduction of first Health Insurance Scheme and extending to full Maldivian coverage by 2014.

Figure 1-2: Progression of health insurance scheme of Maldives



2. Births in Maldives

In 2019,

- 99% were in a hospital
- 69% of live births occurred in Male' city health facilities
- 45% of livebirths occurred in IGMH
- 51% of babies were boys
- 20% of livebirth took place in private hospitals
- 49% of babies were born by caesarean section
- 51% of babies were born by vaginal delivery
- 44% of babies were born by spontaneous vaginal delivery
- 89% of livebirths were born between 37-4 weeks (gestational age – term deliveries)
- 87% of livebirths had normal weight (2500 – 3999 grams)
- 99% of births were attended by either gynecologist/doctors/nurse/midwife nurse

2.1. Life Expectancy

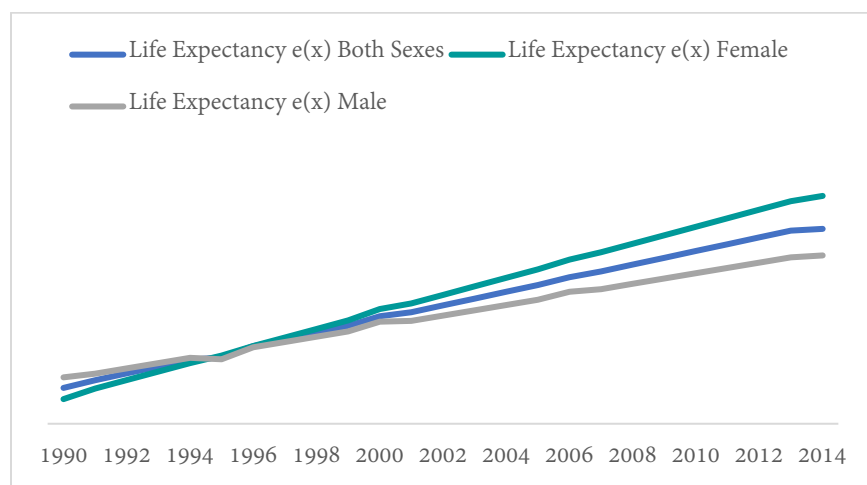
Our life expectancy at birth has increased greatly over the last century. We're expected to live about 18 years longer than people born in 1990. This places us in the top of the WHO-South East Asian Region (SEARO) countries for life expectancy.

Life expectancy for babies born in 2014

Boys—79.0 years

Girls—85.7 years

Figure 2-1: Life expectancy at birth 1990-2014

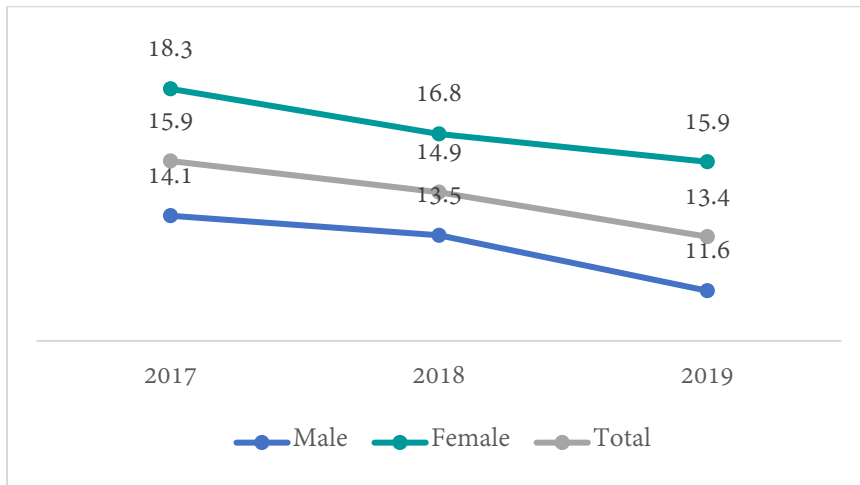


A Maldivian born in 2014 can be expected to live around 82 years, while girl who was born in the year 2014 can be expected to live to around 85-86 years and a Maldivian boy who was born in the same year can be expected to live to around 79 years.

Although in 1990, a Maldivian boy who was born that year was expected to live 2.5 years longer than a Maldivian girl born in the same year, a change in this trend can be observed over the years that followed. At present, a Maldivian girl born in a particular year can be expected to live 6-7 years longer than a Maldivian boy born in the same year.

2.2. Crude Birth Rate

Figure 2-2: Crude Birth Rate, 2017-19

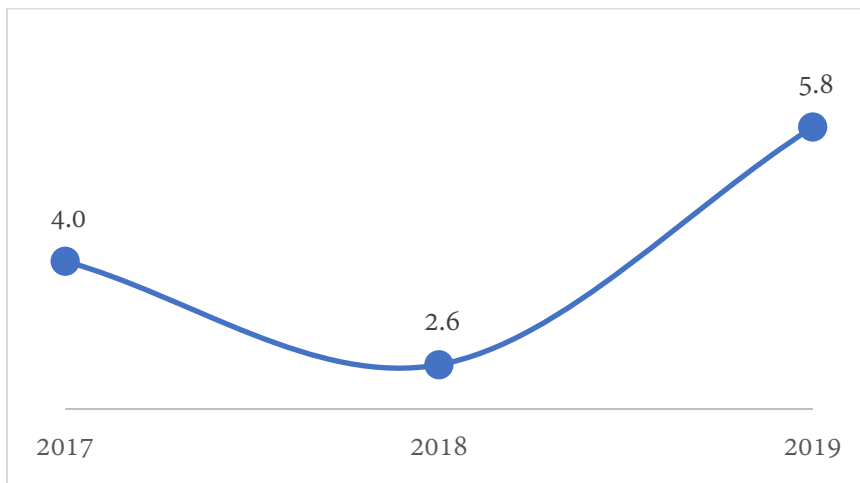


The crude birth rate is the annual number of live births per 1,000 population.

The crude birth rate is generally computed as a ratio. The numerator is the number of live births observed in a population during a reference period and the denominator is the number of person-years lived by the population during the same period. It is expressed as births per 1,000 population.

2.3. Adolescent birth rate (Age: 15 to 19 years)

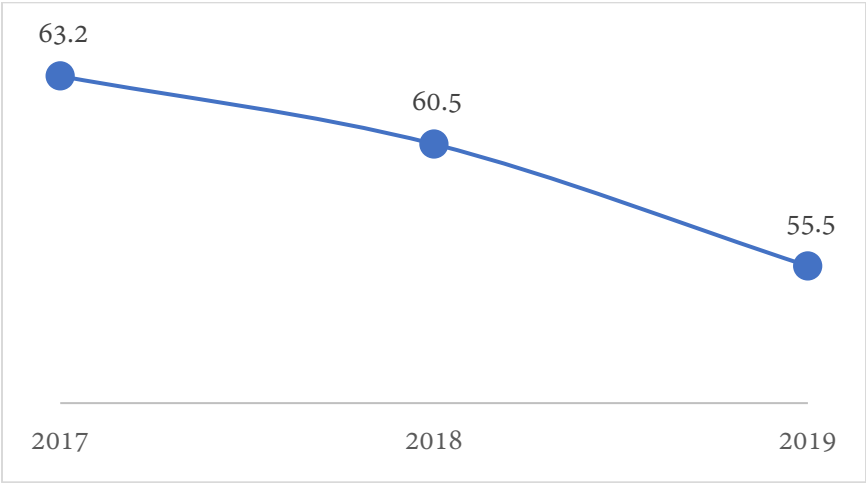
Figure 2-3: Adolescent Birth Rate, 2017-19



The annual number of births to women aged 15-19 years per 1,000 women in that age group. It is also referred to as the age-specific fertility rate for women aged 15-19.

2.4. Reproductive birth rate or fertility rate (Age: 15 to 49 years)

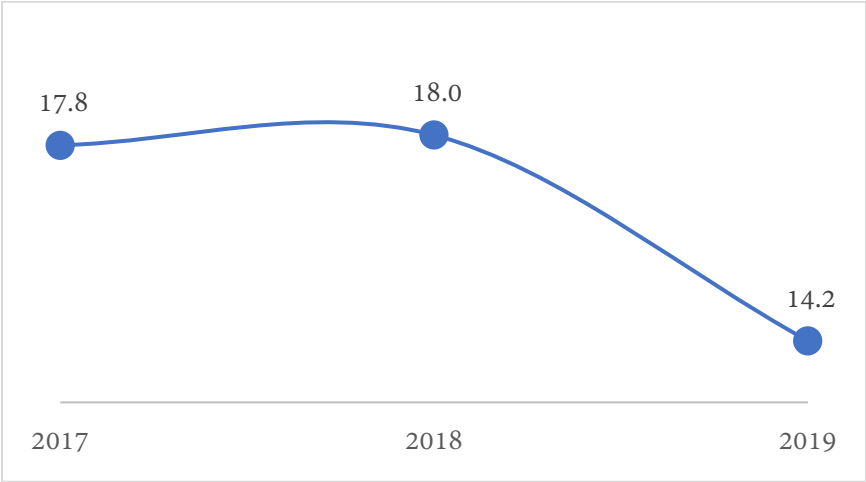
Figure 2-4: Reproductive age birth rate, 2017-19



The **fertility rate** measures the number of **births** per 1,000 women of childbearing age (ages 15 to 49) occurring in a particular year; **birth rates** refer to this measure within particular age groups.

2.5. High risk birth rate (Age: over 35 and under 19 years)

Figure 2-5: High risk age birth rate, 2017-19



The **high-risk birth rate** measures the number of **births** per 1,000 women of high-risk age groups (ages below 19 and over 35) occurring in a particular year; **birth rates** refer to this measure within particular age groups.

2.6. Vital Statistics Indicators

Table 2-1: Vital Statistics Indicators, 2017-19

VITAL STATISTICS INDICATORS ²	2017	2018	2019
Crude Birth Rate (CBR)/'000 population	16	15	13
Crude Death Rate (CDR)/'000 population	3	3	2
Infant Mortality Rate (IMR)/'000 live births	10	7	6
<5 Mortality Rate (<5MR) /'000 live births	11	9	8
Maternal Mortality Ratio (MMR)/100,000 live births	103	61	-
Still Birth Rate (SBR)/'000 live births	5	3	6
Neonatal Mortality Rate (NMR)/'000 live births	8	5	4

Table 2-2: Numbers used in the Vital Statistics Indicator calculations, 2017-19³

	2017	2018	2019*
Total no. of births (Live birth + Still birth+ Abortion)	7,030	6,808	6,350
Total no of live births	6,802	6,586	6,153
Total no of Still births (birth data file)	31	23	39
Total no of Abortions (birth data file)	197	199	158
Total no. of deaths	1,250	1,261	1,054
Total no. of infant deaths	66	48	39
Total no. of Neonatal Deaths (0-27d)	53	34	25
Total no. of <5 deaths	75	57	49
Total no. of maternal deaths	7	4	-
Resident Projected Mid-Year Population (from NBS)	427,964	442,883	458,706

² Rates calculated using the Resident population of 2017- 2019

³ Tentative deaths for 2018 and 2019 - subject to change

3. How healthy are we?

Collectively, in 2019 chronic conditions (to cardiovascular disease, cancer, diabetes or chronic respiratory disease) account for:

- 55% of deaths and 11% of hospitalizations

3.1. Morbidity

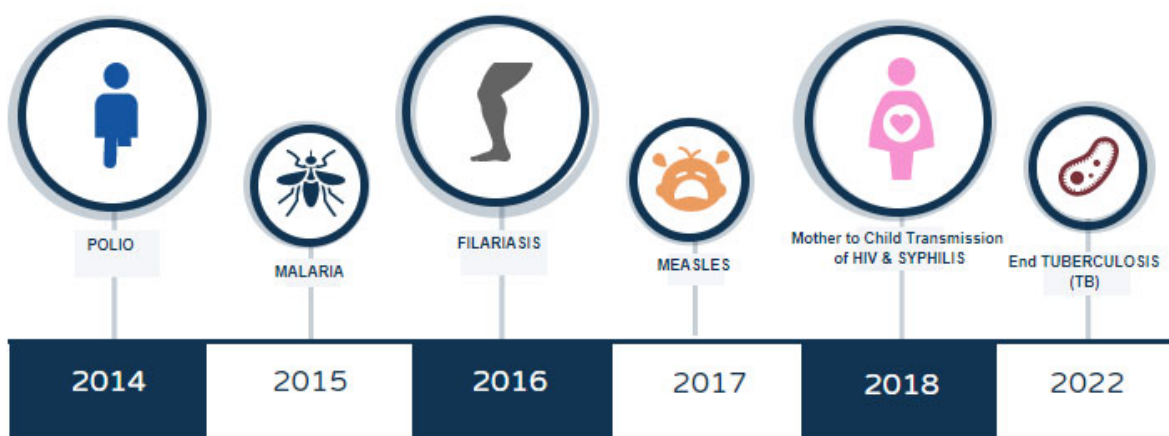
Maldives has double burden of diseases, both communicable diseases and increasing burden of non-communicable diseases. We now face the challenge of controlling non-communicable diseases and addressing social determinants of health while also continuing to strengthen preparedness and control of emerging and re-emerging communicable diseases.

In 2019;

- 56% (24,777) of all hospital admissions were females
- 95% of hospital admissions were locals, of which 54% were females
- 5% admissions were foreigners, of which 4% were males
- 32% of hospital admissions were due to non-communicable diseases
- 40% of hospital admissions were due to communicable, maternal, perinatal and nutritional conditions

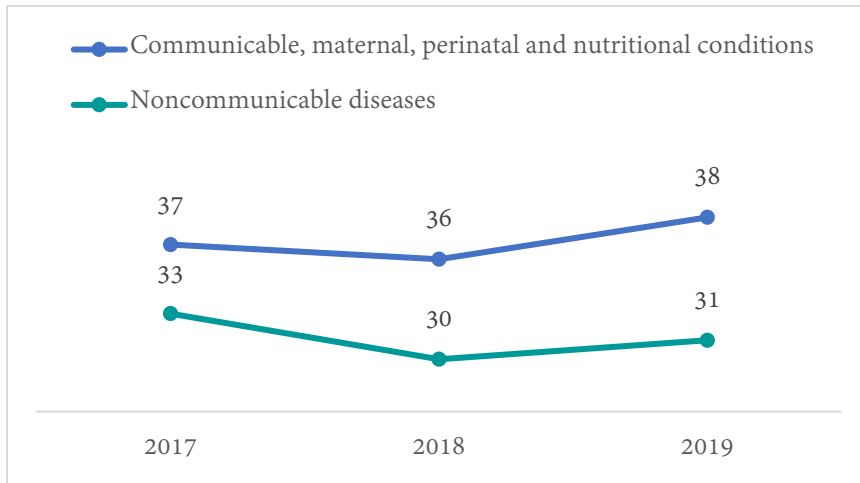
There has been continued improvement in situation of most communicable diseases, while in other diseases, achievements have been sustained. The most remarkable achievements in the past with regard to communicable diseases include Maldives being declared disease free for the following.

Figure 3-1: Elimination of diseases and targets



Prevention of NCDs is given priority by the government. The Health Master Plan proposed for 2016-2025 focuses on prevention of CVDs, Diabetes, renal diseases, COPD and selected cancers. A multi-sectoral Action Plan on the Prevention and Control of NCDs (2016-2020), which is aligned with the Global NCD Targets, is in place. Tobacco Control Act aligned with the global tobacco control treaty WHO Framework Convention on Tobacco Control (FCTC) is in force since 2010.

Figure 3-2: Morbidity rate for non-communicable diseases and communicable, maternal, perinatal and nutritional conditions per 1,000 population, 2017-19



The morbidity rate is the frequency or proportion with which a disease appears in a population.

For calculation purposes total admissions due to specific conditions such as, non-communicable diseases and communicable, maternal, perinatal and nutritional conditions per 1,000 population in a particular year is taken.

Figure 3-3: Morbidity rate for injuries and ill-defined diseases per 1,000 population, 2017-19

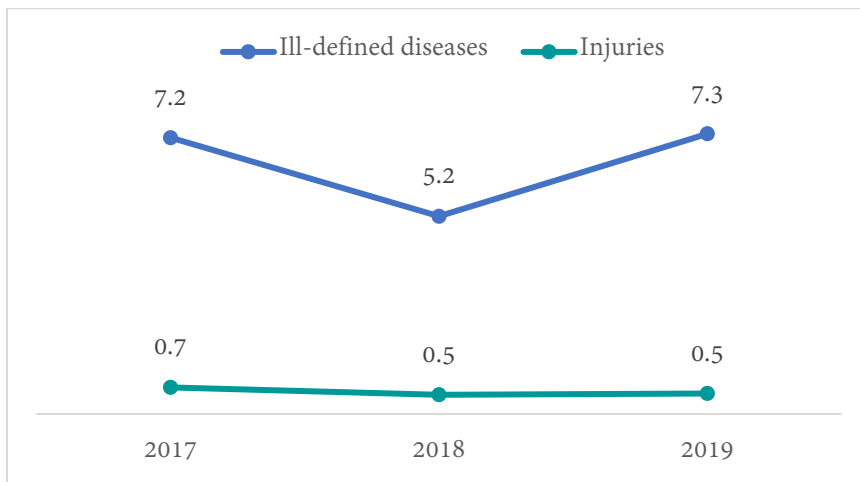
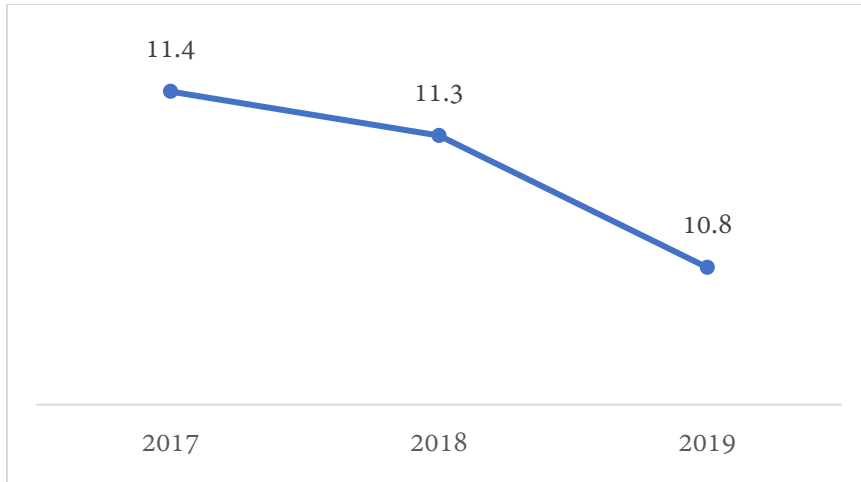


Figure 3-4: Morbidity rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease per 1,000 population, 2017-19



Disease burden from non-communicable diseases (NCDs) among adults is rapidly increasing in developing countries due to ageing. Cardiovascular disease, cancer, diabetes or chronic respiratory diseases are the four main causes of NCD burden: ICD-10 underlying causes of death I00-I99, C00-C97, E10-E14 and J30-J98.

Table 3-1: Top burden of diseases (admissions) by age for 2017-19

Age groups	2017		2018		2019	
0-4	Other perinatal conditions	18%	Other perinatal conditions	21%	Other perinatal conditions	17%
5-9	Upper respiratory infections	8%	Dengue	11%	Dengue	13%
10-14	Dengue	9%	Dengue	18%	Dengue	18%
15-24	Other maternal conditions	14%	Other maternal conditions	13%	Other maternal conditions	11%
25-34	Other maternal conditions	16%	Other maternal conditions	19%	Other maternal conditions	15%
35-49	Other genitourinary system diseases	9%	Other maternal conditions	9%	Other genitourinary system diseases	8%
50-64	Ischaemic heart disease	12%	Ischaemic heart disease	12%	Ischaemic heart disease	11%
65-79	Ischaemic heart disease	9%	Ischaemic heart disease	10%	Ischaemic heart disease	9%
80 and above	Lower respiratory infections	8%	Chronic obstructive pulmonary disease	9%	Lower respiratory infections	10%

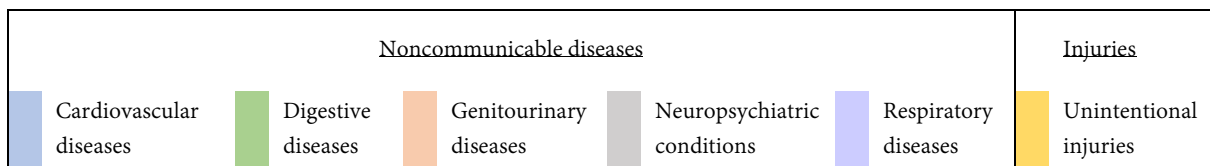
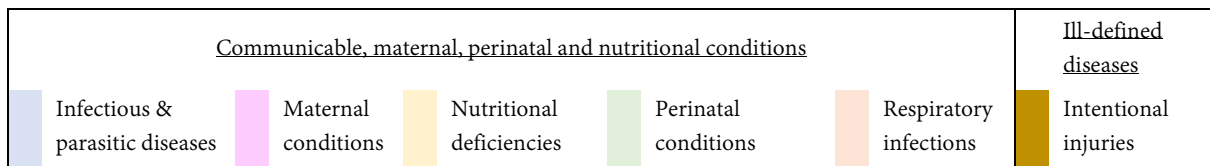
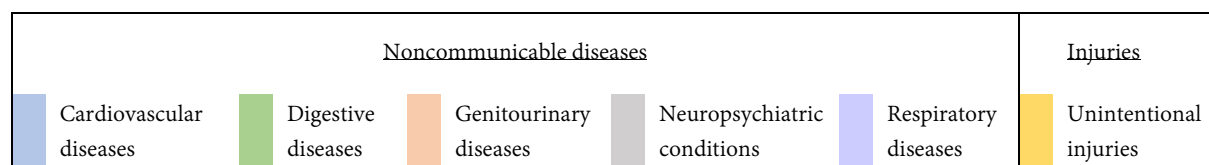
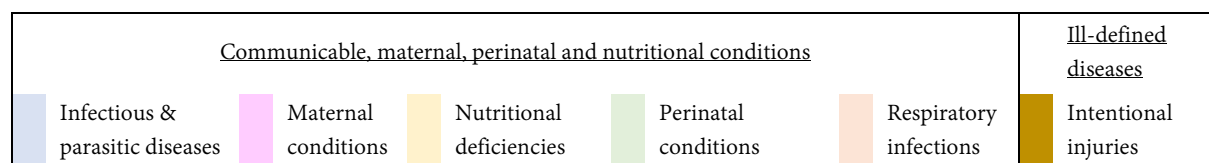


Table 3-2: Top burden disease (admissions) by age and gender for 2017-19

Age groups	Female	Male	All persons
0-4	Other perinatal conditions 19%	Other perinatal conditions 19%	Other perinatal conditions 19%
5-9	Dengue 16%	Dengue 7%	Dengue 10%
10-14	Dengue 14%	Dengue 16%	Dengue 15%
15-24	Other maternal conditions 19%	Dengue 13%	Other maternal conditions 13%
25-34	Other maternal conditions 21%	Dengue 12%	Other maternal conditions 16%
35-49	Other maternal conditions 13%	Other digestive diseases 10%	Other maternal conditions 8%
50-64	Other genitourinary system diseases 9%	Ischaemic heart disease 17%	Ischaemic heart disease 11%
65-79	Chronic obstructive pulmonary disease 9%	Ischaemic heart disease 13%	Ischaemic heart disease 9%
80 and above	Lower respiratory infections 10%	Cerebrovascular disease 8%	Lower respiratory infections 9%



3.2. Mortality

A lot of work has been undertaken to improve maternal, child health and reproductive health situation in the country. Universal coverage in immunization has been maintained. Different studies in the recent past have shown that there is almost universal coverage of antenatal care in Maldives. Almost every birth takes place in a health care facility attended by skilled providers. However, improvements are required to ensure quality in antenatal, intra-partum and postpartum care.

Figure 3-5: Mortality rate for non-communicable diseases and communicable, maternal, perinatal and nutritional conditions per 10,000 population, 2017-19

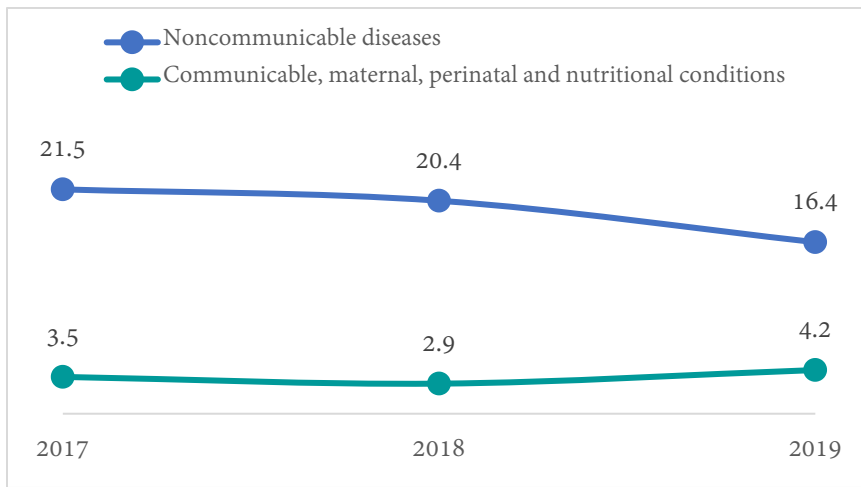
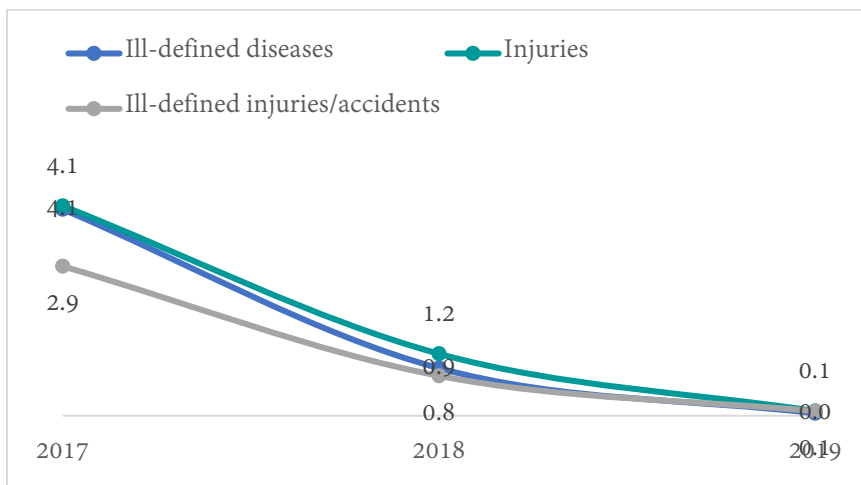


Figure 3-6: Mortality rate for injuries and ill-defined diseases per 10,000 population, 2017-19



With lifestyle changes associated with development and consequently the high prevalence of risk factors such as tobacco use, consumption of sugary and fatty foods and drinks and sedentary lifestyles, chronic non-communicable diseases (NCD) have emerged as the major causes of morbidity and mortality in the country. Cardiovascular diseases (CVDs), chronic respiratory diseases, accidents and injuries, diabetes and cancers are the leading causes of death in the country.

Figure 3-7: Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease per 10,000 population, 2017-19

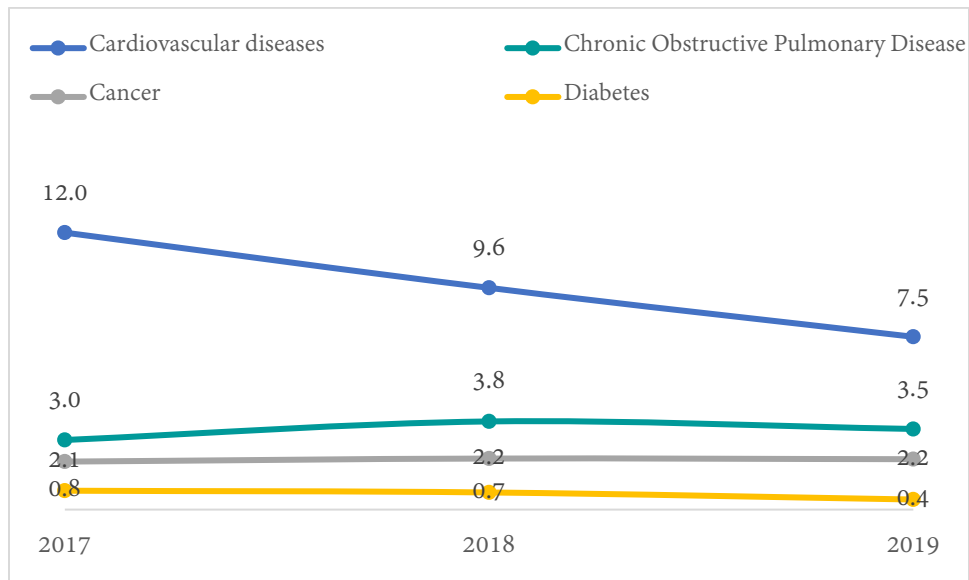


Table 3-3: Top burden of diseases (deaths) by age for 2017-19

Age groups	2017		2018		2019	
0-4	Low birth weight	24%	Low birth weight	23%	Low birth weight	25%
5-9	Neuropsychiatric disorders	38%	Unintentional injuries	33%	Neuropsychiatric disorders	100%
10-14	Inflammatory heart diseases	20%	Not categorised / Multiple Sub-categories	100%	Dengue	25%
15-24	Other cardiovascular diseases	27%	Other cardiovascular diseases	14%	Drownings	10%
24-35	Other cardiovascular diseases	11%	Other cardiovascular diseases	13%	Other cardiovascular diseases	14%
35-49	Other cardiovascular diseases	13%	Ischaemic heart disease	14%	Ischaemic heart disease	15%
50-64	Ischaemic heart disease	16%	Other cardiovascular diseases	14%	Other cardiovascular diseases	12%
65+	Other cardiovascular diseases	15%	Other cardiovascular diseases	13%	Ischaemic heart disease	10%

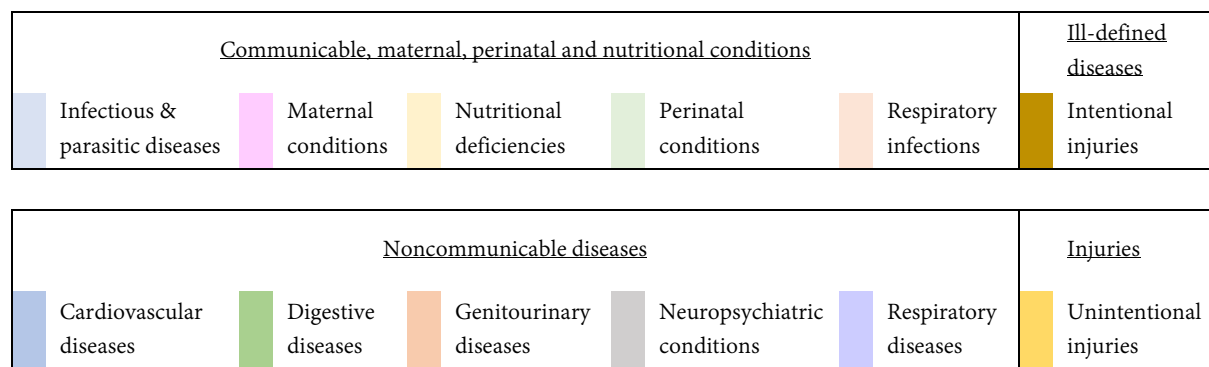
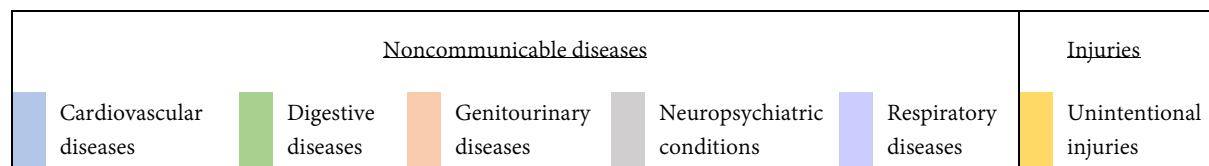
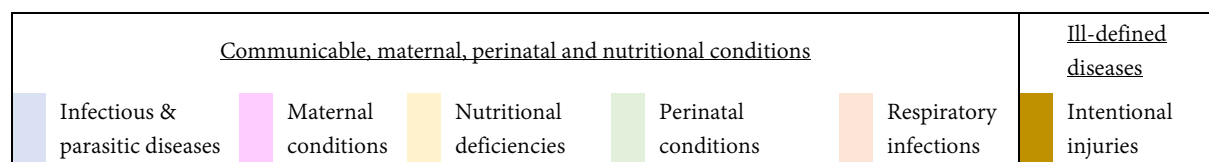


Table 3-4: Top burden disease by age and gender for 2017-19

Age groups	Female		Male		All persons	
Under 5	Low birth weight	10%	Low birth weight	12%	Low birth weight	24%
5-9	Other neuropsychiatric disorders	20%	Other infectious diseases	7%	Other neuropsychiatric disorders	27%
10-14	Other respiratory diseases	8%	Road traffic accidents	8%	Other respiratory diseases	8%
15-24	Other cardiovascular diseases	7%	Other cardiovascular diseases	9%	Other cardiovascular diseases	16%
24-34	Other neuropsychiatric disorders	3%	Other cardiovascular diseases	10%	Other cardiovascular diseases	13%
35-49	Other cardiovascular diseases	2%	Ischaemic heart disease	12%	Ischaemic heart disease	14%
50-64	Other cardiovascular diseases	4%	Ischaemic heart disease	10%	Ischaemic heart disease	14%
65-79	Other cardiovascular diseases	5%	Other cardiovascular diseases	7%	Other cardiovascular diseases	13%
80 and above	Other cardiovascular diseases	6%	Ischaemic heart disease	8%	Other cardiovascular diseases	13%



3.3. Inpatient Beds

Table 3-5: Inpatient beds for Male' and Maldives per 10,000 population, 2017-19

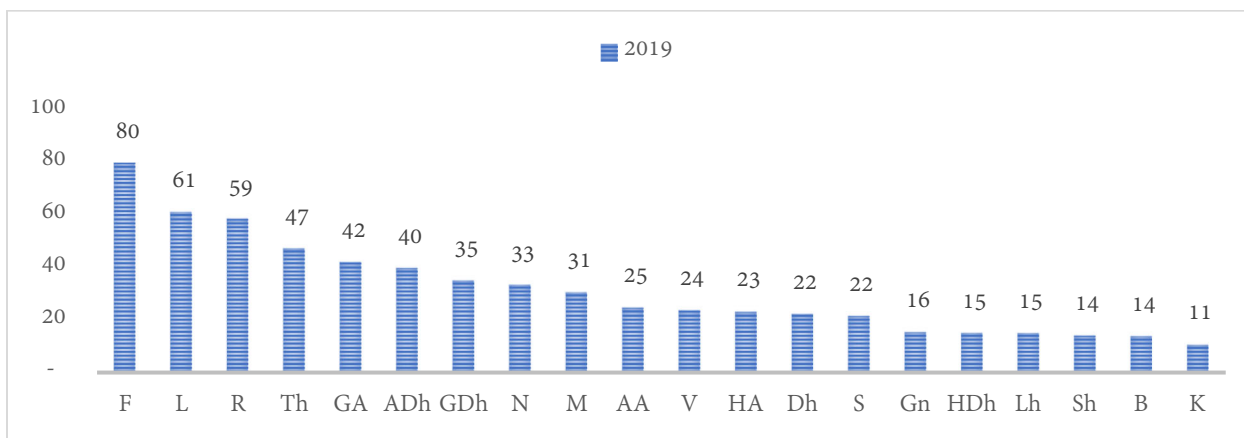
	2017	2018	2019
Maldives	45	44	35
Male'	23	33	40

Total number of hospital beds per 10 000 population, where;

Numerator: Number of hospital beds (excluding labour and delivery beds).

Denominator: Total population.

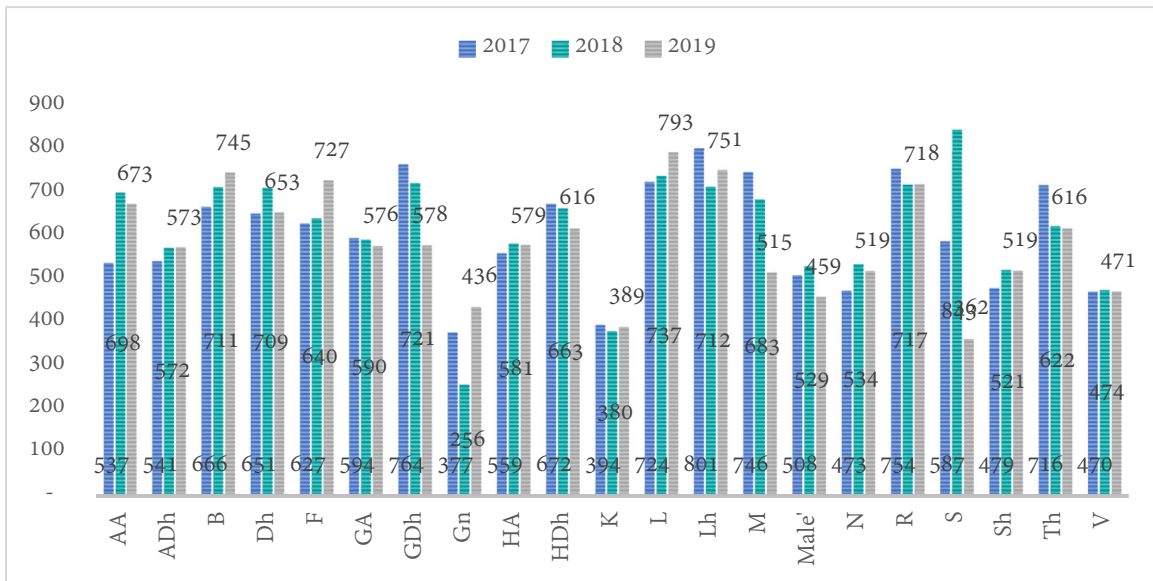
Figure 3-8: Inpatient beds per 10,000 population, 2019



3.4. Outpatients

The number of outpatient visits to health facilities during one year relative to the total population of the same geographical area. Health facilities include all public and private health facilities in which general health services are offered.

Figure 3-9: Outpatients per 100 population, 2017-19



4. Quality of Vital Statistical Performance Index

The Vital Statistics Performance Index for Quality (VSPI(Q)) shows that the score over the years has gone to “medium” (51.5% summary score).

All the areas of the VSPI(Q) have shown above 95 except quality of cause of death reporting (64.6) and level of cause-specific detail availability of data (83.5), making these the priority action areas for improving data quality. This time period (2017-19) showed the highest VSPI(Q) is reported in the Maldives (51.5) [14] when compared with 2010-2012 (48.3). Maldives has also shown progressively highest VSPI(Q) compared to all the WHO SEARO countries throughout the last decade.

Table 4-1: VSPI Quality Component Score for combined years: 2017 - 19

Component	Score
Quality of age and sex reporting	100
Quality of cause of death reporting	64.6
Biologically plausible COD	100
Level of cause-specific detail available	83.5
Completeness of death reporting	95.4
Classification	MEDIUM
Summary score	51.50%

Therefore, it is important to work on the priority areas such as quality of cause of death reporting and level of cause of specific details to improve quality of Vital Statistics.

5. Human Resource for Health (HRH)

In 2019:

- 24 health professionals are there for every 2000 population
- 57% of health professionals reside in the atolls
- 72% of health professionals are Maldivians
- 65% of health professionals are women
- 43% are non-medical staff
- 28% are nurses
- 19% are allied health professionals
- 10% are medical doctors

5.1. Human Resource Status

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

Number of health workers per 10,000 population by type of health worker: The number of health workers available in a country relative to the total population subset by type of health worker. Health workers are defined as all persons eligible to participate in the national health labor market by virtue of their training, accreditation and skills.

Figure 5-1: Health worker density (per 10,000 population) and distribution for 2017, 2018 and 2019

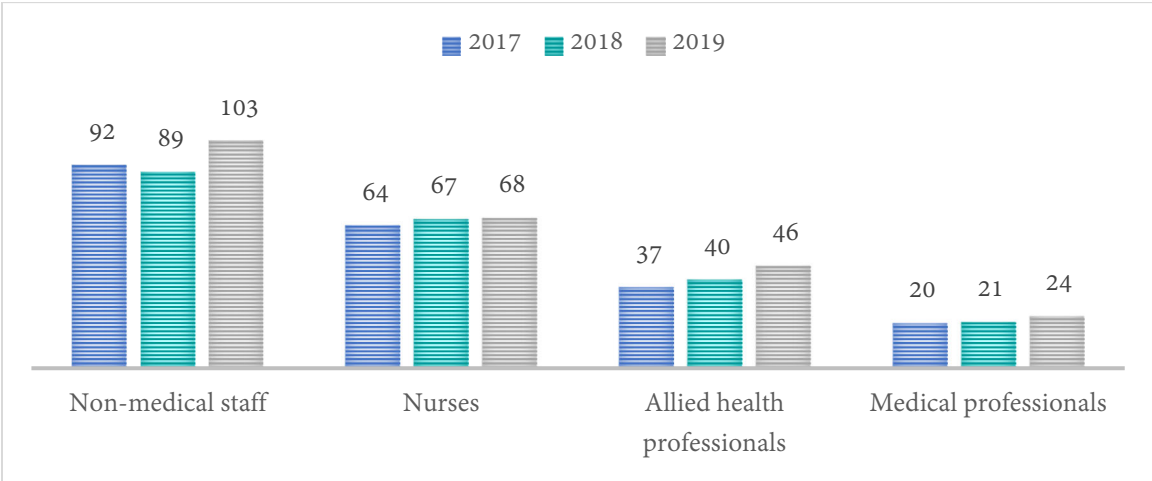


Table 5-1: Health Human Resources by different cadres per 10,000 population for Male' and Maldives, 2017-19

All HRH	2017	2018	2019	Professionals of Behavioral Sciences	2017	2018	2019
Male'	275.3	297.9	365.3	Male'	1.4	1.7	2.5
Maldives	774.9	777.4	851.0	Maldives	1.8	2.2	3.4
Medical Specialists	2017	2018	2019	Clinical and Physical Therapists	2017	2018	2019
Male'	19.4	20.9	24.5	Male'	2.0	2.6	2.7
Maldives	30.1	31.9	36.6	Maldives	3.1	4.0	4.0
General Doctors	2017	2018	2019	Community health professionals	2017	2018	2019
Male'	16.6	17.3	21.7	Male'	1.6	1.9	4.4
Maldives	42.5	41.9	46.1	Maldives	45.6	40.8	40.5
Nurses	2017	2018	2019	Medical Laboratory Professionals	2017	2018	2019
Male'	97.9	116.8	119.0	Male'	13.9	13.8	16.7
Maldives	234.1	241.3	239.9	Maldives	28.9	27.6	32.6
Radiographers	2017	2018	2019	Pharmacy Professionals	2017	2018	2019
Male'	4.0	4.2	5.2	Male'	20.1	24.1	34.8
Maldives	7.2	7.1	7.8	Maldives	36.8	51.8	65.4
Dentists	2017	2018	2019	Non-medical staff	2017	2018	2019
Male'	5.5	5.5	5.7	Male'	92.8	89.1	128.1
Maldives	6.5	6.9	7.6	Maldives	334.0	317.8	364.1
Professionals of Traditional, alternative and complementary medicine				2017	2018	2019	
				Maldives (Atolls only)	4.3	4.3	3.1

Figure 5-2: Health Human Resources per 10,000 population per atoll, 2017-19

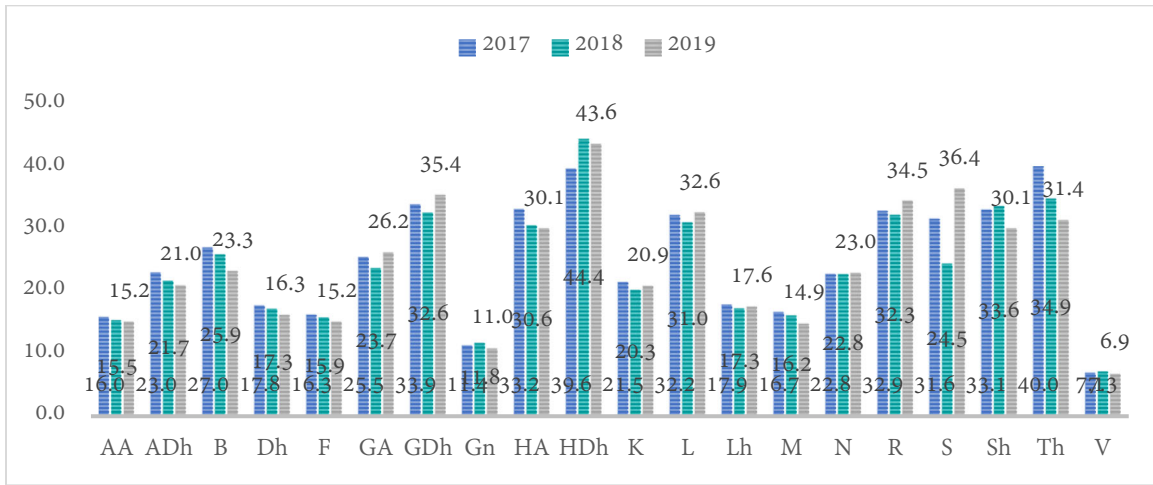


Figure 5-3: Specialists per 10,000 population per atoll, 2017-19

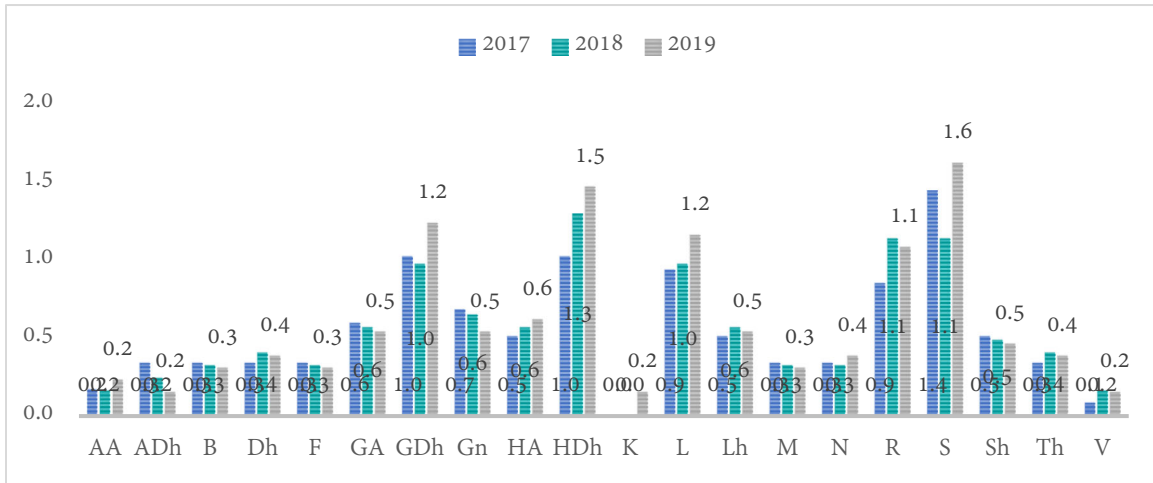


Figure 5-4: General Doctors per 10,000 population per atoll, 2017-19

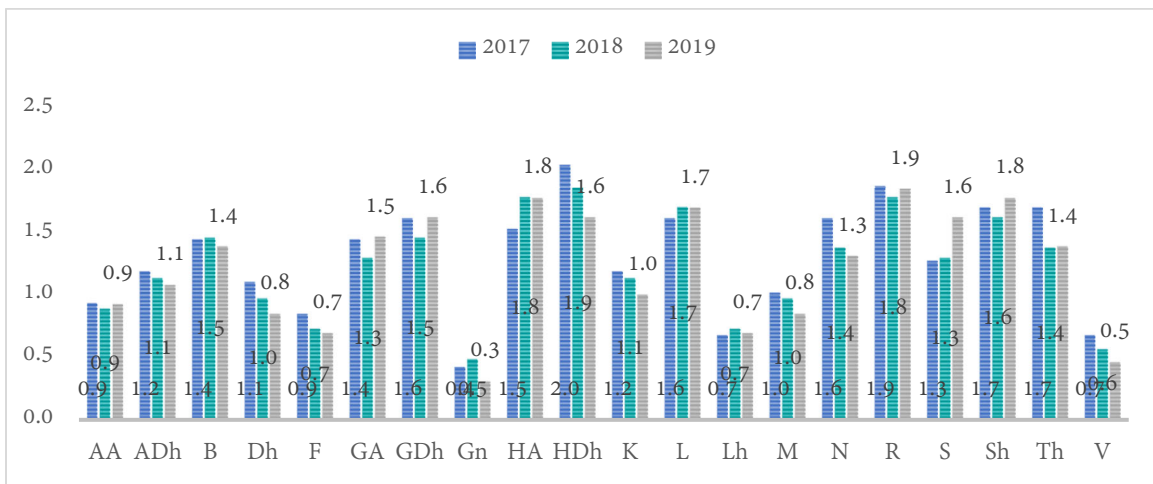


Figure 5-5: Nurses per 10,000 population per atoll, 2017-19

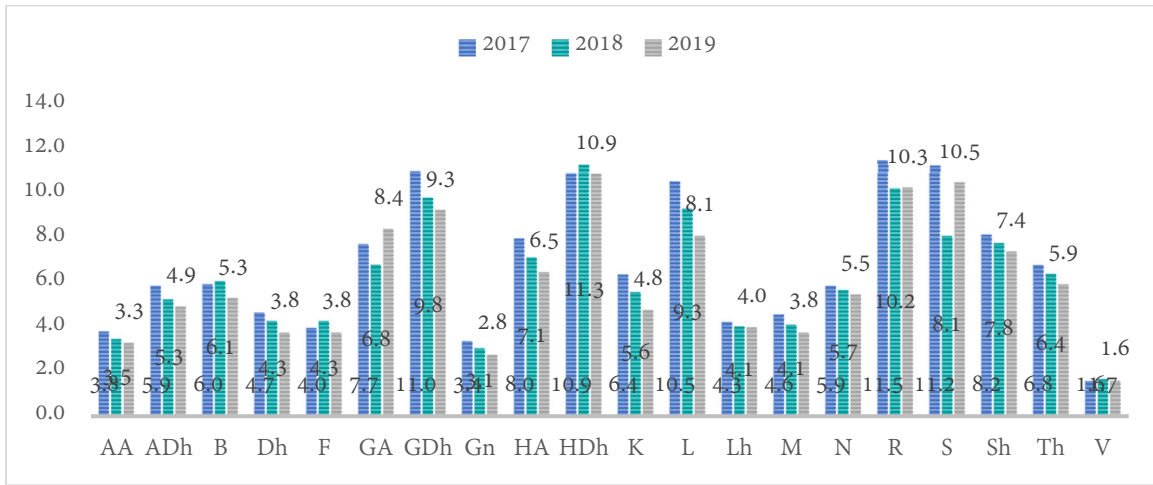


Figure 5-6: Community Health Professionals per 10,000 population per atoll, 2017-19

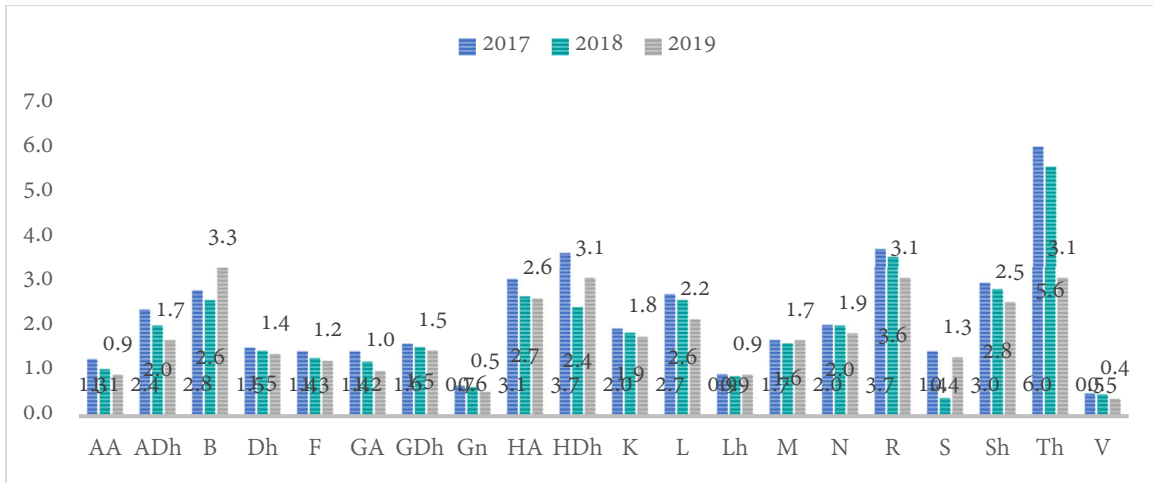
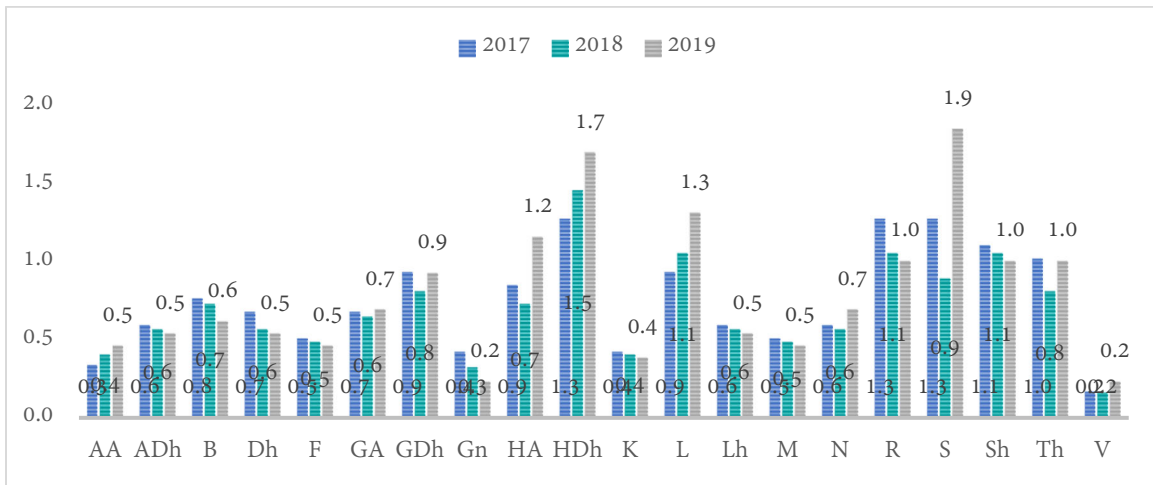


Figure 5-7: Medical Laboratory Professionals per 10,000 population per atoll, 2017-19



6. Information, Research and Advocacy

The Health Master Plan 2016-2025 of Maldives has three strategic areas – Governance, Public health protection and Health care delivery. Health research finds mention in the strategic focus area of Health Care Delivery under section 3.3 - Enable timely surveillance of diseases, births, deaths, morbidity patterns as well as social determinant of health through an integrated health information systems and research. It has three strategies listed under it.

1. Identify Research Priorities and manage research to meet information needs for programming, planning and policy
2. Strengthen research management, ethics and publication of academic literature based on research
3. Build Capacity in the area of health information management and research

Thus, it is apparent that there is a strong government commitment to promote health research in Maldives. This has resulted in many new initiatives. A research prioritization exercise was conducted recently with all stakeholders and priority areas of research for the duration 2017-2019 were identified. A data release policy has been framed which allows all stakeholders to access research data generated by Government of Maldives by applying for it. Further, the Ministry of Health publishes a health research bulletin yearly with abstracts from health researches.

Under health services act which came into force in 2015, a multi-disciplinary National Health Research Committee exists, though it mainly serves as national ethics committee. A decision to convert this into a National Health Research Council (NHRC) has been taken, thus, a regulation with a detailed term of reference is worked out and shared with Attorney General Office.

Further, a Health research Policy was published in October 2017. The National Health Research Policy has five main objectives. These are to;

1. Establish a national health research agenda, which is updated periodically, through a consultative and transparent process.
2. Ensure that the research being conducted in the country meets the highest international standards by establishing effective mechanisms for its oversight
3. Increase availability of funds for health research by mobilizing internal and external financial resources
4. Promote research by strengthening individual and institutional capacity for health research, incentivizing research and building effective partnerships.
5. Promote the use of evidence in policy and program planning and evaluation by establishing appropriate mechanisms for dissemination of research results.

This facilitated a first time ever Research Award on World Health Day 2018.

6.1.Challenges

1. There is no coordination between NHRC and other health research ethics committees in Maldives.
2. There is no health specific health journal currently published in Maldives.
3. The country has limited local institutional and individual capacity for conducting research. Few studies have found their way into publication in a peer-reviewed journal indicating inadequate scientific writing capacity.
4. Inadequate research resulting in lack of evidence-based decision making and inadequate demand for evidence resulting in no research being produced exists which needs to be broken.
5. Lack of research culture – leading to similar type of research being submitted to NHRC.

7. Annex

Table 7-1: Population table used in the calculations, 2017-2019

Sex	2017		2018		2019	
	Male	Female	Male	Female	Male	Female
All ages	243,597	184,367	254,612	188,271	266,433	192,274
0 year	4,111	3,755	4,119	3,765	4,134	3,779
1	4,108	3,748	4,121	3,760	4,138	3,776
2	4,059	3,729	4,082	3,751	4,094	3,762
3	3,705	3,374	4,079	3,698	4,106	3,715
4	3,708	3,358	3,676	3,381	4,048	3,705
1-4 years	15,581	14,209	15,959	14,590	16,387	14,959
5-9 years	19,056	17,501	19,134	17,460	19,083	17,163
10-14 years	14,395	13,586	15,429	14,540	16,483	15,556
15-19 years	15,825	13,534	15,572	13,095	15,697	12,940
20-24 years	30,575	17,017	32,159	16,562	33,725	16,094
25-29 years	38,035	20,559	40,367	20,483	42,872	20,188
30-34 years	29,642	19,922	31,747	20,664	33,456	21,287
35-39 years	20,399	14,955	22,015	16,005	23,823	17,081
40-44 years	14,614	11,378	15,338	11,750	16,292	12,289
45-49 years	11,748	10,197	12,012	10,360	12,434	10,555
50-54 years	8,702	8,183	9,099	8,512	9,590	8,946
55-59 years	7,404	7,115	7,539	7,332	7,550	7,373
60-64 years	4,585	4,201	5,105	4,784	5,719	5,494
65-69 years	2,717	2,622	2,838	2,643	3,004	2,728
70-74 years	2,135	2,197	2,101	2,143	2,072	2,135
75-79 years	2,032	1,879	1,951	1,906	1,897	1,915
80 years and above	2,041	1,557	2,129	1,678	2,216	1,792

Table 7-2: Atoll population table used in the calculations, 2017-2019

Location	Males			Females			Total		
	2017	2018	2019	2017	2018	2019	2017	2018	2019
Republic	243,597	254,612	266,433	184,367	188,271	192,274	427,964	442,883	458,706
Atolls	126,739	130,533	134,587	106,518	107,386	108,241	233,257	237,919	242,828
Male'	116,857	124,080	131,846	77,850	80,885	84,032	194,707	204,965	215,879
S	13,111	13,533	13,994	10,446	10,483	10,518	23,557	24,016	24,513
HDh	10,729	11,055	11,396	10,707	10,846	10,980	21,436	21,901	22,377
R	8,931	9,176	9,431	8,307	8,395	8,493	17,239	17,571	17,924
K	10,878	11,345	11,851	5,825	5,904	5,986	16,703	17,248	17,837
HA	7,276	7,442	7,616	7,384	7,428	7,467	14,660	14,870	15,083
L	7,734	7,964	8,209	6,240	6,299	6,360	13,974	14,263	14,569
GDh	7,904	8,102	8,319	5,916	5,916	5,912	13,819	14,018	14,231
Sh	6,610	6,771	6,939	7,001	7,078	7,160	13,612	13,849	14,099
N	6,297	6,486	6,689	6,048	6,111	6,172	12,345	12,597	12,861
ADh	6,155	6,421	6,703	4,435	4,509	4,581	10,590	10,931	11,284
Th	5,777	5,916	6,066	4,701	4,712	4,716	10,478	10,627	10,782
B	5,653	5,795	5,951	4,763	4,779	4,793	10,416	10,574	10,744
GA	6,019	6,179	6,357	4,119	4,119	4,112	10,138	10,298	10,470
GN	4,742	4,884	5,033	4,558	4,599	4,635	9,300	9,483	9,669
Lh	4,601	4,707	4,819	4,395	4,415	4,433	8,996	9,122	9,252
AA	4,100	4,238	4,381	3,181	3,226	3,271	7,281	7,464	7,652
Dh	3,575	3,690	3,813	2,849	2,868	2,891	6,424	6,559	6,703
M	2,880	2,944	3,010	2,519	2,530	2,542	5,399	5,474	5,552
F	2,518	2,601	2,686	2,350	2,394	2,441	4,868	4,995	5,127
V	1,251	1,283	1,324	772	775	777	2,023	2,058	2,101



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