Maldives

Emergency and Humanitarian Action

Country Report

The Maldives

HAZARD PROFILE

Straddling the equator in the Indian Ocean, the Republic of Maldives is an archipelago of 1190 small islands stretching over 820 km north–south and 128 km east–west. Only 196 islands are inhabited, and another 88 islands have been developed into tourist resorts (Source: Census 2006, Ministry of Planning and National Development).

The Maldives is exposed to multiple natural hazards such as storms, tidal waves and heavy rains in the south Indian Ocean, which cause physical damage to the infrastructure, especially the coastal line leading to severe beach erosion. In addition, the country is susceptible to human-induced disasters such as oil spills and aviation-related hazards.

Although the Maldives is vulnerable to a wide range of natural disasters, given its unique geography and geology, it had never experienced a major disaster till the tsunami of December 2004.

Factors affecting vulnerability

- Some areas such as the capital Malé have a very high population density (103 693, [Source: Census 2006] in an area of 2 sq.km).[1]
- There is inadequate critical infrastructure such as health and education in islands with a small population.[2]
- The entire nation has an elevation of no more than two meters above sea level, thus it is particularly vulnerable to climate changes that cause a rise in sea levels.
- As the country is dependent economically on the fisheries and tourism sector, hazards related to the sea have the potential to severely affect the economy.
- Outreach services to several islands are difficult due to poor transport and communication.

Health hazards

Due to a well-functioning primary health-care system with a comprehensive national surveillance system, the majority of endemic infectious diseases are under control. The Maldives has been a malaria-free country since 1984. At the end of 1995, the incidence rate of leprosy was 0.1 and the prevalence rate was 0.3 per 1000. Thus, the Maldives is very close to achieving zero transmission status with respect to leprosy. Tuberculosis, which had a prevalence of 35 cases per 1000 in 1974, had declined in 1995 to about 0.66 per 1000. Childhood TB (under 5 years) is almost non-existent due to the high rate of BCG vaccination. Diseases of public health concern include dengue fever, acute respiratory infections and diarrhoeal diseases, which are among the ten most common communicable diseases.[3]

HIV/AIDS and STIs:[4] The Maldives is "highly vulnerable" to an HIV/AIDS epidemic largely because of a sharp rise in the number of people injecting drugs, as revealed by a government assessment (in conjunction with UNICEF and WHO) conducted in 2006 on AIDS. The country is characterized by "high risk and vulnerability and low prevalence".

This means that while the number of cases of HIV infection remains low – from 1991 to 2006 there were 13 cases involving Maldivians – the potential for an explosion in infection rates remains real.

Dengue and chikungunya: WHO reports that there was an outbreak of dengue in the Maldives in 2006. This is endemic and sporadic outbreaks occur.[5] More than 3500 cases of chikungunya were confirmed in the Maldives in December 2006 alone.[6] This was the first time this disease was reported in the Maldives. From 1 December 2006 to 18 February 2007, a total of 10 831 (4.5% of the population) cases of chikungunya were reported to the Department of Public Health. Out of 196 inhabited islands, 121 islands reported the disease. No deaths were reported. A downward trend of the disease was observed since 12 January 2007 (week 7) and the outbreak was declared under control on 13 February 2007 (week 11).[7]

Avian flu: There is no incidence of avian flu in the Maldives as of now; however, it is anticipated that there is a latent risk of an outbreak through the movement of infected migratory birds and the import of live poultry and contaminated poultry products from other countries. A six-month project between the Government of the Maldives and UN Development Programme (UNDP) titled “Capacity Building for National Prevention and Preparedness for Avian Influenza and Human Influenza in the Maldives” was inaugurated on 15 January 2007. The Government has invested in establishing rapid response measures for detection and diagnosis, and generating awareness of the high risk among the general public. However, additional investment is required for case management in the event of a pandemic.

Thalassaemia: The Maldives has a high prevalence of the genetic blood disorder thalassaemia. WHO Maldives estimates that one sixth of the population is a carrier of the disease and one in every 250 children is born with the full-blown condition. The prevalence rate of beta-thalassaemia is 18–20%.

Emerging and re-emerging diseases such as leptospirosis and scrub typhus are other health threats.

EXISTING DISASTER MANAGEMENT SYSTEM

Legal framework

Disaster preparedness and response is relatively new to the Maldives. Following the tsunami, the Government set up a Ministerial Committee and a Task Force for disaster risk reduction and management. The National Disaster Management Centre was created by Presidential Decree in 2006 and the roles of the Centre were specified. A Disaster Reduction and Management Bill is currently being drafted.

The Ministry of Health (MoH) is mandated with medical and public health preparedness and response for disasters. The Health Master Plan 2006–2015 identifies policy direction and goals for national disaster preparedness at all levels of the health sector. One of the priority areas in the Seventh National Development Plan (2006–2010) is natural disaster preparedness and mitigation.

The various policies outlined in the Plan include the following:

Policy 1: Make Maldivians safe and secure from natural disasters through information dissemination, and planning and coordination of national response actions.

Policy 2: Alleviate and eliminate risks to life and property from natural or man-made hazard events.

Policy 3: Deliver prompt and efficient relief and support in the event of a hazard.

Policy 4: Strengthen the information base on hazards and disasters to inform, educate and better protect the public.

Disaster management in the health sector[8]

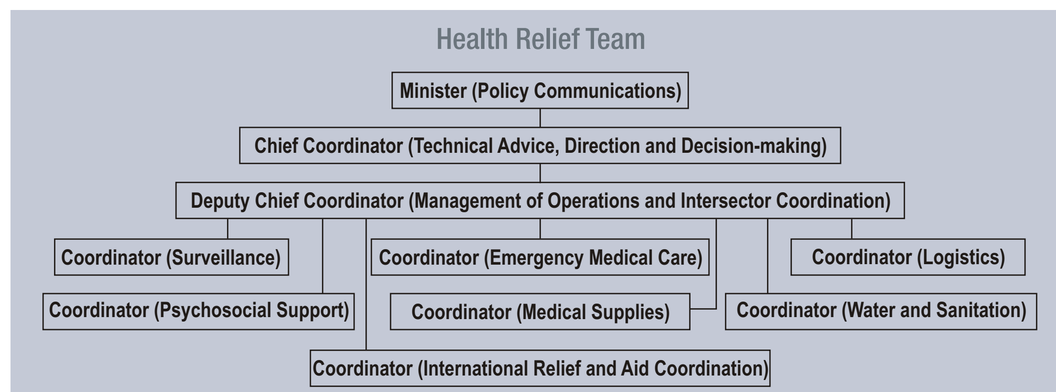
The health system in the Maldives inclines towards a totally integrated system where most of the financing, provision and stewardship is the responsibility of the Government. However, there are several private clinics ranging from single-doctor consultations to polyclinics with laboratory services and some with inpatient capacity. The system is further complemented by a few NGOs participating in public health functions, a competitive pharmaceuticals market, traditional medicine to some extent and a major private tertiary hospital.

The health services are organized in a five-tier system. Central institutions functioning under the MoH include the Department of Public Health (DPH), Department of Medical Services, Maldives Food and Drug Authority and the Indira Gandhi Memorial Hospital (IGMH). The National Thalassaemia Centre (NTC) functions under the Department of Medical Services. Their services embody the fifth or highest referral level. At the fourth level, there are 6 Regional hospitals; at the third level, 13 Atoll hospitals; at the second level, 86 health centres; and at the first level, 36 health posts and 51 family health service units staffed by family health workers.

The provision of health services to all Maldivians is difficult and expensive due to the geography of the country. The islands are dispersed across 90 000 sq. km and the transportation infrastructure is not well developed.

No emergency preparedness and response (EPR) plans existed in the Maldives before the tsunami, except for the emergency airport contingency plan. This plan, among others, includes protocols for the Indira Gandhi Memorial Hospital (IGMH) in the capital Malé. By September 2005, the MoH had developed a health sector EPR draft plan, supported by WHO which, however, is still in draft form (once finalized, this will become part of the National Disaster Management Plan).

- Disaster health working group: This technical unit was established post-tsunami and is responsible for developing the health sector EPR plan, as well as implementing, monitoring and evaluating the EPR programme. The team is composed of representatives from different departments across the health sector. The working group has been dormant for the past year.
- Health relief team: A health relief team was created immediately after the tsunami. Its structure is given below.



A permanent EPR focal person will be assigned and the work of EPR will be integrated into the Health Systems Development Unit in the MoH in the medium term. This unit will be in charge of all aspects of implementation of the EPR programme.

Disaster management in the non-health sector

The National Security Services (now the Maldives National Defense Force) is the first-line authority for disaster management. Efforts are being made to include disaster management in all areas of work in the country. The Ministry of Defence and National Security, Ministry of Finance, and Ministry of Planning and National Development lead the emergency response and relief effort in collaboration with other departments, UN agencies and other development partners. The Disaster Management Centre is the focal point for response, relief and recovery activities. All government ministries are involved in disaster management.

The National Disaster Management Centre

The Centre includes the following divisions:

National Disaster Relief Coordination Unit (NDRCU): The NDRCU is headed by the Chief Coordinator of the National Disaster Management Centre. All relief coordination programmes will be implemented and monitored by the respective sectoral ministries who will report periodically to the Chief Coordinator.

National Economic Recovery and Reconstruction Programme: The main objectives of the National Economic Recovery and Reconstruction Programme include planning and coordination of the redevelopment programme to revitalize the islands destroyed by the tsunami; and formulation of programmes and projects to revive the economy of the Maldives. The Programme consists of two units:

(1) The National Economic Recovery Unit (NERU) coordinated by the Ministry of Finance and Treasury (MoFT);

(2) The Housing and Infrastructure Redevelopment Unit (HIRU) coordinated by the Ministry of Planning and National Development (MPND).

Transport and Logistics Unit (TLU): The Unit is responsible for coordination and provision of transport and logistical support to all recovery and reconstruction programmes.

Aid management: The Government has established a Trust Fund to receive funds from the budget as well as from local and foreign sources for relief and reconstruction work. The Fund is overseen by a Board of Trustees, chaired by the Auditor General. The Board has representations from all key sectors and partners including the private sector, government and international agencies. All donors are encouraged to put their funds through the Trust Fund to increase the efficiency and effectiveness of aid utilization.

WORK OF WHO[9]

WHO was the first UN agency to establish a country office in the Maldives and the WHO Office in the Maldives was opened on 25 February 1965. Maldives is the first country in South-East Asia to eradicate malaria and WHO was the major partner of the country in this achievement. With WHO's support, the country was also the first in South-East Asia to introduce the viral hepatitis B vaccine for all newborns.

WHO's collaboration with the Maldives over the current and past biennia has embraced a broad-based approach for meeting the country's national health development needs. Currently, the WHO biennium collaborative programme 2006–2007 in the Maldives covers 26 projects (from 15 in 2000–2001).

WHO provided extensive technical support to the MoH and other relevant sectors in overall health development activities to achieve the Health Master Plan (1996–2005) objectives. WHO supported EPR activities even before the tsunami by assisting with the development of an EPR plan. WHO technical assistance has also been provided for upgrading the IGMH emergency department, as well as in implementing the hospital preparedness plan for mass casualties.

Collaboration on HIV/AIDS-related activities has been an Inter-Agency initiative under the UN Theme Group on HIV/AIDS which WHO chairs. In collaboration with UNICEF and UNAIDS, WHO supported the DPH/MoH in conducting an HIV/AIDS risk assessment and will provide technical assistance for the development of the second HIV/AIDS National Strategic Plan 2006–2011. WHO has been coordinating different activities related to preparation of the Avian Influenza and Human Influenza Pandemic Preparedness Plan in support of the MoH and Ministry of Agriculture, Fisheries and Marine Resources (MoAFMR).

FUTURE PLANS OF WHO

The main priorities of the MoH are described in the draft Health Master Plan 2006–2015. This and other policy priorities in the Vision 2020 offer WHO a potential role to support policy and promote appropriate technologies to implement health sector reforms in the country.

Proposed priority areas and strategies for the WHO Country Cooperation Strategy (CCS) for the period 2007–2011 have been agreed upon by the MoH. During the period of the CCS, WHO will assist the MoH in various health programmes as needed. However, major assistance will be provided in the following areas:

- Strengthening health systems
- Emergency preparedness and response
- Integrated surveillance for communicable diseases
- Food safety
- Environmental health
- Non-communicable diseases, mental health and health promotion
- Information and research
- Newborn health

PRIORITY NEEDS

- A designated focal point is needed in the MoH with adequate training in DM, preparedness and response.
- The Health Sector Disaster Preparedness Plan needs to be finalized and detailed standard operating procedures and action plans developed to implement the strategies for preparedness identified in the Plan.
- Table-top and simulation exercises for health response need to be conducted.

CONTACT DETAILS
WHO Representative
Dr Jorge Mario Luna
PO Box 2004
Malé 20-04
Republic of Maldives
Telephone: 00-960-332-1682, 332-7519, 332-2410, 331-3564
Fax: 00-960-332-4210
Email: lunaj@who.org.mv
WHO registry: whomav@who.org.mv
EHA Country Focal Point
Ms Laila Ali WHO Maldives Malé
Telephone: 00-960 332 7519, 332 2410
Fax: +00-960-332-4210
Email: laila@who.org.mv

[1]*http://www.un.org.mv/unrc/15*

[2]*http://www.searo.who.int/en/Section1257/Section2263/Section2301_12216.htm*

[3]*http://www.searo.who.int/en/Section1257/Section2263/Section2301_12216.htm*

[4]*http://www.minivannews.com/pdf/AIDSsurvey.doc*

[5]*For most recent updates on the chikungunya and dengue fever situation in Maldives see http://maldivestoday.com/archives/74 as also updates on the WHO Maldives website, http://www.who.org.mv*

[6]*http://www.haveeru.com.mv/beta/english/?page=details&id=13333*

[7]*Chikungunya outbreak in the Maldives. Department of Public Health, Republic of the Maldives, 2007*

[8]*http://www.searo.who.int/en/Section1257/Section2263/Section2301_12216.htm*

[9]*http://www.who.org.mv/EN/Index.htm*