

# Addressing Social Determinants of Health in Maldives

Report of a national workshop in Male', Maldives

23-25 November 2009

Ministry of Health and Family in Collaboration with WHO South-East Regional Office (SEARO).

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Male', November 09

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## Executive Summary

The Ministry of Health & Family in collaboration with World Health Organization organized, the first national workshop on Social Determinants to Health ,at Male', Maldives, between 23-25 November. It was held with an overall objective of examining the role of different sectors in addressing social determinants of health in Maldives. Other workshop objectives were: providing a platform for an exchange of experiences on reducing the health equity gap; linking salient elements of the “Colombo Call for Action” to national strategies and policies for reducing the health equity gap; and delineating required actions for the Ministry of Health & Family and other sectors to reduce health inequities.

The workshop had national and international participation. The 38 workshop participants included: resource persons; representatives from four countries from the region; and local representatives from public and private sector. The participants deliberated upon social determinants of health (SDH) during the three days. The workshop included a field visit to Hulhumale to identify the differences in infrastructure, social and living conditions between Hulhumale and national capital Male'.

Based on the group work and discussions, national actions for addressing Social Determinants to Health in Maldives were identified as follows:

- Advocate with policy makers for integrating health in all policies. For example, healthy environment, employment, affordable housing, waste management, safe drinking water, early childhood development, healthy diet and discouraging tobacco use;
- Advocate for policies and legislations promoting re-distribution of power, money and resources to disadvantaged groups;
- Sustain and expand public sector financing of health services in order to reduce disparities related to access to health services and enhance social protection; and to ensure affordability of emergency and routine medical referral;
- Promote multi-sectoral alliances among public –private sectors, civil society and community groups for reducing health equity through addressing SDH. As part of health

governance, this would require the creation and facilitation of a democratic space for voicing competing views or opinions on reducing the equity gap;

- Establish a sustainable institutional mechanism at Ministry of Health and Family with adequate funding and mandate to coordinate and manage intersectoral action through the “whole government approach” in order to reduce the health equity gap by addressing social determinants of health. This includes appointment of a focal point at MOHF to achieve desired outcomes;
- Advocate for integrating in all national policies “reducing health equity” and this would include in all priority public health conditions (tobacco control for Non-communicable diseases, climate change adaptation for communicable diseases and new threats to health etc); and
- Strengthen the existing institutional infrastructure and community participation for promoting, supporting and protecting health rights of socially disadvantaged groups (women, children and elderly)

Further, recommendations for WHO were identified as follows:

- Assist to build national capacity in monitoring and evaluation of the impact of health equity on programmes and policies, e.g, privatization, private public partnerships (PPP), healthy public policies and assessment tools among others;
- Provide technical support for integrating health in all relevant policies;
- Support to strengthen existing information systems to improve monitoring of health disparities for evidenced based decision making; and
- Support quantitative and qualitative research in Maldives to examine social and cultural determinants that influence health outcomes

## **1. Introduction**

### **Background**

During the regional meeting held in Colombo in February 2009, the Minister of Health and Family Dr Aminath Jameel announced that SDH is a new area for Maldives and she would like to hold a similar workshop at a national level in Maldives to sensitize nationals on this important issue and to improve multi-sectoral participation in addressing SDH in Maldives. Immediately after this workshop preparatory planning work for holding a national SDH meeting in Maldives started and upon request, WHO agreed to provide the financial and technical assistance for this workshop.

It was also evident in the regional meeting held in Colombo in 2009 that data availability to evaluate health inequities was a common challenge in most of the countries who participated in the meeting. Further, unlike most other participatory countries at this meeting, for Maldives, the lack of technical expertise in data analysis of SDH was an additional challenge. With the national meeting in planning stage, through WHO assistance, it was also decided to conduct the first SDH analysis in Maldives in 2009 and to present the findings of this study at the planned national SDH workshop in Maldives.

### **General Objective**

To examine the role of different sectors in addressing social determinants of health in Maldives.

### **Specific Objectives**

- Exchange experiences on reducing the health equity gap through action on social determinants of health/SDH;
- Link salient elements of the “Colombo Call for Action” to national strategies and policies for reducing the health equity gap through addressing social determinants of health; and

- Delineate required actions for the Ministry of Health & Family and other sectors to reduce health inequities through addressing social determinants of health

## **2. Business Sessions**

### **Inauguration Ceremony**

The Minister of Health and Family, Dr Aminath Jameel delivered the opening address at this ceremony. Minister welcomed all international participants to Maldives and stated that the presence of Vice President/VP at the inauguration ceremony of workshop indicates the high level commitment by the government towards health of its citizen. Minister mentioned that this workshop was extremely important as it concerns not only the health but all other sectors and all walks of the society. Moreover, minister referred to the stewardship role of the health sector in addressing the social determinants of health.

The second address was by the WHO representative to the Maldives, Dr. J.M. Luna. According to Dr.Luna the major causes of disease and premature death lie outside the domain of the health sector and that social and economic determinants are the root causes. In this context, this workshop and the first SDH analysis for Maldives was referred to as a step in the right direction for Maldives. Dr.Luna also mentioned that this workshop was the first of its kind and that WHO was encouraged by the leadership and vision demonstrated by the government of Maldives through the Ministry of Health and Family.

Similar to the previous speakers, in the address by the chief guest of the inauguration ceremony, the Vice president of Maldives also mentioned that health sector alone cannot reduce the gaps in health equity between individuals and communities, i.e. there is need for inter-sectoral participation in addressing this cross-cutting SDH issue. He mentioned that the health systems were at the stage of reform, including some possible changes with health insurance and decentralization of health services. Further, with examples Vice President emphasized on the need to reexamine the existing health systems through the lens of societal issues including values and culture.

## Session 1: Exchange of National Experiences on Addressing Social Determinants of Health

The findings of the first SDH analysis for Maldives were then presented by WHO consultant, Dr. Ravi P. Rannan Eliya. According to Dr. Ravi, based on the national health indicators, there were rapid improvements in the overall health status and health outcomes in Maldives. However, that now there needs to be a shift from focusing on the overall national health status to evaluating health inequities within communities and between communities in Maldives and addressing these issues.

Unlike the situation in Male', health services in the islands were pro-poor. Also, access to medicine was considered inequitable as most of the pharmacies were from the private sector. In the remote islands, there are inequities in access to health as a result of lack of a regular and affordable transport mechanism within Maldives.

The findings of the SDH analysis and recommendations for policy direction were presented in three main categories: (1) Health system inequalities, (2) Disparities in Mortality and (3) Non Communicable Diseases/NCDs and NCD risk in Male' (capital island of Maldives). On the latter, Dr. Ravi referred to the emergence of non communicable diseases, concentrated in the poor, as a main challenge in the Maldives. This is a similar trend to that seen in most developed countries. Dr. Ravi mentioned that it was important to improve service provision as well as health promotion initiatives specially targeted to most vulnerable populations.

The discussions focused a lot on the relatively high public health financing in Maldives and on the optimal public funding level for Maldives. Dr. Ravi stated that in terms of public health financing, at first glance it might be perceived that the public funding levels are very high in Maldives compared to other SEARO countries. However, he said that Maldives should be compared only to countries with a similar geography and in this sense, the public health funding for Maldives was quite similar to countries with a dispersed geography like Pacific Islands. Given the dispersed geography of Maldives the benefits of economies of scale cannot be experienced at island level. Hence, the cost of providing health care is much higher in Maldives compared to most SEARO countries.

## Session 2: Overview of Social Determinants of Health

In the morning session two presentations were given. The first presentation was by Dr Davison Munodawafa, WHO SEARO, who presented an overview of the recommendations of the Commission on Social Determinants of Health/CSDH: (1) improving daily living conditions, (2) tackling the inequitable distribution of power, money and resources and (3) measuring and understanding the problem and assessing the impact of action. The Colombo Call for Action was then shared with participants by Dr.Palitha Abeykoon, Sri Lanka.

Common theme in the discussions which followed the presentations were the stewardship role of Ministry of Health and Family in addressing SDH, the importance of better understanding of health equities that exist (i.e, establishing a national surveillance system to explore health equity gaps), inter-sectoral role in reducing health inequities, instruments/indicators to measure SDH, importance of reviewing all national programs/projects from a health equity lens and devising initiatives to sustain measurements to address SDH.

In the afternoon session, the focus was on sharing international experiences in addressing social determinants of Health. The first presentation was on “Urbanisation and Health: Bangladesh Perspective” by Md. Abdul Mannan, the Joint Chief of Planning and Md.Rafiqul Islam Khan, Deputy Secretary, Health Economics Unit, Ministry of Health and Family Welfare, Bangladesh. The main theme was that urbanization is inevitable, urbanization is also increasingly linked with poverty and therefore, governments need significant investments to reduce poverty and urban health strategy.

The second presentation was by Dr Dorji Wangchuk, Director General, Department of Medical Services, Ministry of Health, Bhutan. The core values of Bhutan were clearly evident in their focus on measuring all programs/projects first with the gross national Happiness index to ensure alignment of all new initiatives with the happiness objective. Several participants mentioned that the Gross National Happiness/GNH index was a unique and holistic measure and Bhutanese were using this concept effectively in their programmes and projects.

The next presentation was “Thailand – Health Equity by in all Policies/HiAP” by Dr. Ugrid Millintangkul and Mrs.Kannikar Bunteongjit, Deputy Secretary Generals, National Health Commission Office (NHCO), Thailand. The link with health reform and participative health policy formulation was quite evident in this presentation. In Thailand a National Health Assembly, representing different government sectors, civil societies, other agencies, forms a forum for exchange of ideas and information and ensures participation of all key

stakeholders in the formulation of healthy public policies. The basic principle guiding this assembly was referred to as ‘the triangle that moved the mountain, i.e, triangle with its three corners; creation of relevant knowledge through research, political involvement and social movement or social learning. Further, in the discussion, Thailand participants mentioned some critical success factors in reducing health equity in Thailand, namely participatory decision making ultimately leading to strong commitment from all parties involved, using the concept of the triangle that moved the mountain and by using any open window as an opportunity to address SDH (for example, use of political changes in Thailand to push forward SDH agenda).

Next Prof. Saroj Jayasinghe, University of Colombo presented on “Establishing National Mechanisms for Addressing SDH”. In this presentation several initiatives to address SDH in Sri Lanka were described. Prof. Saroj mentioned that there was a proposal for Sri Lanka to establish a Commission to deal with health inequalities using a social determinants approach. Common theme in the discussions that followed the presentation was that Sri Lanka has gone a long way in bridging the health equity gap. Some factors that could have contributed to this (in addition to the health system) include political developments (In terms of voting rights) , socioeconomic improvements in the country, universal access to education provided by the state ‘free’ at the point of delivery and strengthening of universal access to health care (i.e, work in the area of Primary Health Care and Maternal and Child Health).

The last presentation of day one was by Dr. Eugenio Villar, Coordinator, Department of Ethics, Equity, Trade and Human Rights (ETH), WHO Geneva, on “Synergies between Social Determinants of Health and Climate Change”. The main message presented by Dr. Eugenio was that climate change has the potential to widen inequities and therefore initiatives to address climate change must be carefully planned and viewed through an equity lens.

### **Session 3: Closing the Gap through Actions on Social Determinants of Health**

Day two started by a presentation of “Reflections of day 1” by Dr. Eugenio Villar, Coordinator, Department of Ethics, Equity, Trade and Human Rights (ETH), WHO Geneva. Along with a summary of the main discussion points from Day 1, Dr. Villa mentioned that the commitment of the Maldivian government to address SDH was evident with both the SDH analysis and this national workshop.

The next presentation briefing on the main challenges in Maldives in the three group work topics was presented by Ubeydulla Thoufeeq, Deputy Director, Ministry of Health and Family. He highlighted challenges in early risk identification and access to referral mechanisms in maternal health. He said that despite successes maternal anemia and child malnutrition persists in Maldives. He noted the social determinants that are shaping the health of the mothers and children such as domestic violence and unsafe environments for children. He called for re-examining the existing public health programs in terms of quality, cost and impact e.g. immunization and child nutrition.

With regard to tackling non-communicable diseases the limited delivery of health promotion including an increasingly medical service delivery model, lack of secondary prevention guidelines and inherent disease burdens like Thalassemia was noted. Consumption of tobacco and unhealthy food were presented by Ubeydulla as main drivers for the high non-communicable diseases burden in Maldives. Further, he mentioned that the congested living conditions (especially in the capital Male') and lack of urban planning coupled with economic migration has facilitated conditions for ill health in Maldives.

#### **Common discussion areas after presentation**

- The impact of Private public partnerships at rural communities and need to fill in gaps in service provision to special needs groups and vulnerable groups in the population. The need to assess the impact of PPP on health sector and the cost effectiveness measurement was also noted
- The additional challenges posed by calls from certain sections of the society to refrain from accessing family planning services
- The importance of viewing national initiatives and policies from an equity angle
- Brief overview of the new social protection policy in Maldives (including universal health insurance) providing several benefits to the poor and vulnerable groups in the community

## **Group work 1: Actions to Address the Social Gaps identified in the SDH Analysis for Maldives**

Participants were placed in three groups each focusing on different aspects about an important health issue with regards to addressing SDH as identified by the SDH analysis for Maldives. The three topics selected for group work included: (1) health and urbanization, (2) maternal and child health and (3) non communicable diseases/NCDs. The general objectives of group work 1 were as follows:

- To identify priority public health issues for Maldives related to the selected group topic, and
- To discuss and reach consensus on actions for reducing health equity gap through addressing social determinants of health in Maldives.

Each group identified and presented four specific actions that required leadership of Ministry of Health in closing the gap in SDH, three sustainable national actions in reducing health equities and three barriers to effectively implement partnership to address the specific group topic. Please refer to Annex 4 for the list of specific actions proposed by the groups in group work 1.

### **Common Discussion areas**

- The main common themes in all three presentations include concern over the effects of private public partnerships/PPPs on health equity. It was quite evident in the discussions that experiences from other countries were that private sector services have the potential to reduce access to care by the poor and therefore worsen inequities. Therefore, more information about experiences from other countries, technical analysis of the PPP initiatives in Maldives through equity lens and increased capacity of nationals in this area was needed at this stage. It was recommended that it is best to use non-profit PPPs in service management or services contracts and also to focus on the aspect of corporate social responsibility, especially in hospital care.
- Civil society and other sectors involvement should be balanced with the ministries initiatives. While some initiatives are best done by the government others might be best left to civil society or private partners. For example, Health promotion campaigns could be done by MOHF in collaboration with NGOs. However, NGO might find it difficult to operate a health facility in a small island (due to the associated sustainability and

financial issues). Participants stated that there was need to strengthen the capacity of NGOs and government should play a key role in this.

- Limitations in the available data sources to evaluate equity gaps were discussed by several participants in all three presentations. Mainly, equity stratifiers were not adequately used in studies and routine data collection systems, therefore it was suggested that Maldives and even WHO GENEVA to include disaggregated data with equity stratifiers in designing surveys and data systems.

## Field visit

Participants arrived at Hulhumale at 1410 hrs. The purpose of the visit was to share the housing development plan at Hulhumale with particular focus on the planned social services, industrial and residential services within Hulhumale. Participants were reminded of the housing difficulties in the capital island, Male' so that they can compare the housing plan at Hulhumale with that in Male'.

Participants first visited the Housing Development Corporation's Exhibition Centre at Hulhumale and were then taken for a tour of Hulhumale. According to international participants, the urban design in Hulhumale has the features of a modern urban development plan. Participants reported that in comparison with Male', the roads in Hulhumale were clean and green, had proper parking facilities, less traffic and lower level of pollution. There were community buildings for specific types of recreation, parks, and open places for physical and recreational activities. Adequate land was allocated for an international medical centre. Currently, there is a medium size hospital with some specialties. However, due to the close proximity to Male' most residents of Hulhumale visit the tertiary health facilities in Male'. A lot of the residents in Hulhumale, still come to Male' for employment. Hence, even though a lot of the social facilities are available in Hulhumale there some service areas like employment facilities that need strengthening for complete realization of the development vision for Hulhumale. Further, it was also evident that the Hulhumale project is still in the developmental phase and the ultimate target is to ensure Hulhumale is self-sufficient.

## Common Discussion areas

- The role of private sector was a major constituent in the Hulhumale development plan. In this plan, there were a lot of initiatives planned for private for-profit organizations but not so much for private not-for-profit organizations. Participants expressed that the involvement of non-for-profit sector was very important for improving the social services in the community
- A lot of urban development initiatives had been undertaken by the government (in addition to Hulhumale developmental project), including Villingili urban development project, to improve the housing conditions in Male'. However, there were no studies conducted to evaluate the impact or effectiveness of these urban development initiatives. It was suggested that Hulhumale be used as a field laboratory for prospectively investigating the sociological and health implications of its urban planning development. This will enable researchers to identify 'best-practice' for urban development.

## Session 4 – Group Work 2

Participants were placed in three groups each focusing on different aspects of the CSDH recommendation topics. The three topics selected for group work included: (1) tackling the inequitable distribution of power, (2) improving the living conditions and (3) measuring and understanding the problem and assessing the impact. The general objective of group work 2 were to discuss and agree on policy and strategy issues/activities including evidence gathering and dissemination required to tackle the given group work issue in Maldives

Based on the group topic each group was given three specific tasks from the following four actions:

- Identify three specific activities that could be implemented with other partners to address the group topic;
- Propose three research topics/issues where critical evidence is needed;
- Identify three sustainable national actions to measure and understand problem with regards to SDH; and,
- Propose three policy/legislative measures required to establish a mechanism to measure and understand the equity gap.

Please refer to Annex 5 for the list of specific actions proposed by the groups in group work 2.

### **Key messages from discussants**

- The importance of promoting local handicrafts to resorts and tourists as a method to increase the finances received by local communities
- To improve participation in SDH discussions at all levels in the community (not only focusing on high level) and also to include different cadres in these discussions (not only women or minority groups)
- With the introduction of Private Public Partnerships/PPPs to health sector, health finances and power will move from public to private sector so it is imperative to review all PPP health initiatives from an equity perspective as well as to conduct a societal discussion on impacts of PPPs in health
- As the first SDH analyses for Maldives identified stunting as an issue, this area needs to be highlighted more and further work done. Nutrition is at the tip of the iceberg and its causes related to SDH including education, employment, transport etc.
- Instead of developing a new SDH council/committee to use the existing councils or committees to address SDH issues in Maldives. Eg, use National Planning Council
- Although mortality data is coded and used to generate national statistics, coded morbidity data is not available at a national level (both from public and private sector)
- With Maldives moving towards PPPs in health, it was important to establish a mechanism whereby relevant health statistics are reported from all health facility operators (private and public) to the concerned government authorities on a regular basis.

### **Closing Session**

On behalf of the drafting committee, Ms. Aishath Samiya, Deputy Director of Policy and Planning Division, Ministry of Health and family presented the draft recommendations for Maldives to address SDH. Participants and senior policy level of MOHF provided comments and suggested amendments to the presented meeting recommendations.

Dr.Aminath Jameel, the Minister of Health and Family stated that she was satisfied with the progress made to date on national initiatives to address Social determinants of Health in Maldives. Mr. Abdul Bari Abdulla, the State Minister of Health and Family also reiterated the

importance of this national consultation on disseminating the results of the first Maldives SDH analysis and formulating country actions to close the gap in health inequities in Maldives.

Finally, Dr. Sheena Moosa, the Permanent Secretary of Ministry of Health and Family thanked the meeting organizing team at Ministry of Health and Family, WHO SEARO and country office, resource persons and participants representing relevant local sectors, agencies and SEARO countries for their support and assistance towards achieving the objectives of this consultation.

## **Final Recommendations to address SDH in Maldives**

Based on deliberations during the workshop the following recommendations were made:

### **Government of Maldives**

- Advocate with policy makers for integrating health in all policies. For example, healthy environment, employment, affordable housing, waste management, safe drinking water, early childhood development, healthy diet and discouraging tobacco use;
- Advocate for policies and legislations promoting re-distribution of power, money and resources to disadvantaged groups;
- Sustain and expand public sector financing of health services in order to reduce disparities related to access to health services and enhance social protection; and to ensure affordability of emergency and routine medical referral;
- Promote multi-sectoral alliances among public –private sectors, civil society and community groups for reducing health equity through addressing SDH. As part of health governance, this would require the creation and facilitation of a democratic space for voicing competing views or opinions on reducing the equity gap;
- Establish a sustainable institutional mechanism at Ministry of Health and Family with adequate funding and mandate to coordinate and manage intersectoral action through the “whole government approach” in order to reduce the health equity gap by addressing social determinants of health. This includes appointment of a focal point at MOHF to achieve desired outcomes;
- Advocate for integrating in all national policies “reducing health equity” and this would include in all priority public health conditions (tobacco control for Non-communicable

diseases, climate change adaptation for communicable diseases and new threats to health etc); and

- Strengthen the existing institutional infrastructure and community participation for promoting, supporting and protecting health rights of socially disadvantaged groups (women, children and elderly)

### **World Health Organization/WHO**

- Assist to build national capacity in monitoring and evaluation of the impact of health equity on programmes and policies, e.g, privatization, private public partnerships (PPP), healthy public policies and assessment tools among others;
- Provide technical support for integrating health in all relevant policies;
- Support to strengthen existing information systems to improve monitoring of health disparities for evidenced based decision making; and
- Support quantitative and qualitative research in Maldives to examine social and cultural determinants that influence health outcomes

## **Annex 1: Address by his Excellency, Mohamed Waheed, the Vice President of Maldives, at the National Workshop on Social Determinants of Health**

23 November 2009

Hon Ministers,

Guests from other countries,

Ladies and Gentlemen,

When we talk about the social determinants of health it is very difficult to separate the health of individuals, families and communities. They seem to be all related.

Individual health campaigns: Both mental and physical health – each contributing to the other.

An individual lives in a family and community environment, in a society that comprises of people, organizations, institutions and the ecosystem.

Individual is in a way surrounded by the social, cultural and physical environment.

I tend to think that the individual's mental and physical make up is an extension of the cultural and physical environment.

Our thoughts are shaped by the collective thoughts within society as if the individual mind is an extension of the societal mind or minds. As a result, a large majority of the people often think alike. Societal beliefs about the causes of disease for example affect the way people treat them.

Cultural factors that affect health include the perception of disease, the causes of it and its prevention and cure. Until recently Maldivian society did not acknowledge stunting as an important health issue. Obesity was seen as a sign of good health. As a result, malnutrition was not recognized as a public health issue – similarly, prevention from disease included keeping children indoors or hiding children from evil beings and their spells.

Until today, many societies are struggling to stop harmful practices such as female circumcision. Societal beliefs about the role of women affect women's health and development. Women are

systematically deprived of life saving care. Maternal mortality rates remain high in societies where gender inequality is high.

With advances in science, our understanding of the causes and effects of disease have changed to a great extent. Therefore, one of the most important dimensions of health systems development has become the substitution of traditional beliefs with modern ones based on proven results verified according to empirical studies.

Through public awareness programmes peoples' understanding of health has to be changed. For that to happen, the collective beliefs about health in society must also change. For example you cannot have an influential cultural institution spreading traditional messages which contradict the modern scientific findings.

Cultural intervention in health must include training of traditional leaders and spreading the new knowledge among influential institutions within society.

We have been talking about what I call the societal mind and how that affects individual beliefs and values.

What is equally important are the physical and institutional manifestations of those beliefs. For example, traditional healers and medicines coexist side by side with modern health systems.

Any new system requires training of its professionals and the development of new institutions to a level that will be acceptable to the beneficiaries. Health service providers at all levels need professional recognition and respectable remunerations.

In short the new system of health care must replace the traditional system and become part and parcel of the social system.

The extent to which modern health systems reach out to the population depends on how it is organized and what underlying interests determine its social formation. Those who are following the US health care reform efforts will understand that health systems like other social systems are affected by material interests.

History has taught us that conservative political thought has always represented narrow interests, those of the wealthy. Health systems that are entirely run by private corporations tend to exclude the poor. Universal health coverage including the poor will require state intervention and social protection.

This is especially so at times of economic distress. Unemployment, reduced wages, and absence of social protection can put excessive stress on families and reduce their ability to access health services. We also know that at times of hardship women and girls tend to suffer more. Families

make decisions to allocate their limited resources according values they attribute to individual members of their family. Men and boys often get the preference.

In Maldives, an additional societal factor that affects quality of health services is population congestion in Male and depopulation in remote islands. Relatively better but stretched services in male continue to attract more customers from other islands. Continued inflow can cause systems breakdown.

Perhaps there is no area where you see the relationship between values, societal circumstances, and health of the people than in the area of youth health and development. Youth unemployment, lack of opportunities for young people in Maldives is alienating them and causing societal distress, societal diseases such as drug addiction and mental health.

I believe we must seriously, in all sectors, begin to address this issue of youth unemployment and development.

Time has come for us to re-examine the provision of health services from a more holistic perspective taking into account social dimensions. We can no longer focus entirely on the management of existing institution. Changing hands don't necessarily create the additional capacity required to extend services and to improve quality.

We must assess what the additional requirements for services is and plan them according to demographic changes, population migration, inflow of migrant workers, and the changing needs for health services.

It is my hope that the new Report on Social Disparities in Health in Maldives will greatly contribute to strengthening the national health system.

## **Annex 2: Address by the Minister of Health and Family, Dr.Aminath Jameel, at the National Workshop on Social Determinants of Health**

23 November 2009

Excellency Vice President Dr. Mohamed Waheed Hassan Maniku,

Excellencies, Distinguished invitees and participants,

First of all let me thank His Excellency Vice President for gracing this inauguration. His presence clearly indicates the high level commitment by the government towards health of its citizen. Thank you sir!

This is an extremely important workshop because it concerns not only the health but all sectors and all walks of the society. However health sector need to be the key player in addressing the social determinants of health.

Social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and yet those that are avoidable differences in health status seen within and between countries. These inequities arise from inequalities within and between societies and are due to social and economic conditions and their effects on people's lives that determine their risk of illness.

Hence every aspect of government and the economy has the potential to affect health and health equity. Finance, education, housing, employment, transport, may not have the main aim of their policies on health, but they certainly have strong bearing on health and health equity.

While policy coherence is crucial – different government departments' policies must complement rather than contradict each other in relation to health equity. For example, economic policy that actively encourages the production, trade, and consumption of foods high in fats and sugars to the detriment of fruit and vegetable production is contradictory to health policy.

Faced with the worst recession since World War 11 the world economy is deeply mired in severe financial and economic crisis. Although its impacts are not uniform no country has been immune from the current downturn. As its impact increases both in scope and depth worldwide

the crisis poses a significant threat to the world economic and social development, including to the fulfillment of MDGs.

Your Excellency,

Distinguished invitees and participants,

Today, in terms of per capita GDP, Maldives is one of the richest countries in the region of South Asia. However as we emerge from three decades of gross mismanagement of our limited financial resources and inadequate human resource development, the first democratically elected government that took office in November 2008 is faced with huge challenges with the daunting task of having to deal with huge fiscal and budgetary challenges.

However we are optimistic.

Despite several challenges we have already achieved 5 of the 8 MDGs.

Maldives have already achieved MDG 1, but there is growing income disparity between urban and the rural population. Poverty dynamics analysis also showed that many in the non-poor fell back into poverty and that there is rise in unemployment among youth.

Although we can achieve the MDG 2: in time in halving the proportion of people with hunger we are faced with the challenge to promote locally grown food and change dietary habits of our people.

While we have achieved MDG 3 in achieving universal access to primary education, we are proud to note that our literacy rate of 98 is one of the highest in the world. Now it is time to focus on quality.

Goals 4 to eliminate gender disparity still needs concerted effort Maldives. Today more and more women are engaging themselves in decision making levels and in politics. More legislation need to be made and enforced with regard to the rights of women and to stop abuse.

Goal 5 of reducing by two-third, in the under-five mortality rate have already been achieved in 2005. However while reducing Maternal Mortality Rate is on track, accessibility to essential obstetric care, early detection of high risk cases in the outer islands are issues that need to be addressed urgently. We need to accept that our lifestyles are changing rapidly with development and urbanization there are new emerging challenges to the health system. The emergence of NCDs is putting a heavy burden to the already burden economy. In the recent years the medical model preceded the public health model in our health care system. We reiterate that PHC is the right approach to strengthen the health systems and improvement of the social determinants of health for achieving the MDGs.

We have been able to contain the low prevalence of HIV/AIDS and remained free of Malaria since its eradication in 1984. Prevalence of TB is low but the few cases of MDR need greater attention.

We have maintained our stand in ensuring environmentally sustainable economic development. We realize that we are among the most vulnerable to the climate change and to strengthen our convictions recently our new President of the Maldives has unveiled a plan to make our country carbon-neutral within a decade.

Today while talking of health we cannot ignore the impacts of climate change are already evident in the Maldives with a marked increase in weather conditions and coastal erosion. Over the medium-term, the main threat comes from temperature rise and acidification of the surrounding ocean. Both impacts could lead to the extinction of our prized coral reefs and the sea, the very livelihood of our economy, our two principal industries – tourism and fisheries.

Your Excellency,

Distinguished invitees and participants,

We strongly believe that the social needs of people cannot be left to the markets but we believe that public sector alone cannot provide all the essential services to its population. As in many governments Maldivian government is confronted by fiscal constraints that force us to carefully prioritize and restrict public expenditures.

Maldives is currently in a period of transition with respect to health care financing. The mode of financing is still fee for service with out of pocket payments. Currently the major sources of financing include the government budget; Social Health Insurance, out-of-pocket expenditures; safety net programs for senior citizens, the registered poor, the disabled and those on the pension scheme; and donors. The new government has committed to provide universal health insurance by 2010 through the Social Health Insurance and social security ensured through National Pension Scheme ratified by the Citizen's Majlis in April 2009.

We are progressing well but we cannot be complacent and we need to learn from the experts and from the experience of others. That's the purpose of this workshop. We need to understand that we have a heavy responsibility ahead.

In conclusion I would like to once again thank the Vice President for his presence. And also take this opportunity to express our gratitude to the international agencies in our efforts.

I wish every success to this workshop and hope that those participants from other countries will have a pleasant stay in the Maldives and take back sweet memories of this beautiful country.

### **Annex 3: Address by the Representative to the WHO, Maldives, Dr. J.M Luna, at the National Workshop on Social Determinants of Health**

23 November 2009

It is acknowledged that the major causes of disease and premature death lie outside the domain of the health sector, and social and economic determinants are the root causes. In Maldives, health inequities and inequalities exist between the rich and the poor, males and females and across age groups.

Maldives participated in both Regional Conferences on Social Determinants of Health held in Colombo, Sri Lanka in 2007 and 2009. In 2009, the Honourable Minister attended together with Health Ministers from Bangladesh, Bhutan and Sri Lanka. The Colombo Call to Action (to be presented also in this Workshop) was adopted by delegates and four Ministers of Health (Bangladesh, Bhutan, Maldives and Sri Lanka). Among the issues raised in the Colombo Call is the need for national strategies and plans of action, assessment of the scope and magnitude, causes and profile of health inequities, and to establish or strengthen where appropriate, inter-sectoral mechanisms to build and sustain actions for closing the equity gap and monitor progress.

In that context, today's Workshop is a step in the right direction for Maldives because has conducted a health equity analysis to profile the inequities, and now we are holding a national consultative meeting to share the findings as well as chart the way forward in closing the equity gap through addressing social determinants of health. The Workshop is the first of its kind among SEAR countries and WHO is encouraged by the leadership and vision demonstrated by the Government of Maldives through the Ministry of Health and Family. This National Workshop is taking place at a time when WHO is calling for global leadership to address health equity across sectors. It is timely that the Ministry of Health and Family, Maldives seeks to establish inter-sectoral action and integrate health in all policies in order to establish mechanisms for working within and outside the health sector. The outcomes of this National Workshop definitely guide future directions in the way we address public health concerns. WHO looks forward to participating in the deliberations and also to the recommendations from this National Workshop which would guide our future collaboration in this important area.

## Annex 4: Specific actions from Group work 1

### Specific actions requiring MOHF leadership include:

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#### *Group 1- Health and Urbanization*

- To identify the gaps of services between urban and rural areas
- To use all sectors (including other sectors, NGOs and private sector) to provide the services that are already not provided to the community. Eg, can use transport mechanism in nearby resorts to move patients from rural islands to atoll hospitals or use the coast guard services to transport serious patients
- To take a leadership role to coordinate and improve the linkage between health and other sectors including the transport sector to improve better access to health services
- To take a lead role in establishing a national coordinating body focusing on minimizing SDH
  - This coordinating body can supervise if all sectors are doing enough to address SDH
- Increase health promotion activities and awareness specially targeted to the vulnerable groups in both rural and urban locations

#### *Group 2 - Maternal and Child Health/MCH*

- Advocacy at high level and sensitization of all stakeholders on health equity gaps in this area
- Lobbying with the National Planning Council to ensure that public policy decisions are taken in consideration of MCH issues
- Capacity building, for newborn care and obstetrics
  - Including increased investments for emergency care for MCH
  - Resource mobilization for training in MCH (including the increased capacity of national training institutes)

- Facilitate Private sector involvement (including investment), particularly in establishing a reliable transport service between health facilities
- With increased private sector involvement MOHF needs to ensure that the relevant policies, legislations and monitoring framework are in place
- Facilitate partnerships with civil society (CSO/CBO) for MCH services
- Ensure the relevant policies, legislations and monitoring framework/ development on NGO-CBO role in MCH services are in place

### *Group 3 - Non Communicable Diseases*

- Generate and analyze data to routinely evaluate gaps, define important categories (e.g, injuries) and evaluate impact of interventions like Public Private Partnerships/PPPs
- Community participation and capacity building of civil society to be involved in decision making and implementation
- Institutional arrangements as well as regulations for intersectoral action (e.g, National health council in Srilanka with health ministers and other sector ministers)
- Capacity building of MOHF and other ministries for health equity policies and actions

### **Sustainable national health actions for addressing SDH in Maldives include:**

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#### *Group 1- Health and Urbanization*

- Targeting and developing provinces other than Male' (capital island)
- Establishing taxation mechanism in Male' and try to earn more money / revenue which can be utilised for developing islands (i.e. alternative financing which can be allocated to health sector ,in addition to the earmarked budget from the central government).
- Mechanism to create Corporate Social Responsibilities (CSR) – corporate societal responsibilities

- E.g. Tourist resorts boats to be utilized for carrying patients in case of emergency. Best to include some mandatory provisions for CSR in relevant regulations or laws.
- Continuing and strengthening decentralization policies
- Strengthening the laws and regulations which will contribute to reducing the inequality gaps between rural and urban areas, eg. Decentralisation, social corporate responsibility law
- Improving the financial mechanisms including the distribution of resources in an effective and efficient manner, less services available for rural compared to urban now.

*Group 2: Maternal and Child Health/MCH*

- To ensure the availability, affordability and quality of nutritious food needed for MCH at all levels
- Routine collection of data for analyzing the gaps in MCH (including health equity stratifies)
- Public/consumer education in MCH
- Multi-sectoral collaboration and commitment (Ensured through the high level policy mechanism at National Planning Council)
- Education and Youth involvement
  - Adolescent and youth education
  - Inclusion of health education including MCH in the primary and secondary/vocational training curriculum

*Group 3: Non Communicable Diseases/NCDs*

- Legislation and regulation in relation to food, smoking etcetera
  - Taxing and banning of certain foods. Eg, Banning the import of food items with trans fats into the country

- Restrictions on Tobacco use. Eg, Srilanka banned smoking
- Against advertisement of junk food and smoking
- Increased education, information and communication with regards to NCDs and improving community social participation
- Consider interventions in physical environment. Eg, In urban planning can consider areas free of vehicles, recreation and physical exercise facilities

**Barriers to effective implementation of partnerships (between public and private sector) to reduce the SDH gap in Maldives include:**

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*Group 1: Health and Urbanization*

- Geographic Barrier – small communities living in different islands
- No law to enforce social corporate responsibility in Maldives.
  - Eg: Sea planes – No law to provide provisions for special need groups like free or subsidized transportation mechanism for children with disability in the sea planes
  - Eg: Bhutan - 2 seats in airplanes are reserved for patients at subsidized (lower) rates
- Lack of or insufficient grass root awareness on reasonable expectations for health policy in urban and rural settings (considering the geographical and other challenges) in the public and private domain
  - Previously people did not know enough about health policies enough to demand
  - Current situation is reversed and people's expectations are too high
- Commercial viability and sustainability of each PPP initiative not assessed through equity lens
- Resource constraint and non-availability of modern facilities in rural area
- It is more costly to introduce modern health facilities in rural area compared to urban area.

- No established system of transport between islands
- Suggestion from group was to focus on Introducing green transport policies
  - Eg:Motorbikes are limited in Villingili

*Group 2: Maternal and Child Health/MCH*

- Information asymmetry
- Commercial viability and sustainability of providing MCH services in dispersed populations
- High costs associated with the absence of economies of scale
- Adverse impact on the poor and vulnerable if private public partnerships are introduced without assessment through equity lens
- Limited number and capacity of civil society, including CSO/CBOs
- Shortage of human and financial resources for improving MCH

*Group 3: Non Communicable Diseases*

- Mindset of relevant government officials, community leaders and politicians
  - Unless equity is considered as an important factor in policy formulation or program formulation, might not be able to reduce equity gap
- Lack of institutional capacity to generate data on equity (MOHF, other ministries and communities)
- Lack of technical knowledge or unknown impacts of certain interventions (eg. Private Public Partnerships/ PPPs) on health equity

## **Annex 5: Specific actions from Group work 2**

### **Group 1: Tackling the inequitable distribution of power, money and resources**

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#### **Community based activities that could be implemented along with other partners**

- Create dialogues to raise issues and ideas from all levels in the community eg, via radio, TV channels, internet and community interest groups
- Community Based intervention programmes through empowerment such as Community Based Rehabilitation (CBR)
- Introducing micro credit system within the community eg, for fishing communities to promote and expand their business.

#### **Research topics or issues where critical evidence is required to fully understand the opportunities / challenges**

- Operational research on how to empower the people especially in atolls/ islands.
- Resource mapping and proper management by the local government.
- House hold financing (earning and spending) mechanism in Male' and in islands

#### **Policy and/or legislative measures**

- Improve the access to tertiary education for women.
- Formation of policy and legislation on population and aging.
- Participation of more women in the parliament, cabinet etc (eg. To change regulation to ensure that a minimum of 10% should be women to raise the voice of minorities in parliament, cabinet etcetera)

## **Group 2: Measure and understand the problem and assess impact**

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### **Actions that require Ministry of Health and Family leadership**

- Improve vital registration system
- Strengthen the quality of coding
- Link patients medical records to national registration data base
- Improve and standardize the morbidity statistics
- Train and build capacity on morbidity statistics in the atolls
- Improve survey designs
- Better framing of questions to track inequalities and SDH e.g: Vulnerability Poverty Assessment, households Incomes Survey and STEPS (external) Survey, Demographic and Health Survey etc.
- Strengthening capacity of MOHF, DNP, NGOs and other relevant sectors
- Form Working Group on SDH and Inequities (MOHF together with Department of National Planning)
- Build capacity in both SDH analysis and policy formulation to
  - assess and focus on priority areas (e.g. mental health)
  - ensure evidence is translated to policies

### **Policy and/or legislative measures**

- Policies to bring about actions on vital registration system, improving survey designs and building capacity
- Legislation on collecting information by institutions (including private sector and NGOs)

### **Group 3: *Improve Living Conditions***

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#### **Community based activities that the Ministry of Health and Family could implement along with other partners**

- Health promotion activities
- including , nutrition,hygiene, water and sanitation
- (collaboration with Ministry of Housing, Transport & environment , Ministry of Education & NGOs)
- Rainwater harvesting and testing of water quality
- Community empowerment
- Addressing vector control and Waste management in collaboration with other sectors

#### **Research topics or issues where critical evidence is required to fully comprehend the implementation gap**

- Social and cultural practices concerning hygiene, food consumption, accessing health services
- Waste Management Assessment
- Whether community needs are taken into consideration
- Assessment of harvesting and usage practice of water
- Assessment of pollution in Maldives and increase in respiratory disorders (Male')

## **Policy and/or legislative measures**

- Formulation of Health Act to address SDH
- Housing policy for the needy or poor
- Subsidy for the needy and poor
- Imposing limitations on the rent
- Legislation on increasing access to disabled persons (in building etc)
- Legislation on controlling vehicle numbers and emissions

## Annex 6: Programme

### Health Sector Role in addressing Social Determinants of Health

Male, Maldives, 23-25 November, 2009

<b>Day 1: 23 November, 2009</b>	
8.30 - – 09:00	Registration
09:00 – 9.00 – 9.05 9.05 – 9.10 9.10 – 9.20 9.20 – 9.45	<p><b>Inaugural Session</b></p> <p>Recitation of Holy Quran</p> <p>Speech by Minister Dr. Aminath Jameel / Minister of Health &amp; Family</p> <p>Speech by Dr. J.M Luna /WHO Representative to Maldives</p> <p><b>Speech by Chief Guest Vice President Dr. Mohamed Waheed Hassan Manik</b></p>
<b>Session 1</b>	
<b>Exchange of national experience on addressing social determinants of health</b>	
9.45 – 10.30	<ul style="list-style-type: none"> <li>• Maldives Health Equity Analysis - Dr Ravindra Rannan-Eliya, WHO consultant</li> </ul>
10.30 – 10.40	Group Photo
10.45 – 11.10	<b>Tea Break</b>
<b>Session 2</b>	
<b>Overview of Social determinants of health</b>	
11.15 – 12.30	<ul style="list-style-type: none"> <li>• CSDH Recommendations – Dr Davison Munodawafa,WHO SEARO</li> <li>• Colombo Call for Action – Sri Lanka – Dr Paitha Abeykoon, Sri Lanka</li> <li>• Discussion</li> </ul>
12:30 – 13:30	<b>Lunch</b>
<b>Sharing experiences on addressing social determinants of health</b>	
13:30 – 15:00	<ul style="list-style-type: none"> <li>• Bangladesh – Urbanization and Health: Bangladesh Perspective – Dr Md Abdul Mannan and Mr M.Rafiqul Islam Khan</li> <li>• Bhutan – Gross National Happiness Index – Dr Dorji Wangchuk,</li> <li>• Thailand – Health equity in all policies (HiAP) – Mrs Kannikar Bunteongjit and Dr Ugrid Milintangkul</li> <li>• Discussion</li> </ul>

15.00– 15:30	<b>Tea / Coffee</b>
15:30 – 16:15	<ul style="list-style-type: none"> <li>• Sri Lanka – Establishing sustainable national mechanism for addressing SDH – Prof Saroj Jayasinghe</li> <li>• Synergies between social determinants of health and climate change: - Dr Eugenio Villar , Coordinator, Department of Ethics, Equity, Trade and Human Rights (ETH), WHO Geneva</li> </ul>
16:15 – 16:45	<ul style="list-style-type: none"> <li>• Discussion</li> </ul>
<b>Day 2: 24 November, 2009</b>  <b>Session 3: Closing the gap through action on social determinants of health</b>	
9.00 – 9.15	Reflection of Day 1
09:15– 9.25	<ul style="list-style-type: none"> <li>• Main challenges in Maldives in the three group work 1 topics – Ubeydulla Thoufeeq, Deputy Director, Ministry of Health and Family</li> </ul>
9:25 – 10:15	<p><b>Group work: Actions to address the social gaps identified in the SDH analyses for Maldives</b></p> <ul style="list-style-type: none"> <li>- Health and urbanization</li> <li>- Maternal and child health</li> <li>- <b>Non communicable diseases</b></li> </ul>
10:15 – 10:30	<b>Tea Break</b>
10:30 – 11:30	<ul style="list-style-type: none"> <li>- Continue group work</li> </ul>
11:30 – 12:30	<ul style="list-style-type: none"> <li>- Group Work: Report Back</li> </ul>
12:30 -13:30	<b>Lunch</b>
13.45	<p><b>Field Visit –</b></p> <ul style="list-style-type: none"> <li>- <b>Departure from Male’</b></li> <li>- <b>Arrival at Hulhumale’</b></li> <li>- <b>Visit Housing Development Corporation’s Exhibition Centre / site seeing TOUR</b></li> <li>- <b>Tea Break</b></li> <li>- <b>Departure from Hulhumale’</b></li> <li>- <b>Arrival in Male’</b></li> </ul>
14.00	
14.10 – 15.40	
15.40 – 16.10	
16.15	
16.30	

<b>Day 3: 25 November, 2009</b>	
9.00 – 9.15	Reflection of Day 1 – Mariyam Nazviya, Ministry of Health and Family
09:15 – 10:00	Field visit: Report back – Hassan Mohamed, Deputy Director, Ministry of Health and Family
10:00 – 10:30	<b>Tea Break</b>
	<b>Session 4: Group Work</b>
10:30 – 12:00	<ul style="list-style-type: none"> <li>• Discuss required actions to “improve living conditions” in order to reduce the ‘cause of the causes’ of premature death and illness;</li> <li>• Discuss required actions to “tackle the inequitable distribution of power, money and resources”;</li> <li>• Discuss required health sector actions to “measure and understand the problem and assess the impact</li> </ul>
11:30 – 12:30	<ul style="list-style-type: none"> <li>• Group Work: Report Back</li> </ul>
12:30 – 13:30	<b>Lunch</b>
	<b>Session 6: Summary, Recommendations and Conclusions</b>
13:30 – 15:30	<ul style="list-style-type: none"> <li>• Draft Summary, Recommendations and Conclusions (Drafting committee)</li> </ul>
15-30 – 16.00	<b>Tea</b>
	<b>Session 7: Closing</b>
16.00 – 16.15	Closing Ceremony – Prioritized country action for addressing SDH – Aishath Samiya, Deputy Director, Ministry of Health and Family
16.15 – 16.25	Speech by Dr. Aminath Jameel / Minister of Health & Family
16:25 -16:30	Closing statement by Dr. Sheena Moosa/Permanent Secretary of Ministry of Health & Family

## **Annex 7: List of Participants**

### **Resource Persons**

Dr. Davison Munodawafa

WHO SEARO

Dr Ravindra Rannan-Eliya

Director, Institute for Health Policy and Research Associate

Sri Lanka

### **WHO Geneva**

Dr. Eugenio Villar

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**Srilanka**

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Dr Palitha Abeykoon

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Mr Hassan Mohamed

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Mr.Ubeydulla Thaufeeq

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Assistant Director

Ms. Mariyam Nazviya

Assistant Director

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Mr. Hussan Rasheed

Deputy Director General

Ministry of Education

Ms. Aminath Nashia

Director

External Resouces Management

Ministry of Finance and Treasury

Mr. Ismail Ali Manik

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Ministry of Finance and Treasury

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Ministry of Human Resources, Youth and Sports

**Non Governmental Organizations, Maldives**

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Family Planning Doctor

Society of Health Education

Ms. Fathimath Rasheedha

Senior Program Coordinator

Diabetic Society of Maldives

Ms.Shidhatha Shareef

Deputy Director

Care Society