Multi-sectoral Action Plan For The Prevention And Control of Noncommunicable Diseases in Maldives (2014-2020)

May 27, 2014

Abbreviations

ARC	Advocating Rights for Children
BCC	Behavior Change Communication
CBOs	Community Based Organizations
CDD	Communicable Disease Division
DSM	Diabetes Society of Maldives
FHS	Faculty of Health Sciences
FCTC	Framework Convention on Tobacco Control
GSHS	Global School Health Survey
HIS	Health Information Systems
HPA	Health Protection Agency
HRD	Human Resource Division
HSD	Health Service Division
IGMH	Indira Gandhi Memorial Hospital
MED	Ministry of Economic Development
MFDA	Maldives Food and Drug Authority
MOA	Ministry of Agriculture
MOE	Ministry of Education
MOF	Ministry of Finance
MOHG	Ministry of Health and Gender
MOHI	Ministry of Housing and Infrastructure
MRL	minimum residual limit
MYS	Ministry of Youth and Sports
NCDs	Non-Communicable Diseases
NDA	National Drug Agency

NGOs	Non-Governmental Organizations
NIE	National Institute of Education
PEN	Package of Essential NCDs
PHS	Public Health Surveillance
PIH	Planning and International Health
SAARC	South Asian Association For Regional Cooperation
STEPS	WHO STEPwise approach to surveillance
STO	State Trading Organization
UOM	University of Maldives
WHA	World Health Assembly

Foreword (President/Vice President)

Foreword by World Health Organization Representative

Noncommunicable diseases (NCDs)-cardiovascular diseases (CVDs), cancers, chronic respiratory diseases and diabetes are the biggest cause of deaths in the world. Due to high burden of NCDs on national economies and health systems, the heads of the States and Governments committed for a global action to control NCDs in the UN Political Declaration on NCDs in September 2011. To realize this commitment, WHO has developed Global Action Plan (2013-2020) to provide a road map for member states and developmental partners to control NCDs and identified 9 voluntary global targets to be achieved by 2025. The WHO has accelerated providing support to the member states to develop country specific national action plans to work towards the 2025 NCD global targets.

The WHO Country Office is delighted to be a partner with the government to develop a multisectoral action plan for the prevention and control of NCDs (2014-2020) in Maldives. This effort will be critical to halt and reverse increasing stress NCDs are bearing on Maldivian population and the country.

NCDs have emerged as the main cause of morbidity and mortality in the Maldivian population. The prevalence rates for NCDs(excluding injuries) was already ten times higher as compared to communicable diseases in 2008 in the Maldives. CVDs jumped from the tenth in 1990 to the first position in 2010 contributing to 6.2% of the Years of life lost (YLLs). The leading causes of deaths in 2012 were CVDs, ischemic diseases, hypertensive diseases ranks on the top diseases followed by chronic respiratory diseases and diabetes.

NCDs are expected to be a key challenge for the population health as the country is increasingly exposed to globalization and NCD risk factors: tobacco use, importation of unhealthy food (diet rich in saturated fats or high salt consumption) and inadequate consumption of vegetables and fruits and urban sedentary lifestyles.

WHO in partnerships with other UN organizations will be pleased to support the commitment of the national action plan of the Republic of Maldives in the nation’s endeavor to achieve NCD national targets by 2025.

(Dr. Akjemal Magtymova)

WHO Representative

PART I- Background Situation

Introduction

The health status of the Maldivians has improved significantly in the last decades. The life expectancy increased from 57 years in 1990 to 75 years in 2009 and the other indicators such as maternal and child survival rates have also shown similar leap. [1] Maldives ranks one of the top countries in the SAARC after Sri Lanka in health indicator achievements. As the economy and living standards improve, the country is also experiencing the epidemiological transition with a swift change of disease burden from communicable to noncommunicable diseases. Chronic noncommunicable diseases are emerging as the main cause of morbidity and mortality in the country with the fast changing lifestyle and development. NCDs (including injuries) account for 78 % of the total disease burden.[2]

NCDs are expected to be a key challenge for the population health as the country is increasingly exposed to globalization and NCD risk factors: tobacco use, importation of unhealthy food (diet rich in saturated fats or high salt consumption) and inadequate consumption of vegetables and fruits and urban sedentary lifestyles. NCDs have far reaching negative externalities not only through health of the affected individual, but losses incurred to family members, society and country due to productivity loss and prolonged care and treatment needed for a member with NCDs.

Burden of NCDs

NCD have been taken over the communicable disease for quite some time in the Maldives. The age standardized mortality rates for non-communicable disease (excluding injuries) was ten times higher as compared to communicable diseases in 2008 (598 per 100 000 population versus 59 per 100 000 population).[1]

The leading causes of deaths in 2012 were cardiovascular diseases (CVDs), ischemic diseases, hypertensive diseases ranks on the top diseases followed by chronic respiratory diseases and diabetes.[2]

[1] World Health Statistics 2012

[2] Maldives Health Profile 2014, MOHG, March 2014

CVDs jumped from the tenth in 1990 to the first position in 2010 contributing to 6.2% of the Years of life lost (YLLs). Similarly the ranking of diabetes and COPD burden also moved up.[3] In terms of the absolute figures, circulatory deaths in 2008 was 395, and respiratory deaths was 158 of the 1070 deaths, [4] NCDs clearly exceeding 50% of the annual mortality for that year.

Risk Factors

Dietary habits, high blood pressure, high body mass index and smoking were in the top five attributable leading risk factors for the burden of disease in the country.[3] Population/city based surveys show that the prevalence of NCD risk factors has not shown any appreciable decrease in the population in the past decade. A special focus needs to be placed to prevent NCD risk factors in children and as persons growth and development in childhood has a profound impact on future health and quality of life enjoyed in adulthood, and represents an opportunity in terms of improving the overall lifetime health of populations and promoting rights to health for all.

Tobacco use: Tobacco use is highly prevalent in the Maldivian society. The STEPS surveys in 2004 and 2011 shows that there is little change in smoking prevalence. Although there is a slight decrease in prevalence of smoking (22.0% in 2004 versus 18.3% in 2011), the initiation of smoking tended to have shifted to a younger age (21.6 in 2004 versus 19 years in 2011). Not only is the overall prevalence of current smokers quite high (19%) of which mostly men contributed to smoking (34.7%), the dose of smoking was hazardous with a mean daily cigarette sticks of 14.3. (STEPS survey 2011). Another major concern is the alarming exposure to second hand smoke; 21.3% reported being daily exposed at home and 17.1% at work place. Close attention must be paid to the growing culture of tobacco use among youths; according to the GSHS 2009, among young people aged 13- 15 years, 72% reported trying cigarettes before 14 years of age, and about 9% of children aged 13-15 years smoked on one or more occasions in the past 30 days.

Alcohol use: Overall prevalence of current drinkers is less than 1 % as per the STEPS 2011. Although this is encouraging, statistics suggest that a small portion of young children are taking up alcohol as well according to the GSHS 2009. Nearly 4% of children reported consuming alcohol and majority who drink consume in an amount to get drunk.

Fruits and vegetable consumption: Fruit and vegetable consumption is also falling far behind the recommended intake. In Male City, 92.6% of men and 94.6% of women consumed only one

[3] Global burden of disease country report -Maldives

[4] Vital Registration System, Ministry of Health & Family 2009

serving of fruits and /or vegetables per day [5] much lesser than WHO recommended serving of five portions of fruits and vegetables in a day. In a typical week, fruits were consumed on 3.3 days and vegetables on 3.8 days. This may indicate low awareness on the need to consume fruits and vegetables as well as access and affordability issues.

Unhealthy diet: Maldivians also appear to consume diet rich in saturated fats. National micronutrient survey conducted in 2007 shows that more than 95% consume iodised salt. There is no data of mean salt intake for Maldivian population. The expert opinions speculate that salt consumption would much higher than the recommended level of <5 g/day. [6]

Physical inactivity: Sedentary lifestyle may be high. According to the STEPS survey 2011, 45.9% (39.1% man and 52.4% women) were not achieving the recommended level of physical activity in Male' City. In fact the level of physical inactivity in 2011 almost remained the same as compared to 2004. According to the GSHS 2009, about 70% of children did not achieve required level of physical activities.

Metabolic risk factors: Approximately a fourth (26%) of Male' residents were overweight in 2011. Females were more **overweight** as compared to males (27.8% versus 23.5%) and the same was true for obesity (14.5% in females versus 8.6% for males). According to the STEPS (2011), 16.6 % were currently hypertensive or taking medication for raised blood pressure.

DHS 2009 shows that 6% of the children under the age of 5 years are overweight. It is believed that this figure is on the rise. This is a huge concern as childhood obesity can lead to adult obesity, which is associated with several health conditions including cardiovascular diseases and some cancers.

Progress , Challenges and Opportunities For Control of NCDs

Health Master Plan (2006-2015) recognizes health promotion and NCD prevention as a key approach to improve population health. The two year national strategic plan (2008-2010) for NCD was yet another clear step taken to address NCDs. Even though the Strategic Plan could not be implemented at a full scale, important milestones were achieved. The key ones were instituting NCD surveillance through NCD STEPS survey, creation of NCD Unit at the HPA, enactment of tobacco laws, piloting Package of Essential NCDs (PEN) intervention and sensitizing political bodies on NCDs in the country.

[5] WHO STEPS survey on risk factors for noncommunicable diseases Maldives, 2011

[6] Interview with Dr. Ali Nazeem, MD (Internal Medicine), Indira Gandhi Memorial Hospital, Male', April 17, 2014

The health system is well distributed and staffing levels of doctors, nurses and other health workers have improved in the past few years particularly through the hire of expatriates from outside. The health centers and hospitals are equipped to provide basic level of care for all health services including NCDs. The role of the growing private health services is increasing and further engagement in participation and implementation of NCDs will increase the coverage and options of NCD services as well. Special attention must be paid in maintaining equity in access to NCD services due to geographical spread of islands.

Sizeable numbers of NGOs are directly or indirectly engaged in prevention and control of NCDs and other health issues. NCDs need to be managed within the existing framework of the Maldives legal and governance structure creating an inclusive process for all sectors participation and contribution. While managing the basic health care services, the capacity of tertiary care facilities cannot be ignored. Expansion of PEN is needed to strengthen NCDs in the primary care system while developing referral linkages with regional and tertiary hospitals. Capacity improvement is required for national tertiary institutions as well. Currently, IGMH, regional hospitals and ADK hospital provide the tertiary services; capacity improvement is required for advanced NCD management through training of health care professionals, upgrading level of care of NCDs in these institutions and improving referral linkages for NCD treatment outside the country.

The state sponsored social health insurance-Asanda, provides universal coverage which is an immense safety net for the Maldivians. However, the insurance scheme needs to be responsive to address the gaps that may arise with the surging population needing NCD medical care and to minimize out of pocket payments and catastrophic health expenditure.

Urbanization and demand of physical space will also be a challenge for physical activity promotion. Ever increasing traffic volume and associated pedestrian accidents are a problem in Male'.[7] This provides an invaluable opportunity to rethink the urban structural development, vehicle import policies and restructuring major cities like Male' to enable long range planning.

Sole dependence on the imported food products, the country needs strong domestic policies. Capacity strengthening is required at the MFDA to ensure proper regulation of the quality of imported food products and other goods. The globalization effects of trade are palpable with high use of tobacco, fast acculturation of beverage promotion and changing food habits in the country. With the implementation of a risk factor based model of NCDs prevention and control, influences and conflict of interest of tobacco, food and beverage industries can be transparently managed.

[7] Injury prevention program, HPA

Existing school based healthy lifestyle programs, momentum in tobacco laws, growing interest of NGOs for NCD prevention and control and recognition by non-health government sectors on NCDs as a cross sectoral issue holds a great opportunity for a true multisectoral response for NCDs in the Maldives.

PART II- Approaches And Strategic Actions

Process of Development of the Multisectoral NCD Action Plan

The Action Plan was developed through a multi-step process of consensus building of the stakeholders. In February 2014, a seminar/meeting was organized to sensitize multistakholders about the immense health, social, and economic burden of NCDs and the global and regional NCD action plans. One of the recommendations of this meeting was to develop a national NCD action plan with inputs from all stakeholders. A technical consultant of the World Health Organization was appointed to initiate the discussion and the gather views and suggestions from the stakeholders from April 13-May 6, 2014. The consultant did the desk review of key documents including the National Strategic Plan for Prevention and Control of noncommunicable diseases in Maldives, 2008-2010, Integrated National Nutrition Strategic Plan 2013-2017, Strategy for Prevention of Cervical Cancer, Health Master Plan, Tobacco Control Act (Law 15/2010), Maldives, Health Promoting Schools Policy, National Standard For Labelling (Draft) , MFDA-FCD STAN 4-2014 and NCD related WHO strategies and guidelines. (Refer to appendix 1) Existing mandate/documents of different sectors were reviewed and taken into account.

In addition to individual stakeholder meetings, a two day thematic cluster meetings were conducted among stakeholders on April 21 and 22, 2014.(Refer to appendix 2) The recommendations of the stakeholders were compiled and the draft document was circulated for feedback. A final stakeholder consultation was held on April 30, 2014 which was also attended by the Minister of MOHG and Deputy Minister of MOHI. The Multisectoral NCD Action Plan was submitted to the Hon'ble President and the approval was granted on XXXXXX vide order XXXX.

Context

The Republic of Maldives recognizes the increasing prevalence of NCD risk factors and the growing burden of NCDs in the population as a developmental issue. In order to tackle the growing urgency of the NCD burden in a swift and decisive manner, the Multisectoral NCD Action Plan (2014-2020) will be a national blue print and will provide a clear pathway in the nation's pursuit to join the global fraternity to achieve the voluntary NCD targets for 2025. The Action Plan builds on the past initiatives implemented under the Maldives National Strategic Plan for Prevention and Control of NCDs 2008-2010. The Action Plan is also motivated by nation's commitments made at the international and regional forums most importantly among others being:

- The Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of NCDs (September 2011)

- Global Action Plan for the Prevention and Control of NCDs (2013-2020) endorsed through resolution WHA66.10 (May 2013)
- Declaration of the Thirty-first Meeting of the Health Ministers in SEARO
- Resolution of the 66th Regional Committee of SEAR

Scope and Linkages

The Multi-sectoral NCD Action Plan will cover four key modifiable risk factors (tobacco use , consumption of diet with high saturated fatty acids, hydrogenated vegetable oils, high salt, physical inactivity and alcohol use, key metabolic risk factors (obesity, hypertension and raised cholesterol) and four key NCDs (cardiovascular diseases, diabetes, chronic obstructive pulmonary diseases and cancer). The Action Plan will ensure a holistic approach embracing policy, legal and structural components necessary to address complex social determinants of NCDs and their risk factors. Most importantly, the Action Plan will have heavy reliance on the partnership of non-health stakeholders and their efforts to integrate NCD prevention strategies within their plans. Within the Health Sector, the Action Plan will build synergies with the existing programs such as tobacco control, maternal and child health, injury prevention and road safety, environmental health, nutrition, mental health and prevention of substance abuse to name a few.

Determinants and Risk Factors of NCDs

The action plan will be guided by the pyramidal framework shown below to prioritize NCD interventions. The framework portrays the influence of social determinants, effect of globalization and urbanization on the metabolic risk factors and subsequent development of the clinical NCD conditions. The increasing burden of NCDs is attributed to social determinants of health, in especially population ageing, rapid and unplanned urbanization, effects of globalization (such as trade and irresponsible marketing of unhealthy products), low literacy and poverty. The policies addressing social and economic determinants at the macro level have impacts on NCDs. The health sector related interventions generally targeted at the upper level of the pyramid are costlier while interventions at the lower portion of the pyramid caters to larger population are cost effective and multisectoral in nature. The framework demonstrates the need of a comprehensive approach addressing the various levels of determinants for implementing NCD prevention and control.

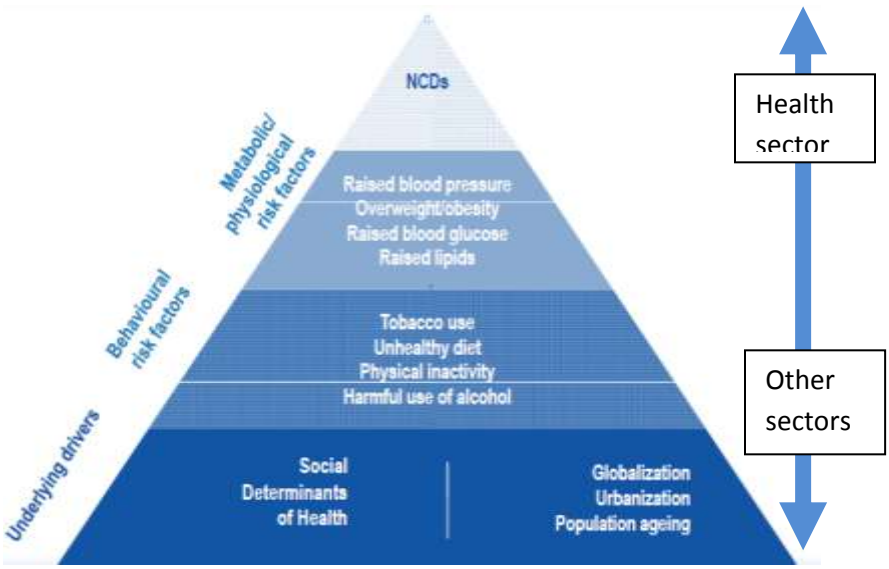


Figure 1: Determinants of NCDs. Adapted from SEA Regional NCD Action Plan

Vision

For all people of the Republic of Maldives to enjoy the highest attainable status of health, well-being and quality of life at every age, free of preventable NCDs, avoidable disability and premature death.

Goal

To reduce preventable morbidity, avoidable disability and premature mortality due to NCDs in the Republic of Maldives.

Specific Objectives

1. To raise the priority accorded to the prevention and control of noncommunicable diseases in the national agendas and policies according to international agreed development goals through strengthened international cooperation and advocacy
2. To strengthen national capacity, leadership, governance, multisectoral action and partnership to accelerate country response for the prevention and control of noncommunicable diseases
3. To reduce modifiable risk factors for noncommunicable diseases and underlying social determinants through creation of health-promoting environments
4. To strengthen and orient health systems to address the prevention and control of noncommunicable diseases and underlying social determinants through strengthening primary health care approach.

5. To promote and support national capacity for high quality surveillance, operational research and monitoring and evaluation for the prevention and control of noncommunicable diseases

Targets For 2025

The country goals for 2025 will align with the regional targets with only a slight variation. There will be nine national goals, making exclusion of the goal viii on reduction of indoor air pollution from solid fuel used for cooking in the regional NCD action plan.

(i) A 25% relative reduction in overall mortality from cardiovascular diseases, cancers, diabetes, or chronic respiratory diseases
(ii) A 10% relative reduction in the harmful use of alcohol
(iii) A 30% relative reduction in prevalence of current tobacco use in persons aged over 15 years
(iv) A 10% relative reduction in prevalence of insufficient physical activity
(v) A 30% relative reduction in mean population intake of salt/sodium
(vi) A 25% relative reduction in prevalence of raised blood pressure
(vii) A Halt the rise in obesity and diabetes
(viii) A 50% of eligible people receive drug therapy and counseling (including glycaemic control) to prevent heart attacks and stroke
(ix) An 80% availability of affordable basic technologies and essential medicines, including generics, required to treat major NCDs in both public and private facilities

Guiding Principles

The NCD national action plan relies on the following overarching principles and approaches.

Focus on equity: Policies and programmes should aim to reduce inequalities in NCD burden due to social determinants such as education, gender, socioeconomic status, ethnicity and migrant status.

Multisectoral actions and multistakeholder involvement: To address NCDs and their underlying social determinants and risk factors, functioning alliances are needed within the health sector and with other sectors (such as agriculture, education, finance, information, sports, urban planning, trade, transport) involving multiple stakeholders including governments, civil society, academia, the private sector and international organizations.

Life-course approach: A life-course approach is key to prevention and control of NCDs, starting with maternal health, including preconception, antenatal and postnatal care, and maternal

nutrition; and continuing through proper infant feeding practices, including promotion of breastfeeding and health promotion for children, adolescents and youth; followed by promotion of a healthy working life, healthy ageing and care for people with NCDs in later life.

Balance between population-based and individual approaches. A comprehensive prevention and control strategy needs to balance an approach aimed at reducing risk factor levels in the population as a whole with one directed at high-risk individuals.

Empowerment of people and communities: People and communities should be empowered to promote their own health and be active partners in managing disease.

Health systems strengthening: Revitalization and reorientation of health care services are required for health promotion, disease prevention, early detection and integrated care, particularly at the primary care level.

Universal health coverage: All people, particularly the poor and vulnerable, should have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative, rehabilitative and palliative basic health services, as well as essential, safe, affordable, effective and quality medicines and diagnostics without exposing the users to financial hardship.

Evidence-based strategies: Policies and programmes should be developed based on scientific evidence and/or best practice, cost-effectiveness, affordability, and public health principles.

Management of real, perceived or potential conflicts of interest: Public health policies for the prevention and control of NCDs should be protected from undue influence by any form of vested interest. Real, perceived or potential conflicts of interest must be acknowledged and managed.

Strategic Priority Action Areas

The priority activities for the Republic of Maldives are structured around four strategic action areas. Implementation of these strategic actions will lead to a reduction in overall mortality from the four main NCDs. All actions will be implemented in close collaboration with other health programmes such as infectious diseases control, maternal and child health, immunization, school health and occupational health services and the programmes of other stakeholders.

Strategic action area 1: Advocacy, partnerships and leadership. Actions under this area aim to increase advocacy, promote multisectoral partnerships and strengthen capacity for effective leadership to accelerate and scale-up the national response to the NCD epidemic under the national government.

Key actions:

- Establish a High Level NCD Taskforce and a NCD Unit/MOHG as a secretariat under the Presidential directive
- Advocate to parliamentarians, City Council members, Local Councils
- Institute School Health Promotion Board at the MOE, Workplace Health Promotion Board at the HPA, Urban Planning Board at the MOHI and Enforcement Board at the Maldives Police
- Advocate greater resource allocation to fund NCD activities within the sectoral plans
- Explore and map funding partners for NCD prevention and control

Strategic action area 2: Health promotion and risk reduction. Actions under this area aim to promote the development of population-wide interventions to reduce exposure to key risk factors. Effective implementation of these actions will lead to reduction in tobacco use; increased intake of fruits and vegetables; reduced consumption of saturated fat, salt and sugar; reduction in harmful use of alcohol; increase in physical activity; and reduction in second hand exposure to tobacco smoke.

Key actions:

- Gazette tobacco law
- Promote tobacco smoke free homes to eliminate exposure of children to second hand smoke in homes and reduce exposure to second hand smoke in other settings
- Adapt WHO Global Strategy to Reduce the Harmful Use of Alcohol and raise public awareness on the harmful effects of alcohol
- Implement BCC and mass media national campaigns on healthy lifestyle promotion using national recommendations of physical activity and diet
- Develop progressive fiscal and legislative policy measures pertaining to trade to reduce access and educate population to minimize consumption of saturated fatty acids and banning of hydrogenated vegetable oils
- Implement healthy lifestyle promotion for school children of all age groups in school settings
- Adapt a public health approach to address alcohol use among young people
- Adopt urban structural alignment to promote walkability and physical activity in Male'
- Create two open air mass physical activity grounds providing free physical activity sessions by a professional instructor
- Advocate for swimming as a physical activity and construct washrooms near swimming pools to promote swimming
- Pilot work place health promotion initiatives in six organizations: MOHG, Civil Service Institute, Bank of Maldives, STO, Dhiraagu and Ooreedoo

Strategic action area 3: Health systems strengthening for early detection and management of NCDs and their risk factors. Actions under this area aim to strengthen health systems, particularly the primary health care system. Full implementation of actions in this area will lead

to improved access to health-care services, increased competence of primary health care workers to address NCDs, and empowerment of communities and individuals for self-care.
Key actions:

- Scale up PEN interventions in all health centers
- Establish one national Quit line and twenty five tobacco cessation clinics (one each in health center and other tertiary health facilities)
- Expand cervical, oral and other cancer screening programs
- Introduce NCD clinics including provision of care for diabetes
- Train primary health care workers on NCD interventions and train specialized tertiary care teams
- Provide long term trainings for specialists
- Strengthen ex-country referral system by reviewing and renewing MoUs with the treatment centers abroad
- Sign MoU with Asanda and pharmacies for non-interrupted drug availability for basic NCD treatment
- Establish diabetic patients as peer counselors
- Develop patient information system

Strategic action area 4: Surveillance, monitoring and evaluation, and research. This area includes key actions for strengthening surveillance, monitoring and research. The desired outcome is to improve availability and use of data for evidence-based policy and NCD programme development.
Key actions:

- Sustain population based surveillance by continuing ongoing STEPS and GSHS
- Introduce compliance monitoring program for tobacco rules
- Strengthen capacity of NCD surveillance at the Public Health Surveillance Unit
- Conduct Walkability Survey in Male' to assess the pedestrian friendly environment to promote physical activity
- Conduct a pilot study on salt consumption
- Conduct a total diet study
- Monitor MRL in food content
- Develop a hospital based cancer registry
- Conduct six monthly progress review meetings among stakeholders Conduct mid-term evaluation in 2017 and end line evaluation in 2020

PART III- Management Framework

The implementation of the Multisectoral Action Plan requires engagement of relevant stakeholders from the government, non-government bodies and private sectors. NCD prevention and control being a multi-dimensional and cross cutting in nature, effective mechanisms are required to coordinate for a successful implementation of the Action Plan.

Two-Staged Implementation

The seven year Multi-sectoral Action Plan will be considered as a two stage approach.

Stage I: The first stage will be implemented from 2014 through 2017. Under this phase, the focus will be to initiate pilot interventions, prepare and launch the national behavioral change communication (BCC) and media campaign, address policy gaps and legal provisions needed to address NCDs, train human resources, and to streamline procurement and supply chain of medicines and equipment. A mid-term evaluation of the action plan will be conducted at the end of 2017.

Stage II: This stage will be implemented from 2018 through 2020 after making adjustments based on the recommendations of the midterm review. The focus of this phase is to accelerate the BCC and media campaign, expand prevention programs, scale up the pilot interventions and address the quality of service delivery.

Role of Stakeholders

Highlight of roles of stakeholders are presented in the following table. The action plan will remain flexible to include any partners not envisaged or included at the time development of the plan in future.

Table 1: Roles of key ministries and other stakeholders

Sl. No.	Ministry/Agency	Potential roles in NCD prevention and control
1.	Office of the President/Council of Ministers	Provide national policy directives and funding for Multisectoral NCD Action Plan
2.	Ministry of Education	Integration of healthy lifestyle programs on NCD prevention in schools through curricular or non-curricular approaches ,advocate for ban of food with high trans fat and physical activity, dissuade children from consuming tobacco and other harmful substances
3.	Ministry of Youth and Sports	Promotion of national guidelines for physical activity and diet
4.	Maldives Police	Enforcement of tobacco and other NCD related regulations
5.	Ministry of Agriculture	Promote production of fresh vegetables at affordable prices
6.	Maldives Broadcasting Corporation	Regulate ban on advertisement and sponsorships by alcohol, tobacco and unhealthy food
7.	Ministry of Economic Development	Pricing and taxation of tobacco, alcohol and unhealthy food products
8.	Maldives Customs	Enforce and implement pricing and taxation of tobacco, alcohol and unhealthy food products regulations
9.	Ministry of Housing & Infrastructure	Enforcement and implementation of urban design and healthy urban planning
10.	City/ Atoll/Island Councils	Advocate for good urban planning, implement physical structural policies and integrate NCD advocacy in their sectoral plans
11.	Ministry of Health and Gender	Mass media campaigns for prevention of NCDs, provision of clinical services for NCD patients, regulate tobacco laws and food safety laws
12.	Media Organizations	Promote mass media for healthy lifestyle promotion and NCD advocacy
13.	CBOs /NGOs	Advocacy and promotion of NCD services , health education and peer outreach
14.	Private Sector	Assert corporate social responsibility by promoting physical activity at the work place, creating smoke free workplaces and educating on healthy food

High Level NCD Taskforce:

A High Level NCD Taskforce will be constituted under a special directive of the President to oversee the multisectoral activities for NCD action plan. In particular, the Taskforce will be responsible for:

- Guiding stakeholder implementation of multi-year work plans
- Informing the government on the national policy and legal issues related to NCD control including ways to allocate greater financial resource for NCD response
- Maintaining the momentum and national spirit for NCD response

The High Level Taskforce will be adequately represented by the parliament, government agencies, civil societies, NGOs and media organizations. The Taskforce will meet once in four months or a minimum of three times a year. Detailed terms of reference of the High Level NCD Taskforce and the NCD Unit/Secretariat will be approved by the President. The Taskforce and the Secretariat will come into function on the day of granting approval by the President.

NCD Unit/MOHG

The MOHG will be responsible for the national coordination for the NCD response. The the NCD Unit in the Health Protection Agency will be the secretariat to the High Level NCD Taskforce and the coordination point for the Multisectoral NCD Action Plan. The NCD Unit therefore will be strengthened with additional human resources to perform the secretarial, coordination and implementation functions of the national action plan as shown in the following;

BOX 1: The key responsibilities of the NCD Unit

As a Secretariat to the Multisectoral High Level NCD Taskforce:

- Call regular meetings of the Multisectoral High Level NCD Taskforce
- Prepare agenda, present issues and document the proceedings and circulate the minutes of the meetings to all stakeholders
- Invite submission of issues to the stakeholders to be included in the meeting
- Invite issue-based presenters from stakeholders when required
- Complete the process of formation of subcommittees and provide assistance to the subcommittees
- Prepare national reports related to NCD response and ensure timely submission and follow up with the Office of the President and the Cabinet
- Prepare national reports related to NCD response and conduct proper dissemination of reports to the law makers, donors, UN agencies and other stakeholders

As a coordination point:

- Conduct and coordinate regular progress reviews among the stakeholders
- Conduct stakeholder's annual work planning workshop to develop NCD actions plans and ensure that plans are implemented in line with the Multisectoral NCD Action Plan
- Ensure regular submission of the activity progress reports from stakeholders and compile the reports
- Orient stakeholders on the requirement and format of activity report
- Advice stakeholders on issues related to implementation

As an implementing agency:

-Implement NCD unit work plans of the MOHG

Sub Committees for High Level NCD Taskforce

The NCD Unit as a secretariat will propose formation of subcommittees as and when deemed necessary. Constituting a permanent technical committee is not necessary as the issues in NCDs and lifestyle promotion is too diverse to rely on a fixed committee. Formation of subcommittees will be approved by the High Level NCD Taskforce. The function of a subcommittee is to deliver a particular task requiring broader consensus and inputs from a team. When an issue can be addressed by a single agency, Taskforce may call upon the designate agency present the issues through an official correspondence singed by the chair/vice chair of the Taskforce. Clear terms of reference with deliverables and time frame for the assignment will be stated in the letter.

Subcommittee will be dissolved by the Taskforce after satisfactorily completing the task. The dissolution will also be officially conveyed through a written correspondence from the chair/vice chair of the High Level Taskforce.

Formation of Agency Boards/Committees

As agencies embrace the NCD Action Plan, at times stakeholders are likely to face unforeseen policy challenges, legal and implementation issues that need support and wisdom of the many. In such situations, stakeholders are recommended to resort to dialogue and problem solving mechanisms through formation of committees, holding consultation of field experts or engaging in cross-sectoral consultations as necessitated by the issue at hand.

Tobacco Control Board is already functional. In addition, the following key stakeholder boards are recommended as not having these boards may risk poor delivery on the action plan.

School Health Promotion Board

The health promotion board will be formed at the Ministry of Education. The main function of the board will be to guide the implementation of school based programs reflected in the Action Plan.

The board will be chaired by a high level executive of the MOE. Varying memberships are encouraged with the following mandatory stakeholder representation: adolescent and child health program of MOE, a representative of the MOHG, representatives from school principals, a representative of a NGO. The board will meet a minimum of once in three months. The minutes and recommendations of the board will be shared with the NCD Unit/HPA routinely.

Work Place Health Promotion Board

The Workplace Health Promotion Board will be based at the NCD Unit of the MOHG. The main function of the board is to guide the implementation of the agencies involved in piloting workplace health promotion in Male' and to guide expansion of similar approaches in work places in the Maldives.

The board will be chaired by a member from the one of the pilot sites: Civil Service Institute, Bank of Maldives, STO, Dhiraagu and Ooreedoo. The other board members will be invited from the Diabetes Society, Society for Health Education, Civil Service Commission, a Fitness Center in Male'. HPA will be a permanent board member. The board will meet a minimum of once in three months and maintain proper documentation of the meetings.

Urban Planning Board

The Urban Planning Board will be based at the Ministry of Housing and Infrastructure. The Urban Planning Board amongst its other agenda is to advocate for integration of planning and

design affecting the built environment and physical availability of urban spaces and consider health in urban planning approach. The board will be chaired by a senior executive or an elected member of the Ministry.

The board will consist of members from Male' city council, two health experts from the MOHG and Faculty of Health Sciences, and two NGO members in addition to other stakeholder representatives. The Board will meet a minimum of once in three months. The minutes and recommendations of the board will be documented.

Enforcement Board

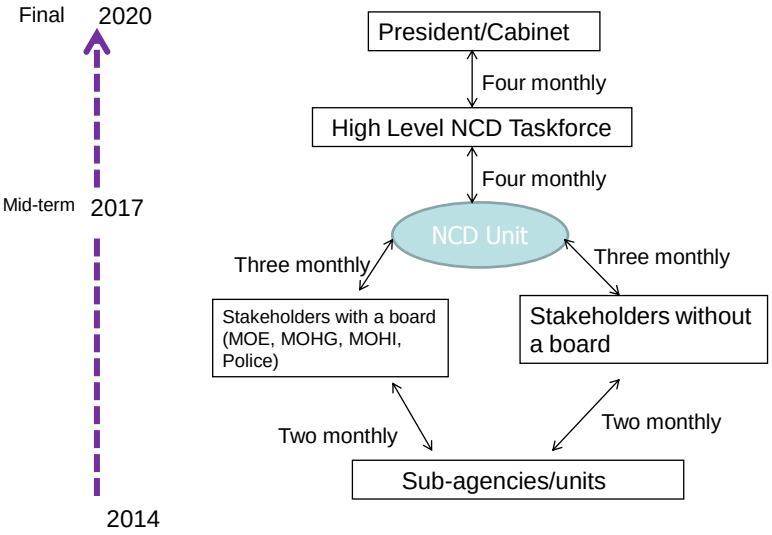
The Enforcement Board will be led by the Police Department. The key function of the Enforcement Board is to promote cooperation among the enforcement agencies and improve enforcement of tobacco laws, food safety regulations, food marketing and packaging laws and any other related regulations affecting NCDs. The stakeholders will review the enforcement status, discuss issues regarding the enforcement and find solutions for better enforcement at a national level and not merely for Male' City

The board will be chaired by a High Command in Police. The mandatory board members include a representative each from HPA, MFDA, Maldives Customs, a NGO and a Media organization. Like other boards, enforcement board will also meet a minimum of once in three months and minutes of the meetings will be properly documented.

Appraisal and channel of communication

A proper line of coordination and communication is a necessity to facilitate smooth coordination and timely flow of information. Information flow pertains to tracking the performance of stakeholders through routine submission of progress report to the Secretariat (NCD Unit) and onward submission of information to the President. The flow chart below depicts the channel and frequency of flow of reports from the stakeholders.

Flow chart 1: Appraisal channel & frequency of reporting of progress of activities for Multi-sectoral NCD Action Plan



PART IV- Monitoring The Results

Process monitoring of stakeholder work plan

Stakeholders will be accountable for their work plans. The work plan will be integrated within their sectoral plans. The national monitoring and evaluation (M& E) protocol for the Multisectoral National NCD Action Plan will be finalized through a stakeholder meeting and seek endorsement of the High Level Taskforce.

In order to track the implementation progress, three monthly activity progress reports will be collected by the NCD Unit/Secretariat at the end of March, June, September and December. A special activity reporting forms will be developed by a team of stakeholders. Stakeholders will be oriented on the coordination protocol and reporting format. During the subsequent years of implementation, any new coming members will also be oriented on the coordination protocol and reporting format.

The NCD Unit will review the progress and provide feedback within the 14 working days of the receipt of activity reports. The feedback will include the progress against the set indicators.

The progress for 2020 will be measured through few critical process indicators and short term and medium term outcome indicators. The key indicators are defined for each risk factor, diseases and other service delivery areas. Process and short term indicators are aimed towards midterm plan (2017) and the medium term and few long term indicators are expected to be achieved by 2020. The majority of the long term indicators should be achieved by 2025.

A summary of critical indicators to be used for tracking the progress of the Multisectoral NCD Action Plan along their means of verifications and key assumptions are described in the following tables:

Table 3: Tobacco control indictors and means of verification (Mov)

Process (2014-2017)	**Short term (2017)**	**Medium (2020)**	**Long term (2020-2025)**
Revision of tobacco law to align with the provisions of the FCTC (Mov: Gazetted document of the government)	Pictorial warning and packaging of tobacco products (Mov: Annual market survey of tobacco products by HPA)	People aware about health effects through pictorial warning on tobacco packages (Mov: market survey of tobacco products by HPA)	Prevalence of tobacco use among adolescent reduced Age standardized prevalence of tobacco use among persons aged 18+ years
Revision of tobacco taxation policies (Mov: Print of tobacco taxation policy document)	Incremental tobacco tax collection adjusted to inflation (Mov: Annual revenue report of Customs)	Tobacco consumers reporting reducing/quitting tobacco use due to high cost (Mov: Survey questionnaire adapted for STEPS and GSHS collected five yearly)	
Intense enforcement program		Decrease in smokers in smoke	

on tobacco rules in smoke free zones , designated places and underage sales (Mov: Written work plans of police and HPA for joint enforcement activities)	Rapid response enforcement teams visiting the sites (Mov: Annual jointly published reports on violation and penalty by police and HPA)	free designated sites (Mov: Annual compliance check reports of the tobacco control unit/HPA)	
Compliance check program through decoy purchase attempts for tobacco laws as an quality improvement tool (Mov: Decoy shopping evaluation protocol)	"No smoking " and " no tobacco sale below 18 years" prominently displayed in designated smoke free zones (Mov: Annual published report of decoy purchase attempt)	Increase in observation of smoke free restaurants, bars, hotels and legally designated public places (Mov: Annual published report of decoy program)	
Assumptions: Tobacco law is gazette and funds are available for implementation of activities			

Table 3 : Indicators for physical activity promotion and means of verification (Mov)

Process (2014-2017)	**Short (2017)**	**Medium (2020)**	**Long term (2020-2025)**
Develop national physical activity guidelines for all age groups in various settings (Mov: Print documents of national physical activity guidelines)	Information dissemination on social media and other media programs (Mov: BCC and mass media campaign strategy annual report)	More people of all age group aware on the recommendations of physical activity (Mov: Mid-term evaluation report of BCC and mass media campaign and STEPs and GSHS)	Prevalence of insufficient physical activity adolescents defines as less than 60 minutes of moderate to vigorous intensity activity daily Age standardized prevalence of insufficient physical activity persons aged 18+years (defined as less than 150 minute of moderate-intensity activity perweek , or equivalent)
Healthy lifestyle promotion in schools (Mov: Annual work plans targeting healthy lifestyle promotion)	Physical activity programs integrated as school wide policy to achieve national physical activity recommendations at school setting (Mov: Annual progress report of MOE)	School children are aware and engage in physical activity promoting sessions at school (Mov: GSHS)	
Pilot healthy lifestyle at workplace (Mov: Signed MoUs of participating stakeholder and HPA)	Number of organization integrating work place healthy lifestyle promotion in key corporate and government settings (Mov: Activity reports of the pilot workplaces)	More workers involved in physical activity at work place (Mov: Evaluation report on pilotting work place healthy lifestyle promotion in five organizations)	
Improvise urban structural designs in Male' city and other major urban settings (Mov: Annual work plans of urban planning board and Male' city council)	Functional Urban Planning Board with City Council and HPA representative and NGOs established at MOHI Develop urban structural changes improvising long term design plans Pedestrian designated streets (Mov: Activity report of Urban Planning Board and Male' city council) Two public physical activity promoting grounds established	Streets conducive for pedestrians (Mov: Walkability survey once in five years) People participating in regular physical activity at the public ground increased (Mov: Annual assessment report on use of public ground of HPA)	

	in Male' (Mov: Physical verification of sites)		
Assumptions: Greater leadership by school systems , City Council and Ministry of Urban Development and Infrastructure and funds available for health promotion			

Table 4 : Indicators for promotion of healthy diet and means of verification (Mov)

Process (2014-2017)	Short term (2017)	Medium term (2020)	Long term (2020-2025)
Adoption of national dietary recommendation for all age groups and for different conditions and information integrated into national BCC & mass media campaign (Mov: Published mass media and BCC strategy)	Increase airtime for healthy lifestyle events on mass media channels such as in social media,(Facebook, twitter), TV, radio and print media (Mov: Air time contract award document and activity reports of the media organizations)	Increase awareness of dietary recommendations in population (Mov: STEPS and GSHS and midterm and end line evaluation reports)	Age standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ year Population achieving recommended level of servings of fruits and vegetables
Adoption of policies to reduce of food products high in saturated fatty acids and eliminate hydrogenated vegetables oils in food supply(Mov: Published policy documents)	Increase public educational programs on risk of transfat and hydrogenated vegetables oils in integrated BCC campaign (Mov: Activity reports, Contract award documents for mass media of HPA) Increase monitoring of food contents of salt and saturated fatty acids and transfat levels((Mov:Annual published market inspection reports of MFDA/HPA)	Decrease market availability of food products with high content of transfat and hydrogenated oils (Mov: Annual published market inspection reports of HPA/MFDA) Reduction in consumption of food containing transfat and hydrogenated vegetable oil (Mov: STEPS survey)	
Introduce policies to reduce food marketing to children for non-alcoholic beverages and food high in saturated fatty acids , transfat, high sugar or salt (Mov: Published policy documents of HPA)	Decrease in advertisement of non-alcoholic beverages and food high in saturated fatty acids, transfat, high sugar or salt decreased (Mov: Annual media assessment reports by HPA/NGOs)	Decreased accessibility and availability of non-alcoholic beverages and food high in saturated fatty acids , transfat, high sugar or salt in the market (Mov: Annual market assessment reports by HPA/NGOs)	
Assumptions: Legal measures in place for banning food with high contents of hydrogenated vegetable oils and transfat and funds are available to advocate healthy diet			

Table 5 : Indicators for prevention and control of alcohol use

Process (2014-2017)	Short term (2017)	Medium term (2020)	Long term (2020-2025)
Adopt of relevant components on Global Strategy on Reducing Harmful Use of Alcohol (Mov:	Increase educational programs on alcohol abstinence among young people (Mov: Annual	Population aware on alcohol abstinence policy (Mov: STEPS	Relative reduction in harmful use of alcohol (10%)

Published policy document)	activity reports of stakeholders compiled by NCD Unit) Alcohol involved road crashes and alcohol-involved crime (Mov: Published joint annual report of HPA and police)	survey)	
Assumptions: Police provide good cooperation and funds are available			

Table 6 : Indicators for NCD and metabolic risk factors and means of verification (Mov)

Process (2014—2017)	Short term (2017)	Medium term (2020)	Long term (2020-2025)
Package of Essential NCD (PEN) intervention integrated in all health centers (Mov: MOHG training activity reports)	Health workers skilled on PEN intervention (Mov: Three yearly clinical audit report) Policies for palliative care for cancer patients through opioid analgesics (Mov: Three yearly clinical audit report)	NCD patients treated and counselled using NCD protocol (Mov: Three yearly clinical audit reports) Better quality of life for cancer patients receiving opioid analgesics (Mov: Three yearly clinical audit report)	At least **50%** of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes
Introduce supportive services for counseling and self-support of NCDs or risk factors (Mov: Activity report of MOHG/NGOs)	Patient-peers involve in tobacco cessation services and diabetes peer counseling (Mov: Clinic activity report of health center/NGOs)	Increased duration of abstinence among former tobacco users Improved quality of life of diabetic patients (Mov: Clinic activity and performance report by health centers/NGOs)	
NCD prevention through cervical and oral cancer screening and vaccination for hepatitis (Mov: Annual work plan documents of MOHG)	More health workers trained and health facilities providing cervical and oral cancer screening (Mov: MOHG activity reports) Hepatitis B for children and high risk adults receive vaccination (Mov: Reports of MOHG)	Increase uptake of eligible women for routine cervical screening program (Mov: Annual ANC screening records of MOHG for women aged 30-49 screened for cervical cancer) Number of people screened for oral cancers at health centers (Mov: Annual activity reports on oral cancer screening Increase coverage of hepatitis vaccination for children and high risk adults and (Mov: EPI coverage for third dose of vaccination coverage for children/MOHG)	
Streamline drug supply between Asanda , pharmacies and MOHG (Mov: MoU between three	Timely refill of stocks at pharmacies (Mov: Annual stock monitoring assessment at	Non-interrupted refill of NCD drugs and supplies by patients (Mov: Three yearly clinical	

agencies)	pharmacy outlets and patient interviews/MOHG)	audits)	
Assumptions: Funds are available for capacity development of the health workers and procurement of supplies			

Critical Factors Of The Action Plan

Several factors are critical to the success of the Action Plan as listed below. Faltering of one or more of these factors will severely risk the success of the Action Plan. These factors must be therefore closely managed at every stage of implementation.

- Political stability and commitment of the government to NCD remain unchanged
- Proposed fiscal policies and legislation and regulations to support policies are endorsed
- The NCD unit in MOHG is supported with required strength of capable staff
- Other stakeholders including the enforcement agencies effectively participate in implementing the NCD action plan
- Proposed boards/ committees are diligently able to meet and function
- Annual work planning and review exercises are conducted routinely
- Adequate financial resources are committed
- WHO and other donors provide continued partnership, support and guidance at the country level

Acknowledgement

The Multi-Sectoral Action Plan For Prevention and Control of Noncommunicable Diseases in Maldives (2014-2020) was developed through iterative consultations among the stakeholders representing government and nongovernment organizations. The NCD Unit/Health Protection Agency of the Ministry of Health and Gender coordinated and chaired the stakeholders meetings.

The Southeast Asia Regional Office and the Country Office For Maldives of the World Health Organization provided the financial and technical support to develop the Action Plan. The document was prepared by Dr. Gampo Dorji, a visiting consultant for the World Health Organization. Dr. Renu Garg, the Regional Advisor on NonCommunicable Diseases, WHO SEARO, NEW DELHI provided the overall guidance for shaping this document.

Appendix 1: Documents Consulted

1. National Strategic Plan for Prevention and Control of noncommunicable diseases in Maldives, 2008-2010
2. Integrated National Nutrition Strategic Plan 2013-2017, Health Protection Agency, Ministry of Health, Rep of the Maldives
3. Strategy for Prevention of Cervical Cancer, HPA, MoH
4. Health Master Plan, Affordable and Quality Health Care for All, Ministry of Health, Republic of Maldives
5. WHO STEPS survey on risk factors for noncommunicable diseases Maldives, 2011
6. Action plan for the prevention and control of noncommunicable diseases in South-East Asia, 2013-2020, World Health Organization
7. Global Action Plan for the prevention and control of noncommunicable diseases 2013-2020
8. Global Status Report of NCDs 2010, World Health Organization
9. Tobacco Control Act (Law 15/2010), Maldives
10. Health Promoting Schools Policy, December 2004, Ministry of Education & Ministry of Health
11. Maldives Health Statistics 2009, Ministry of Health & Family, Republic of Maldives
12. School Health Policy 2011, Ministry of education and Ministry of Health and Family, Republic of Maldives
13. National Standard For Labelling (Draft) , MFDA-FCD STAN 4-2014

Appendix 2: Stakeholders participated in developing the Action Plan

Advocating Rights for Children

Department of Customs

Dhamana Veshi Urban Health Center, Male'

Diabetic Association of Maldives

Faculty of Health Science Male' City Council

Indira Gandhi Memorial Hospital

Local Government Authority

Maldives Police Office

Ministry of Economic Development

Ministry of Education

Ministry of Health and Gender

Ministry of Housing and Infrastructure

Ministry of Youth and Sports

National Drug Agency

Villingili Health Center

Strategic action area 1: Advocacy, partnerships, and leadership

1.1 Advocacy

Desired outcome: NCDs prioritized in the national health and development agenda

Indicators: NCDs included in the national health plan or national development agenda, or both

Actions	Specific activities	Units	#units	Year (2014-2020)							Agencies	Budget	Budget source
				14	15	16	17	18	19	20			
1.1.1 Integrate NCDs into health planning processes and development plans with special attention to social determinants of health	1.1.1.1Host annual **work planning** meetings on NCD with other units of the MOHG	20/year			→	→	→	→	→	→	HPA*/PHS/ Stakeholders		
	1.1.1.2Organize one six monthly **progress review** meetings among NCD multi-stakeholders	20/year			→	→	→	→	→	→	HPA*/PHS/ Stakeholders		
	1.1.1.3Launch NCD action plan in each stakeholders coinciding with the national multi-sectoral launch day										Stakeholders		
1.1.2 Generate and disseminate evidence on the relationship between NCDs and other development issues	1.1.2.1.Prepare policy and advocacy briefs containing NCDs and economic costs and burden, poverty, food security and gender equality										PIH*/HPA		
	1.1.2.2Advocate parliamentarians on links between duties, taxation and imports on health outcomes for tobacco and other harmful commodities										HPA		
1.1.3 Raise public and political awareness/understanding about NCDs through social marketing, mass media and responsible media reporting	1.1.3.1Conduct a half day **annual** advocacy meeting with parliamentarians/ministers/Atoll council members and political appointees to brief on the progress of NCD response	30/year				→	→	→	→	→			
	1.1.3.2Observe the NCD Action Plan launch day as a special advocacy day by organizing a workshop among MOHG Units, Hospitals and Health Centers and Private Clinics	30/advocacy									HPA*/All Units of MOHG/ Health facile.		
	1.1.3.3 Develop and adopt a national campaign brand and logo for NCD prevention and lifestyle promotion to advocate in TV, radio, social media, bill board and print media										HPA*/ Stakeholders		
	1.1.3.4 Engage national football team in health promotion to improve sports performance and create a model lifestyle advocate					→	→	→	→	→	HPA		
1.1.4 Provide adequate and sustained resources for NCDs by	1.1.4.1.Explore avenue for increasing budget for NCD interventions through **routine** dialogue with the Ministry of Finance and the Government	25 one event			→	→	→	→	→	→	HPA/ Stakeholders		

increased domestic budgetary allocations, innovative financing and other means	1.1.4.2Advocate sectoral budget allocation in the Youth and Sports and Ministry of Education and other sectors				→	→	→	→	→	→	HPA		
1.1.5 Explore resources for NCD prevention and control from existing initiatives such as GAVI Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Bill and Melinda Gates Foundation	1. 1.5.1 Identify potential grantors to address NCDs or NCD risk factors or lifestyle promotion and successfully acquire funds to support a project through a grant proposal										All sectors		
	1.1.5.2 Train stakeholder workshop on grant writing and proposal development (1 international consultant for 10 days & 5 day workshop for 15 members)										PIH/MOHG/ MOE/IGMH/ Schools/ City Council/ NGOs		
1.1.6 Mobilize the UN Country Teams and link NCDs into the UNDAF processes	1.1.6.1 Conduct **annual** meeting with WHO country office and UN partners to mobilize UN contribution to NCD risk factors				→	→	→	→	→	→	PIH*/MOE*/ HPA*		

1.2 Partnerships

Desired outcome: National and subnational mechanism/s for multisectoral actions established and functioning

Indicators: Multisectoral national NCD policy, strategy or action plan, which integrates several NCDs and shared risk factors, developed and operational

Actions	Specific activities	Units	#units	Year (2014-2020)							Agencies	Budget	Budget source
				14	15	16	17	18	19	20			
1.2.1 Set up an effective national multisectoral mechanism(commission, agency or task force) reporting to the Head of State (or delegate) to plan, guide, monitor and evaluate the enactment of multisectoral national NCD policies and plans and to secure the necessary budget	1.2.1.1 Set up a High Level NCD Task Force to direct and guide the implementation of the Multi-sectoral NCD action	30/year									MOHG		
	1.2.1.2 Conduct minimum four monthly meeting of High Level National NCD Taskforce	30/year			→	→	→	→	→	→	HPA		
	1.2.1.3 Set up stakeholder board: School Health Promotion Board, Workplace Health Promotion Board, Urban Planning Board and Enforcement Board and conduct three monthly meetings	30/year			→	→	→	→	→	→	HPA		
1.2.2 Assess the health impact of policies in non-health sectors e.g. agriculture, education, trade, environment, energy, labour, sports, transport, urban planning	1.2.2.1Conduct a socio-economic impact assessment of NCDs in the Maldives (Hire of international consultant for 30 day work)	1											

1.3 Leadership and governance

Desired outcome: MOHG effectively leading and coordinating the national NCD prevention and control programme

Indicators:

- Operational NCD Unit in the MOHG with adequate staff and funds for major NCD activities including primary prevention and health promotion; early detection and treatment; and surveillance and monitoring of NCDs

Actions	Specific activities	Units	#units	Year (2014-2020)							Agencies	Budget	Budget source
				14	15	16	17	18	19	20			
1.3.1 Set up and/or strengthen a national unit for NCDs in the health ministry with suitable expertise and resources for needs assessment, strategic planning, policy development, multisectoral coordination, programme implementation, and evaluation	1.3.1.1 Recruit a program manager for NCDs to coordinate and implement the multisectoral national NCD Action Plan										HPA/HRD		
	1.3.1.2 Recruit a professional BCC specialist to guide the NCD campaigns for the multisectoral NCD Action Plan										HPA/HRD		
	1.3.1.3 Review the roles of the NCD Unit and redefine the organizational functions to align with the implementation of the multisectoral NCD prevention										HPA/HRD/PIH		
	1.3.1.4Create a NCD surveillance unit within the Surveillance/Epi and public health preparedness division Unit. Refer to 4.1.2.										HPA/HRD/ PIH/HIS		
1.3.2 Implement national multisectoral policies and the action plan through collaborative partnerships with multi-stakeholders, including government agencies, NGOs, civil society, academia, and the private sector	1.3.2.1Develop **management and coordination** protocol for key stakeholders involved in NCD Action Plan and seek endorsement of the High Level National NCD Taskforce										HPA		
	1.3.2.2Conduct an annual two hour orientation program of stakeholder focal points on **management and coordination protocol**										HPA		
1.3.3 Strengthen skills and capacity of	1.3.3.1 Develop a three hour NCD Advocacy Communication Tool containing leadership, communications and NCD										HPA		

workforce for implementing the national action plan and to deal with the complexity of issues relating to NCDs including multisectoral action, advertising, behavioural change, health economics, food and agricultural systems, law, business management, trade, commercial influence and urban planning, and education, among others	complexities												
	1.3.3.2Conduct training of key focal points from stakeholders and Atoll on NCD Advocacy Communication Tool										HPA		
	1.3.3.3 Train healthy city urban planners										MOHI		
	1.3.3.6 Train media communications and development personnel										HPA		
	1.3.3.7 Training of media personnel on health reporters										HPA		
	1.2.3.9 Train sea physical activity instructors and divers										MYS		
	1.2.3.10 Train physical activity trainers					→	→	→	→	→	NGO		

Strategic action area 2: Health promotion and risk reduction

2.1 Reduce tobacco use

Desired outcome: Tobacco use reduced

Indicators:

- Adoption of comprehensive national policies and legislations to reduce tobacco use
- Age-standardized prevalence of current tobacco use among persons aged 18 years and older
- Prevalence of current tobacco use among adolescents

Actions	Specific activities	Units	#units	Year (2014-2020)							Agencies	Budget	Budget source
				14	15	16	17	18	19	20			
2.1.1 Accelerate full implementation of the WHO FCTC	2.1.1.1 Convene tobacco control board meetings regularly (every two months at the minimum for 15 members)			■	→	→	→	→	→	→	HPA		
	2.1.1.2 Participate in international policy dialogues related to tobacco control (3 meetings/year for 2 people)			■	→	→	→	→	→	→	MOHG/MED/ Revenue/Police		
2.1.2 Strengthen tobacco surveillance system to monitor tobacco use and prevention Policies	2.1.2.1Develop compliance check program such as decoy shopping to assess compliance to tobacco policies such as sales below 18 years and observation of smoke free zones & conduct 2 yearly assessment (10 shoppers and 2 experts evaluators for 10 days annually)				■		■		■		HPA*/Police		
	2.1.2.2Hire an international consultant to develop the compliance check protocol and program for the first compliance check (21 days)				■						HPA		
	2.1.2.3. Revise guidelines for food inspectors of HPA to conduct tobacco inspections in restaurants, cafes, hotels and train the food inspectors	Regular		■							HPA/MFDA		
	2.1.2.4 Conduct quality check and coordination meetings between food inspectors, and City Council members and police (minimum 2 meetings/ year for 10 inspectors)			■	→	→	→	→	→	→	MFDA*/HPA/Police		
2.1.3 Assess the prevalence of habitual use of carcinogenic substances (betel nut chewing, pan masala, gutka, etc.) and develop effective regulations for its prevention and control	2.1.3.1 Adapt STEPs survey questionnaire and include habitual use of carcinogenic substances in next STEP surveys												
	2.1.3.2 Raise awareness on cancer risks of betel nut chewing, pan masala, gutka by including in health promotion campaign				■	→	→	→	→	→	HPA		
	2.1.3.3 Advocate for banning of food preparations and packages containing carcinogenic substances by raising issues in public forums (3 advocacies /year)				■	→	→	→	→	→	HPA/MED		

2.1.4 Raise taxes and inflation-adjusted prices on tobacco products (in line with WHO FCTC Article 6)	2.1.4.1 Review and revise the current taxation for a progressive tax regime (3 meetings for 10 members)										HPA/MED/ MIRA/ FINANCE/CUSTOMS		
	2.1.4.2 Train officials in the key agencies such as Trade, Economics, Finance and Health on taxation and economics of tobacco (4 day meeting for 5 members)				→	→	→	→	→	→	MOHG/ MED/ MIRA/ Finance/Customs		
2.1.5 Implement 100% tobacco free environments in line with the Chapter 1, Tobacco Control Law and in line with WHO FCTC Article 8)	2.1.5.1 Notify smoke free zones of the legal requirements to observe smoke free zones along with the violation penalties in Male and Addu cities (20 workers for 5 days)										HPA*/Police		
	2.1.5.2 Modify the signs for greater visibility and include a pictorial health warning (1 day meeting for 5 members)										HPA		
2.1.6 Warn people about the dangers of tobacco, including through hardhitting mass-media campaigns and large, clear, visible and legible text and pictorial health warnings (in line with WHO Articles 11, 12)	2.1.6.1.Introduce a branded campaign on dangers of tobacco, deglamorizing and empowering for the avoidance of tobacco on social media (eg, face book, tweeter), TV, radio and public service (total air time of 4 months.year)										HPA		
	2.1.6.2 Develop and air/disseminate short video clips, radio messages and print messages (total air time of 4 months/year					→	→	→	→	→	HPA		
	2.1.6.3 Erect visible billboards or digital screens in key locations highlighting dangers of tobacco use and tobacco rules in all key islands (total of 7 in Male and Addu cities)				→	→	→	→	→	→	HH	HPA	
	2.1.6.3 Integrate health risks of tobacco and raising urgency of health problem of tobacco use deglamorizing and empowering for the avoidance of tobacco in school education and curriculum and integrate NCD prevention into life skill training for youth..				→	→	→	→	→	→			
2.1.7 Implement rules comprehensive bans on tobacco advertising, promotion and sponsorship as per the Chapter 4 of the Tobacco Control Law and in line with WHO Article 13)	2.1.7.1Monitor tobacco advertisements, promotion and sponsorship by inspection teams	No cost			→	→	→	→	→	→	HPA		
2.1.8 Offer help to people who want to stop using tobacco (in line with WHO FCTC Article 14)	2.1.8.1Set 25 tobacco cessation clinics and majority based in tertiary, regional and Atoll hospitals with two additional cessation clinics in Male					→	→	→	→	→	IGMH*/HSD		
	2.1.8.2 Develop tobacco cessation counseling guidelines and standards										IGMH*/HSD		

	2.1.8.3.Train 50 tobacco cessation counselors (Four day trainin)					→					IGMH*/HSD		
	2.1.8.4 Procurement of furniture and basic equipments to set up cessation clinics (chair, tables , Air conditioner, computer and other office accessories)					→					HSD/HPA		
	2.1.8.5 Set up one 24 hour Quitline to provide support and assistance and directions to cessation services in the country (Telephone bills and line connection)										HPA		
	2.1.8.6 Recruit 5 full time trained counselors for the Quitline	Pay									HPA		
2.1.9 Protect tobacco control policies from commercial and other vested interests of the tobacco industry in accordance with national law (in line with WHO FCTC Article 5	2.1.9.1Adopt guidelines on FCTC 5.3 and accelerate implementation to monitor tobacco packaging and pictorial requirements and disclosures on content for tobacco products										HPA		
2.1.10 Regulate the contents and emissions of tobacco products, tobacco product disclosures and the methods by which they are tested and measured (line with WHO FCTC Articles 9 and 10	2.1.10.1 Establish collaboration for product testing of tobacco with WHO collaborating laboratories in the region (Protocol development and discussions for 5 members for 2 days)										HPA		
	2.1.10.2 Train staff for handling the samples for shipment and transportation (5 members for 3 days)										HPA		
2.1.11 Take measures to eliminate the illicit trade of tobacco products, including smuggling, illicit manufacturing and counterfeiting (in line with WHO FCTC Article 15)	2.1.11.1 Ratify FCTC protocol on elimination of illicit trade of tobacco products (15 members for 1 day)										HPA		
	2.1.11.2 Review and revise existing legislation where necessary to comply requirement of protocol on illicit trade of tobacco (10 members for 1 day)										HPA/MED		
2.1.12 Enforce prohibition of sale of tobacco products to, and by, minors in line with the Chapter 2 of the Tobacco Control Law and in line with the WHO FCTC Article 16	2.1.12.1. Regulate visible display of signs prohibiting sale of tobacco products below 18 years in tobacco sale points (shops, hotels, restaurants and café)										MED		
	2.1.12.2 Institute 2 yearly compliance check by sending underage looking clients to attempt purchase (Hire 10 underage looking shoppers for 5 days)										HPA		
	2.1.12.3 Assess existing legislative framework and amend										HPA		

	to meet the recommendations of Article 19 of FCTC												
2.1.13 Monitoring and Evaluation	2.1.13.1 Generate an annual national report of tobacco control board on progress tobacco control	Print Copies				→							
	2.1.13.2 Prepare biannual report on FCTC for international reporting	Print copies									HPA		
2.1.14 Strengthen enforcement for tobacco	2.1.14.1 Create a special enforcement unit dedicated to drugs, tobacco and alcohol in the police with adequate staff for field enforcement										Police*/HPA/MDFA		
	2.1.14.2 Institute a joint inspection committee for police and HPA with clear terms of reference of coordination between Police and HPA (3 monthly meeting for 10 members)										HPA*/Police/MFDA		
	2.1.14.3 Visit by 10 senior police officer and 15 junior officers at best practice sites in the region for enforcement of tobacco (7 days training)	25				→					Police*/HPA		
	2.1.14.4 Trainers trained on special enforcement ay the ISLE for innovative enforcement for tobacco and other health regulations (15 trainers for 3 days)					→					Police*/HPA		
	2.1.14.5 Training of special enforcement agents including HPA staff at the ISLE (30 inspectors for 2 days)										HPA		
	2.1.14.5 Prepare a forseeable joint as well as independent enforcement annual workplans for Police, HPA for monitoring of tobacco and alcohol rules (7 members for 1 day)					→					HPA		
	2.1.14.6 Conduct inspection visits as per the work plan					→					HPA		
	2.1.14.7 Prepare inspection reports and share it with the tobacco control board and NCD Unit on a three monthly basis					→					HPA		
	2.1.14.8 Raise penalty for violation of smoking rules from Rf 500 to a significant amount to make it adequately deterrent for violators					→					Tobacco control board*/HPA		
	2.1.14.9 Develop mechanism to for fine collection so that all penalties are collected in a systematic and transparent manner in consultation with the legal expertise of the Attorney General (2 one-day meetings for 10 members)					→					HPA*/Police/Revenue		
	2.1.14.10 Set up CCTVs in key public places to monitor violations for smoking in Male and Addu City (15 CCTVs)					→					Police		

2.2 Reduce harmful use of alcohol

Desired outcome: Harmful use of alcohol reduced

Indicators:

- Adoption of components of Global Strategy to Reduce the Harmful Use of Alcohol in the Maldivian context
- Integration of alcohol detoxification services along with substance abuse prevention programmes

Actions	Specific activities	Units	# Units	Year (2014-2020)							Agencies	Budget	Budget source
				14	15	16	17	18	19	20			
2.2.1 Accelerate implementation of the Global Strategy to Reduce the Harmful Use of Alcohol	2.2.1.1 Hold national consultations to discuss the need for adoption relevant components of the Global Strategy to Reduce the Harmful Use of Alcohol in the Maldivian context to address use of alcohol (15 members for 1 day)										HPA* Police		
	2.2.1.2 Implement selected provisions of Global Strategy to Reduce the Harmful Use of Alcohol and raise public awareness on the harmful effects of alcohol					→	→	→	→	→	HPA* Transport Ministry		
2.2.2 Strengthen health services to provide prevention and treatment intervention to individuals affected by, alcohol-use disorders and associated conditions	2.2.3.1 Provide detoxification services at hospitals for those in acute alcohol withdrawal stage						→	→	→	→	Hospitals*		
	2.2.3.2 Introduce brief intervention for counseling for alcohol users						→	→	→	→	HPA*		
	2.2.3.3 Conduct awareness program for youths and potential user groups on effects of alcohol abuse						→	→	→	→	HPA* MOE*		
2.2.3 Restrict or ban alcohol advertising and promotions	2.2.4.1 Assess prevalence of indirect advertisement of alcohol and alcohol like products in the Maldivian					→	→	→	→		HPA*		

	market(Hire 1 national consultant for 15 days and 5 research assistants for 7 days)												
	2.2.4.2.Take countermeasures to stop indirect advertisement by food and beverage companies					→	→	→	→		HPA*		
2.2.5 Implement effective drink-driving policies and measures	2.2.5.1 HPA coordinate with police and review forms to capture drink-driving information (2 meetings/year for 5 members)				→	→	→	→	→		Police* HPA		
	2.2.5.2 Publish an annual report on drink-driving in the Maldives	Print copies			→	→	→	→	→		HPA* Police		

2.3Promote healthy diet high in fruits and vegetables and low in saturated fats/trans fats, free sugars and salt

Desired outcome:

- Increased intake of fruits and vegetables
- Reduced consumption of saturated fats/ trans fats, sugar and salt
- Reduced cardio metabolic risk

Indicators:

- Adoption of national policies to reduce the impact on children of marketing of foods and non-alcoholic beverages high in saturated fats, transfatty acids, free sugars or salt
- Adoption of national policies that limit saturated fatty acids and virtually eliminate partially hydrogenated vegetable oils in the food supply

Actions	**Specific activities**	**Units**	**#units**	**Year (2014-2020)**							**Agencies**	**Budget**	**Budget source**
				14	**15**	**16**	**17**	**18**	**19**	**20**			
2.3.1 Accelerate implementation of the Global Strategy on Diet, Physical Activity and Health	2.3.1.1Develop food based dietary guidelines for all age groups including children										HPA (Nutrition)		
	2.3.1.2Recruit an international expert to develop food based guideline (1 consultant for 3 weeks)										HPA		
2.3.2 Implement WHO's set of recommendations on the marketing of foods and non-alcoholic to children, including mechanisms for monitoring	2.3.2.1Develop a national guideline to monitor marketing of foods and non-alcoholic beverages to children (2016-2017) (5 members for 2 days workshop)										HPA		
	2.3.2.2 Regulate and monitor energy drinks and beverages high in sugar and caffeine on mandate health warnings (2 meetings for 10 members)						→	→	→	→	HPA*/Trade/ MFDA		
2.3.3 Develop policy measures and	2.3.3.1 Review accessibility , affordability and										MOA*/MED/		

guidelines in collaboration with various stakeholders such as food producers, processors, retailers and consumers to promote affordability, availability and acceptability of healthier food products including for vulnerable groups	accessibility to healthier food options and choices and propose measures to improve Conduct six monthly stakeholder meetings and take measures to make policy improvement through one stakeholders meeting (15 members for 1 day)										Revenue		
	2.3.3.2 Form an expert committee to review accessibility , affordability and accessibility and make policy recommendations to the government (7 member national experts for 1 month)										MOA*/MED/ Revenue		
2.3.4 Establish regulations and fiscal policies including taxes and subsidies to promote consumption of fruits and vegetables, whole grains and discourage consumption of unhealthy food options high in saturated fat, transfat, sugar and salt	2.3.4.1 Develop a fiscal policy mechanism to promote promote consumption of fruits and vegetables, whole grains, and discourage consumption of unhealthy food options high in saturated fat, transfat, sugar and salt through the National Food and Nutrition Council (2015-2016)										MOA*/MED/ Revenue		
2.3.5 Carry out public campaigns through mass media and social media to inform consumers about a healthy diet high in fruits and vegetables, whole grains, low in saturated fat, transfat, sugar and salt	2.3.5.1Develop a mass media campaign for healthy diet for all age groups including disease specific needs and young children										HPA		
	2.3.5.2Develop the campaign materials (TV clips, radio jingles, print materials)										HPA		
	2.3.5.3Erect electronic and regular billboards promoting healthy diet in right locations (parks, congregated places and schools)										HPA		
2.3.6 Promote and support exclusive breastfeeding for the first six months of life, continued breast feeding until two years and beyond and timely introduction of complementary feeding	2.3.6.1Advocate existing infant and young child feeding guidelines through health facilities and media				→	→	→	→	→	→	HPA		
	2.3.6.2Create a stakeholder including politicians forum to develop a policy for maternity leave for 6 months and promote exclusive breast feeding for working mothers both in private and public sector				→	→					HPA		
	2.3.6.3Expand training of mother support groups to promote breast feeding minimum two groups per year with 30 mothers in each group					→	→	→	→	→	HPA		
	2.3.6.4 Training of health workers on breast feeding promotion (50 HW each year for 2 years)					→					HPA		
2.3.7 Promote nutrition labelling, according but not limited to, international standards, in particular the Codex Alimentarius,	2.3.7.1 Accelerate enactment of Food Act and implement the provisions										MFDA		
	2.3.7.2 Develop and enforce protocols for minimum residuals limits (MRLs) for pesticides, chemicals,										MFDA/MOA		

for all pre-packaged foods including those for which nutrition or health claims are made	metallic contents and food additives for domestic and imported products and institute a strong codex standards (MFDA) including food labeling of trans fat and saturated fatty acids				■								
	2.3.7.3 Conduct total diet study and define MRLs (15 research assistants + 1 international consultant for 30 days)							■			HPA*/MFDA*		
	2.3.7.4 Develop food labeling regulations including declaration on content of trans fat and hydrogenated vegetable oil				■						MFDA*/HPA/ MED/ Maldives Customs		
2.3.8 Strengthen capacity of national institutions for testing and monitoring the content of saturated fat, transfat, salt and sugar in processed food	2.3.8.1 Train inspectors to conduct MRLs monitoring program (15 inspectors for 10 days)				■	→	→	→	→		MFDA*/MOA		
	2.3.8.2 Improve lab services to conduct MRLs and food quality test				■						MFDA		
	2.3.8.2 Train inspectors to monitor content and label including saturated fat, transfat, salt, sugar in all imported and domestically produced food					■	→	→	→		MFDA*/HPA		
2.3.9 Develop and implement national salt reduction strategies in line with WHO Recommendations	2.3.9.1 Develop national salt intake guidelines					■					HPA		
	2.3.9.2 Conduct regular salt iodization test			■							MFDA		
2.3.10 Regulate private industry to voluntarily reduce salt in packaged food and monitor compliance	Conduct advocacy to reduce salt content in food in hospitality service industry					■	→	→	→		HPA		
2.3.11 Undertake representative surveys to measure population salt/sodium intake	2.3.11.1 Conduct 24 hour salt intake or 24 hour salt urinary excretion survey as a pilot study in Male				■						PHS/HPA		
2.3 12 Establish policies and regulations to eliminate partially hydrogenated vegetable oils (PHVO) in the food supply and limit saturated fatty acids and monitor compliance of private sector with the regulations	2.3.12.1Legislate elimination of partially hydrogenated vegetable oils (PHVO) in the food supply and limit saturated fatty acids							■			HPA/MED		
	2.3.12.2Introduce monitoring compliance of private sector with the regulations								■	→	HPA/MED		
2.3.12 Replace saturated fat and trans-fat with unsaturated fat	2.3.12.1Prepare advocacy briefs and disseminate on replacement of saturated fat and trans-fat with unsaturated fat using media and public education				■	→	→	→	→		HPA		

2.4 Promote physical activity

Desired outcome: Desired outcome: Physical inactivity reduced

Indicators:

- Prevalence of insufficiently active persons aged 18 years and older
- Prevalence of insufficiently active adolescents (defined as less than 60 minutes of moderate to vigorous intensity activity daily)
- Age-standardized prevalence of overweight and obesity in adolescents (defined according to the WHO growth reference as: *overweight* – one standard deviation body mass index for age and sex; and *obese* – two standard deviations body mass index for age and sex)

Actions	Specific activities	Units	#units	Year (2014-2020)							Agencies	Budget	Budget source
				14	15	16	17	18	19	20			
2.4.1 Adopt and implement national guidelines on physical activity for health	2.4.1.1.Develop national physical activity guideline including for age groups and for land, sea and indoor activities (5 member national team for 14 days)										HPA		
	2.4.1.2Meeting of technical experts to develop the national physical activity guidelines										HPA		
2.4.2 Develop policy measures and guidelines in conjunction with relevant sectors and stakeholders to promote physical activity through activities of daily living including through "active transport", recreation, leisure and sports.	2.4.2.1Promote and adopt selected destinations and islands as public places for picnic spots, weekend visit spots to promote healthy lifestyle										NGOs/CBOs		
	2.4.2.2 Review vehicle import policy laws and take measures to reduce import policies through increase import tax										Transport*/ MOHI		
	2.4.2.3 Promote swimming as a healthy living and life skill for Maldivians and maintain cleaner public swimming pools					→	→	→	→	→	City Council*/MYS		
	2.4.2.4 Review school physical activity policies and implement measures to promote physical activity for students of all age groups					→	→	→	→	→	MOE		
	2.4.2.5 Develop workplace physical activity guidelines										HPA		
	2.4.2.6 Conduct advocacy meetings of heads of the identified work places and school principals and implement physical activity guidelines					→	→	→	→	→	MOE		
2.4.3 Advocate to town planners for designing increased public	2.4.3.1 Appoint a representative of health promotion division of the MOHG and a relevant representative of the MOE in the					→	→	→	→	→	MUID*/HPA		

spaces supportive of physical activity	urban planning board												
	2.4.3.2 Organize regular health briefs related to NCDs to urban planners and City Council					→	→	→	→	→	HPA*/ City Council/MOHI		
	2.4.3.3 Review national urban planning policy to integrate and highlight key health promoting indicators in the urban planning laws/policies										MOHI/City Council		
	2.4.3.4Brand special zones in Male City and other islands for treks and physical activity and conduct public advocacy to promote these zones										City Council*/ MOHI		
2.4.4 Establish legislation to ensure new housing developments include safe spaces for walking and cycling and swimming	2.4.4.1 Review code of housing designs/policies to assess whether safe spaces for walking and cycling are addressed										MOHI/City council		
	2.4.4.2 Develop and enforce guidelines and safety standards for urban construction sites, mechanical work, cement warehouses and automobile workshops and any business sites which cause public hazards					→	→	→	→	→	MOHI/City Council		
	2.4.4.3 Designate vehicle free zones to promote walkability and physical activity within the inner parts of Male city and near schools through a joint approach of Male City Council and Ministry of Transport and Ministry of Urban Planning and Infrastructure					→	→	→	→	→	City Council*/ Transport Ministry/MOHI		
	2.4.4.4 Promote greater use of bicycle to substitute motor bikes and cars within the inner city of Male										City Council*/ Transport Ministry*/ MOHI*		
	2.4.4.5.Develop standards and regulations to improve pedestrian space and pedestrian zones in Male										City Council/ Transport Ministry/MOHI		
	2.4.4.6 Develop appropriate washroom facilities near public beaches and swimming areas in major islands to attract more people for increasing physical activity in water						→	→	→	→	Local councils/ City Councils/ Atoll Councils		
2.4.5.Carry out mass-media campaigns and social marketing to raise awareness on benefits of physical activity throughout the life cycle	2.4.5.1Design a physical activity national campaign strategy focusing on all age groups and all settings including workplace and schools					→	→	→	→	→	HPA		
	2.4.5.2Conduct door to door campaign by integrating in the home visit programs of primary care health workers					→	→	→	→	→	HPA		
	2.4.5.3Development of campaign materials (clips, fliers, posters, leaflets, billboards), video clips and radio messages										HPA		
	2.4.5.4 Create open public physical activity grounds with professional instructors for males and females , two in Male City and expand to other major islands					→	→				Male City Council/MOHI		

	2.4.5.4 Promote indoor physical activity centers in Male and other major towns				→						MYS/ Private enterprises		

2.4 Promote healthy behaviours and reduce NCDs in key settings

Desired outcome: Reduced risk of NCDs among school children/students at educational institutes, and workforce

Indicators:

- National guidelines for health promoting schools/students at educational institutes developed and adopted
- National guidelines for workplace wellness programmes developed and adopted

Actions	**Specific activities**	**Units**	**#units**	**Year (2014-2020)**							**Agencies**	**Budget**	**Budget source**
				14	**15**	**16**	**17**	**18**	**19**	**20**			
2.5.1 Enable and facilitate intersectoral action in schools and workplaces through establishment of intersectoral working groups, task teams or focal persons in charge of developing and coordinating health promoting activities	2.5.1.1 Institute School Health promotion board for schools / integrate within the existing functions of School Health Coordinating Committee										MOE		
	2.5.1.2 Integrate healthy lifestyle promotion (physical activity, diet, avoidance of tobacco use and drugs in school standards and develop school nutrition and activity framework										MOE		
	2.5.1.3 Pilot work place health promotion in Male and Addu City, Institute Workplace Health Promotion Board										HPA/ Stakeholders		
	2.5.1.4 Train Atoll council members on tobacco and health promotion advocacy (five councils per year) to support regulations to tobacco and other healthy lifestyle initiatives	LGA									HPA		
	2.5.1.5 Provide small grants to Atoll Council members to integrate tobacco control initiatives, second hand smoke and healthy lifestyles in their community activities						→				MOF		
2.5.2 Appoint and train focal persons or other appropriate coordination mechanisms between Ministry of Health and	2.5.2.1 Undertake MoU between MOE and MOHG and Gender Department as an interim measure to support visit of public health workers to schools in islands to conduct health sessions including healthy lifestyle for teachers and students										MOE*/ MOHG		
	2.5.2.2 Develop a guide/module for health workers and school										HPA/MOE		

Ministry of Education to promote effective interventions in schools and pre-schools	teachers to advocate healthy lifestyle education in school for all grades including young children												
	2.5.2.3Develop and implement awareness and behavior change sessions for children, parents and training programmes for teachers										MOE		
	2.5.2.4 Mainstream health and healthy lifestyle in the education curriculum for all grades including young children										MOE		
	2.5.2.5 Integrate healthy lifestyle in the pre-service teacher training curriculum by the University of Maldives										UOM/MOE		
	2.5.2.6 Collaborate with in-service training program at the NIE to introduce healthy lifestyles education										MOE*/NIE		
	2.5.2.7 Training of school health coordinators and school health officers on healthy lifestyle										MOE/MOHG		
	2.5.2.8 Review physical education and healthy lifestyle classes and integrate healthy lifestyles for children in higher grades VII and above										MOE		
	2.5.2.9 Explore collaboration of FHS to train health workers on school education for certain period										MOE		
2.5.3 Establish health promoting schools with guidelines for implementation and mechanisms for monitoring and evaluation	2.5 3.1 Implement school health policies catering to all health needs including healthy lifestyle promotion in schools										MOE		
2.5.4 Conduct advocacy and training workshops to promote healthy behaviours in schools and workplaces	2.5.4.1 Organize exposure visits for school 15- 25 principals from private and public to learn health in schools in the region										MOE		
	2.5.4.2 Train school principals from private and public to implement healthy lifestyle promotion in school environments for children of all age groups										MOE		
2.5.5 Establish health promoting workplaces with guidelines for implementation and mechanisms for monitoring and evaluation	2.5.5.1Advocate work place health promotion pilot initiatives in MOHG, Civil Service Institute, Bank of Maldives, STO, Dhiraagu and Ooreedoo										HPA/ Stakeholders		
	2.5.5.2 Evaluate the workplace health promotion initiatives and scale up if found effective										HPA		
	2.5.5.3 Develop guideline to monitor progress of school health including healthy lifestyle policies in school system												
	2.5.5.4Generate annual report on school health including process indicators for coverage of school health program including healthy lifestyle promotion & report to High Level NCD										MOE		

	Taskforce												
2.5.6 Ban foods high in saturated fat, sugar and salt from school premises and workplace catering facilities	2.5.6Monitor school canteen for food products and integrate the indicator in the annual MOE report				→	→	→	→	→	→	MOE		

2.6 Reduce household air pollution

Desired outcome: Household air pollution due to passive smoking

Indicators: Reduction in proportion of households exposed second hand smoking

Actions	Specific activities	Units	#units	Year (2014-2020)							Agencies	Budget	Budget source
				14	15	16	17	18	19	20			
2.6.1 Create awareness and develop appropriate strategies to reduce exposure to second-hand tobacco smoke in households	2.6.1.1Prepare health risks of second hand smoke through indoor smoking and introduce an anti-second hand smoke campaign using mass media					→	→	→	→	→	ARC*/HPA		
	2.6.1.2 Employ information dissemination on dangers of smoking by distributing leaflets and fliers to households during primary health care workers household visits					→	→	→	→	→	HPA*/ARC*		
	2.6.1.3 Disseminate information leaflets advocating dangers of indoor smoking of homes through pest control visits in Male and other Cities					→	→	→	→	→	City Council		
	2.6.1.4 Create a smoke free household registry at health posts/centers where household member/s voluntarily stopped indoor smoking for the past 30 days and is verified during home visits and registered **as smoke free household in all Atolls**					→	→	→	→	→	HPA*/ARC*		
	2.6.1.5 Advocate primary health workers and tobacco cessation clinics on **smoke free household program and circulate a guideline for criteria of smoke free homes**					→	→	→	→	→	HPA*/ARC*		

2.6.2 Monitor household air pollution	2.6.2.1 Create a routine monitoring statistics board to monitor Atoll statistics of smoke free homes										HPA*/PHS*/ ARC*		

Strategic action area 3: Health system strengthening for early detection and management of NCDs and their risk factors

3.1 Access to health services

Desired outcome: Universal health coverage and equitable access to prevention, early detection and treatment of NCDs

Indicators:

- Availability and affordability of quality, safe and efficacious essential NCD medicines, including generics, and basic technologies in both public and private facilities
- Access to palliative care assessed by morphine-equivalent consumption of strong opioid analgesics (excluding methadone) per death from cancer
- Availability of HPV vaccines according to national programmes and policies
- Proportion of eligible persons receiving drug therapy and counseling for diabetes and prevention of diabetic complications
- Proportion of eligible persons receiving drug therapy and counselling to prevent heart attacks, strokes and chronic respiratory diseases
- Proportion of women aged 30–49 years screened for cervical cancer at least once, or more often
- Proportion of "at risk" population screened for oral cancer at least once or at regular intervals

Actions	Specific activities	Units	#units	Year (2014-2020)							Agencies	Budget	Budget source
				14	15	16	17	18	19	20			
3.1.1 Integrate and scale-up cost-effective NCD interventions, based on national policies and priorities, into the basicprimary health care package with referral system to all levels of care in order to advance the universal health coverage agenda from two Atolls to 19 Atolls	3.1.1.1 Adapt PEN protocols to Maldivian context and finalize list of essential drugs and technology at various levels					→					HSD*/HPA		
	3.1.1.2 Training of health center staff including medical officer on PEN interventions (500 staff)										HSD*/HPA		
	3.1.1.3 Training of hospital NCD team including doctors, nurses and public health officer in 19 hospitals, five regional hospitals, one tertiary hospital (IGMH) and two private hospitals (Each team has 5 people)						→				HSD*/HPA/ DSM		
	3.1.1.4 Introduce a weekly NCD clinic in regional and Atoll hospitals to provide diabetic services						→				HSD*/HPA Hospitals/ DSM		
	3.1.1.5 Appoint national doctors as the focal points for NCDs										HSD		

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	for sustaining the action plan												
	3.1.1.6 Train new doctors, nurses and NCD counselors on PEN and patient information records						→	→	→	→	HSD*/HPA		
3.1.2 Establish quality assurance and quality improvement systems with emphasis on primary health care	3.1.2.1 Conduct **three yearly** clinical audits on NCD management in all levels of care to assess fidelity to NCD protocols										HSD		
	3.1.2.2 Review integration of NSPA initiatives with the PEN intervention to avoid duplication for NCD care and management										HPA*/NSPA /HSD		
3.1.3 Strengthen referral systems for management of NCDs	3.1.3.1Develop a referral policy for NCD patients from lower level to higher levels of health facility and implement the referral policy						→	→	→	→	HSD*/HPA/ Hospitals		
	3.1.3.2Sign a MoU with the government with the referral centers for cancer treatment and other NCDS in the third country clearly specifying policies and procedures						→	→	→	→	HSD*/IGMH		
	3.1.3.3Upgrade the services for tertiary care by introducing National Diabetic and Metabolic Center at the IGMH										IGMH		
3.1.4 Improve efficiency in the procurement, supply management and access to essential NCD medicines and technologies including through the full use of trade-related aspects of intellectual property rights (TRIPS) flexibilities	3.1.4.1Undertake a memorandum of understanding with Asanda, pharmacies and the MOHG to ensure continued supply and availability of uninterrupted stock of NCD drugs										HSD		
	3.1.4.2Conduct stock monitoring of NCD drugs in pharmacies on an annual basis and report stock outs and take corrective measures to improve supply of NCD drugs and technologies						→	→	→	→	HSD		
3.1.5 Ensure the availability of life-saving technologies and essential medicines for managing NCDs in the initial phase of emergency response	3.1.5.1Explore policy to provide subsidy to manage government pharmacy in health centers OR improve supply management by requiring Asanda pay pharmacies on time to ensure regular stocking of essential NCD and other drugs												
3.1.6 Develop and implement a palliative care policy using cost-effective treatment modalities, including opioid analgesics for pain relief	3.1.6.1 Develop a policy for palliative care guidelines for cancers, COPD, CVD and diabetes including opiod analgesics for pain relief of terminal cancer care										IGMH*/ ADK/ HSD		
	3.1.6.2 Develop NCD education module and integrate NCD education in the home visit program of health workers										DHS*/HPA		
3.1.7 Improve coverage of hepatitis B vaccination	3.1.7.1 Introduce hepatitis B vaccination for adult high risk adult groups including health workforce						→	→	→	→	HPA		
3.1.8 Strengthen education and awareness on early detection of	3.1.8.1 Mass media communication on cancer signs and early care seeking and prepare leaflets for cancer education										HSD/HPA IGMH		

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common cancers including breast cancer, cervical cancer and oral cancer													
3.1.9 Strengthen basic facilities of primary health care facilities for prevention and early diagnosis of cervical cancer and oral cancer	3.1.9.1Develop oral health promotion and oral cancer screening protocol for primary care health workers												
	3.1.9.2Train primary care workers on oral cancer screening and promotion of oral hygiene										HSD/HPA		
	3.1.9.3Expand VIA screening program for cervical cancer to six regional hospitals and tertiary hospital					→	→	→	→	→	HPA/HSD		
	3.1.9.4Expand the cervical screening camps to Atolls using the existing protocol					→	→	→	→	→	HPA/HSD		
	3.1.9.5Procurement of equipments for establishments cervical screening camps (mobile colposcopy)					→	→	→	→	→	HPA/HSD		
	3.1.9.5Advocacy and awareness for cervical cancer screening by providing pamphlets at the ANC setting				→	→	→	→	→	→	HPA		
	3.1.9.6Integrate breast cancer screening in awareness program										HSD		
	3.1.9.7 HPV vaccines to be made optional vaccine up to Atoll level (2015)					→	→	→	→	→	HSD		
3.1.10 Review existing programmes and integrate service delivery for prevention and control of NCDs	3.1.10.1 Organize joint health sector NCD review meetings with nutrition, HIV, tuberculosis, reproductive health, Private Hospital, MFDA, IGMH, Faculty of Training and PPD on a six monthly basis to discuss progress and issues				→	→	→	→	→	→	HPA*/HSD		
	3.1.10.2 Identify list of integrated steps to be taken in each sectors after the review and follow through				→	→	→	→	→	→	HPA/ Sectors		
	3.1.10.3 RH develop pregnancy education package to educate physical activity and diet promotion in pregnancy and integrate in routine RH counseling programs					→	→	→	→	→	HPA		
	3.1.10.4 Hepatitis B vaccination for high risk adults					→	→	→	→	→	HSD		
	3.1.10.5 Integrate healthy lifestyle counseling in Mental health program										CDD/*HPA		
	3.1.10.6 HIV/AIDS and TB program for patient education on healthy lifestyles				→	→	→	→	→	→	HPA		

3.2 Health workforce

Desired outcome: Improved competence of health workforce for prevention, early diagnosis and management of NCDs
Indicators: Percentage of primary health care workers trained in integrated NCD prevention and control

Multisectoral Action Plan Matrix For Prevention And Control of NCDs in Maldives (2014- 2020)

Actions	Specific activities	Units	#unit	Years							Agencies	Budget	Budget source
				14	15	16	17	18	19	20			
3.2.1 Identify competencies required and invest in improving the knowledge, skills and motivation of the current health workforce to address NCDs, including common co-morbidity conditions	3.2.1.1Develop lifestyles, NCD and health counseling course and integrate in nursing and counseling programs				■						FHS		
	3.2.1.2 Align Primary Health Care workers programs with the PEN interventions to address WHO recommended interventions at the primary care level				■						FHS		
	3.2.1.3 Train faculty on tobacco cessation programs				■								
	3.2.1.4 Integrate tobacco cessation curricular lessons in PHC, nursing and counseling programs					■					FHS/ HPA		
	3.2.1.4Train 2 endocrinologist and 2 oncologists in MD for tertiary hospital					■	→	→	→		IGMH*/ HSD		
3.2.2 Incorporate prevention and control of NCDs in the pre-service and in-service training of all health workers, professional and nonprofessional (technical, vocational), with an emphasis on primary care	3.2.2.1Review content adequacy of healthy lifestyle module and integrate as a core competency for all categories of trainees for personal education						■				FHS		
	3.2.2.2 Identify a set of national faculty trainers for NCDs and PEN intervention from FHS and IGMH to build national capacity for NCD trainings				■						HPA/HSD/ FHS/IGMH		
3.2.3 Develop career tracks for health workers through strengthening postgraduate training, with a special focus on NCDs, in various professional disciplines and career advancement for non-professional staff	3.2.3.1 Negotiate with medical council of Maldives and support clinical fellowship courses for care and treatment of diabetes, CVD, COPD and cancer in the region			■							HSD*/HPA		
	3.2.3.2 Train fellows in diabetes, COPD, CVD and cancer management (10 people)				■	→	→	→	→	→	HSD/IGMH		
	3.2.3.3Develop a trainers module that covers wide aspect NCD risk factors, NCDs and **communication and advocac**y for health workforce					■					HPA		

3.3 Community-based approaches

Desired outcome: Communities/patients empowered for self-care

Indicators: National guidelines on self-care for prevention and management of NCDs developed and adopted

Actions	Specific activities	Units	#units	Year (2014-2020)							Agencies	Budget	Budget source
				14	15	16	17	18	19	20			
3.3.1 Create awareness to empower people to seek care and detection for better management of their conditions	3.3.1.1 Engage people with NCDs as advocates and peer outreach programs in areas of high needs in Male City (20 advocates)					→	→				IGMH/ Urban health center/DSM		
3.3.2 Develop patient education/self-care guidelines for prevention and control of NCDs in consultation with a wide variety of stakeholders	3.3.2.1 Develop patient self-care fliers for diabetes, COPD, Cancers and other chronic diseases and distribute at the health facility during consultation						→	→	→	→	IGMH*/ADK Urban health center/DSM		
	3.3.2.2 Distribute the fliers through pest control workers of the city council and community visits of the primary health care workers and peer outreach workers					→	→	→	→	→	City Councils/ Local Councils		
3.3.3.Encourage the formation of community coalitions and patient groups, and build their capacity	3.3.3.1 Promote diabetic groups and train patients to engage as peer counselors in Male and other islands					→	→				IGMH*/ADK/ DSM		
	3.3.3.2 Integrate healthy lifestyle promotion including prevention of tobacco use in life skill education for outreach programs for youth					→	→	→	→	→	MYS		
	3.3.3.3 Train peer outreach workers to reach school drop outs in congregating venues on tobacco and healthy lifestyle promotion in Male and Adddu City (30 outreach workers)	30									MYS		
	3.3.3.4 Train staff counselors of Drug Treatment and Rehab Center in Himmofushi to integrate healthy lifestyle promotion and tobacco cessation counseling for substance abuser (9 counselors)	9				→	→	→	→	→	NDA		
	3.3.3.5 Train counselors of one Community Service Center, six detox centers, and one methadone clinic to integrate tobacco cessation counseling services (24 counselors)	24				→	→	→	→	→	NDA		

	3.3.3.6 Train core trainers in NDA to train counselors and prevention counselors (5 core trainers)	5				→					NDA		

Strategic action area 4: Surveillance, monitoring and evaluation and research

4.1 Strengthen surveillance

Desired outcome: Improved availability and use of information on NCD mortality, morbidity, risk factors and health system response

Indicators: National risk factors surveys using standard methods conducted every three to five years

Actions	Specific activities	Units	#units	Year (2014-2020)							Agencies	Budget	Budegt source
				14	15	16	17	18	19	20			
4.1.2 Institutionalize NCD surveillance through an appropriate governing mechanism to enhance ownership, sustainability and coordination at country level.	4.1.2.1 Create a NCD surveillance unit within the Surveillance/Epi and public health preparedness division Unit to undertake NCD surveillance and evaluation studies										PHS*/ HPA		
	4.1.2.2 Recruit three full time dedicated staff in the unit	Full time	pay								PHS*/ HRD		
4.1.3 Build national capacity for data management, data analysis and data use for advocacy, as well as for programme planning and monitoring progress in prevention and control of NCDs	4.1.3.1 Train two masters in biostatistician (one for MOHG and one of FHS)	Person year	2								FHS* HPA*		
	4.1.3.2 Train one faculty in masters in epidemiologists for FHS	Person years	1.5								FHS		
	4.1.3.3 Train a data management expert	Person years	1								HPA*/HRD		
4.1.4 Strengthen vital registration and civil registration systems and improve medical cause of death reporting by proactively engaging relevant stakeholders/sectors	4.1.4.1 Conduct a three day workshop to review reporting cause of death and include refine reporting using ICD classification to capture NCDs	Person days	15								Health info*/ PIH		
	4.1.4.2 Orient doctors to report the cause of death through digital orientation program such as screen shot display										Health Info*/ PIH		
4.1.5 Strengthen national cancer registration including population based registries	4.1.5.1 Develop cancer registry in IGMH in collaboration with Cancer Center in Trivandrum , HPA , Asanda and regional hospitals (Travel perdiem for 2 experts 15 days each)	Person days perdiem	30								IGMH*HSD		
	4.1.5.2 Workshop for cancer registry development between Trivandrum And IGMH (5 people for three days)	Person days	15								IGMH* HSD		
	4.1.5.3 Train key people to document cancer registry in IGMH and regional hospitals (10 people for one day)	Person days	10								IGMH		
4.1.6 Strengthen national cancer registration including correct	4.1.6.1 Develop cancer registry for oral cancers in IGMH and ADK through a expert consultation (5 people for 3	Person days	15								IGMH		

diagnosis, encoding and recording of oral cancer	days)												
	4.1.6.2.Train core team for cancer registry and IGMH and ADK (3 people for 2 days)	Person days	6								IGMH		
4.1.7 Integrate surveillance for NCDs into other national health surveys	4.1.7.1 Carry out five yearly STEPS surveys including step 3 and if possible use eSTEPS (27 research assistants and data entry for 35 days)	Person days	945								HPA* PHS		
	4.1.7.2 Carry out five yearly national school health surveys (age 13–17 years) using the global school-based student health survey (GSHS) to collect data on multiple risk factors (e.g. physical activity, tobacco, overweight and obesity, alcohol) (20 research assistants and 1 consultant for 30 days)	Person days	600+30										
	4.1.7.3Conduct small pilot study for salt consumption using 24 hour urinary sample in Male City (1 international consultant 21 days)	Person days	21								PHS*		
	4.1.7.4 Conduct walkability survey in Male City (1 International consultant and 14 research assistants for 30 days)	Person Days	30+420								HPA*/ PHS City Council Urban Planng.		
4.1.9 Disseminate results of surveillance widely to all stakeholders	4.1.7.5 Conduct dissemination workshops for STEPS survey, GSHS among key stakeholders (50 stakeholders , half day)										HPA		
	4.1.9.2.Develop dissemination 2-3 page briefs of STEPS survey and GSHS and circulate to primary health care workers, schools and NGOs and multisectoral agencies involved in NCD interventions	Print copies	5000								HPA		

4.2 Improve monitoring and evaluation

Desired outcome: Timely reporting and use of information to improve NCD programme													
Indicators: National progress report on key national, regional and global indicators and targets published periodically													
Actions	**Specific activities**	**Units**	**#Units**	**Year (2014-2020)**							**Agencies**	**Budget**	**Budget source**
				14	**15**	**16**	**17**	**18**	**19**	**20**			
4.2.1 Develop national targets and indicators based on the global and regional monitoring framework and linked to a national multisectoral policy and action plan	4.2.1.1 Refine the M and E protocol for the NCD action plan to establish process indicators through a national workshop (15 people 1 day)	Person days	15								HPA* Focal persons from stakeholders		
	4.2.1.2 Seek endorsement of M & E protocol from the High Level NCD Taskforce (1 meeting for 10 members)	Sitting fees	10								HPA		
	4.2.1.3 Orientation of focal points from key stakeholder on M & E Protocol		15								HPA		
	4.2.1.4 Conduct six monthly progress review of key process indicators among multi-stakeholders (15 stakeholders)		15			→	→	→	→	→	HPA		
4.2.2.Design and conduct evaluation of NCD interventions periodically	4.2.2.1Conduct mid-term evaluation of NCD action plan in 2017 hiring a external consultant and a team of national experts (1 international consultant and 4 national team for 21 days)	Person Days	21+84								HPA* MOE/MOHI, Police and stakeholders		
	4.2.2.2Publish mid-term evaluation report and disseminate to key stakeholders	Print copies	100								HPA		
	4.2.2.3Conduct and end line evaluation of the NCD action plan in 2020 hiring an external expert and national experts (1 international consultant and 4 national team for 21 days)		21+84								HPA* MOE/MOHI, Police and stakeholders		
	4.2.2.4Publish end line evaluation report and disseminate to key stakeholders	Print copies	100								HPA		
4.2.3 Publish biennium reports	4.2.3.1 Publish two yearly NCD Action plan progress report and submit to WHO, other donors	Print copies	100								HPA		

on progress made in NCD prevention and control including reporting on progress towards national targets and goals	and stakeholders												

4.3 Strengthen research

Desired outcome: Relevant evidence generated and used for national policy and programme development

Indicators: Availability of a national research agenda and a prioritized research plan for prevention and control of NCDs

Activities	Specific activities	Unit	#units	Year (2014-2020)							Agencies	Budget	Budget source
				14	15	16	17	18	19	20			
4.3.1 Develop, implement and monitor a priority national research agenda for prevention and control of NCDs, based on consultation with national experts, WHO and other stakeholders	4.3.1.1 Institute a national team to discuss future research priority for NCD and their risk factors (15 people for 1 day meeting)	Person days	15								*HPA/ *FHS		
	4.3.1.2 Publish additional priorities for future implementation through national workshop	Print copes	20								*HPA/ *FHS		
4.3.2 Strengthen national capacity for research and development	4.3.2.1 Train national research ethics committee on NCD ethical issues (15 people for 2days)	Person days	30								Research Council		
	4.3.2.2 Recruit a trainer (National trainer on ethics)	Person days	5								Research Council		
	4.3.3.1 Training on operational research for HPA from FHS (10 people for 2 days)	Person days	20								HPA		
4.3.4 Strengthen collaboration between national and regional research centres	4.3.3.4.1 Send national researchers to regional research centers to acquire NCD research development skills (10 participants for 5 days each)	Person days	50		→	→	→	→	→		HPA*/ HRD*		