Country Report for the Maldives

Evaluation of South Asia's Current Community Health Worker Policies and System Support and their Readiness for Community Health Workers' Expanding Roles and Responsibilities within Post-Astana National Health Care Strengthening Plans

Date: January 2022

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Commissioned by UNICEF Regional Office for South Asia

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Special thanks to:
The participants in the Maldives who took part in the study, the Maldives Ministry of Health and Health Protection Agency and UNICEF Country Office staff who supported the study.

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Acronyms

ANC	Antenatal Care
AYFHS	Adolescent and Youth Friendly Health Services
BCC	Behaviour Change Communication
CEDAW	Convention on the Elimination of All forms of Discrimination Against Women
CHW	Community Health Worker
CHO	Community Health Officer
CMNH	Centre for Maternal and Newborn Health
CPD	Continuing Professional Development
CPR	Contraceptive Prevalence Rate
CSC	Civil Service Commission
DV	Domestic Violence
FCSC	Family and Children Service Centre
FHW	Family Health Worker
FHO	Family Health Officer
FP	Family Planning
GE	Gender Equality
GBV	Gender-Based Violence
GFPs	Gender Focal Points
GOM	Government of Maldives
HPA	Health Protection Agency
KI	Key Informant
KII	Key Informant Interview
LSTM	Liverpool School of Tropical Medicine
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
MOGFSS	Ministry of Gender, Family and Social Services
MPHF	Maldives Public Health Forum
NCDs	Non-Communicable Diseases
NGO	Non-Governmental Organization
PHC	Primary Health Care

PHCW	Primary Health Care Worker
PNC	Postnatal Care
QI	Quality Improvement
QOC	Quality of Care
RH	Reproductive Health
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
ROSA	Regional Office for South Asia
SAP	Strategic Action Plan
SDG	Sustainable Development Goals
SOP	Scope of Practice
UHC	Universal Health Care
UNEG	United Nations Evaluation Group
WDCs	Women's Development Centres
WHA	World Health Assembly
WHO	World Health Organization

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Executive Summary

Introduction and background

The Astana Declaration of 2018 reaffirmed the importance of Primary Health Care (PHC) in achieving Universal Health Coverage (UHC) and the health-related SDGs. Community Health Workers (CHW) are the backbone of PHC and evidence highlights their effectiveness in delivering a range of preventative, promotive and curative services. In the South Asian context of ongoing demographic and epidemiologic changes, there is an urgent need to enhance the contribution of CHW programmes to PHC strengthening and achieving the post-Astana goals and commitments in the region.

To understand the CHW policies and system support in place to support the effective functioning of CHW programmes, and to determine the key policy adjustments and interventions needed to address any gaps, a formative evaluation was conducted of CHW policies and systems support in South Asian countries. The evaluation also assessed the readiness of CHW programmes for their expanding or changing roles and responsibilities within the post-Astana national health care strengthening plans.

There are two cadres of CHW in the country – the Family Health Worker (FHW, or Family Health Officer) and the Community Health Worker (CHW, or Community Health Officer – CHO). There are three different grades of CHOs: Assistant CHO, CHO and Senior CHO. Both the CHW and FHW cadres are formal salaried government staff, employed by the MoH and fully integrated into civil service structures. CHWs are based in the Public Health Unit of the atoll hospital or island level health centre (HC) and provide a range of public health, preventative and curative services, including reproductive health services. Family Health Workers (FHWs), originally community-based, are now attached to the HC, but continue to conduct home visits and outreach activities.

Objective and intended use of the evaluation

The overall objective of the evaluation is to understand the congruence between the current profiles, policy framework and system support for CHWs, especially those involved in Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) programmes, and the profiles, policy framework and system support required to better serve RMNCAH, and to respond to PHC reform and strengthening in seven South Asia countries, including Maldives.

The findings will inform national government plans and enhance UNICEF's and partner's advocacy and technical guidance to local governments who are instrumental in PHC priority setting, resource mobilization and allocation and the recruitment of the PHC workforce, including CHWs, under national decentralization policies.

The evaluation responds to the following three key evaluation questions (KEQ):

- **KEQ 1:** What are the current profiles, roles and responsibilities, policies and system support in relation to each CHW cadre?
- **KEQ 2:** What policy and system support improvements are needed to realistically optimize the CHW profiles

and roles and responsibilities of CHWs to better serve maternal and newborn health and to respond to the post-Astana or PHC reforms and strengthening.
- **KEQ 3:** What prioritized measures can be taken by government and partners to strengthen health policy and system supports to optimize the contribution that each CHW cadre is able to make to PHC?

Maldives has made significant socio-economic progress over recent decades. Poverty has shown a consistent reduction and the country's overall Human Development ranking increased significantly. The Government of Maldives' (GoM) investment in health reflects its high-level commitment to achieving UHC and the Sustainable Development Goals (SDGs). The public health system is the main health service provider in Maldives, with facilities stratified into primary, secondary and tertiary levels of care. However, Maldives continues to be heavily reliant on expatriate health professionals, and assuring the quality of services delivered continues to be challenging. Although the government is committed to providing PHC services for all its citizens, including preventative care, its policy has tended to focus on curative and hospital-based care.

Methodology

The evaluation used a mixed methods approach that combined a desk review and key informant interviews (KII). The review examined available national policies, plans and strategies, country reports, peer reviewed publications, reports from donors/development partners, international and local non-governmental organizations (NGO), evaluation reports, training guidelines, and CHW databases. In addition, qualitative data was collected through 18 interviews with 18 national level key informants (KIs) involved in the CHW programmes.

A semi-structured topic guide and a gender-specific guide, informed by the evaluation framework and analysis plan was used to collect data. Analysis was conducted using NVivo Version 11 based on: the WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes (WHO, 2018); the health system building blocks (WHO, 2007); PHC levers (WHO/UNICEF, 2018); the WHO Gender-responsive Assessment Scale (WHO, 2011); and the Steege et al (2018) conceptual framework.

Gender analysis

The evaluation also included a comprehensive gender analysis that sought to determine the extent to which GESI considerations are incorporated into CHW programmes and policies.

Findings

1. Current CHW profiles, roles and responsibilities, policies and systems support

The findings below relate to KEQ 1.

Current CHW profiles and roles and responsibilities

There are two cadres of CHWs in the country – the FHW and the CHW. CHWs can be both men or women, while a majority (83 per cent) of FHWs are women. The FHW cadre was introduced when there were no other health care providers available on the islands to ensure the provision of services in these communities. This cadre is being phased out, with none produced for over 10 years.

Key policies and policy environment for CHWs

The GoM is committed to improving the quality of care in Maldives through the provision of quality, equitable and affordable service delivery to all citizens. Towards this, several policies and strategies are currently in place. These include the GoM's Strategic Action Plan (SAP) (2019-2023); the National Health Master Plan (HMP) 2016-2025; the National Reproductive Health (RH) Strategy 2014–2018; the National RH Programme; the National Family Planning (FP) guideline; the National Standards for Adolescent and Youth Friendly Health Services; the MoH National Child Health Strategy (2016-2020); the 2018 Maldives Healthcare Quality Standards; the Multisectoral Action Plan for the Prevention and Control of NCDs in Maldives (2016–2020); and the National Health Workforce Strategic Plan 2014–2018.

The Maldives National Forum on Revitalizing Public Health (MPHF) for policymakers, senior government officials, development partners and other key stakeholders has been set up to promote high level dialogue on the need for, and the potential impact of investing in public health for national development.

The health system has undergone major changes in recent years as a result of transitions in the governance and political context, including the decentralization of the public healthcare delivery system and dissolution of the single coordinated system into six separate systems in 2010 and 2011. While the Health Protection Act of December 2012 restored the single system, it is acknowledged that these changes in government and health policy resulted in stressors and shocks to the health system, with a loss of institutional memory and destruction and disruption of processes. Further reforms, especially in relation to the decentralization of the health sector and the reorganization of health care provision, have been proposed by the current administration, including enhancing the role of dedicated CHWs.

CHW roles and responsibilities and focus on RMNCAH

The functions and activities of the CHWs are documented and set out in the Scope of Practice (SOP) for CHWs and Primary Health Care Workers (PHCWs), recently developed by the Maldives Allied Health Council.

CHWs and FHWs are no longer involved in deliveries, and their RMNCAH remit is mostly limited to conducting reproductive health clinics in the facility. They support the implementation of up to 15 national public health programmes coordinated by the HPA. CHWs are now almost exclusively based in the Public Health Unit of the HC or hospital, and rarely visit homes. Many CHWs have a significant management and administrative role within the facility and may sometime be facility-in-charge. CHWs and FHWs also play a key role in data collection and reporting.

Several factors were found to affect the effectiveness of CHWs. These include their changing roles to more facility-

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based, administrative and managerial responsibilities, lack of protocols and guidelines for CHW roles, lack of support to CHWs, workload pressures due to staff shortages, CHWs' own gender attitudes, poor teamwork, weakening of the already limited preventative and promotive services previously provided by CHW and, and poor recognition of the CHW profession.

Selection, education and certification

CHW entry requirements are set by the government and different levels of courses are offered by Faculty of Health Sciences, Maldives National University. The training includes practical training in health facilities and community-based training.

Several challenges and barriers were highlighted in the enrolment for training and in the training itself. These include lack of clarity on roles and responsibilities of CHWs, need for more practical training, declining interest in PHC courses, gender barriers in recruitment, resource constraints for in-service training, and lack of systematic in-service training.

Management and supervision of CHWs

On completion of training, CHWs can return to their original post or apply for a vacant post elsewhere as advertised by the atolls or across the MoH. CHW salaries are low, especially in the more remote islands. There is also disparity between the remuneration of public health and CHW cadres, and that of the curative health professions, and this is a major cause of CHW dissatisfaction. The lack of a career pathway and career advancement opportunities were also factors linked to low motivation, lack of job satisfaction and attrition among the CHW cadre. Due to prevailing gender-related barriers, although the majority of PHC graduates are female, it is mostly men who are in the senior positions.

There were no CHW supervisory posts identified and there are no arrangements in place for training CHW supervisors or mechanisms for the provision of supportive supervision for CHWs. Insufficient funding, shortages and turnover of technical and supervisory staff, and geographical barriers with dispersed islands were some of the factors hampering the provision of regular supervision and monitoring. Supportive supervision from the atoll level to island level health facility is also weak and infrequent, with the majority not providing this type of supervision at all. The reasons for such poor supervision practices were attributed to demotivated senior staff, lack of professionalism and poor attitudes towards the job.

Integration into the health system and community

While the CHW cadres are employed by the government and their training is publicly funded, public health and preventative services were perceived to be neglected. The PHC team was also perceived to lack teamwork. CHWs worked alone and were both physically and professionally separated from the curative health team.

Drugs, equipment, and supplies are generally available – without stockouts – except in some islands where they experience stockouts of contraceptives and other supplies.

In the past, CHWs and FHWs had good relationships with families and the community. However, with the medicalization of service delivery and the neglect of preventative/promotive services, many CHWs and FHWs have lost their status and the trust and confidence of the community.

Private sector contribution to CHW programmes

The private sector is not involved and makes no financial or technical contribution to the education, training or employment of CHWs in Maldives.

Financing and resource mobilization

The major source of health funding is from the government and much of the financing has targeted curative and hospital-based care. Underfunding of public health and preventative services has impacted PHC workforce strengthening, including attracting and retaining public health workers and CHWs at PHC level.

2. Prioritized measures to optimize the contribution of CHWs to respond to post-Astana requirements and PHC strengthening

The findings below respond to KEQ 3.

2.1. Policy support measures

Public Health Revitalization

Government policies and the political leadership need to **redress long-standing underinvestment in public health and preventative services and the medicalization of care**, all of which had adversely impacted on the effective and efficient delivery of PHC and community-based care.

Integrated PHC Services

It is expected that the revitalisation process will provide the opportunity to **reorient the services and provide a continuum of care**, and that there will be **renewed focus on a community health approach.** At the PHC level, roles and responsibilities and scopes of practice across all PHC cadres should be clearly defined, supported by appropriate job descriptions, guidelines, and work processes.

Decentralization

Any effort at decentralization, as being debated in parliament, must learn from the lessons of previous experiences and every effort should be made to **mitigate any further shocks or disruptions to health systems and the health workforce.**

Leadership and Governance

Robust leadership and management capabilities within the Ministry of Health will be required to drive the GoM SAP agenda for health, lead large-scale reforms, health system strengthening, including building a competent PHC workforce, and ensuring equitable and quality integrated services at PHC level. **Shortages and high turnover of HPA technical staff needs to be addressed** to provide this leadership and to realise the government's ambitions.

Financing

Increased financing and **adequate funding allocations for cost-effective public health and preventative services**, including CHW programmes, are needed.

Community Engagement

Community engagement, education and empowerment are necessary conditions for reversing the over-medicalization of health, for changing mindsets and unhealthy behaviours, and to enhance the take up PHC and preventative services. The PHC team, including CHWs, need to be supported and enabled **to re-engage with and empower the community.**

Health Workforce Policies

Robust and evidence-based workforce policy and plans aligned with national policies and strategies are needed.

There should be recognition at the policy level that the **role of the CHWs needs to be strengthened and optimized**, and this should be reflected in their remuneration, accountability framework, overall support system and an enabling environment.

Addressing gender

The MoH needs to aim for more gender-sensitive policies and practices to move towards a more gender transformative approach. One of the barriers in making policies more gender-responsive is the lack of financing and human resources to ensure the consistent application and implementation of the policies. Improved understanding among ministries and the Island Councils of their shared roles and responsibilities in advancing gender equality and gender-responsive programming will be key for improved RMNCAH access and use.

2.2. System support improvements

Optimizing CHW roles and responsibilities

Optimizing CHWs and FHWs roles and responsibilities would be a key strategy in addressing the current health workforce shortages, especially as the CHWs are a multi-skilled cadre. Clarifying and coordinating the functions of all facility and community-based providers would improve and enhance teamwork and integrated service delivery approaches. CHWs can have a clear role in providing facility- and home-based ANC and PNC services, SRH services for adults, adolescents and youth, and in the prevention of SGBV. The intermediary treatment provided by many of the doctors currently deployed to the islands could as well be provided by trained CHWs with improved supervision, mentoring and accountability, thus reducing reliance on expatriate workforce and building local resources.

Pre-service education and in-service training

The current PHC course curriculum needs to be more responsive and aligned with current needs. Sexual- and gender-based violence (SGBV), its health consequences and appropriate responses, should also be integrated into the PHC curriculum and covered regularly through in-service training for CHWs. More robust and cost-effective mechanisms are required to provide quality in-service training (IST), mentoring and continuing professional development (CPD). IST strategies and practices should also consider the gendered-specific needs and responsibilities of women, while the participation of women in IST should be enabled and encouraged.

Management and supervision

Greater efforts should be made to make CHW jobs and careers more attractive, in terms of the remuneration and incentives provided, and in developing a career pathway. The extent to which women's competing gendered responsibilities and gendered-specific needs affect their employment needs and preferences, and their ability to take up CPD or opportunities to advance professionally in their careers should also be considered and monitored in the development and implementation of the new professional structure. It is vital that adequate resources and financing are allocated for effective monitoring and supportive systems and processes.

Addressing gender in CHW programmes

CHWs require more sensitization and training on gender norms in the community and how they influence access to health and health care. CHW cadres could play a greater role in promoting gender equality, gender-responsive programming and preventing GBV. FHWs that are well embedded and accepted in the community. They also have a role in ensuring men and boys have access to the health and social services they need and in challenging and changing harmful gender and social norms by working with men.

Recommendations

Recommendation 1: **Leadership at the highest levels, including the President's Office , the MoGFSS, and the MoH, as well as Civil Service Reform is imperative for public health revitalisation.** There is a need for greater clarity on leadership roles and responsibilities across the health sector vis-à-vis public health.

Recommendation 2: **The scope, the roles and responsibilities of both the CHW and the FHW, should be revisited to ensure that these are still appropriate and feasible** given the changing disease burden, proposed revitalization and reforms, and the new technical and job 'structures' under development within the CSC. CHWs can also play a critical role in providing nurturing care, early childhood development, nutrition services through existing platforms, prevention and early detection of NCDs, vector prevention and control and sexual and GBV.

Recommendation 3: **The PHC team, including CHWs should be supported and enabled to 're-engage with and empower the community'** and to be more 'proactive in identifying the issues in the communities,' since community partnerships are vital. On the demand side, renewed efforts are also needed to rebuild the confidence of individuals and families in CHWs and community-based services.

Recommendation 4: **Policies and strategies should be contextualized to build and retain local capacity in the islands.** CHWs and other community-based cadres who understand local contexts will be more effective in communicating with and influencing these communities and families and bringing about the desired behaviour change.

Recommendation 5: Robust and evidence-based **workforce policy and plans, aligned with national policies and strategies are needed to ensure that PHC health workforce meets the health needs of the population and support the achievement of health outcomes and targets.** Such health workforce planning, which outline current and future workforce requirements, should be undertaken in collaboration with the FHS. HR policies should focus on the equitable distribution of these CHW cadres across the country, as well as developing and supporting their performance and productivity.

Recommendation 6: **The evaluation recommends additional and ring-fenced allocations for promotive and preventative services at PHC level.** Strengthening and enhancing PHC services will also reduce the current pressures on secondary and tertiary facilities, as well as the financial burden of delivering such care at these levels.

Recommendation 7: **Greater efforts should be made to make the jobs of CHW and FHW more attractive.** Job satisfaction was a key factor in CHW effectiveness, and a number of issues were identified that influence this, including remuneration, career pathways, recognition of their work and the profession, job enrichment and decision-making authority.

Recommendation 8: **The curriculum for CHWs should be more responsive and aligned with current needs.** It should include content on adolescent health, NCDs, community engagement and behaviour change communication (BCC), gender equality and equity, as well as the use of mobile technologies and social media platforms for health promotion and education.

Recommendation 9: **Reinforcing and refreshing CHW's initial basic education and training through a continuum of structured learning, including IST, mentoring and CPD is recommended** to maintain and update CHWs competencies, improve their performance and the quality of care they provide, as well as motivation and retention of these cadres. IST strategies and practices should also consider the gendered-specific needs and responsibilities of women, especially their family roles and obligations.

Recommendation 10: It is recommended that **adequate resources and financing are allocated for effective monitoring and supportive systems and processes** and to ensure quality health care is delivered by CHWs. Improving the quality and frequency of supportive supervision processes should include increasing the availability and distribution of supervisors across atolls and islands; strengthening their skills, competencies and attitudes to ensure supervisors are effectively; and regularly conducting supervision and supporting health care providers in improving their performance.

Recommendation 11: The **gendered dimensions of health workforce issues should be recognized and health workforce polices should ensure that gender disparities** in the remuneration, planning, recruitment, deployment, retention and motivation of these cadres and the overall PHC workforce are well addressed.

Introduction and background

Country context

Maldives is an archipelago consisting of 1,192 tiny coral islands that form a chain stretching 820 km in length and 120 km in width. The islands are administratively grouped into 20 atolls. At present, a total of 187 islands are inhabited, but with an ongoing population consolidation programme, the number of inhabited islands is gradually decreasing (MoH, 2016). In 2019, it was estimated that Maldives had a total population of 512,038, with 38 per cent residing in Male, of which 366,176 (72 per cent) are Maldivian (UN, 2019). In 2018, 33 per cent of the population was between the ages of 0 and 17 (UN, 2019).

Maldives has made significant socio-economic progress over recent decades. Poverty has shown a consistent reduction and the Maldives is now an upper middle income country, with a per capita gross domestic product (GDP) of $9,088 in 2017 (UN, 2019). The country's overall Human Development ranking increased significantly, climbing from 109th of 187 countries in 2011 to 101st of 189 countries in 2018 (UN, 2019). However, the poverty gap continues to be a concern, with only a small reduction in the atolls, and an increasing trend in Male.

Maldives has seen major transformations of its governance since the constitution was ratified in 2008. The country has high levels of the fiscal deficit, driven in part by high public spending, which threaten macroeconomic sustainability. The introduction of welfare schemes – utility subsidies and allowances for vulnerable populations, social health insurance and old age pensions – puts further pressure on the fiscal deficit. Given its geographic insularity, dispersed population and high transaction costs there is limited potential for economies of scale (UN, 2019).

The GoM's investment in health reflects its high-level commitment to achieving UHC and the Sustainable Development Goals (SDG); more than 9 per cent of its GDP was spent on the health sector in 2018, (WHO, 2018). Maldives has made notable progress towards achieving SDG-related health outcomes, including increased life expectancy, and a decline in maternal, newborn and child mortality. The under-5 mortality and infant mortality rates have declined sharply in the country. As of 2017, the under-5 mortality rate was 11 per 1000 live births, and the neonatal mortality rate stood at 8 per 1000 live births (WHO, 2019). However, this change largely reflects improvements in the health of infants and older children, with newborns accounting for a disproportionate number of the total under-5 deaths (MoH 2016).

The maternal mortality ratio (MMR) for 2016 was 54 per 100,000 live births (WHO, 2020), but there are reportedly wide fluctuations each year. The majority of births (95 per cent in 2016) occur in a health facility, with 85 per cent in a public facility and 10 per cent in a private health facility. However, the caesarean section rate is high at 32 per cent (WHO, 2018), which may subject some women to unnecessary risks during childbirth and post-partum. In 2016, 99 per cent of births were assisted by a skilled provider; with 71 per cent assisted by a gynaecologist; 14 per cent by a nurse or midwife; and 9 per cent by a doctor. Some 80 per cent of women and 82 per cent of newborns received a postnatal check within 2 days of birth (MDHS, 2017).

The contraceptive prevalence rate (CPR) in Maldives is low. Contraceptive use by married women declined sharply from 2009, dropping from 35 per cent of women using any contraceptive method in 2009 to 19 per cent in 2016/17. Use of modern methods also fell, from 27 per cent of married women in 2009 to 15 per cent in 2016/17. Among women aged between 15 and 19, 2 per cent had started childbearing (MDHS, 2017).

The country has achieved high rates of immunization coverage (WHO, 2018). MDHS 2016/2017 data showed EPI coverage with 77 per cent having all routine vaccines completed. However, childhood malnutrition is still a problem, with 17.3 per cent of children underweight and only 48 per cent of infants exclusively breastfed for six months in 2016.

The country has also achieved success in the control of communicable diseases, including elimination of diseases such as malaria, measles and lymphatic filariasis, and high rates of immunization coverage (WHO, 2018). It has achieved the goal of universal primary education and has maintained a high literacy rate for several years. Challenges remain, however, and it was found that secondary-level education achievement rates stand at only 47 per cent, with major disparities between Male (58 per cent) and the atolls (30 per cent) in 2012 (World Bank, 2012) . In 2017, 58 per cent of students passed in five subjects at O level, of which 72 per cent were in Male and 51 per cent in the Atolls (Ministry of Education, 2019).

The socio-economic and environmental transitional situation poses new challenges in terms of access to health services, changing lifestyles, diseases pattern and preventative measures (WHO, 2018) which threatens the achievement of SDGs. New health challenges are emerging, including growing rates of non-communicable diseases (NCDs), which accounted for 81 per cent of total deaths in 2014. Although tuberculosis (TB) prevalence is low, there continues to be a high risk of transmission. Similarly with HIV, although the prevalence of HIV is very low, risks of HIV and sexually transmitted infections (STIs) remain high due to unsafe and harmful practices such as unprotected sex, commercial sex work, men who have sex with men (MSM) and needle-sharing among injecting drug users (WHO, 2018). Disabilities including mental health and psychosocial well-being continue to be a challenge for Maldives. Maldives has one of the highest carrier rates of the beta-thalassaemia in the world. WHO highlighted that "meeting the demand for better quality health services across the country, while making the health sector less dependent on expatriate health professionals, who account for 82 per cent of physicians and 55 per cent of nurses, was also a pressing need" (WHO, 2018).

Further challenges include limited health access for an increasing migrant population, with many coming from neighbouring countries that have a high prevalence of communicable diseases such as TB, HIV, malaria. The country is also vulnerable to the impact of climate change, and associated health threats, including the spread and re-emergence of vector-borne diseases, such as dengue and chikungunya, which are serious public health problem (WHO, 2018). The above context and status of SDGs affect the implementation of CHWs and their subsequent performance.

Specific linkage to the SDGs: The SDGs call for an accelerated return to principles of a more holistic PHC approach. This evaluation is more directly related to the following SDGs: SDG 3 – Ensure healthy lives and promote well being at all ages; and SDG 5 – Achieve gender equality and empower all women and girls. The WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes, which was the key framework for the study, also notes that "policy and investment decisions on health workers have broader implications on several other targets of the SDGs, including job creation, economic growth, gender empowerment and education."

Object of the evaluation

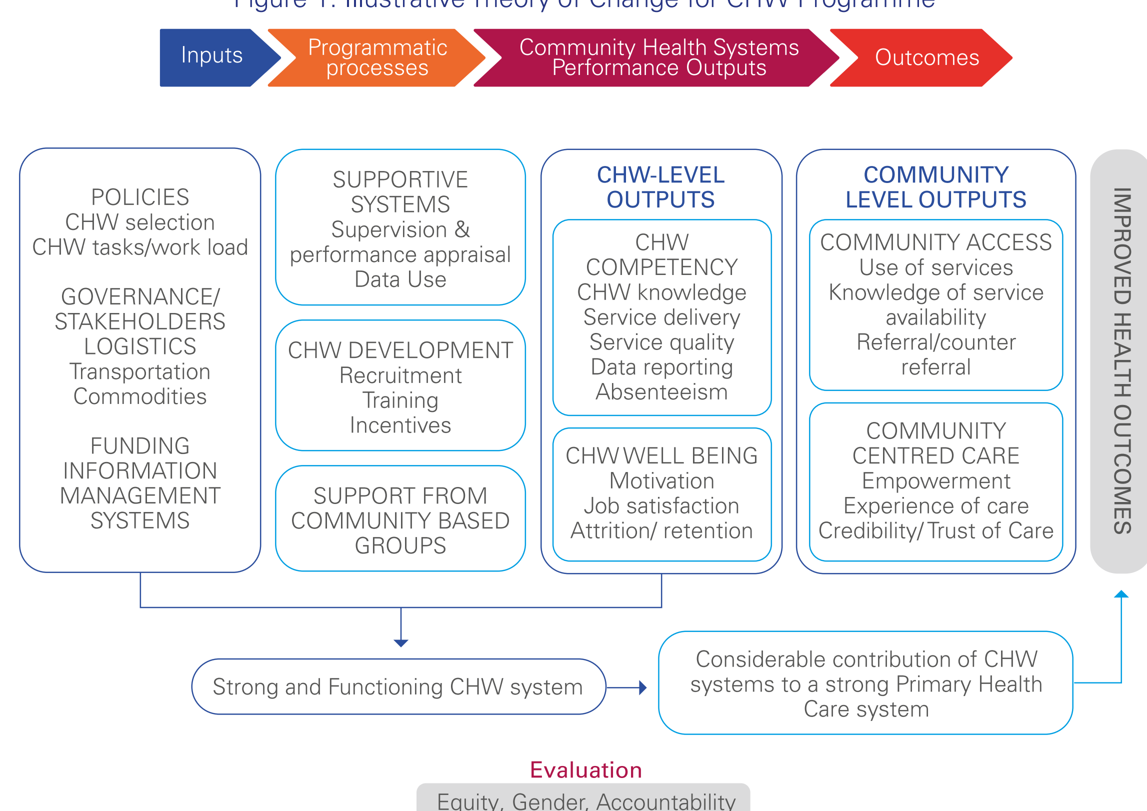
In 2018, the Astana Declaration reaffirmed PHC as the most inclusive, effective and efficient approach to enhance people's health and set PHC as the route to UHC and the health-related SDGs. In this context, CHWs play an important role in advancing health protection and promotion and timely care-seeking at PHC level. Part of this declaration focuses on strengthening the PHC health workforce and thereby CHW programmes.

The Astana Declaration envisioned:

1. Governments and societies that prioritize, promote and protect people's health and well-being, at both population and individual levels, through strong health systems;
2. PHC and health services that are high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated and committed;
3. Enabling and health-conducive environments in which individuals and communities are empowered and engaged in maintaining and enhancing their health and well-being;
4. Partners and stakeholders aligned in providing effective support to national health policies, strategies and plans.

While the evaluation is not theory-based, the WHO Guideline on Health Policy and System Support to optimize Community Health Worker Programmes, which was the key framework for the study organizes the contribution of CHW to PHCs around three broad areas: 1) selection, education and certification of CHWs; 2) management and supervision of CHWs; and 3) integration into, and support by, health systems and communities. The assumption is that with the necessary policy and system support related to these broad areas (i.e. supportive policies, investment, quality education, supervision and management systems and improved integration of community health into formal health systems), there will be improved contribution of CHW programmes to PHC strengthening. Governance, investment (financing), and monitoring and evaluation are also key to ensure that these investments lead to expected improvements in PHC service provision and health outcomes. (Figure 1)

Figure 1: Illustrative Theory of Change for CHW Programme



Adapted from Agarwal et al.[1]

There is a need to enhance the contribution of CHW programmes to PHC strengthening and achieving the post-Astana goals and commitments. It is therefore important to understand the CHW policies and system support that are in place to support the effective functioning of CHW programmes, and to determine the key policy adjustments and interventions needed to help existing CHW cadres' transition into effective contributors to RMNCAH and to the PHC of the future in South Asian countries, including Maldives.

To contribute to knowledge generation in this area, the Centre for Maternal and Newborn Health (CMNH) at the Liverpool School of Tropical Medicine (LSTM) was commissioned by the UNICEF Regional Office for South Asia (ROSA) to conduct a formative evaluation of CHW policies and systems support in South Asian countries, and their readiness for expanding or changing roles and responsibilities within the post-Astana national health care strengthening plans. This regional evaluation covers seven of the eight South Asian countries that fall under the remit of UNICEF ROSA (Afghanistan, Bangladesh, Bhutan, **Maldives**, Nepal, Pakistan and Sri Lanka) and assesses CHW policies and system support at national level only.

One of the initial activities of the evaluation was a desk review, for which the LSTM evaluation team reviewed peer-reviewed publications and policy documentation, relevant to CHWs programmes, with a focus on the provision of RMNCAH services. A key output of the desk review was the mapping of the available CHW cadres in each of the seven countries, which was then shared with and validated by stakeholders in each of the countries, including the UNICEF country offices.

CHW programmes and cadres in Maldives, as right holder as well as duty bearer

The LSTM evaluation team adopted the WHO definition of a CHW: "Health workers based in communities (i.e. conducting outreach beyond PHC facilities or based at peripheral health posts that are not staffed by doctors or nurses), who are either paid or volunteer, who are not professionals, and who have fewer than two years training but at least some training, if only for a few hours" (WHO 2018).

For Maldives, the LSTM team, in consultation with UNICEF ROSA and the UNICEF Maldives Country Office, confirmed that there are currently two CHW cadres active in the country:

- Family Health Workers (FHWs)
- Community Health Workers (CHWs)

These two CHW cadres fall within the WHO CHW definition and it was agreed that they would be covered by this evaluation. The two cadres under review, namely, the FHW and the CHW, were validated with national stakeholders as the key CHWs in the country before the commencement of the study.

Both the CHW and FHW cadres are formal salaried government staff, employed by the MoH and fully integrated into civil service structures. CHWs are based in the Public Health Unit of the atoll hospital or island level Health Centre and provide a range of public health, preventative and curative services, including reproductive health services. FHWs, originally community-based, are now attached to the Health Centre, but continue to conduct home visits and outreach activities.

[1] Agarwal et al., A conceptual framework for measuring community health workforce performance within primary health care systems, Resources for Health (2019) 17:86

Figure 2: Public health care system in Maldives

Public health care system in Maldives		
Primary level	**Secondary level**	**Tertiary level**
Island level health care centers – qualified medical doctor, nurse, lab, pharmacy	Atoll level regional hospital – Secondary level curative care an public health services	Indira Gandhi Memorial Hospital – Tertiary curative care, advanced diagnostic services

It was reported that the titles of these cadres have now been officially changed, with MoH officials, and HR data from both the MoH and Civil Service Commission (CSC) referring to these cadres as Community Health Officers (CHO) and Family Health Officers (FHO). The CSC data reflects three categorises or grades of CHOs: Assistant CHO, CHO and Senior CHO.

However, the MoH Maldives Allied Health Council's 2019 Scope of Practice refers to both a CHW and a Primary Health Care Worker (PHCW), with both cadres carrying out the same set of activities (Maldives Allied Health Council, 2019). The Council indicates that for registration purposes, the minimum required educational qualifications for both the CHW and FHW cadre is a PHC Certificate level qualification, while the PHCW cadre is required to have a PHC Diploma (Maldives Allied Health Council, 5 July 2019).

GoM is committed to improving the quality of care in Maldives through the provision of quality, equitable and affordable service delivery to all citizens. Towards this, several policies and strategies are in place. These include: the GoM's Strategic Action Plan (SAP) (2019-2023); the National Health Master Plan (HMP) 2016-2025; the National Reproductive Health (RH) Strategy 2014–2018; the National RH Programme; the National Family Planning (FP) guideline; the National Standards for Adolescent and Youth Friendly Health Services; the MoH National Child Health Strategy (2016-2020); the 2018 Maldives Healthcare Quality Standards; the Multisectoral Action Plan for the Prevention and Control of NCDs in Maldives (2016–2020); and the National Health Workforce Strategic Plan 2014–2018.

The Maldives National Forum on Revitalizing Public Health (MPHF) for policymakers, senior government officials, development partners and other key stakeholders has been set up to promote high level dialogue on the need for, and the potential impact of investing in public health for national development.

Key stakeholders, their needs and roles

Countries in South Asia have large numbers of CHWs whose training, duties and retention schemes form a rich and confusing tapestry. Across South Asia, CHWs play a substantial role in PHC: through individual counselling; in community education and engagement; in the establishment of trust based bridges between communities and health service planners and providers; and, in the facilitation of evidence generation and use at the micro-community level. Most are female CHW cadres developed to support promotion of desirable family planning, maternal and child health, immunization, nutrition, sanitation and hygiene practices. Due to insufficient funding, village based volunteers were replaced by volunteers or minimally remunerated CHWs with assigned catchment areas covering multiple villages. Neither they nor the health centers they were affiliated with provide either the range of services or the quality of care that is acceptable for the PHC reforms underway. Community health workers work with diversity of partners, Ministry of Health being a critical partner.

The beneficiaries of CHW's services are socio-economically depressed communities who are disproportionately affected by a wider range of illnesses and their health needs remain largely unaddressed. The Astana Declaration therefore reiterated the need for promotive, preventative, curative, rehabilitative services and palliative care to be made accessible to all. Too many vulnerable individuals, families and communities fall into deep poverty due to health conditions that are largely either preventable or more likely to have better outcomes if diagnosed and treated early. The global health community therefore reaffirmed the need to accord higher priority to community-based health promotion and disease prevention, early diagnosis and care at the PHC level. They also decried the systemwide inefficiencies and the poor accountability of service providers that maintain the levels of out of pocket health expenditures highest among those who can least afford them, in exchange for what is strikingly fragmented, poor quality care.

Severe shortages and markedly uneven distribution of health workers are a major impediment to the attainment of the ambitions stated in the Astana Declaration, especially at the PHC level and in areas where communities are socio-economically depressed. The following comprises of the general list of other stakeholders:

- Ministry of Health department and programmes at national and subnational levels
- Other government agencies – local government, etc.
- Professional councils

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- Training institutions
- Development partners
- Donors and multilateral agencies
- Formal/facility-based health workers
- Not-for-profit organizations and community groups
- Civil society/communities

As a key partner in the Community Health Roadmap – a global collaboration to accelerate investment in community health – UNICEF works with Governments and other development organizations to elevate community health in national agendas. UNICEF's approach integrates service delivery across sectors – including health; nutrition; early childhood development; social protection; education; and water, sanitation and hygiene.[2] UNICEF strengthens community health systems and provides promotive and preventive care to remote communities around the world. UNICEF also supports and trains community health workers to provide essential services, prevent the spread of diseases and respond to humanitarian crises.

Purpose, objectives and scope of the evaluation

The overall objective of the evaluation is to understand the congruence between the current profiles, policy framework and system support for CHWs, especially those involved in RMNCAH programmes, and the profiles, policy framework and system support required to better serve maternal and newborn health , and to respond to PHC reform and strengthening in seven South Asia countries, including the Maldives.

The specific objectives of the evaluation are presented below:

- Evaluate current existing policy and system support in terms of the 15 areas of the WHO Guideline, including a gap analysis, to develop country-specific, prioritized recommendations for action. This should provide insight on how governments and partners can redesign and/or strengthen CHW programmes while ensuring that the quality of RMNCAH service delivery is protected and enhanced.
- Identify and prioritize ways in which the WHO recommendations can be translated from vision to action in a manner that creates functional integrated CHW teams within functioning support systems, in decentralized and non-decentralized national political and administrative systems that are aligned with the objectives, context and architecture of the national health system in each country.
- Consider how the process of strengthening CHW policies and system support can be made dynamic, responsive to context-specific evidence, linked to social accountability systems, and promote local, area specific, and national learning and innovation.
- Evaluate the extent to which the content of proposed national PHC and CHW related policy adjustments currently articulate effective transition management, to enable CHW cadres to be effectively reoriented into integrated and functional teams that are expected to cover expanding sets of community health services for the Post-Astana vision of community health systems strengthening for universal health coverage.

[2] source: https://www.unicef.org/health/community-health

In addition, the evaluation included a comprehensive gender analysis that sought to determine the extent to which GESI considerations are incorporated into CHW programmes and policies. See specific details below and in the attached gender analysis report

Intended Utilization and Users

The findings of this evaluation are expected to influence the community health systems strengthening plans. Evaluation findings will be used for UNICEF's community health agenda and priorities and its partnership building and leveraging of technical and financial resources to strengthen national CHW programmes in Maldives to accelerate the strengthening of community health systems within ongoing or planned PHC reforms. The findings will also inform national government plans and enhance UNICEF's and partner's advocacy and technical guidance to local governments who, in many South Asia countries, are instrumental in PHC priority setting, resource mobilization and allocation and the recruitment of the PHC workforce, including CHWs under national decentralization policies.

The evaluation will be used to support the identification of priorities and sequencing of long to medium term health systems strengthening initiatives to ensure that system support functions, such as training, management, and supervision to enable CHW programmes function effectively. Such initiative will also support their integration and support from health systems and communities to enable CHWs contribute within PHC teams, as well as be effective members of their communities, helping to address the social determinants including gender, that affect the health and well-being of the communities they serve. In addition to UNICEF, government of Maldives, other users will include implementing partners and other stakeholders who support programmes aided by CHWs.

Scope of the Evaluation

Subject of the evaluation

The evaluation adopts the definition of a CHW used in the WHO guideline (WHO, 2018) and focuses on the two identified CHW cadres in the Maldives – the PHM and the PHI- and the policies and system support that enable and guide their work. Other health workers to whom CHWs relate are described for context where necessary, and to the extent that they form part of the support structure for CHWs, but they are not covered by this evaluation.

Geographical scope

The evaluation in Maldives assessed CHW policies and system support at the national level only. The evaluation team conducted interviews with key informants at this level to elicit their views and explore their perspectives on CHW policies, system support and on any planned or ongoing PHC reforms in the country.

Temporal scope

The evaluation is primarily focussed on existing policies or policies under design and therefore covers the period from early 2018 onwards, with reference to historical CHWs policies, where necessary.

Key Evaluation Questions

The evaluation responds to the following three key evaluation questions (KEQ), based on the evaluation matrix in Table 1:

1. **KEQ 1:** What are the current profiles, roles and responsibilities, policies and system support in relation to each CHW cadre?
   This is a descriptive KEQ. The key framework used to address this evaluation question was WHO Guideline as described below. All the data collected and analysed to address this question adopted a gender lens.
2. **KEQ 2:** What policy and system support improvements are needed to realistically optimize the CHW profiles and roles and responsibilities of CHWs to better serve maternal and newborn health and to respond to the post-Astana or PHC reforms and strengthening.
   This evaluation question entailed assessing actual or prospective country level commitments driven by the Astana Declaration and/or planned or ongoing PHC reforms, and the implications for existing CHWs policies and system support. A gender lens was also adopted in responding to theis KEQ to ensure gender-responsive efforts/strategies can be identified.
3. **KEQ 3:** What prioritized measures can be taken by government and partners to strengthen health policy and system supports to optimize the contribution that each CHW cadre is able to make to PHC?
   This evaluation question entailed synthesising the key findings from KEQ 1 and KEQ2, and assessing what possible reforms, including gender-informed reforms are necessary and should be implemented, in order to enhance the contribution of CHW programmes to PHC, and to ensure gender equality, equity and responsiveness, given the individual country contexts.

The evaluation was informed by the indicative evaluation matrix below. The matrix was developed before data collection. However, not all aspects were achieved and/or addressed by the evaluation for various reasons. For example, although the original intention was to identify and analyse gaps in existing CHWs policies and system support against PHC reform agenda, post-Astana commitments or PHC system strengthening plans, unfortunately there was little or no information available (from secondary or primary sources) on these areas. At the time of the evaluation, few countries had articulated or developed stand-alone post-Astana commitments or PHC plans that covered community health systems.

Table 1: Indicative Evaluation matrix

Evaluation questions	Primary Data Sources	Secondary Data Sources	Data Analysis & evidence generation	Outputs
KEQ 1: What are the current profiles, roles and responsibilities, policies and system support in relation to each CHW cadre?	Key Informant interviews with UNICEF Country Office staff Key informant interviews with national level stakeholders including representatives from Ministry of Health, Ministry of Gender, Ministry of Women's Affairs, & other relevant line ministries; health policy makers, health planners and RMCAH programme managers; professional associations and regulatory bodies; international NGOs; international service providers (ISPs), local NGO; development partners; and funders	These data will be extracted and analyzed as part of a desk review, but also revisited and expanded once the desk review is completed and the second phase of the evaluation is being carried out to triangulate findings wherever possible. Sources include: • National Policies • National plans and strategies • National Reports • Peer reviewed literature • Donor reports • Evaluation reports • Training guidelines • CHW databases	Narrative synthesis of findings from key peer-reviewed and grey literature from across the eight countries produced from desk **review**. Synthesis structured around the 15 components of the WHO CHW guideline, gaps identified and options for improvement as well as further study in the second phase of the evaluation proposed. A framework (informed by the 15 components within the WHO Guideline; selected health systems strengthening/ building blocks (leadership and governance; service delivery; and financing); as well as factors related to gender and equity, engagement with the private sector; alliance-building; and resource mobilisation) and on-going or planned post-Astana reforms or PHC strengthening plans was developed during inception phase to guide the data collected and **analyzed from** the **key informant interviews** Throughout, key challenges and areas for adaptation and strengthening will be identified by participants. Data will then be synthesised by cadre, across cadres within a country, and across countries to generate top-level findings at the regional, national, and cadre levels. The analysis will involve transcript familiarisation, coding and synthesis of relationships between themes	Map of CHW cadres to be assessed in each country, validated and finalized with countries Map of policies related to community health worker programmes to be assessed for each country validated and finalised Map of available information for each country against the 15 core components in the WHO Guideline, key health systems building blocks and other factors including private sector involvement, alliance building, and resource mobilisation created and validated Framework for analysis constructed informed by WHO Guideline, key health systems building blocks and other factors and identified gaps.
KEQ 2: What policy and system support improvements are needed to realistically optimise the CHW profiles and roles and responsibilities of CHWs to better serve maternal and newborn health and to respond to the-post Astana or Primary Health Care (PHC) reforms and strengthening.				Map of post-Astana commitments for each country where available Map of ongoing and planned PHC reforms and PHC systems strengthening plans Gap analysis of existing CHWs policies and system support against PHC reform agenda, post-Astana commitments or PHC system strengthening plans.
KEQ 3: What prioritized measures can be taken by government and partners to strengthen health policy and system support to optimize the contribution that each CHW cadre is able to make to PHC	Data sources as per KEQs 1 and 2		Synthesis of analysed data from KEQs 1 and 2	Recommendations and reform options to enhance the contribution of CHW programs to PHC systems strengthening within the country context using relevant levers in the WHO and UNICEF[3] Operational Framework Set of feasibility and prioritization criteria to support countries in developing an action plan aimed to optimize the contribution that each CHW cadre is able to make to PHC. All recommendations and options adopt a gender lens and are gender responsive

[3] Primary health care: transforming vision into action. OPERATIONAL FRAMEWORK. Draft for consultation A World Health Organization and the United Nations Children's Fund (UNICEF), 2018

Methodology

The LSTM team used a mixed methods approach for this evaluation. This formative evaluation is intended to help with the ongoing strengthening and evolution of the PHC components of national health systems. It is not an impact evaluation that seeks to measure the impact of CHWs, CHW programmes or the health system. This distinction has guided the selection of the methods to be used for this Evaluation.

1. Data collection tools

1.1. Desk review

The LSTM team undertook a desk review of available national policies, plans and strategies, country reports, peer reviewed publications, reports from donors/development partners, international and local non-governmental organizations, evaluation reports, training guidelines, and CHW databases. The review focused particularly on CHWs programmes and CHW cadres involved in RMNCAH service delivery. Data extracted and analysed as part of the desk review were revisited and expanded on during the implementation phase of the evaluation to triangulate findings wherever possible.

Specifically, the desk review mapped out and validated available CHW cadres, their roles and responsibilities and system support across 8 South Asian countries and identified any post-Astana or PHC strengthening plans. It reviewed international literature, and regional and national CHW policies, strategies and programmes against the WHO 15 policy options and recommendations, health system building blocks and highlighted gaps. A key aspect of the desk review was the analysis of the extent to which CHW programmes are gender-responsive. It also generated a list of key international and national references and resources that were used to guide the overall evaluation process, which was circulated to all the country offices to enable them to identify any additional secondary data sources that the team should examine.

1.2. Key informant interviews (KIIs)

The desk review was complemented by qualitative data, collected through interviews with national level key informants (KIs) involved in CHW programmes. For Maldives, LSTM, in consultation with the UNICEF Maldives Country Office drew up the list of KIs to be interviewed, which comprised national level government officials, representatives from United Nations' agencies, development partners, local and international NGOs, health professional councils and training institutions. To save on resources and manage the time available for the study, key informants were sampled purposively to generate a diverse sample of participants, to ensure that data derived from KIIs were as rich as possible, and to ensure the inclusion of a gender-balanced range of organizations, cadres, and stakeholders.

A semi-structured topic guide and a gender specific guide, informed by the evaluation framework (Table 1) and analysis plan (Table 2), were used by the LSTM evaluator to collect data to respond to the three KEQs, and to validate and triangulate the desk review findings, as well as collect any information not availed through the desk review. Using these guides, the LSTM evaluator sought to elicit and explore KIs' views and perspectives on a range of topics including national CHW programmes, cadres and health system support; the policy environment; the role of gender in the design and implementation of CHW programmes; financing and resource mobilization; and the contribution of the private sector to CHW programmes.

A member of the LSTM evaluation team conducted a total of 18 KIIs with 18 key informants, including one gender-focused KII in the Maldives, between 6 and 14 November 2019.

Participation of key stakeholders and duty bearers

Stakeholders and duty bearers participated in different capacities. UNICEF personnel participated in the selection of key informants. The LSTM evaluation team provided guidance for the UNICEF COs on a range of potential national level KIs for inclusion in the study, comprising policymakers and programme managers from the Ministry of Health, and other line ministries, including Ministry of Gender; Ministry of Women's Affairs and representatives from professional councils, associations and regulatory bodies, training and academic institutions, international and local NGO; United Nations' agencies, development partners and funders and the private sector. A list of KIs for each country was then drawn up, validated and finalized. Selected persons participated in the KIIs.

Three members of the LSTM evaluation team also participated in the UNICEF Regional Management Team (RMT) meeting in Nepal in April 2019. They presented an overview of the evaluation and preliminary findings from the desk review, facilitated a question and answer session, and elicited feedback and inputs from participants on the study. During the UNICEF RMT, the LSTM evaluation team also conducted KIIs with UNICEF country office representatives. Another level of participation was the review and validation of country reports. Both UNICEF and the relevant government stakeholders provided feedback on the reports before being finalized.

2. Data analysis

The transcribed KIIs material was cleaned and then underwent a framework analysis by the LSTM team using NVivo Version 11. A data analysis plan, shown below, was formulated identifying topics for analysis drawn from the WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes (WHO, 2018), the health system building blocks (WHO, 2007), PHC levers (WHO/UNICEF, 2018) the WHO Gender-responsive Assessment Scale (WHO, 2011), and the Steege et al (2018) conceptual framework. Other topics, such as PHC reforms and the contribution of the private sector were also included in the analysis to help address and respond to the research questions.

Table 2: Analysis Plan

Topic	HS Building Block	PHC Levers	Gender dimensions	Research questions
CHW programmes and cadres	Health Workforce	PHC workforce	Availability of gender-sensitive, responsive and transformative CHW policies and programmes; implementation and evaluation of such policies; maintenance of sex-disaggregated CHW workforce data and use for design of CHW programmes	KEQ 1
CHW roles and responsibilities	Health Workforce; Service delivery	PHC workforce; Service delivery	Division of roles/services between male and female CHWs; barriers to delivery of particular services to women, men, adolescents by female and male CHWs; constraints on female CHW mobility; expectation that female CHWs roles will be voluntary/unpaid; other axes of inequity and gender (religion, ethnicity/race, disability, poverty, education, age); provider cultural and gender norms	KEQ 1
Selection, education, certification	Health Workforce	PHC workforce	Requirements for selection for CHW training/ education and impact of men and women's competing gendered responsibilities on ability to take up training and/or CHW roles; recognition and certification of knowledge and skills; affirmative action to preferentially select women to empower them and, where culturally relevant, to ensure acceptability of services by the population or target group; adaptation of education/training approaches and materials for illiterate or those with low educational levels.	KEQ 1 & 2
Management and supervision, including remuneration, contracting and career ladders	Information; Health Workforce	PHC workforce; monitoring and evaluation	Family and household dynamics and impact of responsibilities/obligations/demands of male and female CHWs on employment needs and preferences; accommodations in employment contracts and work environments to support needs and preferences of women CHWs, including mobility, family responsibilities and relocation after marriage; women's access to supervisory positions; support from supervisor with gender-related issues for male and female CHWs; support with maternity leave and during mensturation; fair remuneration and compensation including financial and non-financial incentives; participation in community/ health facility leadership roles; cultural and gender barriers to remaining in the CHW role; career progression opportunities; provision of safe and secure workplaces, including gender based violence, and basic amenities and necessities for male and female CHWs; strategies used by CHWs to remain safe; CHW accountability and responsibility for performance and delivery of services/task	KEQ 1 & 2
Integration with health system and communities, including target pop size, data collection and use, types of CHWs, community engagement, and availability of supplies	Health Workforce; Medical Products	Engagement of community; Appropriate medicines and products	Acceptance, trust, respect for female and male, married/unmarried CHWs by the community and the formal health system; relationship with facility based providers; access to and take-up of RMNCAH services from male and female CHWs by community members; representation of female CHWs on community and health facility leadership/management committees; impact of expanding target population size on ability of females to undertake CHW role	KEQ 1 & 2

Topic	HS Building Block	PHC Levers	Gender Analysis	Research questions
RMNCAH focus	Service delivery	PHC workforce	Acceptability of RMNCHA services provided by male and female CHWs; access to and take up of RMNCAH services from male and female CHWs by community members;	KEQ 2
Leadership and Governance	Leadership and governance	Political commitment and leadership; Governance and policy frameworks	Efforts/progress towards gender-sensitive, responsive and transformative CHW policies and programmes; gender power relations and access to resources	KEQ 1, 2 & 3
PHC reforms	Service delivery; Health Workforce	PHC workforce; Adequate funding and equitable allocation of resource; Political commitment and leadership; Governance and policy frameworks	FFormulation of gender-sensitive, responsive and transformative CHW policies, programmes and practices that consider and address gender inequalities; resources and action to transform unequal and harmful gender inequalities; design appropriate indicators to measure impact of reforms on gender equity; participation of CHWs and community members in design, implementation and evaluation of gender policies; and implementation of gender-sensitive system support; CHW participation and representation in leadership and decision making; disaggregated CHW data by, for example, sex, age, and location; consider gender composition of the CHW/PHC workforce; conduct assessments with participation of CHWs and community members	KEQ 2
Financing and Resource mobilisation	Financing; Medical products; Service delivery	Adequate funding and equitable allocation of resource	Remuneration/compensation of CHWs; gender-sensitive planning and budgeting for CHWs and community health systems in processes; gender-sensitive budgeting for PHC and community-based health programmes	KEQ 2 & 3
Private sector	Service delivery; Health Workforce; Medical Products	Engagement with private sector providers	Private sector employers' gender policies and practices	KEQ 2 & 3

Figure 3: Conceptual Framework on gender analysis

Source: Steege et al., 2018

Additional documents were identified by KIs during the conduct of the KIIs, and these were reviewed by the LSTM team. A full list of references is found in Annex 3. Findings and results from the analysis of the twelve KIIs, and the additional secondary data are presented in the findings section. In all cases respondents' comments and insights are quoted verbatim. However, some have been shortened and where it has been deemed necessary, explanations are also included to improve clarity.

2.1. Gender Analysis Frameworks

The gender analysis draws on the Steege et al. (2018) conceptual framework (Figure 3), which focuses on gender relations and factors affecting the working lives of community health service providers at the individual level (family and household dynamics, decision-making competing demands), the community level (social and cultural norms, acceptability, trust respect) and the health system level (gender policies and gendered system support, roles and responsibilities, and integration). At the individual level, family influence and household dynamics are important factors affecting CHWs; at the community level, safety and the ability to move around are aspects considered; while at the health systems level, gender relations and norms affecting training and supportive supervision, remuneration and career progression are important factors considered. (Steege et al., 2018).

The analysis also draws on the WHO Gender-responsive Assessment Scale (WHO, 2011) (Figure 4) to determine the extent to which GESI considerations are incorporated into CHW programmes and policies.

The scale includes five stages of GESI responsiveness within policy and programming as follows:

- **Gender-unequal:** perpetuates gender and other forms of inequality by reinforcing unbalanced norms, roles and relations.
- **Gender-blind:** ignores gender and other forms of inequality.
- **Gender-sensitive:** considers gender and other forms of inequality, but takes no remedial action to address it.
- **Gender-specific:** considers gender and other forms of inequality and takes remedial action to address it but does not change underlying power relations.
- **Gender-transformative:** addresses the causes of gender-based and other inequalities by transforming harmful norms, roles and relations through the inclusion of strategies to foster progressive changes in power relationships.

3. Frameworks used to inform data collection and analysis

The evaluation uses the WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes (WHO, 2018)[4] and the policy and system enablers it identifies, and in particular, the 15 policy recommendations. It presents, as a benchmarking framework to map and assess CHWs policies and system support, and identify gaps and areas to optimize CHW programmes.

The Guideline's 15 policy recommendations are organized around three broad areas as follows:

1. Selection, education and certification (selection, duration of pre-service training, competencies in pre-service training curriculum, pre-service training modalities and competency-based certification)
2. Management and supervision (supportive supervision, remuneration, contracting agreements, and career ladder)
3. Integration into and support by health systems and communities (target population size, collection and use of data, types of CHWs, community engagement, mobilization of community resources, and availability of supplies).

For the purposes of the evaluation, **health system support** is defined as the support that the health system needs to provide to optimize CHW programmes, including the education, training, management, supervision, remuneration and compensation of CHWs, the provision of commodities and supplies, clear definition of roles and responsibilities, and expectations, as well as adequate financing and the integration of such programmes into the health system and the community.

The evaluation framework is also informed by the WHO six health system building blocks (WHO, 2007), namely, leadership and governance; service delivery; health system financing; the health workforce; medical products, vaccines, and technologies; and health information systems. In addition, the governance, policy, and finance and operational levers presented in the WHO and UNICEF Operational Framework (WHO/UNICEF 2018) provides useful benchmarks levers for assessing progress on PHC strengthening.

The LSTM team adopted a gender lens in the review of secondary data, the design of the data collection tools, and the analysis of the data. A gender-specific topic guide was designed to target key informants with specialist knowledge of, or responsibility for gender and CHWs, to enable a more in-depth exploration of the gender issues and constraints that impact the effectiveness of CHW programmes, and the identification of efforts to address these constraints to improve the functioning of CHW programmes and cadres and strengthen PHC. The gender component of the evaluation drew on the Steege et al (2018) conceptual framework of gender norms and relations across the levels of the individual provider, the community and the health system.
As mentioned above, the team also assessed CHW programmes and policies using the WHO Gender-responsive Assessment Scale (WHO, 2011) that presents findings along the five levels of the scale including, 1) gender-unequal; 2) gender-blind; 3) gender-sensitive; 4) gender-specific; and 5) gender-transformative.

Citations (and in some cases, links) to the frameworks are included in the reference section in Annex 3.

Application of a Rights-based approach, and Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) and Gender Equality and the Empowerment of Women

As reflected in the frameworks applied, this evaluation uses a gender-responsive evaluation methodology, and data analysis techniques. Moreover, because women comprise a substantial number of CHWs in many SA countries, the evaluation also

[4] WHO (2018) Guideline on health policy and system support to optimize community health worker programmes. https://apps.who.int/iris/bitstream/hanle/10665/275474/9789241550369-eng.pdf?ua=18

Figure 4: Gender Responsive Assessment Scale

Gender unequal – Perpetuates Inequalities
Gender blind – Ignores inequalities
Gender sensitive – Acknolweges but does not addresses inequalities
Gender specific – Considers and addresses inequalities
Gender transformative – Aims to transform unequal and harmful inequalities

looks at aspects of inequality, examining how existing policies and systems may unequally affect women in the selection, training and promotion in the different CHW cadres.
At the core of this evaluation is an assessment of Gender Equality and the Empowerment of Women(GEEW). Both the WHO Gender Responsive Assessment Scale and the framework proposed by Steege et al. which are used in this evaluation focus on gender equality and empowerment. The ability of existing systems to reach all persons including those who are marginalized is also explored.

4. Ethical standards

The proposal for the evaluation was submitted to the Institutional Ethics Review Committee of LSTM and full ethical clearance for the study was granted by LSTM (REC 19-037). LSTM has ensured, in line with its internal policies and code of conduct, that the research associated with the evaluation follows the ethical principles and considerations outlined in the United Nations Evaluation Group (UNEG) Ethical Guidelines for Evaluation and UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis (CF/PD/DRP/2015-001). In addition, the UNEG norms and standards were observed.

Written, informed consent was obtained from all KIs in this evaluation using the LSTM Research Ethics Committee (REC) consent template, adapted for this evaluation. The template consists of an information sheet and certificate of consent. LSTM's stringent procedures for obtaining consent adhered to the Helsinki declaration on the rights of subjects. These rights included autonomy (ability to participate or withdraw from the study at their own free will), beneficence (that the benefits of participation to the respondent outweigh the possible harms) and justice. Written consent included the participants' consent to participate in the interview and for the interview to be digitally recorded to aid in the transcription.

The participant information sheet, which explained the purpose of the study and all the possible benefits and harms, was provided to respondents in advance of the interviews and also reviewed with the participant, if required, before the start of the interview. The participant was provided with the opportunity to ask questions and responses were provided to the queries and issues raised. Participation was on a voluntary basis and all participants were assured that they had the right to withdraw from the interview at any stage without needing to offer any explanation. Participants were also encouraged not to disclose any information they are not comfortable with sharing and to decline responding to any statement they considered sensitive.

Every effort was made to ensure that the confidentiality and privacy of participants was protected at all stages of data collection and processing. Confidentiality and anonymity were ensured and assured to the participants explicitly in writing and verbally at all stages of the study to ensure that no data or responses/statements could not be traced to the participant.

All members of the LSTM evaluation team involved in conducting the KIIs received training in good interviewing skills and principles of data confidentiality. Participants were informed about the study in advance (written communication and telephone calls for KIs and before data collection to ensure that participants understand the purpose of the study and their rights to participate (voluntarily) or not and to withdraw from the study at any time without prejudice.

All interviews were conducted in English and were transcribed verbatim soon after collection, anonymized and all identifying information removed. The transcribed KII material was cleaned and then underwent a framework analysis by the LSTM team using NVivo Version 11. Recordings of interviews were stored on password-protected data devices.

5. Limitations and mitigation measures taken by evaluation team

- Availability and quality of secondary data related to VHWs
  - **Mitigation** measure: To ensure maximum responsiveness of stakeholders and access to relevant and quality data, the LSTM evaluation team has sought the support and guidance from UNICEF country offices in approaching and following up with relevant partners to obtain the necessary information. Processes for the quality assurance of secondary data put in place for the desk review were applied and where possible, triangulation of data collected through KII was used to validate findings.
- Limitations of the qualitative research methods used such as participant and interviewer bias during the key informant interviews (KII)
  - **Mitigation:** The LSTM evaluation team used topic guides with open-ended questions to minimize interviewer/facilitator bias and probe with follow-up questions to clarify intent and meaning. Independent coding of qualitative data was performed by the LSTM team to minimize the risks of bias.

- Limited generalizability of the evaluation findings due to the limited availability of stakeholders for interviews during the field visit.
    - **Mitigation:** By using qualitative research methods such as KIIs, the evaluation team seeks to get in-depth information to answer evaluation questions. Generalizability is not the main goal of qualitative research. The LSTM evaluation team used purposive sampling carefully of 'information-rich' participants to represent (not statistically) the broad types of informants relevant to our evaluation.
- All interviews conducted in English affecting the ability of participants to fully articulate views and insights
    - **Mitigation:** Probes were used to ensure that respondents understood the questions. There was careful review of KI guide to ensure that the level of English used was most appropriate for the respondents.

Findings

1. Current CHW profiles, roles and responsibilities, policies and system support

This section responds to **KEQ 1** and provides an overview of the current profiles, roles and responsibilities of the identified CHW cadres in Maldives that are involved in the provision of RMNCAH services – namely, the CHW and the Family Health Worker (FHW). It also reviews and assesses the policies and support these cadres receive from the health system. Some informants, both male and female, were previously CHWs and were able to provide a provider insight and perspective on CHW policies, programmes and system support.

- **KEQ 1:** What are the current profiles, roles and responsibilities, policies and system support in relation to each CHW cadre?

1.1. CHW Profiles

The CSC, CHO and FHO data provide information on the sex and age of these cadres (Table 3). In 2019, there was a total of 224 Assistant CHOs, CHOs and Senior CHOs in post, of which 54 per cent were female. The majority of filled posts were at Assistant CHO level (124/55 per cent),with 13 per cent at the Senior CHO level. Across all categories of CHOs, the majority were aged between 31 and 40 years, and within this group most were Assistant CHOs. Most Senior CHO posts were held by men; 20 posts were filled by men compared to 10 by women. The majority of men in these senior CHO posts were aged between 51 and 65 years, and while women occupied fewer of these posts, there was a wider age range, from 31 to 65 years.

Of the current 241 FHW/FHOs, the majority were women (83 per cent), spread across all age groups, ranging from 35 to 65 years, with the majority aged between 41 and 50 years. Most of the 42 male FHOs were in the 51 to 60 year old age group (Table 4).

Table 3: Filled CHWs/CHOs posts by type, age and sex

Age	Assistant CHO		CHO		Senior CHO		Total
	M	F	M	F	M	F	
24-30	6	8	3	12	0	0	29
31-40	43	50	20	23	1	6	143
41-50	5	8	2	9	4	2	30
51-59	3	0	1	0	11	2	17
62-65	1	0	0	0	4	0	5
Total	58	66	26	44	20	10	224

Source: Civil Service Commission, 2019

Table 4: Sex disaggregation of Family Health Officer (FHO) by age

Age	F	M	Total
35-40	38	4	42
41-50	91	8	99
51-60	65	24	89
61-65	5	6	11
Total	199	42	241

Source: MoH, 2019

As no information was available on the total number of approved FHO and CHO posts, it was not possible to ascertain vacancy rates. The distribution of the CHW across the islands was also not possible to discern due to the non-availability of such disaggregated data.

For this study, the original post titles of CHW and FHW are used.

1.2. Key policies and policy environment for CHW programmes

1.2.1. National and Health Policies

GoM is committed to improving the quality of care in Maldives through the provision of "quality, equitable and affordable service delivery" to all citizens (MoH, 2018). Given the current demographic and epidemiological transition the country is undergoing and the rapid economic and social changes it is experiencing, the GoM's overall national long-term goal is to address current and emerging health challenges and empower people to lead healthy lives, aligned with the global SDGs. The development of people-oriented and accessible health systems is a priority, with a focus on good governance and multi-stakeholder participation for disease prevention and quality health service delivery (MoH, 2016). Health policies and strategies set out the healthcare delivery system of Maldives and the government's commitment to ensure the availability of quality health services and UHC for the population (MoH, 2016).

The GoM Strategic Action Plan (SAP) (2019-2023) is the central policy framework and planning document, aligned with the SDGs, that guides Maldives' overall development direction. It identifies the key challenges facing the health sector and sets out policy priorities and strategies to address these. Key health polices and strategies proposed in the SAP, among others, include promoting and advocating a healthy lifestyle with a key focus on PHC and preventative care, and strengthening safe motherhood and child health and nutrition programmes. Further, it proposes reorganizing health care provision and "revitalizing community health workers to play an enhanced role" as part of the PHC team in "case finding, prevention and promotion". Related actions include building the capacity of CHWs to promote healthy lifestyle and provide health education, and "reviewing their service mandate" to assign key responsibilities and establishing a mechanism for CHWs to "regularly visit homes for health check-ups and awareness."

Respondents acknowledged the broad scope of the SAP, as well as its focus on PHC, preventative care the revitalization of CHWs, and strengthening health education and community-based care.

'The Strategic Action Plan is a very broad policy, with very broad areas where we need to focus, like CHWs. There's a lot of focus on preventative care, on community health workers, and redefining roles, and this area is a huge focus of the current government as well' (KI1 – MOH).

The goals of ensuring quality health services and UHC for the population is reflected in the overarching MoH health policy, the National Health Master Plan (HMP) 2016-2025, which focuses on governance, public health protection and health service delivery. The HMP outlines the strategic direction for the health sector and articulates three specific outcomes: (i) building trust in the national health system; (ii) reducing disease and disability among the population; and (iii) reducing inequities in access to health-care services and medicines. GoM expects to achieve the HMP goals in close collaboration with health partners and other sectors for improving the health of the population.

Key strategies under public health protection component focus on RMNCH, adolescent sexual and reproductive health (SRH) and *'customized'* health promotion and education. The delivery of PHC in all inhabited islands' is prioritized including "establishing a system of contact with families" to "create opportunities to educate and empower families for healthy practices," as well as investment in the "training and retention of a professional and ethical health workforce."

The national Reproductive Health Strategy 2014–2018 aims to ensure quality RH service provision that is affordable, equitable meets individual needs and "encompasses the principles of PHC. Around the time of this study, a new integrated RMNCAH strategy has been drafted and validated and is pending finalization and endorsement at policy level.

The national RH programme coordinates the implementation of the RH strategy, including the delivery of safe motherhood and newborn care, FP, sexually transmitted diseases and HIV/AIDS, reproductive morbidities, SRH of adolescents and young adults, partnering with men for SRH, and GBV and sexual abuse. At the time of this study, the MoH had begun work on the development of a new RH strategy for the next five-year period.

The national RH programme has developed standards, guidelines and protocols related to these areas for HCPs providing MNH care and SRH and FP services in health facilities at all levels. The national FP guideline is reportedly non discriminatory and facilitates easy access to services. According to the Maldives Demographic and Health Survey (2016-17), knowledge of contraceptive methods is almost universal, with 98 per cent of married women and 99 per cent of married men aged between 15 and 49 knowing at least one method of contraception,. However, only 37 per cent of married women aged between 15 and 49 have their demand for family planning satisfied in 2016-17. The contraceptive prevalence rate (CPR) for married women aged 15 to 49 dropped dramatically from 35 per cent in 2009 to 19 per cent in 2016-17 (MoH, 2018).

The national RH programme is also responsible for ongoing capacity building and refresher training programmes, and for monitoring and evaluating services and feedback. A review of the RH strategy showed that over 95 per cent of government facilities were implementing basic emergency obstetric and new-born care (BEmONC) as of 2016 (UN, 2019). In line with the prioritization of adolescent SRH services in the HMP, National Standards for Adolescent and Youth Friendly Health Services are also available, with such services being piloted in several parts of the country.

The MoH National Child Health Strategy (2016-2020) provides practical guidance for strengthening the provision of evidence-based interventions for child health and development, while specifically addressing inequalities (MoH, 2016). It is modelled on the Every Newborn Action Plan (ENAP) which emphasizes the delivery of packages of highly effective interventions along the continuum of care. It targets a child population in the age group from 0 to 18 years of age, with a focus on newborn health, birth defect prevention and nutrition. The new RMNCHA strategy builds on this Child Health Strategy and looks at child health from a life course approach.
Maldives has been able to largely provide UHC, but a key remaining challenge has been ensuring quality of service. The 2018 Maldives Healthcare Quality Standards provides a framework for all stakeholders to coordinate, plan,

implement, monitor and evaluate quality improvement (QI) initiatives in health. Stakeholder consultations undertaken to inform the development of the quality standards found that factors such as treatment guidelines and protocols, infection control practices and referral systems were most critical to quality (MoH, 2018 QOC). The Quality of Care (QOC) Framework for assessing and improving quality in health facilities is currently being rolled out (WHO, 2018).

The country is moving from a high burden of communicable diseases towards an increasing burden of non-communicable diseases (NCD), with NCDs accounting for 81 per cent of total deaths in 2014 (WHO, 2018). In 2016-17, 15 per cent of children under five were stunted or too short for their age, including 4 per cent who were severely stunted, while half of children aged between 6 and 59 months suffered from some degree of anaemia (MoH, 2018). The Multisectoral Action Plan for the Prevention and Control of NCDs in Maldives (2016–2020), focuses on preventative and promotive health interventions to bring about lifestyle changes and reduce health risks of the population (WHO, 2018).

The ***Aasandha*** social health insurance scheme was introduced in Maldives in 2012 to protect the population from catastrophic health expenditure and cover the costs of curative services. The scheme has undergone a number of policy changes, from a contributory scheme to a non-contributory scheme with an annual limit of MVR100 000, to the current scheme – Aasandha – which has no annual individual financial limit. Under the scheme, rural populations have access to free public health care, with free referrals to the nearest hospital, including sea transport in emergencies, as well as treatment abroad for services not available in the country.

The revitalization of public health, the strengthening of the overall PHC system and greater integration of the PHC preventative and curative streams have been the focus of policy discourse at the highest level in government and the health sector in recent years. To accelerate progress in this area, the GoM facilitated the Maldives National Forum on Revitalizing Public Health (MPHF) for policymakers, senior government officials, development partners and other key stakeholders to promote high level dialogue on the need for, and the potential impact of investing in public health for national development. In addition, the MPHF facilitated dialogue on the ‘strategic pathways’ for the integration of public health services, both primary and preventative health care and the creation of a continuum of care from promotive and preventative to curative and rehabilitative services.

Key themes included multisectoral and community partnerships; re-orienting health services; human resources for public health; policy and financing; and evidence-based communication for public health. Presenters made the investment case for the inclusion of preventative and public health in all policies across the government and national institutions; and highlighted the urgency of accelerating evidence-based public health measures to achieve the government’s SAP, SDGs and UHC.

It was expected that the MPHF would forge stronger relationships between national and international stakeholders; lead to a better understanding of public health issues, as well as a commitment to implement public health in a holistic manner. A key outcome was GoM’s declaration “to transform 2020 into the Year of Public Health,” which respondents perceived as a very positive step in transforming public health.

‘So we feel nationally, over the years we’ve moved from a very public health, very community-based health system into a curative system. This is the move, starting next year, where we want to change or redirect, rethink about how we deliver health care in the country’ (KI2- MoH).

At the time of this study, the HPA was leading the development of a road map to revitalize public health to be implemented from 2020 onwards, but this was not publicly available.

1.2.2. HR Policies

GoM’s SAP, the HMP, the National Health Workforce Strategic Plan 2014–2018, and the 2018 Maldives Healthcare Quality Standards, set out polices and strategies to address health workforce challenges and to “build and retain a competent, professional health service workforce” for the delivery of services and meaningful Quality of Care (QoC) (GoM 2019; MoH, 2016; MoH, 2018).

Increased attention and investment in the recruitment and retention of the health workforce has improved the availability and distribution of specialists, doctors, and nurses over the years. In 2015, there were 23 doctors, 66 practising nurses, and 14 primary health-care workers per 10,000 population, with local doctors making up 23 per cent of the workforce, and local nurses comprising 56 per cent.

However, Maldives continues to be heavily reliant on expatriate health professionals, who accounted for 82 per cent of doctors and 55 per cent of nurses. Assuring the quality of health workforce continues to be challenging (WHO, 2018). Lack of health workforce leadership and management, especially at the central level, has resulted in less robust workforce planning and deployment, with disparities in the distribution of the health workforce, both local and expatriate, in the public and private sectors, across the country. There are challenges attracting and retaining health workers, including CHWs, in atolls and islands, and the absence of clear career and professional development opportunities has affected health workers’ motivation. (MoH, 2016). The high turnover of health workers and the reliance on expatriate health professionals was also identified as a challenge to maintaining the consistent use of the standard guidelines and protocols to ensure patient safety in the provision of care and management of diseases.

At the time of this study, the Civil Service Commission (CSC) was working on a new job and technical structure for CHW cadres. The proposed structure was still undergoing review at this time and detailed information was not available publicly, but those who had had sight of the proposed structures viewed them favourably.

The Faculty of Health Sciences (FHS) of the University of the Maldives is the only institute in the Maldives to train and produce health care providers. It produces CHW and PHC cadres to certificate, diploma and degree level.

1.2.3. Gender Policies

The Ministry of Gender, Family and Social Services (MOGFSS), including its Gender Department, as well as those

departments responsible for the Family and Children Service Centres (FCSCs) on the islands and the interministerial Gender Focal Points (GFPs) Network, are tasked with coordinating and monitoring gender equality commitments in the country. Women's Development Centres (WDCs) have been established in all inhabited islands.

Maldives ratified the Convention on the Elimination of All forms of Discrimination against Women (CEDAW) in 1993, and gender equality and the promotion of women's rights are well recognized and articulated in national policies (WHO, 2018). The current government is committed to harmonising its national laws, policies and programmes with the CEDAW, and continues to invest in the implementation of the CEDAW despite, "cultural and political resistance" from certain aspects of society and "against strong cultural and religious traditions"(UN, 2019). Respondents perceived the current administration to be "open towards gender-related issues " and acknowledged that the GoM's SAP had "gender mainstreamed into it", which it was felt would ensure that gender was now mainstreamed in all sector plans and sector polices would be more gender-sensitive and responsive. It was also acknowledged that the Government is committed to making necessary policy changes and implementing programmes that raise awareness on eliminating traditional gender stereotyping and bias at all fronts.
The Gender Equality (GE) Act, enacted in 2016, prohibits discrimination on the basis of gender and promotes gender equality in all aspects of public and family life (UN, 2019). Related to the GE Act, a National Gender Equality Action Plan was drafted in 2017 and was expected to be approved in 2019. In addition, the Sexual Offences Act provides for the protection of children and adults from all forms of sexual violence and includes an aspect to prevent rape within marriage. The Child Rights Act was enacted in 2019. The Sexual Harassment Act is expected to provide the necessary protection for women in both public spaces and in the workplace (UN, 2019).

Since the introduction of the GE Act, it was reported that the MoGFSS has endorsed two key gender policies: the "empowerment of women in the political, economic and social sphere", and "zero tolerance to violence against women". The MOGFSS collaborates with the MoH mainly in the development of the health sector's response GBV, as well as in areas such as SRH, FP, mental health and disability. The GE Act was observed to have had a positive effect on improving the gender-responsiveness of health sector programmes, "programmes that are being designed by the health sector are more gender-responsive now" and in ensuring the health system delivers "age-appropriate sexual reproductive information from the education system to the community."

A 2011 Human Rights Baseline Survey reported a high level of sexual harassment in public spaces and the workplace and more so in a rural environment. While there was a lower incidence of the more intimate forms of sexual harassment, these tended to happen more to rural women than urban women. A follow up study, the Rights Side of Life Survey, which focused on examining the knowledge, perceptions and prevalence of domestic violence in the Maldives, was conducted in 2020 (HRCM,FPA & UNDP, 2020). It found that that support for gender equality and women's rights has diminished. The report highlights the "emergence of a religious extremist narrative that has been used to weaken support for gender equality and women's rights." A considerable number of respondents, many of whom were women, felt that gender equality and child rights are not compatible with Islam. The report reveals the need for more transparent and accountable governance institutions and greater awareness of human rights across the country. The findings are expected to provide a basis for policymaking and agenda setting to strengthen systems that promote human rights and prevent domestic violence.

Despite progress in a number of areas, the CEDAW reported that the country's Gender Inequality Index (GII) continues to worsen, dropping from 52nd (2011) to 76th (2017) in ranking. Many of the gains and advances on GE are being threatened and with changing attitudes concerning the rights of women, with fewer men agreeing that women have equal rights in family matters, a decline in women's perception of their own equality, and changes in attitudes to men hitting their wives.

However, recent government policies focus on addressing the root causes of GBV – namely the social norms, and within these the gender norms, which perpetuate gender-based discrimination. In 2016, MOGFSS supported the KURIMAGU campaign, a door-to-door campaign to mobilize greater understanding in society of the importance of gender equality. The MOH has also rolled out its Health Sector Response to GBV Guidelines, which provide protocols for medical screening, examination and response to cases of GBV (UN, 2019).

1.3. Leadership and Governance

The public health system is the main health service provider in Maldives, with facilities stratified into primary, secondary and tertiary levels of care. Primary care facilities are represented by health centres, which are further classified into three grades. Every inhabited island has a health facility, with each having at least a qualified medical doctor and nurse, as well as a basic laboratory and pharmacy. (WHO, 2018). Each atoll, covering a population of 5,000 to 15,000 people, has an Atoll or Regional Hospital, which provides secondary care and coordinates the provision of primary and curative health care in that atoll. These secondary level hospitals are graded based on the bed occupancy and patient load per year and provide specialist services. As well as providing curative services, health facilities provide public health services and functions, which are delivered through public health units.

Tertiary care services include super specialities and advanced diagnostic services. Indira Gandhi Memorial Hospital (IGMH) is the only government facility which provides these services. In 2016, there were 23 public hospitals, six regional hospitals and 14 atoll hospitals and 172 PHC centres. Health care services, including medical examination, investigations, immunization, antenatal care, and drugs, are provided free to all Maldivian citizens.

The MoH is responsible for formulating overall health policies and plans as well as regulating, monitoring and evaluating health service delivery. The Health Protection Agency (HPA) is responsible for regulating public health provision and protection and monitoring of public health services at all levels. Regulatory bodies such as the Maldives Medical Council, Maldives Nursing Council, the Maldives Allied health Council and the Maldives Health Services Board are in place and functioning. The Maldives Allied Health Council registers, licences and regulates 73 different allied health professionals, including community health professionals, such as specialized community health cadres, and the PHCW, CHW and FHW cadres.

Health services are provided through and with the support of state and government institutions, the private and voluntary sectors, and external development partners. The Health Master Plan (2016-2025) acknowledges the importance of close collaboration, partnership and joint action by all stakeholders at national and institutional levels to successfully implement the HMP and achieve national goals, outcomes and outputs (MoH, 2016).

The health system has undergone major changes in recent years as a result of transitions in the governance and political context, including the decentralization of the public healthcare delivery system and dissolution of the single coordinated system into six separate systems in 2010 and 2011. While the Health Protection Act of December 2012 restored the single system (MoH, 2016), it is acknowledged that these changes in government and health policy resulted in stressors and shocks to the health system.

Respondents in this study perceived that leadership transitions and the associated policy change had a negative impact on the health sector and the health workforce, resulting in a "loss of institutional memory" and "destruction and disruption of processes." The downsizing of the civil service and the abolition of posts in 2010 resulted in redundancies and retirement of many health workers and central level public health staff. The health sector was the worst hit sector in the government.

The available literature highlights the loss of the MoH's "strong line of command and unified health service management", disruptions in health information systems and supply chains, loss of skilled health care providers, especially in preventative health and primary health care, a decline in the quality of health care delivery and increased loss of public trust in the health system (MoH, 2016; MoH, 2017). There was a sense among many respondents that "Maldives is still struggling to catch up, get back to what it was."

The current demand for higher levels of care, bypassing the PHC level, overcrowding in tertiary level hospitals and resultant inefficiencies in the distribution of financial, material and human resources, was perceived to be due to a number of factors, but key among these were the political drivers. Politicians election promises of health facilities and doctors were contributing to expectations and demands for specialized care. "These MPs, they say: I will put a health centre or hospital in your health post and we will send MBBS doctors." Politicians' focus on the provision of specialist care was associated with their need to get immediate results, whereas the benefits of public health and preventative care take longer to achieve and are less visible (MoH, 2016).

Respondents observed that people expectations had increased to such an extent that "now if the people have itching, they want to go to dermatologist, not just an MBBS", even if there are only 200, 300 people in the population, they demand for a hospital, demand for a specialist." However, many observed that while people believed these promises, this level of service was "impossible" to deliver and sustain.

Further reforms, especially in relation to the decentralization of the health sector and the reorganization of health care provision, have been proposed by the current administration, including "enhancing the role of dedicated community health workers" (President's Office, 2019). Respondents reported that the SAP strategy of establishing Regional Urban Centres (RUCs) will enable the government to organize the delivery of a comprehensive package of services ("health, education, social services, different service like sports, other services, economic development in a zone"), and to reach all population groups in that zone (comprising 2-3 atolls). The strategy also aims to build people's trust and confidence in these zonal services and ultimately reduce the numbers travelling to Male for health services and care.

Although the government is committed to providing PHC services, including preventative care, for all its citizens, the policy of past governments has tended to focus on curative and hospital-based care. The distribution of PHC centres in Maldives is island-based, not population-based, to ensure access to free health care for the whole population. However, as highlighted in the literature and by respondents in this study, this has resulted in inefficiencies in terms of material, human and financial resources.

The delivery of health services at the primary level services presents a range of challenge, including the geographic isolation of islands, inadequate human resources, weak management capacity, limited career development and professional development opportunities, insufficient supplies and equipment, and inadequate QoC and referral mechanisms (MoH, 2016; MoH 2017P; WHO, 2018).

Poor intersectoral cooperation and coordination for health and the lack of cohesion in the roles and responsibilities of government institutions on cross cutting issues were some of the key health sector challenges identified in the GoM SAP 2019-2023. It recognizes the need to "strengthen health system governance and stewardship" with all political actors in the health sector "sensitized on health sector laws, international obligations and standards" and internationally supported projects "monitored through electronic systems"(GoM, 2019).

While the private health sector in Maldives is relatively small, it has facilities across the islands, although most private health facilities are located in Male. Supply and provision of medicines are managed by State Trading Organizations (STO), and the private sector, with 168 private sector pharmacies and 187 STO pharmacies across all locations in 2016 (MoH, 2016).

Many government specialists work in the private sector and run private clinics. It was perceived that this was contributing to challenges in accessing specialist services in government hospitals. Respondents reported that "it's impossible to get an appointment," because there is such a high demand for these services, with many people having to "wait for three to four months to get a specialist" in the government hospital, while it was much easier to "get him or her privately". Much private care is funded through the government health insurance scheme, so private specialized care is affordable for many.

Public-private partnerships (PPPs) for the provision of health care were experimented with in 2009-2012 in Maldives, but were not very successful. Lessons learned included the need to build public sector capacity for the appraisal, performance assessment and supervision and audit of projects (MoH, 2016).

Local NGOs, such as Society for Health Education, Maldives Red Crescent, Diabetes Society of Maldives, Care Society,

Aged Care Maldives and Journey, also provide a range of health services to diverse population groups including adolescents, the disabled, the elderly and migrants. There were no NGOs identified that focused on maternal and child health.

1.4. CHW roles and responsibilities

There has been significant progress in maternal, newborn and child health outcomes. The significant decline in MMR was attributed to GoM investment in health care facilities and the health workforce, which improved the availability of HCPs on Atoll, and provision of basic PHC on all inhabited islands (UN, 2019). Emergency obstetric care services are also available in almost all health facilities at island level. However, the fluctuating MMR continues to be an area of concern, with ongoing investments focused on strengthening antenatal (ANC), childbirth and post-partum care and ensuring more consistent and equitable access to quality maternal health services across all islands and atolls (UN, 2019). A major reason for the fluctuation is the small population, which leads to a spike in mortality rates with even one or two maternal deaths. Although there is a need for further research and evidence in this area, other possible reasons for that spike could be the relatively high number of unplanned pregnancies, and maternal health factors (e.g. gestational diabetes, high BP, NCDs).

According to the 2016-2017 Maldives Demographic Health Survey (MDHS), the main problems women faced in accessing health care were difficulty in getting an appointment (52 per cent), followed by not having a female health provider (47 per cent) (MoH, 2018).

1.4.1. Community Health Workers

The functions and activities of the CHWs are documented and set out in the Scope of Practice (SOP) for CHWs and PHCWs, recently developed by the Maldives Allied Health Council. It defines these cadres as "community health professionals who deliver primary health care services and play an important role in increasing access to health services" (Maldives Allied Health Council, 2019).

The activities set out in the SOP include patient assessment; clinical investigation and diagnosis; treatment: and therapeutic interventions. 'Other activities' include providing public health and education in areas such as hygiene, disease control, healthy lifestyle and STI; conducting immunization and growth monitoring programmes and reproductive health clinics; dispensing medicines and case and records management, among others. The SOP also identifies activities which are specific to PHCWs who possess a BSc Degree, including those required by International Health Regulation, and the design and conduct of surveys on health issues of the community.

1.4.2. Family Health Workers

The FHW cadre was introduced when there were no other health care providers available on the islands to ensure the provision of services in these communities. They received six months' training and were mostly from the community they worked in. While the FHWs are registered by the Allied Health Council, there was no SOP available for this cadre. They are attached to the island health centre where they report on a daily basis and continue to provide community-based services focused mainly on FP.

This cadre is being phased out, with none produced for over 10 years, and "when they leave the work nobody will be there to replace them." Respondents indicated that this decision was related to the capacity and the quality of training this cadre had, with the MoH requiring better-qualified people. Some of those who met the entry requirement have gone on to undertake the PHC certificate course and have been deployed as CHWs.

1.5. RMNCAH focus

With most births (95 per cent in 2016) happening in a health facility, assisted by a skilled provider, CHWs and FHWs are no longer involved in deliveries, and their RMNCAH remit is mostly limited to conducting reproductive health clinics in the facility. Most people on the islands are within walking distance of a health facility where they can access free services. In most cases, women will seek MNCH services, including ANC and PNC, from the doctor available in the island health centre or hospital , and no longer approach the CHW at all for these services.

Respondents indicated that the CHW cadres now, "handle all the public health programmes, including vaccination, growth monitoring and reproductive health programme, nutrition, everything related to public health". They will provide clinical services when there is no doctor or nurse available, "if there's no doctor, we have to consult as a doctor," and "if there's no nurse, advanced nursing procedures we have to do."

CHWs support the implementation of up to 15 national public health programmes coordinated by the HPA. Each programme has a focal point person on every atoll and island. Depending on the number of CHWs in the facility, they will be assigned as the focal point for a particular programme or for a number of programmes. Programmes include NCD screening and health education, such as for hypertension and diabetes; communicable diseases, such as HIV preventative and promotive activities and monitoring and follow up of TB cases; RH and FP; prevention and surveillance activities for diarrhoea; and vector surveillance and control (MoH, 2018). CHWs are also responsible for implementing the nutrition programme, which includes growth monitoring and immunization, although respondents indicated there is sometimes confusion between the roles of CHW and nurses in the administration of vaccinations.

Increasingly, women prefer to seek obstetric and gynaecological care in the atoll hospital or in Male and deliver in a hospital with specialized care, even with the availability of a doctor in island level health centres (UN, 2019). It was reported that many women "don't have confidence in the doctor." Many are new graduates with limited experience and expertise. They reported that the "doctor is just MBBS and is not "a reproductive health specialist or an obstetrician," and when they have a sick child "they want a paediatrician." Respondents reported that in many cases these doctors are often not willing to take the risk and would rather refer pregnant women to the higher level facility. Some expatriate male doctors on the islands may be unwilling to carry out deliveries for cultural or religious reasons. Expatriate

doctors may not be familiar with the national guidelines and be unable to communicate with patients because of language barriers. These factors including the high turnover and capacity issues mean that rapport building with the patient is weak. On many of the smaller islands, the health facility is focused on PHC only, "with limited equipment, no laboratory, and extremely limited gynaecological capacities" (UN, 2019). Given the limited role of the island level doctor, it was suggested that with their multidisciplinary training, and with further training and support CHWs "can do what the medical officers are doing."

Although CHWs and FHWs have less responsibility for providing ANC and PNC, according to the MoH Healthcare Quality Standards, they are still expected to undertake ANC and PNC visits as per a defined schedule (MoH, 2018). Respondents in this study affirmed this and described how the CHWs continue to have a key role in the provision of ANC and PNC, particularly in the atolls, and related counselling and health education through clinics and home visits. In Male, women may be required to make a return visit to the doctor for these types of services.

'So their roles have changed from earlier times to now. They will not deliver any births. But they will be able to give antenatal care, and the information, counselling and that aspect will be there' (K13- MoH).

'The antenatal clinic is also handled by these community health workers. The ANC clinic and PNC also, they have to do home visits after delivery for 14 days. They have to visit the home and they will find out any risk or any problem and they will give health education' (KI4 –Training Institution).

Respondents reported that "few people will go to the health system to receive any care related to sexual health or family planning." MDHS data show that, overall, 94 per cent of women aged between 15 and 49 who were not using a contraceptive method said they did not discuss family planning either with a fieldworker or at a health facility in the 12 months before the MDHS (MDHS, 2016). Further, only 2 per cent of women not using contraception were visited by a fieldworker who discussed family planning, while 82 per cent of women visited a health facility, but did not discuss FP during that visit. The most common sources of information on FP messages were newspapers, and magazines and leaflets, television and radio. However, it also found that overall, 60 per cent of women and 57 per cent of men aged from 15 to 49 had no exposure to FP messages through any of these four main mass media.

1.5.1. Community and home-based care

On the other hand, as many other respondents highlighted, CHWs are now almost exclusively based in the Public Health Unit of the Health Centre or hospital, and rarely visit homes or provide home-based ANC or PNC services, with FHWs mostly conducting home visits. The overall perception was that community and home-based care were no longer valued. It was perceived that the MoH "don't think that it is important now" and CHW and other HCPs expected "people to come to them in the facility, for counselling, vaccinations, everything happens in the facility." Respondents indicated that the CHW will follow up women who miss facility-based ANC and PNC appointments by phone and will only conduct a home visit if it is deemed necessary.

Domiciliary and home-based care focus mainly on chronic patients, those who are bedridden, the elderly and the disabled. This care is provided by a team from the facility, comprising the doctor, nurse, CHWs and FHWs. Elderly women and men rely entirely on the support of families. However, they are often neglected because of the work demands that families face, so the healthcare teams' support to the families' care is vital (UN, 2019).

1.5.2. Adolescent and Youth Friendly Health Services (AYFS)

CHWs and FHWs face challenges when they engage young people, whose main source of information on SRH was the internet. In a 2019 study of SRH-seeking behaviour among Maldivian youth between the ages of 18 and 25 years by the Society for Health Education (SHE), 90 per cent of the respondents indicated that the preferred place of treatment for both females and males if they encountered any sexual and reproductive problems relating to STIs, was the internet and pharmacies (SHE, 2019). In the same study, girls reported that seeking help from a health professional was "not attractive" because "their parents might come to know of the visit" (SHE, 2019).

Substance and drug use in the 15-19 years age group and associated mental health issues are high and GBV is a key aspect affecting young people's health, especially young women. Various approaches and interventions have been implemented to reach adolescents and young people with appropriate services. For example, National Standards for Adolescent and Youth Friendly Health Services (AYFS) have been developed and school health programme provide adolescents with information on healthy practices and life skills to respond to peer pressure and support their peers. Youth Health Cafes provide health education and referrals to health facilities for counselling and RH services. AYFS clinics established at health facilities provide a range of services including health education, treatment of STIs, and contraception.

It was perceived that there has been some progress accessing adolescents through Youth Cafes and the RH services offered as part of the education system. However, the availability of AYFS and programmes and the range and take-up of services provided were considered limited and, in some cases, adolescents and youth were not aware of the services available. The Health Master Plan 2018-2025 identified that the main issues deterring FP service delivery was the limited availability of primary care workers, who had competing priorities in their management and technical responsibilities, as well as a lack of adequate infrastructure to maintain privacy in health facilities.

Changing religious and societal beliefs were also perceived to be a barrier to the provision and take-up of needs-based SRH information and support to school students. Respondents perceived the availability of SRH services for young people to be value-based, with some CHWs refusing "to give a sexually-active child emergency contraceptive pill, or another contraceptive method, or condom" (SHE, 2019). The rise in teenage pregnancies and abortions, many of which are unreported, were perceived to be associated with the lack of abortion services and/or emergency contraception. The SHE study found that more adolescents and youth sought services from the SHE programmes than any other service available.

A finding of the 2019 SHE study was that mobile teams conducting monthly household visits to raise community awareness on health issues, including SRHR, were more successful in engaging youth than facility-based AYFS. Young people used these opportunities to raise SRHR issues and problems such as STIs, and to request such information informally from these community health team (SHE, 2019). Respondents in this study also felt that home-based care that covers all households with everyone getting the information could help to overcome some of these health seeking barriers. "If the services are coming to them, the way that it's being seen by the community becomes different." The Ministry of Gender, Family and Social Service has found that its door-to-door awareness sessions have been more effective and beneficial in reaching these groups.

CHWs have their own personal beliefs and social norms, which may impact their effectiveness in providing SRH services, especially to adolescent health. "How they grew up also matters, especially when we talk about women's health and as well as role of the man in FP." The culture of silence on sex and sexual health in the country also influences the CHW's behaviour and response.

Families are reluctant to talk about sex and sexuality and many young people lack proper parental guidance on SRHR issues (SHE, 2019). In schools too, teachers may not want to talk about these issues, so young people are not getting the information they need. Cyberbullying and internet grooming are also emerging issues, and when parents and teachers do not discuss these issues and risks, such issues can affect children's mental health. Suicide is reportedly on the rise among boys. Some respondents stressed that boys particularly need support. "Girls are more resilient. They have ways of talking about it. Boys don't talk about it, they don't have a way of actually getting it out of their system, so they end up committing suicide. And traditionally men are seen as not talking."

1.5.3. Gender-Based Violence

Violence against women and girls continues to be widespread and threatens women's empowerment in the Maldives. In 2016, 22 per cent of women aged between 15 and 49 had experienced either physical or sexual violence or both, with 4 per cent of women experiencing physical violence during a pregnancy Further, 17 per cent of ever married women experienced physical, sexual, or emotional violence in the 12 months preceding the DHS either sometimes (8 per cent), or often (8 per cent) (MDHS, 2018). Many people appear to accept domestic violence as the norm in women's lives (WHO, 2018). Due to limited opportunities to access education or employment, people with disabilities, including children and women, remain at high risk of abuse and neglect (WHO, 2018).

While the MoH is providing mandatory training on GBV for the health workforce, the implementation of the health sector GBV guidelines is reportedly not the best, with many HCPs on the islands having never heard of the guidelines (UN, 2019). Respondents reported that health services for survivors of GBV are provided mainly at the central level. Limited awareness among HCPs about the prevalence of GBV also impacts effective screening and response. Further, expatriate HCPs who do not speak the language will need to have a translator present, especially in the rural areas, which may be a barrier to patients' willingness to report and seek support and may risk confidentiality in these small island communities. However, it was not common for women who have experienced physical or sexual violence to seek help from HCPs. Family (59 per cent) was the most common source of help reported.

CHWs are coming across issues such as child sexual abuse, domestic violence (DV) and GBV that are not being reported or dealt with either because they perceive such issues are not within their scope of work or they are family issues and they may not want to talk about the family in the small island communities, where everyone is related. They may also be fearful of repercussions when the preparator is influential or politically strong. Or they may get threats from the community when they raise such issues. Reporting such cases may also have negative consequences for the family, especially when the perpetrator is a family member and he/she is removed from the home, and the family are left with no social protection or economic support. Community members themselves may be reluctant to report such cases, which also affects the willingness of doctors and other HCPs to report.

1.5.4. Mental Health

The provision of mental health services, particularly post-partum depression, was perceived as a neglected area. CHWs were insufficiently trained to provide information and support to women with this condition. Mental health and suicide among men was another area that needed to be addressed. A key policy of the GoM SAP 2019-2023 is to ensure that "mental health is socially accepted, that people with mental disorders have access to high-quality care, that mental health service are integrated within the existing health care system."

1.5.5. Immunization

The problem of vaccine hesitancy was highlighted as an emerging issue, despite the availability and accessibility of free vaccination services. It was perceived that this is being driven by people accessing and using information from the internet that may not be accurate to make vaccination decisions. Respondents observed that new approaches and strategies were needed to reach these people with the correct information, "it's more difficult, people have changed a lot and we need to be changing constantly." A vaccine hesitancy assessment undertaken by UNICEF in 2019 found that in the past, when parents and families had doubts about vaccines, it was the attitudes of CHWs and the fact that that CHWs were confident to give the vaccine to their own children that convinced these parent to accept these vaccines. It may be that CHWs' perceptions of vaccines have changed and/or their conscious or unconscious bias in providing vaccination services may be a factor in the increasing levels of vaccine hesitancy.

1.5.6. Health education

CHWs continue to create awareness and undertake health education and promotion activities. They are expected to conduct health education and counselling "in partnership with the health facility", as well as in the community. "We have a role to make them aware, to give health education and to conduct the screening programmes." They participate

in mass media campaigns for health promotion organized by the HPA and facilitate the celebration of health days in the health facility and the community. They are also expected to engage local civil society organizations in their health promotion activities (MoH, 2018).

1.5.7. CHW administrative functions

Respondents reported that many CHWs have a significant management and administrative role within the facility, some will be the in-charge of the facility, with responsibility for financial and staff issues. CHWs and FHWs also play a key role in data collection and reporting. They are expected to keep manual records on children immunized, elderly clients, pregnant women and PNC cases, and TB cases. They also maintain information on the antenatal and postnatal home visits conducted and the home based care provided for chronic and bedridden patients. CHWs and FHWs compile these data and share them with the atoll capital, who then consolidate them on a monthly basis and send an atoll report to all of the public health programmes. There is no functional HMIS system in Maldives yet.

1.5.8. Urban-based CHWs

Respondents indicated that urban based CHWs focus mainly on NCDs and home visits for bedridden cases. Urban health centres provide a basic package of services and were reportedly not utilized for any RMNCH care, as most people living in Male will seek hospital and specialized care. Despite low utilization levels, these facilities are staffed by a team of doctors and nurses, and as a result, CHWs reportedly get few opportunities to utilize their skills or undertake the full range of tasks in their scope of practice.

1.6. Effectiveness of CHWs

Respondents indicated that in the past when CHW and FHWs were the only health workers on the islands, “they would do all the interventions” and manage all the priority government programmes, with CHWs based and working primarily within their own communities. Both the CHW and FHW would make regular household visits for ANC, PNC, nutrition, vector control, environmental health, and health education. They also had responsibility for the school health programme, supporting teachers deliver the health aspects of the curriculum, as well as oral hygiene, deworming and Vitamin A distribution.

CHWs’ effectiveness in achieving key health outcomes was acknowledged. “All these success stories we had was because of these people”, “it was their work”, they “made a difference and delivered outstanding results for the country and community.” CHWs were perceived to have been very knowledgeable and as having played “a very, very instrumental role” in helping the country achieve milestones in health, and in improving immunization. “If you see the graph of each and every indicator, everything is going up, child mortality, maternal mortality.” At a time when there were no doctors, no nurses, they were credited with achieving and maintaining a malaria- and filaria-free country, eliminating measles, and establishing health systems in the more remote islands. They took care of the community in welfare, healthcare, and everyone was healthy.

One respondent, who had been a CHW but was now working in another part of government, described how a key source of motivation and job satisfaction was when the community changed their behaviours as a result of the CHW’s efforts.

‘The key thing that made me effective was the satisfaction I got when I made the community believe that you should eat well, you should come to the health centre to take delivery, you should drink clean water. These hygienic factors and this awareness, when I see them really doing it, when fruits and vegetables are available in shops, that gives a lot of happiness; that we are doing something to the community. It gave me a lot of motivation’ (K15- Government Agency).

Respondents who had previously been CHWs described how CHW roles and responsibilities had changed dramatically in recent years. These changes, especially in relation to RMNCH, were attributed to a number of factors, including the availability of doctors and nurses on the islands, greater demand for and accessibility of specialist and higher level care, increasing institutional deliveries. In addition, the reorientation of the CHW role to a facility-based administrative function and the low status and recognition of the value and associated decline in the take up of public health and preventative services. “Now there’s a doctor in every island, they are not willing to accept the lower level staffs to do these things,” were also identified as factors contributing to changing roles and responsibilities.

The policy of deploying doctors to every island was cited as one of the main reasons for these changes. “From that point, the doctor became the person who would provide all the antenatal, postnatal, delivery, everything basically and community health workers were more like education, inspection, surveillance and that type of thing.” Some perceived that the introduction of the doctor has contributed to CHW demotivation, with CHWs feeling like they were “second fiddle, not a very important person.”

Other attributed these changes in CHW roles and responsibilities to the overall neglect of preventative services and highlighted how this was resulting in declining health indicators. For example, the increase in dengue cases was attributed to a lack of vector control and management, and health education. Further, infant and child mortality were on the rise. Nutrition services, such as growth monitoring, were also “hugely neglected,” which was attributed to competing priorities on CHWs’ time, as well as a lack of knowledge on the CHW’s part of essential nutrition content and processes.

While protocols and guidelines for the programmes and interventions for which the CHWs were responsible, CHWs may not be familiar with them or do not apply them well. An example given was growth monitoring. This impacted on their effectiveness, with CHWs unclear about the content to be covered and the quality standards to be met. The availability of such guidelines and other job aids was vital, and access to this type of information on new developments and interventions was particularly important, given the infrequent in-service training, supervision and mentoring these cadres received.

Respondents felt that while CHWs and FHWs were knowledgeable and skilled, they were not utilizing these skills

optimally in the provision of care and guidance to families and communities. They were no longer "as instrumental in terms of convincing people on public health issues." A rapid assessment in 2017 found that mothers were by-passing CHWs and either seeking the advice of doctors or doing their own research by accessing information on the internet and social media, and did not know how to discern credible information.

Respondents suggested that CHWs interpersonal communication skills should be refreshed given the changing demographics and demands. They needed to do more to educate people, inform them about the preparation for birth, the value of ANC, beyond the doctors, how nutrition matters.

Respondents reported that staff shortages and capacity gaps within the MoH also affect the support CHWs receive to undertake their roles and responsibilities. For example, one respondent reported that the MoH health promotion unit that used to coordinate and provide training for CHWs on community mobilization, BCC and other types of health promotion is no longer functioning. Health education and awareness raising activities are now fragmented and conducted by the different health programmes. The absence of a focused health promotion agenda driven by the health protection agency (HPA), combined with the severe capacity gaps, and resource constraints over recent years were identified as key barriers to the provision of accurate and reliable health messages. As a result, there was a "big gap when it comes to actually empowering them with those types of skills," as well as in the provision of information on healthy behaviour to empower the community.

With CHWs taking on more administrative and management functions, respondents felt that they were spending too much time on information management and reporting, and "their focus is very much on sending the reports." This situation has also driven the community's demand more doctors, more specialists, and they no longer see the value of health education. As one respondent remarked: "they will demand doctors, laboratory or that type of thing," but they don't demand information, which is surprising."

Workload pressures were reported to be impacting on CHWs effectiveness, which was partly attributed to overall health workforce shortages across the country, as well as among the CHW cadre. Some bigger islands may have two CHWs, but on the smaller islands, there may only be one CHW, who is responsible for MNH, all the other public health functions, as well as reporting "it's mainly very few staff, two or three staff who have to report on disease surveillance, control, immunization, monitoring, a lot of activities for the community, as well taking sessions." It was suggested that workload could be reduced if they were to "reorient the way they work."

Heavy workloads were also as a result of CHWs having responsibility for too many health programmes, which also compromised the quality of the services they provided. For example, while there has been very good coverage of ANC in the country, some questioned the quality of the services provided, "we are not sure what these ANC visits actually comprise of, the quality aspects are not measured."
As a result of these pressures, CHWs had less time to undertake home visits and respondents felt that MCH related health education was now being neglected. Doctors in the health centre were also not providing this education, mainly because of the language barrier. "They don't know the local language and will need to use an interpreter." However, it was also noted that CHWs and FHWs were increasingly being utilized in the island hospitals to shore up staffing levels and to enable these facilities to provide 24/7 care. "Those islands, they use this family health worker as nurses, so they don't have time to go for home visits," leaving them with less time for home-based care.

Authorized absence, including annual, emergency and sick leave, also impact on the effectiveness of the CHWS. Leave benefits in Maldives are reportedly generous. "We have a lot of leave in our country, which means a lot of absence." This not only creates heavy workloads for those left behind, but also constrains the CHW ability to optimally undertake their roles and responsibilities, as well as participate in in-service training.

Age was perceived to be a factor in effectiveness. More senior CHWs and FHWs were still valued and very well respected by the community, and are still very much sought after. "Their opinion still counts a lot, and what they say means a lot to people." "Their accessibility and availability in the community was appreciated by the community, and for the FHWs themselves, "it was not a job, it was beyond a job." However, it was also noted that older CHWs may be too "judgemental" and as a result may "put people off." Younger CHWs, who have less acceptability among the community, often have difficulties raising issues of reproductive health, gender, and mental health, especially with older men, who may feel they lack the necessary life experiences to advise them about their families and children. It was perceived that the more mature women CHWs and FHWs can "easily engage and access men." But respondents also considered that the younger generation of CHWs, who are also familiar with the island community, can "make a difference and can play a key role in accessing different population groups."

Men are often engaged in jobs away from the home, in the tourism or fisheries sectors, and may not be available. Even when they are available, they may not be willing to engage or participate in discussions about contraception and RH, in awareness sessions or gender-sensitisation sessions, as they perceive these to be women's issues. Further, FHWs and CHW's own internalized gender norms may influence the extent to which they involve men in family planning and RH.

Respondents did not feel that gender was a barrier to the effectiveness of CHWs and FHWs, who are now mostly women. While safety on some islands was an issue, they felt that women were fairly mobile and family responsibilities did not affect their ability to undertake outreach work. Most communities accepted male and female CHWs, and there were few religious or gender barriers to women working as CHWs. Reportedly, there used to more male CHWs, but they have "moved up the ladder" or have left to seek employment elsewhere, "maybe at policy level or even at the administration level." As a result, FHW and CHW work is now seen as more of a female career. Men were perceived to have greater career mobility than women, and it was also easier for them to move around.
It was observed that some HCPs can be "very gender-insensitive." People are "not very confident that the information

they share with them will be confidential" and may be concerned that they could "become stigmatized or labelled within the community." As a result there are "a lot of problems that women go through with menstruation and other women-related issues that they don't want to go and talk about."

Poor teamwork and disjointed service delivery approaches also impacted the effectiveness of the CHWs. There were associated with the use and high turnover of expatriate doctors. These doctors are deployed on one-year contracts, although some leave before the end of their contracts, which respondents felt was have too short a time for them to gain a good understanding of the workings of the health system or to establish relationships with the health team and the community. When doctors leave before or at the end of their contracts or are absent for other reasons, "there's a gap in the clinical service" and CHWs "have to take on that burden," but their contribution is often not recognized, which can cause resentment and division among the team.

It was felt that the effectiveness of the CHWs cadres was hampered by the limited recognition of their profession and the overall lack of government support and investment in public health and preventative services. Although the CHWs' scope of work is now well documented, it was perceived that CHWs themselves are unsure of their roles and responsibilities, given the focus on curative care and the expansion of the health workforce at the island level. Reportedly, "a lot of them are not motivated, because they are not sure about their roles, and their career path, what is going to happen." With an increasingly management remit, CHWs are less involved in service provision, and as a result, CHWs themselves do not see the value of public health.

There was a perception that the work of these cadres was not well recognized or valued by the MoH and managers. Their focus was on the doctors and the 'curative side' and this contributed to CHWs' demotivation. It was felt that one of the reasons why CHWs do not realize the importance of what they're doing or how significant their work is, because "nobody's going there and motivating them." In an effort to improve their status and get more recognition and support for their profession CHWs want to change their post title; the scope of practice recently developed by Allied Health Council refers to both CHWs and PHCWs.

Respondents reported that political influences in health service delivery was another factor impacting CHW effectiveness. The delivery of home-based services and the CHW workforce has become highly politicized. "The moment you go into a household and start talking, people will look at which party are you from, which party are you supporting, it's always like the political parties playing against each other." Even in the small island communities, "politics has actually divided people." This impacts the ability of the CHW and FHWs to visit households and families; they need to convince people "they are talking about public health and they can be trusted."

Demand for, and uptake of, health information and education, SRH, adolescent health and mental health services has been changing over recent years. Respondents suggested that the roles and responsibilities of CHW and other HCPs, as well as service delivery models needed to be reoriented to meet the changing health needs and behaviours of the population.

1.6.1. Other PHC and CHW Cadres

CSC workforce data also included a public health cadre, with just over 100 posts and several grades. According to respondents, these cadres who have a diploma in PHC, have the same job description and scope of practice as the CHW. (Table 5)

Table 5: Number of public health cadre by categories

Public Health Cadre	No.
DG Public Health	1
Deputy DG Public Health	1
Directors	2
Senior Public Health Programme Officer	18
Public Health Programme Officer	28
Assistant Public Health Programme Officer	19
Public Health Programme Manager	8
Public Health Programme Assistant	24
Total	101

There are no systems in place for nursing students to get practical community health experience during their pre-service training. Nurses are posted to PHC facilities when they graduate, and they do not provide care in the community, however they participate in RH clinics, well baby clinics and immunization.

A number of NGOs have staff and volunteers working in partnership with communities groups to expand the reach of public health programmes to young people, migrants, the elderly, people with disabilities and women. However, many of these NGOs are Male-based, and their reach to the island-based populations is limited. Programmes and interventions tend to be based on capacity, interests and resources of the individual organization, and as such they may not meet all the needs of the population or reach all populations. There are also some areas that are not covered by civil society activities, such as maternal and child nutrition, and immunization.

As part of its child protection programme, UNICEF is supporting the development of community social groups, an initiative approved by Cabinet. This is a multisector group comprising "the health sector, the education sector, social workers, the police and the Island Council," as well as women's development committee, and NGOs who are active on the island. This group focuses on vulnerable groups such as "children, victims of domestic violence, the elderly, and people with disabilities," and on improving the family situation for these groups. CHWs and FHWs were being encouraged to get involved in the community social groups and to work with these other sectors to address the needs of the family in a holistic manner.

1.7. Selection, education, and certification

1.7.1. Pre-service Education and Training

Selection criteria and entry requirements for training are set by the government, with individuals applying for a place through the Maldives National University. CHWs are produced only by the Faculty of Health Sciences of the National University, which offers an 18-month Advanced Certificate in Primary Health Care (CPHC); a two and a half year PHC Diploma (DPHC); and a four-year PHC Bachelor's Degree (BPHC). The PHC course, previously known as the CHW training course, offers learning pathways for students move from the advanced certificate up to degree level but, "after finishing the advanced certificate they can exit, after diploma also they can exit, or if they want, they can continue to Bachelors." The FHS, as well as a private training institute, the Villa College, offer a Master's in Public Health.

In the past, some CHWs were sent to Sri Lanka for training to certificate level, but reportedly graduates from this course do not have the same level of clinical skills or knowledge of advanced procedures as those trained in Maldives.
The FHS used to offer an advanced certificate in Family Health Work, with a pathway onto the PHC advanced certificate course and the higher level courses and produce FHWs. However, this course is not offered anymore, and this cadre is no longer produced in the country.

1.7.1.1. Training curriculum

The PHC course is taught in English, with some courses, such as disease management, taught by specialists and local and expatriate doctors. The course "empowers students to face the current public health challenges" (Maldives National University, 2019). The PHC curriculum is developed in collaboration with the MoH, in line with WHO and international standards, is MQA accredited and approved by the relevant professional body, in this case the Maldives Allied Health Council.

The topics covered for the advanced certificate include management of diseases, first aid and practical procedures, basic pharmacology, communication in health, environment and community health, microbiology, health promotion, reproductive health, child health for PHC, health services management, and introduction to primary health care. For the diploma, additional topics include epidemiology and biostatistics and practicum in management of diseases nutrition, health services management, and PHC and health promotion. Additional topics covered under the degree programme include computer application, population dynamics and demography, research, health management information systems, quality assurance, epidemiology, ethical and legal practice, project management and international health. It was felt that the Degree was a very comprehensive four-year programme; graduates are "well trained" and have a level of knowledge, skills and competencies to "perform as a doctor, when there is no doctor."

The Mother and Child Health module, which also covered midwifery, has been replaced with a RH module as deliveries now mostly occur in the facility and no longer require the assistance of the CHW. Midwifery is now a separate course. The RH module includes content on "reproductive and gynaecological problems, diseases and newborn care," ANC, PNC, FP, nutrition, health education and counselling. PHC reforms and revitalisation, inter-governmental and inter-sectoral collaboration, and community participation are covered under the PHC module.

The original curriculum was designed to give CHWs all the knowledge and skills they would need to provide comprehensive services, at a time when there were few other health workers and very few island or atoll hospitals. These cadres "were doing the doctor's work in some areas." The PHC curriculum for all levels is reviewed regularly, and was last reviewed and revised in 2016, informed by feedback from the teaching faculty and other stakeholders. Reading materials were updated, and new content was added to address

Figure 5: Selection and training pathways for CHWs in Maldives

Selection

- CHW entry requirements for training set by government

Pre service education

- Courses offered by faculty of Health Sciences, Maldives National University
- Different courses- 18-month Advanced Certificate in Primary Health Care (CPHC); 2-1/2 year PHC Diploma (DPHC); 4 year PHC Bachelor's Degree (BPHC), in English
- Advanced Certificate in Family Health Work used to be offered earlier for FHWs, not any more
- Curriculum developed in collaboration with MoH, in line with WHO and international standards, approved by Maldives Allied Health Council, reviewed and revised regularly, includes clinical and curative component
- Includes practical training and placements in health facilities, community component including home and school visits

Certification

- Certification from Faculty of Health Sciences

In-service training

- By HPA technical staff. Also by development partners and NGOs

emerging diseases and public health issues. For example, an NCDs module was integrated into the curriculum, as well as topics on biostatistics, epidemiology, and international health. A research module was also incorporated into the BSc curriculum. The FHS are currently discussing the development of a one year training programme on emergency services for emergency paramedics with the MoH.

However, as stakeholders at the MPHF highlighted, the FHS needs greater clarity about the roles and responsibilities of these CHW cadres produced through the PHC training course, as well as what is expected of them from the MoH and the Council. This information will enable the institution to make the necessary modifications to the curriculum and ensure that the graduates produced have appropriate and relevant skills and competencies for the job, meeting the needs of the health sector and the population. Further, they need to have access to the HPA protocols and guidelines as they are developed to ensure curriculum review and design is updated and aligned with any new guidance and procedures.

While there is a GBV component in the training curriculum, it was felt that this content should be expanded, and there should also be a dedicated gender module. It was suggested that the NCD module should be a standalone module and incorporate the WHO Package of Essential Noncommunicable Disease Interventions (WHO PEN). Another round of revisions is planned, when the curriculum will be updated, and new material added.

Participants at the MPHF highlighted that staff and students needed more opportunities to participate in "knowledge upgrading," there needed to be more support from and collaboration with MOH/HPA and that public health role and responsibilities needed to be clearly specified, so that "the curriculum can cater for these needs" (Maldives National University, 2019).

1.7.1.2. Training modalities

Practical training and placements in health facilities and in the community for all students is an integral part of the PHC course. Students have opportunities to gain practical skills and competencies in the skills labs in the FHS under the observation of the tutors. They also undertake placements in the hospitals in Male to gain practical skills and competencies in advanced clinical procedures under the supervision of doctors and nurses, "they get all these procedures after practicing." Placements are also undertaken in the laboratories on the islands under the supervision of the hospital, "they have a lot of procedures to get signatures, if they don't get it, they have to do it again." The practical training gives students the opportunity to work with other health professional, and in this way the teamwork is built.

For the community component, they are attached to public health unit, with activities organized and supervised by the CHWs. They accompany the FHWs on home visits, undertake health promotion and education, and get involved in schools visits for the school health programme.

The curriculum covers clinical and curative care, although recent graduates rarely provide this type of care now. With nurses and MBBS doctors in most facilities, "they don't need to do these curative programmes." The only opportunity CHWs get to provide curative care is when the doctor is not available, or where the doctor or nurse does not have the required knowledge and skills to perform a particular procedure. Despite not getting many opportunities to fully utilize all their acquired knowledge and skills, respondents felt that the clinical content, including pharmacology should not be removed from the curriculum, as CHWs may need these skills when the doctor or pharmacist are unavailable.

It was perceived that while efforts were made to ensure students had opportunities for practical training to build their skills and competencies, some respondents felt that CHWs were not fully competent to provide comprehensive family support. While they had the knowledge, they did not always have the skills, as it was perceived the PHC course was mainly theoretical, with limited time provided for practical skills training, "maybe 10 per cent." One example was surveillance, where students are not trained on all the necessary components of surveillance.

1.7.2.3. Enrolment in PHC courses

The university and FHS has capacity to train and produce three to four batches of 30 students each year. However, enrolment and interest in the PHC course has been declining in recent years. In 2018, there was one male graduate from the DPHC course, 17 (13 females and four males) from the PHC BSc course and 11 (nine females and two males) for the Master's in Public Health. Only eight students were enrolled across all the three programmes in 2018. The enrolment and production of CHWs is not aligned to MOH staffing needs or requirements and there is limited communication between the institution and the MoH to agree short or long term production targets. Usually, students that enrol in the PHC courses are CHWs already in the job that wish to improve and upgrade their qualifications and skills, but even interest from this group is declining, partly due to the lack of career pathways and recognition of qualifications.

At the time of this study, the FHS had not received the required number of applications – at least 10, and therefore did not run the course in 2019. In the past, most students enrolled in the PHC courses were men, mainly because there used to be a lot of travel involved in the job. But in recent years more females are applying for the course, partly because there are now less constraints on their mobility. It was reported that FHS faculty are using a number of strategies to attract students and improve enrolment, including facilitating career talks in schools with school leavers.

There were several reasons given for declining enrolment. Respondents in this study, as well as participants at the MPHF, identified that the challenges in attracting candidates to this course and producing PHC cadres were linked to the "limited job opportunities" available to these graduates, as well as their "ambiguous/non-specific roles in the health system." It was reported that rather than seeking employment after acquiring their primary qualification, some will continue in education, moving from the diploma to the degree, and then onto the master's course.

A lack of clarity about CHWs responsibilities and shifting functions on the ground, as well as uncertainty about their role and position within the PHC team, were perceived to be influencing applicants' decisions to enrol on the PHC course. "They don't know whether they are doing clinical work or not, that's why they are not coming for the course." Respondents reported that CHWs working in the health centres were "discouraged" and "fed up" with their jobs and regretted choosing a public health career, mainly because they felt they were unable to carry out the role they have been trained and employed to do, their contribution was not recognized and the public health services they were providing were not valued.

The literature identified the prohibitive cost of higher education, especially for rural girls and boys who have to leave their island and live in Male as well as the social norms that may make it challenging for girls to live away from home (UN, 2019).

In addition, it was perceived that remuneration was not commensurate with the scope of work and level of responsibility these cadres are expected to take on and is not sufficiently attractive to attract students to the training and/or into the public health profession and public health system (Maldives National University, 2019). Other courses, such as the health service management course are now more popular than the PHC course. FHS is having ongoing discussions with the MoH about new training offerings and potential upgrading opportunities for PHC graduates, such as a one year international training programme in emergency services. A proposal for a pilot PHC project in Baa Atoll has also been submitted to the President's office, which will involve FHS designing and delivering blended training programme to upgrade CHWs skills.

There was a sense among respondents in this study that the low status and lack of recognition of the value of public health and PHC professions were also influencing applicants career preferences and choices. Attitudes of politicians, policymakers and health team members towards public health and preventative services were also identified as influencing applications choices Some remarked that "people think that primary health care is not for them, or for our country," because politicians were more interested in curative care. Respondents perceived that due recognition of public health by the government would help attract back student to the course, "if the Ministry's view regarding PHC is changed, then everything will be okay." Students were also discouraged by staff they interact with during their placements, who query their career choice and ask, "why are they doing this primary health care, there is no hope, no future in the country?"

1.7.2. In-service Training (IST)

In-service training for CHWs and FHWs is provided by the HPA technical staff from the different programmes in the areas for which they are responsible. Development partners and NGOs also fund and support various refresher and IST programmes for these cadres.

Development partners and United Nations' agencies provide technical support and funding for in-service training and refresher training sessions in response to specific requests from the MoH, at the start of a new programme or when new policies or interventions are developed and introduced, or to address capacity or service delivery gaps identified through surveys, such as the DHS and MICS. Typically these sessions are run by the respective HPA programmes, usually targeting geographical locations. To date, RMNCAH related in service training has been provided on areas including ANC, pre-conception, safe pregnancies and motherhood, breastfeeding, infant and young children feeding (IYCF), nutrition, anaemia, immunization, counselling, IYCF, BF ENBC, HIV and other speciality areas. NGOs, such as SHE, provide short refresher training on topics such as "how to provide FP contraceptives", "how to provide ANC and PNC", and the type of counselling that should be given to these clients.

A key barrier to ensuring regular and quality in-service training and mentoring were the limited resources available to meet the "high operational costs" of reaching such a widely distributed and dispersed health workforce. The usual training delivery approach was "to train the atoll-level focal points" centrally in Male as "master trainers," and they were then responsible for cascading the training down to other health workers at the atoll and island levels, including the CHW cadres. However, this was a very expensive approach, "to invite even the atoll level focal point for a four-day training here (Male), will cost us more than USD$50,000." The high cost of such training limits the number of participants that can attend and the frequency of the training. "We have 20 atolls, so a maximum of forty participants will be there, so it's like once or twice in a year." Often it is the same CHWs and FHWs who attend these training programmes, year after year. The travel required to participate in the training can be a barrier for some.

Increasingly, more affordable and cost effective approaches are being explored and adopted, such as facilitating training at the atoll or island level for all health workers, as well as providing training remotely using teleconferences. Respondents indicated that in the case of health education and awareness, key talking points on NCDs and other relevant topic will be sent via email to the CHW, who will then use these to conduct awareness and health education sessions during Friday prayers, or on dedicated health days. Providing opportunities for overseas and/or local training was perceived as a key motivator for these cadres.

In addition to resource constraints, it was perceived that IST was not structured or systematic and tended to be delivered on an ad hoc and opportunistic basis. There appears to be limited systems and processes in place to assess training needs or to evaluate the quality, effectiveness and impact of such training, "they need to do training gap analysis because there are a lot of health workers who have not received any single training, for so many years." Another barrier identified to IST delivery was the shortage and high turnover of technical staff at the HPA and other levels to conduct such training. As a result, the overall perception was that CHWs were receiving insufficient in-service and refresher training. While some may get training on specific HPA programmes or interventions, areas such as communication skills and health promotion training are often neglected. "They don't get refresher training in terms of their overall capacity, behaviour change, communication, the health promotion side of things" to enable them effectively "engage with the community and mobilize the community."

Further, the selection of participants for IST and refresher was perceived to be inequitable and biased towards those who were "most influential" and who could self-select, to the exclusion of those who were involved in programme implementation and/or responsible for the specific intervention or task for which the training was being provided. In the case of public health training opportunities, it was reported that "most of the time hospital staff are selected for that training" and island respondents indicated that, "there's no training, but they also need to grow, they also to improve." Some participants may not be able to take up available training opportunities if there is travel involved and they have family and other personal commitments. In addition, it was perceived that the knowledge and skills acquired through such training were not always transferred or applied to the job, "even after training, they go back and it's business as usual."

1.7.2.1. Certification

The FHS certifies PHC course and, depending on the duration of the course award Advanced Certificate, Diploma, Degree, BSc or Masters.

1.8. Management and supervision of CHWs

1.8.1. Deployment

On completion of training, CHWs can return to their original post or apply for a vacant post elsewhere as advertised by the atolls or across the MoH. Based on the MoH staffing structure, the atoll hospital gets approval to announce vacant posts and to interview and recruit CHW to fill these posts.

'After completing PHC course in Maldives, we can work in any area, any field, like in the preventative side, as a community healthcare worker in the island hospitals or the health centres' (KI6- NGO).

Respondents felt that there is less flexibility now as a result of the civil service rules and regulations regarding employment and remuneration, such as facility based staffing norms. These rules no longer allow the atolls to manage the distribution of the workforce as per their needs. Previously, for example, when there were shortages or gaps in the availability of CHWs because of leave or other reasons, "the atoll level will manage, move them around, but now they are fixed to the facility."

1.8.2. Attraction and retention of CHWs

Maldives has a Low Labour Force Participation Rate (LFPR), with men's LFPR at 75 per cent and women's at 42 per cent. Most of the female population is categorized as economically inactive, which has implications for the country realizing its full potential (UN, 2019). There are a number of reasons for women's low LFPR including, lack of job opportunities, inability to get "suitable" jobs, and family responsibilities.

According to the literature a key challenge in ensuring harmonized quality and accessibility of care across the 187 islands is the high turnover of health care providers and maintaining an adequate level of training and quality of care within this context (UN, 2019). Attracting and retaining sufficient number of CHWs has been a challenge in recent years, with waning interest in PHC careers and growing numbers of PHC graduates/CHWs leaving the profession; reportedly some islands have no CHWs. It was perceived that these losses were due to a number of push and pull factors, including the availability of more attractive better paid jobs. "They can get easier jobs, well respected, well paid" and the poor remuneration and limited job mobility within the current public health profession, "there is no career pathway, there is no salary increment, no improvement."

Due to the limited number of approved senior CHWs posts, graduates with diplomas, degrees and masters are reluctant to return to their original job, where their additional training and qualifications are not recognized, and where they will have few opportunities to utilize their new skills and competencies. They are seeking employment elsewhere, once they complete their courses, in the MoH, HPA, in the ports, in school health programmes or with NGOs or other Male based organizations. Reportedly, graduates are also reluctant to take up posts available on islands other than their home island because they would have to live away from their family and would not receive any additional benefits or allowances to cover accommodation and food. Increasingly graduates emigrate or move to "private practice" (MoH, 2016). Others will opt for health management or administrative posts, rather than go to the field. "Where are the trained people; they're not going to the field, they are doing the management and administration."

Employment options exist for PHC graduates in other sectors, for example in the education sector, as counsellors on the school health programme. However, these are not any more attractive than health sector posts; reportedly remuneration for these jobs is lower and there are fewer allowances, e.g. risk allowance, and no opportunities for clinical practice. As a result, the education sector also has challenges in attracting PHC graduates to these posts.

1.8.3. Remuneration and allowances

Respondents indicated that CHW salaries were low, with remuneration a key factor in the low motivation of CHWs. It was reported that "the salary issue" and the absence of a salary structure were the main issues discussed in a CHW Viber group. CHWs remuneration salary was not in line with the cost of living in the Maldives, which was reportedly high, and "with the cost of things, it is very difficult" for them.

Poor remuneration was also linked to the challenges in attracting, deploying and retaining CHWs, especially in the more remote islands. Recruitment is linked to a facility and if a CHW who is not from the island is appointed they do not get the out of island allowance. Therefore, CHWs are reluctant to move away from their home islands and take up postings elsewhere because it was difficult to cover housing costs from the current salary they receive. If they go serve in a community where they are not from, with their salary scale, they will not be able to pay rent. Respondents described that it was different in the past. "When they send a person to another island, if their house is not in that island, they will give them an allowance for that."

As described above, even with an improved qualification, such as a Masters, there is no improvement in CHW salaries. "There are community health workers who do their masters and still they get a very low salary; there's no proper job

structure." When CHWs update their knowledge, they often go back to their original posts jobs without a promotion or salary increment, because there are no higher grade jobs available with this job category .

'When our graduates are going to work, they don't have the posts available. They don't have the vacancies. And they don't get the expected remuneration. They still have to go back to their old jobs' (KI7-Training Institution).

Respondents noted the disparity between the remuneration of public health and CHW cadres and that of the curative health professions. "There is a big difference in salary scale between public health worker and the doctor and the nurses", and this was a major cause of CHW dissatisfaction.

There were perceived inequities with the provision of allowances also. The expatriate health professionals reportedly receive a wide range of allowances. "They are given full accommodation, food allowance, transport allowance, everything is given; that's another issue of demotivation." This was a further source of CHW resentment, which also had implications for team and collaborative work across the PHC team.

Remuneration for health and education sector employees, which have the largest workforces, was particularly low, especially when compared to other sectors, like the police, military, and the judiciary.

1.8.4. Career progression

Respondents highlighted that the lack of a career pathway and career advancement opportunities, "the ladders we can climb up are very few" were factors linked to low motivation, lack of job satisfaction and attrition among the CHW cadre. Lack of job mobility was one reason why CHWs felt disheartened and why CHWs who are very competent and technically sound were choosing to move to more attractive posts in other sectors.

'So why would I choose a profession where I cannot go ahead? And all the community health workers are doing MBA, business administration. So, we are losing them to other industries' (KI8-MoH).

Civil Service Commission data recognizes three CHW grades, including ACHO, CHO and SCHO. Promotion to SCHO level – a Grade 3 SCHO is the equivalent of an assistant director – requires a degree. However, there are few approved SCHO posts available. Some CHWs have remained in the lower level posts for many years, with respondents describing how they might "be stuck in the same position for five, six years or 10 years, without getting any increment," which was "not encouraging for them" and was the cause of "a lot of grievances." Even when they obtain a degree or master's and are "really growing in terms of learning and capacity," they will have no opportunity to advance until a higher position becomes available, and then it is a highly competitive process. In practice, well-qualified staff may remain in an ACHO post, as this is the only available post in the facility.

Even if one does succeed in getting promoted to SCHO, while it attracts a salary increment there is no job enrichment, and much similarity between the responsibilities of the ACHO and those of a Senior CHO. "In the work, there's no difference."

Respondents also indicated that although most PHC graduates are female, it is mostly men who are in the senior positions. The perception was that "most of the time in the managerial level, it's the men," mainly because they were politically connected. It was more difficult for women to advance to the "managerial level." Few health centre managers were women, despite the fact that more PHC graduates were women. Reportedly, the outgoing government "made political appointees for every health facility," with some CHWs promoted into these managerial posts. Apparently these posts were very attractive but short-lived given the change in political leadership. "The salary is there, you get the status, you get the influential power and authority, but the disadvantage is that the influence is short-lived."
There is less job mobility for CHWs who have graduated from Sri Lankan training institutions. They are not recognized or considered for promotion. "We cannot upgrade them because they have not done particular subjects."

The CSC was working with the MoH and Allied Health Council to develop "a professional and technical structure" for the CHW cadres, describing "their tasks, what they will be exactly doing in each level, how they will be categorized, what are the qualifications they require." The CSC has also proposed a new salary scale for the CHW cadre, "based on the ranks", which was under consideration by the Pay Commission at the time of this study. The Council felt that this was a "good opportunity" and would improve career mobility for these cadres.

1.8.5. Supervision

Insufficient funding, shortages and turnover of technical and supervisory staff, and geographical barriers were among the factors highlighted as hampering the provision of regular supervision and monitoring. The limited financing for public health and the operational costs of reaching the widely dispersed health workforce make quality supervision challenging.

Although some respondents described how medical specialists and HPA technical staff would previously make supervision and monitoring visits, this was no longer the case. Respondents did not identify any CHW supervisory posts – it was unclear what supervisory role and responsibility the senior CHO had. There were no arrangements in place for training CHW supervisors or mechanisms identified for the provision of supportive supervision for CHWs. Reportedly this has been case for a number of years, "no supervision, even during the six years of my experience."

CHWs are mostly "responsible for themselves. There is no supervision, we do whatever we feel." Respondents also indicated that this was a major challenge for this cadre as "nobody else within the facility overlooks and identifies what issues they have." The main link for CHWs is with the HPA, who are responsible for supervising the programmatic aspects of their work, but due to staffing shortages in the HPA, it was difficult for the technical staff to undertake the required visits and monitoring trips as it was difficult for them to get around to all the islands. Reportedly, each individual CHW is expected to prepare an annual work plan aligned with global targets, but the development and monitoring of work plans linked to national and local indicators and targets did not appear to be routine activities.

Some indicated that the HPA programmes and other departments, such as the MoH quality assurance division, do conduct some supervision and undertake programme reviews. But this was perceived to be more of a monitoring and inspection exercise. Reportedly, continuous supportive supervision involving the identification of performance improvement areas and the provision of support and mentoring to address these, was not conducted.

Supportive supervision from the atoll level to island level health facility was also perceived to be weak and infrequent, with the majority not providing this type of supervision at all. The weaknesses in supervision were associated with quality issues and the weak compliance in the application of national guidelines, as well as accountability. The reasons for such poor supervision practices were attributed to demotivated senior staff, a lack of professionalism and poor attitudes towards the job. "The whole perception about healthcare has changed, even public servants don't see it as a service, it is seen as a job, that passion and motivation is not there, that's why supervision doesn't really happen; they do supervision because MoH tells them to do it." In the absence of supervision, most CHWs will only have contact with supervisors at the atoll and central levels when they have a question or some enquiry. The supervision of students is also poor: "most of the students, those who are there, they say no supervision, whatever way they do, they do it."

Reportedly, performance appraisals are often conducted over the phone, with little monitoring or follow-up of the CHW attendance, performance, capacity or any problems they might be having. "The supervisor doesn't check any of his activities, whether he attended or not, only, have you done this, yes sir; of course he will say yes, and then give points."

1.8.6. Integration into the health system

While the CHW cadres are employed by the government and their training is publicly funded, respondents felt that the government had neglected public health and preventative services. All emphasized that increased financing and investment was needed to support these cadres, "to work as community health workers." Although the availability of doctors and nurses had improved, these CHWs cadres and their functions were still required. "We don't want them to be a doctor now, because we have doctors, we have nurses." But the government should "respect, recognize them, acknowledge them, and give them responsibilities."

Some felt that the limited availability of approved public health posts and CHW jobs was to a large extent due to the lack of importance the government attached to public health and preventative services. There was a perception that "health workers and HPA are actually at the bottom of the priority list." As a result, many CHWs are not in the health facilities or hospitals, but have taken up employment elsewhere, such as in the airport, in private clinics, or in school health systems.

'There are a lot of students who couldn't get a job, because the ministry itself thinks that they are not important, that they don't need community health workers, they don't need primary health care workers, so we don't get jobs' (KI4-Training Institution).

Respondents felt that teamwork "is the missing factor" and that it was important that all providers in the island health centres and hospitals "really should work together as a team." The expectation is that doctors, nurses, CHWs and the other cadres in the facility work as a team to provide a range of integrated services. However, some respondents described how CHWs worked alone, and were both physically and professionally separated from the curative health team, with a "great divide" and "communication gap" between curative and the preventative services. CHWs have also complained that "they don't feel that they are part of the team." There were suggestions of a rift between the FHW and CHW cadres and as a result this relationship was also not very collaborative. This lack of teamwork had led to a "disconnection with the patient and seeing the patient holistically." It was perceived that service delivery should be more integrated and in particular, there needed to be more linkages between curative and the preventative programmes and services.

1.8.7. Data collection

Data collection, management and reporting, which are still largely manual, paper-based systems, are key responsibilities of the CHWs and FHWs. As set out in the 2018 Maldives Healthcare Standards of Care these cadres are responsible for the daily maintenance of patient census; recording health programme-related information; and collecting information on notifiable diseases and conditions as per HPA guidelines. They are also expected to maintain information on elderly clients, pregnant women and post-natal cases in their area, and keep records of the home visits they undertake and the home based care they provide for chronic and bedridden patients, as well as antenatal and postnatal visits. All such data are expected to be compiled and reported within the prescribed timelines.

Respondents described how CHWs and FHWs record information gathered through the home visits on standard forms and submit these to the public health unit (PHU) at the atoll level, where the data are entered onto spreadsheet. Although CHWs have computers in the facility, these are not yet connected to the online system to enable them to enter and generate data; although this is a planned activity in the roll out of the DHIS2. They have already received training on data collection and entry during the piloting of the District Health Information System 2 (DHIS2). These cadres were perceived to be key to the effectiveness of the DHIS2. "They are the people who will be using, entering data, analysing data, reporting and taking data for decision-making".

The roll-out of DHIS2 is expected to harmonize the collection and analysis of data at facility level and create a more comprehensive information system with indicators for all health programmes, including RMNCAH. Creating such information systems will also enable island level facilities to enter data and "do the analysis themselves." The roll-out of the DHIS2 was initially focusing on the data needed for policy, such as "outpatient numbers, bed numbers, in-patient information," with plans to move onto collating communicable diseases' data in the near future.

In the preparation of the Healthcare Quality Standards, it was found there was an "information disconnect" between the hospital and the public health unit, although both were located within the same campus. The assessment tools developed as part of the Quality Standards Framework were

expected to supersede and replace all the existing parallel assessment checklists.

Respondents indicated that there were multiple stand-alone information systems and reporting mechanisms across the different programmes within the health sector and across other sectors, which created inefficiencies and a heavy administrative burden. Greater harmonization and improved interoperability across all the different systems including HMIS, DHIS2, local council information system and registration and vital statistics was required.

As the *Aasandha* health insurance scheme allows people to seek free services at any level of the health system, respondents reported that it was often "difficult to track and monitor where people are going." For example, 85 per cent of women attend more than five ANC visits, but each of these visits could occur in a different facility and location, with the final one, and possibly delivery, occurring in Male. "It's a very mobile community here, the first visit would be in their island, second would be in the atoll level hospital, and the last trimester they'll come to Malé, because IGMH and ADK, the two hospitals, provide more than 60 per cent of deliveries in the country." Respondents indicated that referral systems, back-referral and linkages between the different levels of care was still weak and could be improved.

1.8.8. Community integration and engagement

It was perceived that in the past CHWs and FHWs had good relationships with families and the community; they were "very powerful people in the island", and "attached to the community." They were trusted and accessible and the community would seek and take their advice "so they believe us, they come to us if something happens at home, they used to call and they would take the advice and follow the instruction that we gave by phone." These CHWs were commanded a lot a of respect within their communities and were perceived to have good "knowledge of the community, as well as professional knowledge, in terms of how to take care of children, nutrition and feeding."

However, the situation has now changed and many CHWs and FHWs had lost their status and the trust and confidence of the community. Respondents perceived that the medicalization of service delivery and the availability of doctors and nurses in health facilities at all levels and the neglect of preventative/promotive services had contributed to this situation. "The community now they feel that they need doctors, not just Medical Officers, they need specialist doctors." Respondents perceived that policies shaped by politicians' election promises, e.g. deploying specialist doctors to every island, were influencing people's expectation and demands for an ideal healthcare system, which had contributed to a reduction in the acceptability of CHWs.

'Nowadays people don't accept community health workers, maybe due to political pressures. These political people go to the islands and they say if they win the election, they will give the island a doctor or some specialists, like that. That's why the community health workers acceptance has gone down' (KI9-MoH).

The community's attitudes towards these cadres had changed and they were less willing to seek care and advice from them, preferring instead to seek medical care from a doctor or specialist, "now they are not well accepted like a doctor in a community," and they are "more confined to delivering vaccines and some home visits."

With the CHW cadres largely facility-based, their interactions and engagement with the community and families through household and schools visits were now minimal. There was a perception that they had lost their connection and 'credibility' with the community and were no longer perceived as "instrumental" or "valuable." The home visits that do occur are mostly conducted by the FHWs. CHWs and FHWs are no longer perceived to be the support mechanism they used to be in the community and communities perceive the home visits they make "as just visiting and checking on things."

With many of the island communities small in size and everyone familiar with one another, there was a fear of lack of confidentiality when seeking care from CHWs for sensitive issues with "people now seeking information in other ways, especially on the internet." Respondents indicated that many CHWs and FHWs were no longer linked into community structures and groups, such as the mothers' groups. Some of these groups were more dynamic now; sourcing health information on the internet and meeting at times that did not correspond with the CHW's working hours, or meeting "virtually," using social media platforms to connect with each other and share information. However, respondents were concerned that "anecdotal evidence is given as much as facts" through these channels.

In addition, political parties have influence, even at the lowest level, and CHWs may be perceived to be affiliated with a particular political party when interacting with households. This creates further mistrust in the community and in some cases, "CHWs are not allowed by people to go to their home."

Respondents indicated that communities in some of the islands can be quite conservative in their religious or cultural beliefs and this impacts on their health seeking behaviours, especially the demand for and take up of SRH services. For example, although emergency contraceptive pills are provided by the health sector in cases of rape, there may be unwillingness among the population to access and use them.

With the necessary system and policy support, it was perceived that CHWs and FHWs could play an important role in the Community Social Groups, that are being established to address the needs of vulnerable and marginalised individuals and their families, working collaboratively with other members of this multisectoral group to meet their needs in more a holistic manner.

The overall perception was that trust in health and other government sectors had broken down. "The whole system is quite shaky; it not just the health sector, it's also education, and other sectors; people don't have the kind of trust that they used to have with the sectors."

1.8.9. Availability of appropriate medicines and supplies

Drugs, equipment, and supplies are generally available – without stockouts – except in some islands where they experience outages of contraceptives and other supplies. Respondents reported that contraceptives and the other supplies are often not delivered on time. Further, the contraceptive methods that are being provided in all the islands are "the condom, the pill or

the injections," and "long-term methods are only available in the capital and the regional hospital or central health centers, where there is a gynaecologist."

Leakages and wastages in the medical supplies and logistics management system was one of the key health sector challenges identified in the GoM SAP 2019-2023.

1.8.10. Private sector contribution to CHW programmes

Reportedly the private sector plays little or no role in CHW programmes. They are not involved and make no financial or technical contribution to the education, training or employment of CHWs in Maldives. The exception is Villa College which offers a Master's in Public Health, introduced three to four years ago.

1.9. Financing and resource mobilization

In Maldives, there are three main sources of financing for the health sector: namely, public, private and external sources. Spending on health is high in Maldives compared to other countries in similar developmental situations. Health expenditure was 9.03 per cent of GDP in 2017 (WHO,2019).

'Maldives spend the highest GDP in the South Asia region on health. Almost ten per cent of GDP on health. Very few countries do that. But that's mainly going to the curative care and the insurance coverage' (KI10 – UN Agency).

Total spending on health from all sources rose by 50 per cent between 2011 and 2014 to 12,641 MVR per person or $810 – almost double the average of upper middle-income countries ($ 436) (WHO, 2018). It was reported that "if current levels of health spending is sustained, Maldives can aspire to achieve global health goals much faster than most of its neighbours" (WHO, 2019).

The major source of health funding is from the government, "government health expenditure, as a percentage of the current health expenditure, is 73 per cent." Household out-of-pocket (OOP) expenditure as a percentage of total health expenditure has decreased and was 20.6 per cent in 2017. Drugs as a percentage of total health expenditure increased from 17 per cent in 2011 to 32 per cent in 2017 (WHO, 2019).

Although the primary focus of the government is to provide equitable access to primary health care services and sustain uninterrupted service delivery at all levels, much of the financing has targeted curative and hospital-based care, for example in 2017, MVR59.4m was spent on outpatient curative care. Curative services are often demanded by the population and provided as a result of political pressure (Rutter, 2019). In 2017, health care spending for preventative care as a percentage of total health expenditure (THE) was 1.5 per cent while health care spending for curative care as a per centage of THE was 77.3 per cent (WHO, 2019).

As evidenced by the examples provided above, underfunding of public health and preventative services has impacted on PHC workforce strengthening, including attracting and retaining public health workers and CHWs at PHC level, as well as the provision of quality training, mentoring and supervision to assure the quality of the services provided. The availability of free services at any level has driven up demand for hospitalised and specialized services. The Aasandha social health insurance scheme, which allows people to seek care at any level has led to increased demand for specialized care "for any illness." It has driven the irrational use of medicines; it is estimated that drugs accounted for around 20 per cent of total insurance cost. Services provided in the peripheral facilities on the islands are available and free of cost, as one respondent remarked, "access to health care is amazing, you'll never see such a structure anywhere, there will be a pharmacy with more than 480 essential drugs, that are free of cost." However, many prefer to seek care in Malé's health facilities and hospitals, which creates pressures, overcrowding and inefficiencies in the delivery of services in these facilities, "you need to wait for three days to get an appointment in some instances."

Respondents felt that the current system was "a very expensive health care system," and that "government expenditure is just increasing and increasing." The overall perception was that resources were not always well utilized, with examples given of previous attempts at decentralization/corporatisation, the current health insurance scheme, and the use of expatriate doctors; "we do things the expensive way." It was reported that the biggest expenditure in the country was on drugs, "30 per cent of the health budget is on drugs" and there is "no strict regulation," "no strategic purchasing" to reduce these costs.

Respondents perceived that the health insurance scheme was being "violated," "people go there and take two, three bags full of medicines, and then sometimes they take them to their friend's pharmacy and sell them there." The scheme is also open to abuse and increasing OOP, with some facilities asking clients to pay more than their required contribution of the cost.

Respondents reported now that Aasandha is an online system, with people having to submit and have their claims assessed online before payment is made, that there are better, "checks and balances in place" and improved management and control of prescriptions and drugs.

2. Policy and system support improvements to optimize CHW programmes

- **KEQ 2:** What policy and system support improvements are needed to realistically optimize the CHW profiles and roles and responsibilities of CHWs to better serve maternal and newborn health and to respond to the post-Astana or Primary Health Care (PHC) reforms and strengthening.

This section responds to KEQ 2, which seeks to identify and assess actual or prospective country level Astana commitments or PHC reforms, and what improvements are needed in existing CHWs policies and system support to achieve these, and to improve the provision of RMNCAH services.

2.1. Policy improvements to optimize CHW programmes to respond to post-Astana requirements and PHC strengthening

This section discusses the policy improvements identified to optimize CHW programmes in the Maldives to better serve maternal and newborn health, and to respond to post-Astana and PHC reforms and strengthening.

2.1.1. Public Health Revitalization

The Astana Declaration recognizes PHC as a cornerstone of a sustainable health system for UHC and health-related SDGs. Strengthening PHC is the most inclusive, effective and efficient approach to enhancing people's physical and mental health, as well as their social well-being (WHO/UNICEF, 2018). CHW programmes as a sub-system of PHC, have a vital role to play in strengthening PHC, in expanding the provision and reach of a range of preventative, promotive and curative services and in achieving universal coverage (WHO, 2016). PHC reforms and strengthening efforts should ensure the comprehensive vision of PHC and the three interrelated components, namely integrated health services, multisectoral policy and action, and empowered people and communities are embedded in the key policy frameworks that govern the health sector (WHO/UNICEF, 2018).

The second of the three resolutions on UHC of the 2019 World Health Assembly recognized the contribution of CHWs and urged countries and partners to allocate adequate resources to optimize CHW programmes. It also emphasized the need for CHWs to be well trained, effectively supervised, and properly recognized for the work they do, as part of multi-disciplinary teams. Further, it recognized that investing in CHWs generates important employment opportunities, especially for women (WHA, 2019).

While Maldives has not articulated any specific post-Astana commitments, the revitalization of public health and promotive and preventative services is a national imperative, emphasized in the GoM SAP and at the 2019 Maldives Public Health Forum (MPHF). The forum facilitated high-level policy dialogue on investing in integrated PHC and the creation of a continuum of care from promotive and preventative to curative and rehabilitative services. The case was made for "promoting health and well-being" to enhance national "resilience, employment and social outcomes" (WHO, 2019 MPHF). In particular, a case was made for greater public health investment and action in tackling the growing NCD burden, ending TB, control and management of vector borne diseases, especially the prevention of dengue in terms of lives saved in Maldives.

The overall perception of respondents in this study was that government policies and the political leadership needed to redress the years of neglect and underinvestment in public health and preventative services and the medicalization of care, all of which had adversely impacted on the effective and efficient delivery of PHC and community-based care. Some suggested that what was needed was a "wellness concept, rather than like a disease specific concept; healthy workplaces, healthy homes, healthy islands, we need to rethink along those lines." An effective public health system would reduce the need for hospitalisation and relieve the current pressures on tertiary level facilities and services "their workload also will be much diminished." It was felt that promoting a preventative focus will also help tackle NCDs and the needs of an aging population.

Respondents recommended the formulation of evidence-based specific public health and/or PHC policy frameworks that, "focus on implementing primary health care properly." The MPHF was received very positively by respondents and was perceived as an important step in the government's commitment to invest in and strengthen public health and PHC. There was a sense that there was widespread support for the public health reforms and improvements proposed in the forum, "there's lots of support, from different stakeholder, genuinely they are interested to change, to improve the health system."

2.1.2. Integrated PHC Services

It was recognized that the government and the MoH were looking at ways to strengthen the public health arm of the PHC system and enhance integrated PHC. Respondents were hopeful that the outcomes of the MPHF, including the promise of a road map to revitalize public health and the declaration of 2020 as the Year of Public Health, would provide the strategic focus, necessary impetus and attract appropriate levels of financing and investment for the transformation agenda. There is the expectation that the revitalisation process will provide the opportunity to "reorient the services provided" and provide a "continuum of care." Teamwork will be promoted, with everyone responsible for public health. There will be a renewed focus and advocacy for a community health approach and follow up of the population in the community, especially for "prevalent chronic diseases." Service delivery will be from the "person perspective," so that the individual "gets more of the right services from the same place" and therefore reducing "self-referrals."

Integrated PHC services and strengthened referral and back referral systems between primary, secondary and tertiary levels of care were recommended to improve the efficiency and effectiveness of service delivery. The coordination between specialists and doctors in atoll or tertiary hospitals and island level providers and programmes especially needed strengthening, "it's like a parallel system," there's no interaction." The integrated service models and team approaches to service delivery presented at the MPHF were seen as positive and "workable" and would contribute to stronger and more effective referral system. However, respondents stressed that this reorientation of services would represent a "major shift "and would need strong leadership from the MoH "somebody in the ministry needs to drive that." It was recommended that such changes should be introduced incrementally, they "cannot happen together in all areas," or be a "big bang like the corporatization," otherwise, "it will fail."

At the PHC level, respondents suggested that roles and responsibilities and scopes of practice across all PHC cadres should be clearly defined, supported by appropriate job descriptions, guidelines, and work processes. This would reduce duplication and ensure respectful and collaborative relations and teamwork across the PHC workforce.

'It's not CHWs or primary health workers, everybody is involved in primary health care. There's a role for nurses, there's a role for doctors, whenever you meet with patients, it's an opportunity to do preventative work, to do health education, to do like screening. That thinking is there now. So we don't just send them to the community health workers for public health work. That's the difference, that's the shift that's going to happen, hopefully' (KI1-MoH).

MoH direction and guidance was needed to enhance multidisciplinary and multisectoral collaboration at the PHC level. Such policy level support would encourage greater involvement and participation of the PHC workforce, including CHWs, in community-based interventions and

groups and contribute to more holistic and cost effective services for individuals and families.

Multisectoral Community Social Groups, an initiative approved by Cabinet, are being established to address the needs of vulnerable groups and their families in a holistic manner. Given their relationships with families in the community, CHWs and FHWs are well placed to play a key role in these groups, ensuring that the specific health need of these individuals and families are also addressed, but they need the necessary policy and system support to enable their participation.

Given the limited resources available for state funding for public health initiatives, respondents suggested that greater collaboration with NGOs who have established networks and partnerships with diverse population groups would enable the PHC workforce to expand the reach of its public health programmes and enhance the sustainability of their interventions.

Decentralization

Respondents expressed concerns about the Decentralization Bill that was being debated in parliament at the time of this study. Many felt that in principle, decentralization was a "good idea" but stressed that policymakers must learn from the lessons of previous experiences and attempts at decentralization, including adequate "preparation," and putting in place appropriate "mechanisms for proper handover and oversight." Polices and interventions should be evidence-based and every effort should be made to mitigate any further shocks or disruptions to health systems and the health workforce.

The expectation is that Island Councils will have a greater role in the delivery of health care. One of the key interventions will be to establish the credibility of the community health worker system and achieve the outcomes of the Health Master Plan, including "improved trust in the national health system."

2.1.3. Leadership and Governance

The Astana Declaration encourages stakeholder alignment in supporting national policies, strategies and plans. Concerted political commitment and leadership from the MoH and the top levels of government that promotes multisectoral policy and action across sectors and stakeholders, will be vital for the revitalisation of public health and for creating stronger, resilient, equitable and sustainable PHC systems.

The coordination and collaboration of stakeholders with different interests, agendas, priorities and operational modalities across the public and private sector, while complex and challenging, will be essential to achieve the Astana vision for PHC, the GoM SAP and the MPHF commitments. The overall perception of respondents in this study was a multisectoral approach was key to building strong and sustainable PHC services "they have to do this health process with all the relevant people, because health is not only health ministry."

It was emphasized that government support was needed to change attitudes and behaviours in relation to PHC services; "if we want to have a good primary health care system, it has to start from the ministry of health." Robust leadership and management capabilities within the Ministry of Health will be required to drive the GoM SAP agenda for health, lead large-scale reforms, health system strengthening, including building a competent PHC workforce, and ensuring equitable and quality integrated services at PHC level.

Leadership at the highest levels, including the President's Office , the MoGFSS, and the MoH, as well as civil service reform was imperative to attract people into the CHW and PHC profession, to motivate and support the existing PHC workforce, to rebuild the community's trust and confidence, and improve the take up of PHC services to achieve the Government's goal to "enhance the health and wellbeing of the population of Maldives" (MoH, 2016). Shortages and high turnover of HPA technical staff needs to be addressed to provide this leadership and to realise the government's ambitions.

Greater clarity on leadership roles and responsibilities across the health sector vis a vis public health was also needed. As one respondent said, "if you ask the policy people in policy, planning and international health, they will say it is HPA's role, but HPA will say it is the policymaker's role, it's a huge, huge confusion, and nobody knows who has to take the lead on it." Once roles are established, sufficient financing and human resources should then be committed to ensure technical staff, managers and health workers with the necessary skills and competencies are in place to implement and monitor the programmes and achieve the expected outcomes. The MPHF also emphasized the need to improve communication between stakeholders within the health sector, with agreed targets for all to work towards and standardized procedures and protocols for all to follow.

Technical support from external partners provided in a coherent and responsive manner will ensure the country fully benefits from all the expertise and resources available in the implementation of the road map and realizing revitalization goals.

2.1.4. Financing

The focus on specialized and curative care has diminished the resource envelope for PHC, especially the preventative and community-based health components. Respondents emphasized the need for increased financing and adequate funding allocations for cost effective public health and preventative services, including CHW programmes. It was suggested that "government funding needs to get redistributed within the system," with adequate resources made available for the proposed reorientation of health services, "targeted to where they will get the maximum impact."

The MPHF made the case that greater investment in public health and prevention had the potential to improve health outcomes and reduce costs. For example, every 10 per cent increase in funding for community-based public health programmes was estimated to reduce deaths due to preventable causes by 1 per cent to 7 per cent (WHO, 2019). Policy review to create more efficiencies in spending on pharmaceuticals was also recommended. Participants at the MPHF recommended that "several steps were required to realign spending pattern so that services are delivered effectively, resources utilized efficiently, and funds distributed equitably." Efforts should be made to avoid any further fragmentation of the health system and skewing PHC incentives towards curative services.

Participants at the MPHF called for additional and ring-fenced allocations for promotive and preventative services at PHC level (WHO, 2019). It was emphasized that with the changing

demographics, high NCD burden and unhealthy lifestyles in the country, that "spending and prioritization on preventative care are imperative, otherwise health expenditure will continue to increase over time"(WHO, 2019). It is vital that government prioritized healthy lifestyles and focus on healthy initiatives and programmes. Sustained investment in public health and PHC will also help to address the identified gaps in CHW programmes, and enable improvements in the production, management and retention of CHW cadres.

There was an overall perception that the available resources for health were not always well utilized, that "we do things the expensive way." There were concerns about the sustainability of the Aasandha health insurance scheme due to over-utilization, absence of gatekeepers, inefficient use of resources and poor public awareness. The mechanism was perceived to be complex, with inadequate coordination among the different entities. The above average usage of outpatient and inpatient services on the financial viability of the scheme were raised in the MoH 2016 National Child Health Strategy (MoH, 2016). A recommendation at that time, and also reflected in respondents' observations in this study, was the need for "systematic public education campaigns that inform the public of the correct use of the insurance scheme." It was suggested that a coherent and efficient model was needed urgently for sustainable health protection system in the country.

MPHF participants also called for the establishment of a public health fund to emphasize the importance of disease prevention over disease control and treatment, create public health awareness, broaden public health activities and build a public health-conscious society (MPHF, 2019).

2.1.5. Community Engagement

Community engagement, education and empowerment are necessary conditions for reversing the over-medicalization of health, for changing mindsets and unhealthy behaviours, and to enhance the take up PHC and preventative services. Meaningful community engagement and participation in promoting healthier behaviours and lifestyles will require community partnerships, engaging formal and informal community leaders, community groups and societies, and other key and vulnerable populations in the planning, delivery, review, and monitoring of PHC programmes and services.

As the MPHF highlighted community partnerships are vital in expanding the reach of programmes, to mobilize community resources, enhance social capital and facilitate resilience against shocks and other stressors. The PHC team, including CHWs, need to be supported and enabled to "re-engage with and empower the community" and to be more "proactive in identifying the issues in the communities." Support system gaps and health workforce challenges have resulted in PHC services that lack responsiveness and strong links to communities, which creates unnecessary and avoidable barriers to effective service delivery. Renewed efforts are also needed to rebuild the confidence of individuals and families in CHWs and community-based services. Positioned within the communities they serve, CHWs can also ensure that community level perspectives influence and inform policy development.

Respondents suggested that policies and strategies are needed to build and retain local capacity in the islands. It was observed that island communities and practices are different, "even if they are very close by islands, communities differ, the practices differ." CHWs and other community-based cadres who understand these local contexts will be more effective in communicating with and influencing these communities and families and bringing about the desired behaviour change.

It was perceived that policies were also needed to "activate the community" and to improve the availability of people "who can work on prevention and who can be at the community level," and who "can look at those aspects that make families vulnerable to diseases." Respondents were of the view that public health and healthier behaviours and lifestyles was everybody's business and given the current policy environment there were opportunities to make real change.

'Everybody has to work on this. It's not only HPA. All the nurses have to work for the change in behaviour, all the doctors have to work on this, everybody has to work, otherwise we can't change. We can't just be in the facility giving service, but that's not enough now. There are opportunities currently, there are policies, we just need to keep the momentum going' (KI1 – MoH).

Strengthening health education was identified as a key priority and utilizing a range of methods. Mobile phones and the media, along with community gatherings and sports tournaments, were key to reaching the population with appropriate health messages. Respondents observed that "communities have changed, they will not come when you call for the session." While CHWs, other community-based providers and NGOS are exploring and utilizing new ways to communicate and educate communities and to rebuild relationships, these efforts need to be scaled up, with the leadership, guidance and support of the MoH and other sectors.

2.1.6. Health Workforce Policies

The Astana Declaration identifies the health workforce as a key driver for PHC success. Adequate financing and sustained investment in the production, management and retention of the PHC workforce including these CHW cadres, especially for staffing hard to reach and remote areas, will be vital for revitalisation and PHC strengthening efforts.

Robust and evidence-based workforce policy and plans, aligned with national policies and strategies are needed to ensure that PHC health workforce meets the health needs of the population and support the achievement of health outcomes and targets. Workforce planning should go beyond profession-specific planning and consider the different cadres and skill mix required to deliver comprehensive and integrated PHC services. Health workforce plans should also consider variations in practice, the use of substitute health workers and the optimization of performance and productivity. Finally the financing available and committed to healthcare and other economic aspects need to be fully considered.

Such health workforce planning, which outline current and future workforce requirements, should be undertaken in collaboration with the FHS, so that this institution can plan accordingly, and ensure its production and supply of CHW meets the demand, as well as the competencies and skills mix required.

In addition to focusing on the training and production of PHC cades, respondents recommended that there should be

recognition at the policy level that the role of the CHWs needs to be strengthened and optimized, and this should be reflected in their remuneration, accountability framework, overall support system and the enabling environment. HR policies should focus on the equitable distribution of these CHW cadres across the country, as well as developing and supporting their performance and productivity. Many challenges highlighted in key health workforce plans and policies have yet to be fully addressed, such as health workforce shortages, overdependence on expatriate healthcare providers, inequitable distribution between Male and the atolls, and high turnover and attrition at island level. Respondents emphasized that health workforce policies and plans and concerted efforts and investments will be required to address these remaining health workforce challenges and to translate and achieve the SAP vision to "build and retain a competent, professional health service workforce and HMP health workforce goals."

In line with many of the strategies and actions in the SAP and HMP aimed at strengthening the health workforce, respondents in this study identified the need for "policies to attract and retain CHWs, better job opportunities for them, and a good career pathway." In addition, they identified the need for more robust health workforce leadership and management, further investment in the local health workforce, clarifying CHWs roles and expectations and defining work processes, providing quality CPD and supportive supervision, and establishing fair compensation system to enhance the quality, performance and retention of the CHWs and the PHC workforce. Strengthening health workforce management capacity at all levels would also ensure that the existing PHC workforce is better distributed and utilized and team approaches optimized.

Respondents indicated that workload pressures on CHWs could be reduced by creating efficiencies, such as prioritising activities, adjusting operating hours, as well as addressing staffing shortages and improving the distribution of the CHW workforce across all the islands in the atoll. Research to understand the push and pull factors that influence CHWs' employment and work location preference and decisions could inform strategies to address these barriers and ensure more equitable distribution and retention of CHWs, especially in the more remote islands.

It was widely recognized in the literature and by respondents that the country's high dependency on an expatriate health workforce jeopardizes the sustainability and continuity of health services. Respondents identified that these expatriate health workers often have language and cultural barriers that impact on the provision of client centred quality services. The short duration of their contracts affects their ability to build relationships with the community, and the time lag between contracts and appointments can disrupt services. It was proposed that there should be less spent on hiring externals, and more investment in local production, and on our own health workers, and their professional development.

There was an overall recognition that it would take the country a long time to reduce their reliance on these expatriate health workers. It was also recognized any change to the current policy would be challenging as it was tied up with politics. "If we remove the doctor from that health facility, their votes will go." Respondents suggested that in the meantime, greater efforts should be made to ensure these health workers were better oriented into this system, but recognized this would be a "difficult task as they keep changing." Respondents suggested that a more cost-effective option would be to reduce the overall numbers of expatriate doctors and have one doctor cover several islands on a rotational basis. CHWs, as a multiskilled cadre ("so many things they can do on their own") could then be better utilized to provide the day to day care required by the population, especially in the smaller islands, which was felt would reduce operational costs.

While respondents identified limited employment opportunities, unclear job roles, low remuneration, and limited career mobility and advancement as some of the key issues influencing the recruitment, retention and motivation of the CHW cadre, there was little articulation of the gendered dimensions of these issues. Health workforce polices should ensure that gender disparities in the remuneration, planning, recruitment, deployment, retention and motivation of these cadres and the overall PHC workforce are well addressed. The generation and analysis of data disaggregated by sex, age and location and other stratifiers will enable a more in-depth assessment of the extent to which gender disparities exist, with findings informing the design of appropriate evidence-based HR policies and practices to address these.

2.1.7. Gender-responsive policies

The 2016 Gender Equality Act promotes gender equality in all aspects of public and family life (UN, 2019). Gender has been mainstreamed into the GoM SAP and health sector programmes are becoming more gender-responsive. However, the draft National Gender Equality Action Plan was not yet approved at the time of this study. Respondents perceived that the health sector could do better in mainstreaming gender, as currently the only policy document is the health sector response to gender based violence and implementation of this was perceived to be patchy. The MoH needs to aim for more gender-sensitive policies and practices to move towards a more gender transformative approach. A 'proper' monitoring system and sharing and using data to inform gender-responsive policies and strategies is also needed.

Other challenges and barriers to the promotion of gender equality identified in the literature need to be addressed, including lack of financing and human resources to ensure the consistent application and implementation of the policies, as well as improving understanding among ministries and the Island Councils, of their shared roles and responsibilities in advancing gender equality (UN, 2019). More robust inter-ministerial coordination in the implementation of the legal and regulatory frameworks and harmonized monitoring and data on the impact of the policies were also critical, as well as greater awareness among population about their rights.

Consultations for the preparation of the 6th Periodic Report on CEDAW highlighted that the reasons for women's low Labour Force Participation Rate (LFPR) requires a greater understanding of the impact of gender norms in shaping the roles, the studies, and the life trajectories that women and girls, and their communities feel are appropriate.

2.2. System support improvements to optimize CHW programmes to respond to post-Astana requirements and PHC strengthening

The section outlines the identified system support improvements needed to realistically optimize CHW profiles, and roles and responsibilities to better serve maternal and newborn health and to respond to the post-Astana or PHC reforms and strengthening. Improvements in CHW education, their management and supervision and their integration into the health system and community are discussed.

Overall, study participants expressed a high level of satisfaction with the performance and effectiveness of these CHW cadres, particularly their contribution to the achievement of positive outcomes.

However, a number of health system support gaps and weaknesses were identified which were affecting the attraction, training, performance and retention of these CHW cadres. Respondents suggested ways in which these could be strengthened to optimize CHW programmes and the roles and responsibilities of CHW cadres, as well as to enhance the continued availability and retention of these cadres. Key among these were revisiting CHWs roles and responsibilities, and improving the education, training, supervision, and remuneration of these cadres, as well as the provision of career pathways.

2.2.1. Optimizing CHW roles and responsibilities

The role of the CHWs and FHWs in achieving significant health outcomes in the country was well recognized. "They make a difference and deliver outstanding results for the country and community." Respondents emphasized the effectiveness of this best practice approach. As a result of CHWs' efforts the country was free of malaria and filaria, and measles had been eliminated, at a time when there were few other health workers available across the country.

Given the health workforce constraints across the country, the CHW cadre was "a very valuable asset of the primary health care system." Greater efforts and investments were needed to produce, develop and retain them. The underutilization of the CHWs and FHWs knowledge, skills and competencies at PHC level was a common theme. Optimizing CHWs and FHWs role and responsibilities would be a key strategy in addressing the current health workforce shortages, especially as the CHWs were a multiskilled cadre, and can perform the clinical functions of a nurse, doctor or pharmacist, as well as undertake public health functions.

It was suggested that the government and MoH could play a key role in improving the recognition and elevating the status of the CHWs and FHWs, which would improve their performance and retention. Respondents suggested that MoH needed to "have a policy on what they expect CHWs to do, where they will go and how they will progress." They needed to "lift the profile of community health work," which would also enhance their acceptance in the community.

Leadership and investment in improving the quality and integration of PHC services were emphasized as key considerations for future PHC planning, budgeting and programming. In addition, the focus now should be improving the "efficiency of these services" to address "equity and equality." Further PHC strengthening, including public health, preventative and curative services, should focus on "quality people-centred services" and on improving the acceptability of PHC services.

While the CHW Scope of Practice has recently been revised by the Allied Health Council, it was recommended that the scope, and the roles and responsibilities of both the CHW and the FHW, should be revisited to ensure that they were still appropriate and feasible given the changing disease burden, proposed revitalization and reforms, and the new technical and job structures under development within the CSC. Reviewing the scope of practice will also provide opportunities to ensure that CHW and FHW roles and responsibilities are aligned with the realities on the ground, current and emerging health demands and the needs of both island and urban populations.

It will be important that CHW and FHW roles and responsibilities are clearly defined, as well as those of other health care providers in the facility. Clarifying and coordinating the functions of all facility and community-based providers would improve and enhance teamwork and integrated service delivery approaches. As part of this process, CHWs and FHWs themselves needed to be reoriented on their roles, to change their mind-set on the value of public health and preventative services, and to fully understand what is expected of them. Respondents perceived that some CHWs are too focused on "managing and overseeing." "They don't see that the primary health care itself is that valuable now." This has created gaps in service provision and has resulted in a decline in demand for their services. Further, managers and other PHC health workers also need to be familiarized with public health functions to better understand and appreciate the work of these cadres.

CHW and FHW roles and responsibilities should also be aligned with the proposed revitalization of the CHW cadre, as set out in the GoM SAP. A revised scope of practice should address identified gaps in facility- and community-based PHC service delivery, such as reproductive health, adolescent health, nutrition, ECD, mental health, NCDs, health education and promotion, behaviour change communication and GBV, as well as community engagement and empowerment.

Any revision of the job descriptions should be informed by an assessment of the capacity of the current FHWs and CHWs, including their utilization and functionality, and an identification of training needs. This information and any proposed changes to the scope of practice should inform the revision of the pre-service PHC curriculum, as well as in-service training content.

Respondents indicated that CHWs and FHWs are still valued in the community. "They are still very respected," "their opinion still counts a lot," and "what they say means a lot to people." The more senior FHWs were perceived as instrumental in advising the community on sensitive issues, such as contraception. Respondents felt that it was important to retain CHWs and FHWs in the community, as many were familiar faces and were trusted by the community. As one respondent observed, the most important thing in building an effective and sustainable PHC system "is the trust of the community with the deliverer."

2.2.1.1. RMNCAH roles and responsibilities

CHWs no longer have a role in deliveries, but many respondents recommended that they should continue to provide facility and home-based ANC and PNC services.

While RMNCH health indicators had improved, respondents warned that the country shouldn't be complacent. They expressed concerns about the stagnating and fluctuating MMR and neonatal and stillbirth death rates. "If we are doing good work, it should still decline, but why is it not going down, what are we not doing?" They also queried the declining fertility and CPR rates and emphasized the need to examine factors contributing to this situation as it may be "a hint of problems to come," because "fertility is an indicator for a lot of other issues." They stressed that the country should also be concerned with emerging STIs, the increase in abortions, and the decline in vaccination rate. They suggested that CHW has a vital role to play in reaching and empowering the population to tackle current these RMNCH issues and emerging trends.

While many are bypassing CHWs to seek specialist and hospital care, respondents identified that for issues such as SRH, women and girls do not want to go to the doctor and are therefore not getting any support and there is an unmet need in this area. However, when they do seek care from the doctors, these providers need to be aware when clients with SRH issues should be referred to a CHW.

2.2.1.2. Adolescent and youth-friendly health services

As identified in the literature (UN 2019; 2019 SHE) and by respondents in this study the provision of AYFHS across the country needs to be strengthened to address the sexual and reproductive health rights and needs of adolescent girls and boys, as well as emerging mental health and social issues. Respondent highlighted that young people aren't receiving the right information.Raising awareness among these groups about the services that were available was also vital. The need to assess and address the SRHR seeking behaviors of immigrant populations, of which a large proportion are youth and men, was also identified.

Respondents suggested that improving the availability, accessibility and take up of AYFS services will require greater involvement of the youth in the design of such services. AYFHS need to be informed by an understanding of how young people themselves define their needs, why they seek help and what help they seek, as well the perceptions of parents, service providers, policymakers and other adults (SHE, 2019).

The SHE study recommends strengthening comprehensive sexuality education (CSE) in school programmes and building the capacity of "school counsellors to provide efficient and effective counselling" to young people in the school system to ensure students have the correct information regarding SRHR (SHE, 2019). Respondents suggested that CHWs and FHWs are well-placed to support teachers and school counsellors with the delivery of the SRH components of the school health programme. Expanding the overall coverage of quality AYFHS will require strengthening the capacity of all PHC health workers on AYFHS, including the FHWs and CHWs, through pre-and in-service training, to enable them to identify and appropriately respond to adolescents and youth health issues, in collaboration with other relevant CHWs and community-based groups.

2.2.1.3. Early Child Development (ECD) and Nurturing Care

CHWs can also play a critical role providing nurturing care, early childhood development and nutrition services through existing platforms. The nurturing care framework has been globally adopted by United Nations' agencies and the World Bank as an essential framework with a package of services (UNICEF, 2018; WHO, 2018).

2.2.1.4. Mental health services

Improving the availability, access and take up of mental health services for all population groups at all levels was highlighted by many respondents. Mental health services outside the capital, Male, are limited, and psychological support is expensive, although there have been renewed efforts to improve on this area, as a result of COVID-19. Mental health for all, particularly for adolescents, as well as post-partum depression, were identified as a neglected areas, and for which there were no data for the CEDAW report. The effective implementation of the GoM SAP will be key for the realization of high-quality integrated mental health care provision and the acceptance and protection of those with mental health issues.

2.2.1.5. GBV

A key health sector related action in the SAP is to "develop health service capacity and mechanisms to support national efforts to address GBV." It also proposes the implementation of a "framework that recognizes the role of women who carry out unpaid and unrecognized labour at home as a major contributor to economic growth" (SAP 2019, Strategy 2.4), with a related activity to "conduct a gender analysis of workplace policies and cultures to assess the changes that need to be brought to accommodate and account for women's unpaid responsibilities."

While there has been a concerted national multisectoral effort to promote gender equality and address GBV and DM in the country (UN 2019), it was perceived that the health sector's response to GBV could be improved. The 2019 Report of the Committee on Elimination of Discrimination against Women noted that challenges in ensuring consistent application of gender equality laws and regulations associated with the high turnover of civil servants in the public sector, including among health personnel. All SRH and adolescent health policies and programmes should address issues of violence, sexuality, and power dynamics in gender relations systematically (WHO, 2011).

Information on sexuality, GBV, DM and the power dynamics in gender relations is not well covered in the PHC training course. CHW and FHW cadres have reportedly undergone gender training provided by the Ministry of Gender, Family and Social Service (MoGFSS), as well as the MoH GBV training. Respondents suggested that the role of the CHWs cadres in the prevention of SGBV and the support of survivors could also be enhanced with further training and support.

CHWs and FHWs and other health care providers, including expatriate staff, should be aware of the possibility of violence as an underlying factor in women's ill-health during pregnancy and post-partum and have the appropriate training and support to check for these signs and monitor the woman during her pregnancy, as well as identifying and addressing any post-partum

mental health issues. Through home visit and their interactions with the family, CHWs and FHWs are also well placed to identify high risk families or family members at an early stage, and to promote family well-being and family security.

2.2.1.6. Gender-responsive services

It was perceived that while many CHWs and FHWs are from the community and understand the context, they needed to be more aware of the mind-set in the community, local norms and traditions, and belief systems of community leaders and members that influence the demand for and take-up of services, including SRH, vaccinations, FP and emergency contraception, and GBV services. With ongoing sensitization and training, CHW cadres could play a greater role in promoting gender equality, safe and responsible relationships, and the prevention of GBV and DV. With increased use of mobile phones and improved connectivity across the islands, the MoH could encourage and support CHWs and FHWs to use mobile apps, not only to raise awareness on these issues, but also to understand the knowledge, attitudes and practices of GE , GBV and DV on the islands.

Respondents felt that that there was still a lot more to be done to make health services more gender-responsive. One area mentioned was the need to work with both girls and boys on teenage pregnancies, which is often seen as a girl's issue. They identified the need to work with and educate boys and men, and girls and women on both sides to advance gender equality and equity, and to bring that equity or the gender element into policies, as well as services.

Respondents recommended that FHWs that were well-embedded and accepted in the community also had a role in ensuring men and boys have access to the health and social services they need. In collaboration and partnership with community groups and other CHW providers, they can work with local women and men leaders to champion the principles of gender equality and to challenge and change harmful gender and social norms. They can also be influential in encouraging boys and men to get more involved in SRHR.

The 2019 Report of the Committee on Elimination of Discrimination against Women stresses the importance of local champions for gender equality and equity, especially as the negative impact of gender norms on both girls and boys persists. As the report highlights, "conservative factions continue to push back on the gender equality gains made, and through the use of social media, may at times incorrectly interpret Maldivian culture and Islamic principles in a manner that hinders the advancement of women and girls' rights, and at times specifically endorses practices such as early marriage."

2.2.1.7. Utilization and expanded role of CHWs

Respondents highlighted that the intermediary treatment provided by many of the doctors currently deployed to the islands could be provided by trained CHWs. It was suggested that it would be more effective and efficient to have a well-staffed and functioning hospital on every atoll, that a "doctor is not required at every level," and on the smaller islands CHWs, who are from the community and understand the context, could competently cater for the needs of this population. "A well-trained community health officer can manage." Many perceived that the financing now used to employ expatriate doctors would better utilized if invested in PHC systems and system support to ensure these CHW and FHW cadres have the necessary skills and supervision to address identified gaps and provide integrated quality facility- and community-based services.

Increasingly, CHWs have taken on administrative and managerial roles and responsibilities, as more of their clinical and RMNCAH functions are undertaken by the doctors and nurses deployed to these island facilities. Respondents suggested that the CHWs' should instead reassume their public health roles. "We have to put them in public health roles, rather than giving a managerial post." It was felt that this would also enhance the public health programmes.

MPHF participants highlighted the limited prevention and early detection of NCDs at the PHC level and the resulting high burden of NCD complications, including hypertension and diabetes, that hospitals are facing (WHO, 2019). Respondents suggested that it was essential that CHW and FHWs provided community-based NCD-related care, especially providing health education and monitoring those with chronic diseases. "They have to be monitored well, given information on healthy lifestyles."

Household visits and home-based care were seen as critical components of the CHWs and FHWs roles and responsibilities. These cadres should also be active at the community level, providing health education and creating awareness and promoting healthy lifestyles. "These community health workers are the people who should make them aware." Vaccine hesitancy was another area identified where CHWs can play a vital role, in helping communities understand how important vaccinations and ensuring that children are vaccinated.

The provision of community-based care was perceived as vital for marginalized populations, for example, pregnant teenagers and for those who were not willing to come to the facility for services. In such cases "it is essential to go out and give information and convince them that they need to seek care." CHWs and FHWs, still command community trust and respect, and with appropriate training and supervision, are well positioned to work with the Community Support Groups that are being established to provide education and raise awareness for the prevention of GBV, and DV, and to counsel and refer survivors for appropriate care, as well as provide follow-up care.

Respondents felt that home-based care for the elderly could also provide opportunities to monitor the health and needs of all family members. "When they go to a home to call on elderly person, they also need to look at the situation of the family, because if the situation in the family is not improving, that elderly person, however much they visit, will not be improved."

It was perceived that CHWs could also have a greater role in vector prevention and control, for example in health education around dengue to promote household action. Emergency responsiveness and disaster management were identified as other areas where CHW cadres could get involved, including providing SRH services during disaster and emergency situations. "They'll have a big role to play in being part of a community team to prepare for and respond to disaster when that happens." It was also suggested that they could also have a role in educating people in the area of "global emergencies, like antimicrobial resistance" and "improving compliance between what a doctor says on antibiotic use and what the community practices."

2.2.2. Pre-service education, in-service training and CPD

The training and production of CHWs has been declining in recent years and there is a lack of interest even from CHWs already in the system in a career in PHC and public health. The literature identified a number of issues to be addressed in the FHS, including faculty development, clinical practice outside the home island, standardization of curricula, and more opportunities for sharing experiences (WHO, 2018).

The production of CHWs needs to be better aligned with the MoH health workforce plan and requirements, with regular communication and dialogue between the institution and the MoH to agree short- and long-term production targets and outputs. Information on CHW requirements would enable FHS to project and plan its enrolment and production and ensure production is aligned with demand. It would also enable the FHS to provide information and reassure potential applicants, including existing CHWs, about employment prospects and career advancement opportunities of a public health career.

FHS faculty are also visiting schools to create awareness of the PHC course and boost enrolment. Respondents were also hopeful that the MPHF was a sign that government commitment and investment in public health would improve, and that this might encourage more students into a public health career. "Because of this conference, they came to know that things are going to be better."

Respondents highlighted that while the curriculum has been reviewed and revised in the last five years, the current curriculum needs to be more responsive and aligned with current needs. Strengthening institutionalized collaboration between the FHS and programme developers (HPA) and managers will be vital to ensure new and updated programme protocols and guidelines are available and accessible to inform the revision and updating of curriculum content. This will also assure the quality of the theoretical and practical training, and the skills and competencies of the graduates produced. Respondents recommended that the curriculum should also include content on adolescent health, NCDs, community engagement and BCC, gender equality and equity, as well as the use of mobile technologies and social media platforms for health promotion and education.

SGBV, its health consequences and appropriate responses, should also be integrated into the PHC curriculum and covered regularly through in-service training for CHWs, FHWs and other health workers, including expatriate staff, involved in the provision of RMNCAH services. Continuous and ongoing sensitization and training should be provided for these cadres to ensure that they themselves do not reinforce gender norms and perpetuate gender inequalities in their work because of their own gender norms. For example, CHWs' and FHWs' own gender biases may affect the SGBV counselling they provide or prevent them from reporting or referring survivors.

Associated with improving the curriculum was the need to ensure that faculty, including classroom teacher and clinical tutors, mentors and supervisors are exposed to regular and continuing professional development and have sufficient teaching and technical knowledge and skills to deliver the curriculum effectively. While the time allocated to classroom teaching was perceived to be adequate, respondents recommended that the duration and variety of clinical and practical training needed to be expanded to provide students with increased opportunities and a range of environments to apply and transfer knowledge and skills and improve their competencies.

Strengthening the links between pre-service and in-service training will be critical for maintaining and updating CHWs competencies, as well as improving their performance and the quality of care they provide. Respondents recommended that IST and CPD needed strengthening and CHWs needed more opportunities for professional development, with more coordinated and coherent approaches proposed to reduce the fragmented approaches and ad hoc manner currently used to provide IST for these cadres.

Many CHWs and FHWs have been in post for several years and reinforcing and refreshing their initial basic education and training through a continuum of learning, including IST, mentoring and CPD is vital. An effective CPD system will also ensure that the skills and competencies of these CHWs are kept up-to-date in the context of changing demographics and disease burden, and new technological advances, practices and procedures. Respondents also identified that the provision of more systematic and structured IST and CPD would also contribute to the improved motivation and retention of these cadres.

The underfunding of preventative services has contributed to the scarcity of resources and the neglect of IST provision, and the current IST delivery modalities are very costly and reach a limited number of CHWs and FHWs. Participants at the MPHF and respondents in this study proposed that more robust and cost-effective mechanisms were required to provide quality IST training, mentoring and continuing professional development (CPD) to enable these cadres to maintain and update their knowledge and skills (Maldives National University, 2019).

Greater use of blended learning approaches, eLearning and smartphone apps could reduce costs and ensure more equity in the availability and accessibility of IST and CPD. Respondents suggested that SOPs, guidelines, job aids and other resources should be more readily available and disseminated to CHWs, FHWs and other health care providers to ensure compliance with international and national protocols and best practice, and improved quality of care. The availability of such resources will also provide opportunities for self-directed learning and reflection, enabling CHWs to improve practice. Social media platforms could also be used to connect CHWs and FHWs across the islands, share information, collectively solve problems and build communities of practice.

Investing in building the capacity of a critical mass of atoll and island-based master trainers, supervisors and mentors will also improve the delivery of needs-based and responsive on-the-job training, coaching and mentoring. This will allow these cadres to update and develop their knowledge, skills and competencies, while remaining within the workplace and community, thereby minimizing disruption to service provision.

IST strategies and practices should also consider the gendered-specific needs and responsibilities of women, especially their family roles and obligations. The participation of women in IST should be enabled and encouraged and they should be able to avail of CPD opportunities. Non-participation

will have implications for their performance and effectiveness in carrying out their responsibilities, and ultimately their career advancement.

2.2.3. Remuneration and allowances

The Astana Declaration emphasizes the importance of providing 'appropriate compensation' for health personnel working at the PHC level. The second of the three resolutions on UHC of the 2019 World Health Assembly urged countries and partners to ensure CHWs were properly recognized for the work they do. Fairly-compensated CHW positions and decent work may attract more applicants into PHC training and public health careers, improving the availability and equitable distribution of these cadres across the islands, and also recognizing their contribution to achieving the Astana vision of PHC and UHC.

Job satisfaction was a key factor in CHW effectiveness, and a number of issues were identified that influence this, including remuneration, career pathways, recognition of their work and the profession, job enrichment and decision making authority. Respondents suggested that remuneration and incentives should be improved to motivate and retain these CHW cadres.

'Motivation needs to be there. There are very few job opportunities available in the Islands. If they have an opportunity to go to other sectors, people go. That's how it is. So it's difficult for us to retain people' (KI3 – MoH).

The overall perception was that PHC and public health careers were not attractive, and remuneration was a factor affecting enrolment on PHC courses and the retention of CHWs in the profession and the health sector. "If we don't provide them a good salary, attractive salary, they will not have much motivation." In the changing social and economic context in Maldives, potential students and CHWs have other career aspirations. With few higher level posts within public health, and no recognition of higher qualifications, CHWs are taking up employment elsewhere.

The role of the CHW and FHW cadres and public health functions were essential for effective PHC services. Respondents suggested that good incentives and allowances and favourable working environments were needed to improve CHWs' motivation and effectiveness. Respondents noted the disparity between curative and public health and preventative health cadres should be reduced, as this was a major cause of CHW dissatisfaction. Inequities in the provision of allowances should also be addressed to improve CHW motivation and improve team and collaborative work across the PHC workforce.

Respondents were encouraged by the new job structure being developed by CSC, which has reportedly proposed a comprehensive compensation package, including salary, benefits and allowances. The remuneration aspect of the structure was perceived as key to improving the attractiveness of the job. It was perceived that if salary was not attractive "nobody will work wholeheartedly, there will always be dissatisfaction from the employees' side. It's a very good career-based structure, but the salary component is a must." The CSC was very hopeful that the Pay Commission would approve the compensation package proposed, and that creating multiple levels and grades from CHO to community health manager, would make the career and profession much more appealing. It was felt with these measures in place the CHW job would be very attractive. The lack of housing allowances and other incentives was a barrier to staffing more remote islands. Reportedly, the CSC has proposed the provision of additional allowances to attract and retain CHWs and other cadres on the more remote islands.

2.2.4. Career progression

The limited availability of career pathways was highlighted as a significant barrier to attracting and retaining CHWs and a key factor in CHWs' motivation. The career mobility of CHWs is extremely limited and many remain at the same grade for several years. The only upward progression option open to them is the SCHO post of which there is a very limited number. While this role attracts a small increment, it provides little job enrichment or increased responsibilities.

Respondents identified that career pathways and the availability of career advancement opportunities was a priority to developing public health in Maldives and to improving motivation, job satisfaction and reducing attrition among the CHW cadre. Improving career mobility for these cadres will not only motivate them, but as role models within the community, they will also encourage and attract others to a career in public health.

The new professional and technical structure for the CHW cadre, being developed by CSC in collaboration with the MoH and Allied Health Council at the time of this study, was expected to create multiple levels and grades from CHO to community health manager. This was perceived to be a positive step in recognizing this cadre, and in addressing some of the system support gaps identified, particularly in the areas of career advancement. Respondents were hopeful that the new structure would lead to greater career mobility for this cadre and enhance the overall public health profession. The Allied Health Council was recommending that senior CHW posts should attract a commensurate salary and attract CHWs with degrees and a certain level of experience.

Reportedly, while the majority of PHC graduates are female, it is mostly men who are in the senior CHWs positions. The extent to which women's competing gendered responsibilities and gendered-specific needs affect their employment needs and preferences, and their ability to take up CPD or opportunities to advance professionally in their careers should also be considered and monitored in the development and implementation of the new professional structure. The effects of these new structures and new compensation packages on staff attitudes and motivation, and on individual and team behaviour should also be monitored to ensure incentives do not 'crowd out' intrinsic motivation or detract from teamwork and integrated service provision.

2.2.5. Supportive supervision

When performed well, and when used to support performance improvement, supportive supervision can have a positive effect on health worker's performance, job satisfaction and motivation and the quality of services they provide, compared to traditional or no supervision. (WHO, 2017; Kok et al, 2018). While supervision is challenging with such a dispersed

workforce as that in Maldives, it is vital that that adequate resources and financing are allocated for effective monitoring and supportive systems and processes and to ensure quality health care is delivered by these CHWs.

There was an overall perception that while some monitoring and review of programmes, overall the supportive supervision system was weak. Improving the quality and frequency of supportive supervision processes to enable performance review and quality improvement was identified as a critical area for improvement. Increasing the availability and distribution of supervisors across atolls and islands, as well as strengthening their skills, competencies and attitudes to ensure supervisors are effectively and regularly conducting supervision and supporting health care providers in improving their performance were key recommendations.

HPA capacity to monitor and supervise programmes and the linkages between the different supervisory levels – HPA, regional an island levels – needed to be strengthened. Besides the recently developed Quality Healthcare Standards Framework, respondents did not identify any specific supportive supervision tools or mechanisms that were in use, and this is an area that needs further attention.

Supervision competencies could also be integrated into the pre-service education curriculum for the more advanced PHC courses, so that these CHW cadres can provide supportive supervision for the ACHOs and FHWs and support them to improve their practice. The supervisory role and mandate of the Senior CHO post was unclear and needs further clarification. However, the supervisory capacity of this cadre could be strengthened and with the necessary support for this cadre could take on a greater role in the direct supervision of the CHWs and FHWs.

Respondents identified a range of barriers to effective supportive supervision, including lack of resources, shortages and unmotivated senior technical personnel at all levels, lack of supervision capacity development, and the widely dispersed workforce. Further analysis of these and other barriers to the provision of supportive supervision is needed to inform the strengthening of the supervisory system, mechanisms and processes, and supervisory capacity.

3. Prioritized measures to be taken by governments and partners to strengthen health policy and system supports to optimize the contribution that each CHW cadre is able to make to PHC

- **KEQ 3:** What prioritized measures can be taken by governments and partners to strengthen health policy and system supports to optimize the contribution that each CHW cadre is able to make to PHC?

The findings in this section respond to KEQ 3 and provide a synthesis of the key findings from KEQ 1 and KEQ2 and identify prioritized measures to strengthen health policy and system support and enhance the contribution of CHW programmes to PHC.

Based on the findings of this study, when assessed against the CHW Programme Functionality Matrix and the policy and system support areas in the WHO Guideline, several elements of the Maldives CHW programme need to be strengthened to improve its functionality. Key among these are in-service training and continuing professional development, career pathways, supervision, remuneration and community integration.

3.1. Prioritized measures to strengthen health policy to optimize the contribution that each CHW cadre is able to make to PHC

The government has demonstrated its commitment to strengthening PHC systems through the facilitation of the Forum on Public Health and the declaration of 2020 as the Year of Public Health. The GOM SAP (2019-2023) prioritizes strengthening the capacity of the PHC workforce and "revitalizing community health workers to play an enhanced role as part of the primary health care team." The Revitalization Road Map, undeveloped at the time of this study, will be key to realizing these policy goals and objectives.

The government has also recognized similar gaps in systems' support to those identified through this study and is exploring ways to address them. These include ways to "make sure CHWs from each island are trained and given special incentives to go back and serve in their respective communities" to ensure a stable CHW workforce in the islands. Options are also being explored to encourage health care providers to take up posts in more remote islands. These are expected to be further elaborated in the Revitalization Road Map. An incentive system should consider a mix of financial and non-financial incentives, with timebound postings so that people are assured that they will be redeployed within a certain period. Along with these interventions, strategies should also focus on the demand side and building people's trust and confidence in PHC and CHWs' services, as well as working with other sectors, to provide holistic family and people-centred services.

The proposed CSC professional and technical structure should address identified system support gaps related to CHW remuneration and career pathways. It is also expected to create greater equity between the remuneration of the curative and public health workforce, which should improve CHW motivation, job satisfaction and teamwork. Such improvements should also enhance the overall attractiveness of CHW jobs and careers and improve the supply and retention of CHWs.

Sustained political commitment, robust leadership and governance systems and adequate and predicable financing will be required to achieve the ambitious Astana vision of PHC and support the development of integrated, functional, resilient and sustainable PHC in Maldives. This commitment and leadership is particularly important because of the complexities associated with the three components of PHC, namely integrated health services, multisectoral policy and action, and empowered people and communities.

Perspectives and participation of actors, including politicians, decision-makers, policymakers, and health care providers, CHWs and community members, in the revitalization of public health and the strengthening of PHC will be key to the acceptability and sustainability of the results. Participatory approaches that promote the engagement and participation

of all stakeholders in the management, implementation and monitoring of the Revitalization Road Map will not only ensure its success, but also safeguard the PHC gains achieved.

Working in partnership with actors from other government sectors (CSC, finance, education, social welfare, MOGFSS) at central, regional and island levels, as well as development partners, will enhance efforts to mobilize the necessary human, financial and technological resources for the successful implementation of the Revitalisation Road Map and a sustainable PHC system.

Leadership and management capacity of subnational leaders, managers and supervisors at central, regional and island levels will need to be strengthened, both in terms of numbers and skills and competencies. These groups will also need the support, decision-space and adequate financial resources to ensure the revitalization process, associated workforce polices, and CHW programmes respond to local realities and the needs of the population.

Achieving the goal of community and people-centred care and equitable access for all to quality and effective health care will require the involvement and participation of individuals, families, formal and informal community leaders, as well as under-represented and marginalized groups. CHWs and FHWs provide the link between families and health services, represent significant social capital and can act as agents of change at the community level. Leveraging their unique experiences, knowledge of the language, norm, traditions and beliefs, and the social determinants of health of these communities will support the achievement of the goals and outcomes outlined in the GoM SAP, the MoH HMP, as well as those propose in the Revitalisation Road Map.

Strengthening community health care systems and investing in the development and management of the CHW and FHWs cadres and other PHC health care providers will contribute to the creation of a well-trained, skilled, motivated and committed PHC workforce and enhance the uptake of PHC services. The availability of an equitably distributed PHC workforce will ensure the population – children, adolescents, women, men, and the elderly – have access to integrated and comprehensive quality PHC services throughout their lifetime, provided in a respectable and acceptable manner in the island facilities and the community. For all services, and RMNCAH services in particular, strong linkages and referral systems across primary, secondary and tertiary levels will ensure a continuum of quality of care and ensure people “get more of the right services from the same place.”

As the findings demonstrate, the Maldives health system is currently skewed towards tertiary, specialized and hospital care. Primary care and public health functions have suffered from decades of underinvestment. To achieve the Astana PHC vision and effectively deliver integrated health services requires political will and commitment to reprioritize resources and reorient services and systems. Spending patterns need to be realigned to ensure services are delivered effectively, resources are utilized efficiently, and funds distributed equitably. As MPHF participants and respondents in this study emphasized, allocating additional and ring-fenced financing for promotive and preventative services at PHC, including CHW programmes, will lead to improved health outcomes and reduce costs. The benefits of investing in public health and the investment cases presented at the MPHF and the proposed Revitalization Road Map will need to be underpinned by government policy frameworks and endorsed at the highest levels for successful operationalization and implementation.

It was vital that the GoM prioritizes healthy lifestyles and focuses on healthy initiatives and programmes to improve the quality of life years and reduce health costs. Community-based care and public awareness through public health services and regular screening programmes could generate significant savings and reduce costs. Sustained investment in public health and PHC will also help to address the gaps identified in CHW programmes through this study, and enable improvements in the production, management and retention of CHW cadres.

CHW programmes should not be perceived as an add-on or CHWs as lesser trained workers. “They may represent a different and sometimes preferred type of health worker” (Glenton, et al, 2013). They are often the foundation of effective PHC systems and, as such, need commensurate investment. Sustained investment and predictable financing in PHC and CHW programmes will contribute to improved access and reduce inefficiencies and inequities. Mobilizing resources for strengthening the existing preventative care workforce and improving performance and quality should be given equal attention.

There were concerns about the sustainability of the Aasandha health insurance scheme due to over-utilization, absence of gatekeepers, inefficient use of resources and poor public awareness. While it was recognized that efforts were ongoing to improve the administration and management of the scheme, it was suggested that a more coherent and efficient model was needed urgently for sustainable health protection system in the country.

Enhancing multisectoral policy, approaches and action will require strengthening policy dialogue and collaboration with the top levels of governments and across sectors, and the involvement of private sector actors and development partners. Working in partnership with actors from other government sectors (including Civil Service Commission, finance, education, gender, family and social services), the private sector and development partners will enhance efforts to mobilize the necessary human, financial and technological resources for the successful implementation of the proposed Revitalisation Roadmap and create sustainable and resilient PHC systems.

3.2. Prioritized measures to strengthen system support to optimize the contribution that each CHW cadre is able to make to PHC.

CHWs have a key role to play in increasing the take-up of PHC services and ensuring that increased investments and the revitalization of public health achieve the expected efficiency gains and health outcomes. Studies have shown CHWs promote healthy behaviours, extend the reach of health systems, help address health workforce shortages and reduce disparities and inequities (Kok et al, 2014; Zulu et al, 2014).

However, as identified through this study and the literature, a range of system support elements and push and pull factors

influence and impact the attraction, performance and retention of the CHW and FHW cadres. Improved understanding and evidence of these factors and influences, and their gendered dimensions, especially from the providers' perspectives, will enhance the development integrated, horizontally aligned and coherent health workforce policies and practice. Strengthening environmental and labour market scanning mechanisms will enable the effects of such strategies to be monitored and any adverse effects on the public health workforce to be mitigated.

Greater integration of curative and preventative services at PHC should provide opportunities to build a more integrated and multidisciplinary PHC workforce and promote a culture of inter-professional collaboration. A critical factor in strengthening synergies and teamwork will be ensuring the scope of work and the roles and responsibilities of the CHW and the other PHC cadres are well defined and their functions are coordinated. Harmonized and coherent health education and promotion strategies and interventions at both the facility and community levels will ensure communities and families receive clear and standardized messages and advice from these multiple cadres.

The adaptation of existing, and development of new CHWs roles that span sector boundaries (education, social welfare, and others) could also promote more integrated care across the community, as well as greater efficiencies and improved resource performance. Robust leadership and governance at all levels will be needed to coordinate and manage such a reorientation of services and to create a conducive institutional culture for multisectoral and multidisciplinary working, as well as monitoring the effects of such changes. Participatory approaches that promote the engagement and participation of all health care providers involved and affected by such changes, including professional councils and training institutions, will be vital to ensure that such improvements and changes are sustained.

While CHWs and FHWs no longer have a role in deliveries, they should continue to provide facility- and home-based RMNCAH services and support the implementation of HPA reproductive, child health nutrition and other relevant programmes. While RMNCAH health indicators had improved, respondents warned that the country shouldn't be complacent. There are many milestones still to be reached. Fluctuating and stagnant MMR and neonatal and stillbirth death rates, declining fertility and CPR rates, emerging STIs and the decline in immunization rate should be monitored. Addressing the identified system support issues and creating the enabling environment in which these cadres can continue to focus on and deliver quality and equitable RMNCAH services, while protecting the gains made, will be key to maintaining the gains made and reaching these milestones.

Revitalizing public health and the roles of CHWs will provide opportunities for these cadres to renew their focus on RMNCH and their core functions, as well as give greater emphasis to improving quality and equity. Addressing the system support gaps identified will also provide opportunities for the CHWs and FHWs to reinstitute community- and home-based care and address the health needs of the whole family, including the SRH, mental health and social needs of adolescents and youth.

Respondents suggested a range of roles and responsibilities for these CHW cadres, including SRH, adolescent health, family health, NCDs, and emergency preparedness, among others. Sustained political commitment and investment will ensure these CHW cadres are available, motivated and retained to deliver this expanded package of services and care to expected quality services. The development and/or strengthening of effective in-service training and supervision systems and processes and improving remuneration and career mobility will also be vital to achieve these objectives. Further, high level recognition and acknowledgement of the value of public health and prevention, and the contribution of these cadres to the achievement of national goals and health outcomes will enhance the status and profile of thee cadres and the community's acceptability and take up of the services they provide.

Changing demographics, socio-economic contexts, and epidemiological transition in Maldives is affecting patterns of health care service utilization and the determinants of demand for health care services. As the findings of this study illustrate, different needs and challenges were identified in the provision of, demand for, and utilization CHWs services across the different islands and populations groups, as well across gender and cultural dimensions. Understanding these dimensions, as well as communities' perceptions and expectations of quality of care, will be key in the design and implementation of differentiated PHC strategies and CHW programmes, and appropriate incentive packages to encourage better utilization of health care services in these areas.

Gender equality and equity and the promotion of women's rights are well recognized and articulated in national policies and this should translate into more gender-responsive sector policies and plans. It will be important that the draft National Gender Equality Action Plan is approved and rolled out to maintain and safeguard the gains and advances made on GE and address changing attitudes and perceptions towards the rights of women. Despite progress in a number of areas, the country's Gender Inequality Index (GII) continues to worsen, dropping from 52nd (2011) to 76th (2017) in ranking. Financing and human resources are also required to improve the functioning of the ministries, institutions and structures that have shared responsibilities for advancing gender equality.

While the health sector has rolled out its GBV Guidelines, these could be better implemented through greater awareness raising. Given the powerful impact that gender has on the health of women and men, it is imperative that health managers and health care providers, such as CHWs and FHWs are equipped with the knowledge and skills to address gender-based health inequities in their work. Strengthening monitoring and information system capability to collect and analyse sex-specific and/or sex-disaggregated data and gender equality indicators, and to generate findings to inform planning and programming is also a vital aspect of formulating more gender transformative policies and programmes.

Further research to understand the impact of gender norms in shaping the roles, the studies, and the life trajectories that women and girls, and their communities, feel are appropriate should also be considered to inform policy formulation and to ensure they address the causes of gender-based disparities and other forms of inequality.

Gender-sensitive and transformative policies and practices for the planning, development and management of the health workforce will be important, especially for the FHW workforce, which is exclusively female. Policies should consider how women's competing gendered responsibilities affect their ability to take up training or opportunities provided to retrain for new positions or to advance professionally in their careers. They should also consider how the gendered responsibilities and gendered-specific needs of women and men also affect their employment needs and preferences.

Respondents suggested that the CHW and FHW cadres should have a role in health security and emergency preparedness. The COVID-19 pandemic has highlighted the need for strong and responsive PHC and community health systems and workforces. CHWs and FHW have critical communication skills and community connections that can be leveraged to boost public health. Not only have CHWs a key role to play in health education and helping to reduce the population's susceptibility to infection, but they are also well positioned to explain and help implement and monitor preventative measures in managing current and future public health crises and outbreaks. CHWs are also vital in preventing interruptions to routine health services – immunization, maternal and childcare services – and increased morbidity and mortality due to non-COVID-19 causes.

Conclusions

CHWs have a key role to play in delivering cost-effective PHC services. They promote healthy behaviours, extend the reach of health systems, help address health workforce shortages, and reduce health disparities (Perry et al, 2014; Vaughan et al., 2015). They also provide promising benefits in promoting immunization uptake and breastfeeding and reducing child morbidity and mortality compared to usual care (Lewin et al, 2010).

Overall, there was a high level of satisfaction with the effectiveness of these CHW cadres and their contribution to the achievement of positive outcomes in RMNCH and communicable diseases in Maldives, as well as their role in health promotion and prevention.

However, a number of policy and health system support areas need to be strengthened to optimize CHW programmes and the roles and responsibilities of CHW cadres, and to ensure the continued availability and retention of these cadres to reach and address the health needs of all population groups. Preserving the valued status of these CHWs in the community, and supporting, recognizing and rewarding their performance and contribution through improved policy and system support will ensure they are available to continue to provide quality facility and community-based public health care and prevention at the PHC level.

It is recognized that such policy and system support to realize the full potential of CHW programmes and their contribution to PHC strengthening and UHC in the country will require an all-of-government approach, sustained political commitment, predictable financing, robust leadership and governance strong partnerships and multisectoral stakeholder collaboration, across health and other sectors, by levels of care and across professional boundaries.

The public health revitalization process will provide opportunities to create the enabling institutional, policy and operational environment to address the identified system support gaps and build stronger and sustainable PHC systems and workforces. Effective communication and multisectoral stakeholder engagement strategies, coherent health workforce policies and practices, and information systems that enable effective performance monitoring, evaluation and learning will support the country achieve the goals and objectives of the GoM SAP, the HMP, the Revitalization Road Map as well as Astana commitments for PHC strengthening.

This study was conducted with a policy lens and focus, and further research will be needed to better understand some of the issues and challenges identified by respondents. Key among these would be studies to examine factors that influence the attraction, performance and retention of CHW cadres, from the perspective of CHW cadres and the communities they serve. Further analysis of the gender dimensions of CHW programmes would inform the formulation of gender-sensitive and transformative policies and practices.

Barriers and facilitating factors to creating an integrated and multidisciplinary PHC workforce, as well as an exploration of appropriate types of CHW programmes and cadres for different settings would provide useful evidence for informing policies and strategies. Local data are also scarce on the deployment and effectiveness of expatriate health professionals and client and community satisfaction; evidence could be improved in this area. There is also a need for more cost-benefit analysis and studies of the various CHW interventions to assess effectiveness, relevance and efficiency as well as value for money.

Finally, establishing robust supportive supervision systems and monitoring and evaluation mechanisms will enable the monitoring of the public health revitalization process, and measurement of its effectiveness and impact on the PHC system and workforce.

Recommendations

Recommendations were derived by the evaluation team based on all findings including responses from respondents on evaluation question three. This question solicited information on prioritized measures that could be taken by government and partners to strengthen health policy and system supports to optimize the contribution that each CHW cadre can make to PHC. Respondents' responses on this question were interpreted considering the other information from all data sources including the desk review. Moreover, the report including recommendations was reviewed by the relevant stakeholders, including the UNICEF staff in the country and region.

Given the system-building nature of the recommendations, all recommendations must be spearheaded by the Government of Maldives. Relevant development partners in the country should advocate as well as provide the technical support for implementing the recommendations according to their capacity.

The evaluation team presents below a key list of recommendations that have already been narrowed based on the findings. Prioritizing the recommendations further is

difficult given that most of the recommendations are required to improve and enhance the policies and system to address the needs of the PHC and CHWs in the country.

Recommendation 1: **Leadership at the highest levels, including the President's Office , the MoGFSS, and the MoH, as well as civil service reform is imperative for public health revitalization.** The ongoing revitalization process should consider addressing all the gaps to attract people into the CHW and PHC profession, to motivate and support the existing PHC workforce, to rebuild the community's trust and confidence, and ensure equitable and quality integrated services at PHC level. There is a need for greater clarity on leadership roles and responsibilities across the health sector vis-à-vis public health. (Actor: Government of Maldives)

Recommendation 2: **The scope, the roles and responsibilities of both the CHW and the FHW, should be revisited to ensure that these are still appropriate and feasible** given the changing disease burden, proposed revitalization and reforms, and the new technical and job structures under development within the CSC. Reviewing the scope of practice will also provide opportunities to ensure that CHW and FHW roles and responsibilities are aligned with ground realities, current and emerging health demands and the needs of both island and urban populations.
CHWs can also play a critical role in providing nurturing care, early childhood development, nutrition services through existing platforms, prevention and early detection of NCDs, vector prevention and control and sexual and GBV. (Actor: Government of Maldives)

Recommendation 3: **The PHC team, including CHWs should be supported and enabled to "re-engage with and empower the community"** and to be more "proactive in identifying the issues in the communities" since community partnerships are vital. On the demand side, renewed efforts are also needed to rebuild the confidence of individuals and families in CHWs and community-based services. Positioned within the communities they serve, CHWs can also ensure that community-level perspectives influence and inform policy development. (Actor: Government of Maldives)

Recommendation 4: **Policies and strategies should be contextualized to build and retain local capacity in the islands.** It was observed that island communities and practices are different, "even if they are very close-by islands, communities differ, the practices differ." CHWs and other community-based cadres who understand these local contexts will be more effective in communicating with and influencing these communities and families and bringing about the desired behaviour change. (Actor: Government of Maldives)

Recommendation 5: Robust and evidence-based workforce policy and plans, aligned with national policies and strategies are needed to ensure that PHC health **workforce meets the health needs of the population and support the achievement of health outcomes and targets.** Such health workforce planning, which outline current and future workforce requirements, should be undertaken in collaboration with the FHS, so that this institution can plan accordingly, and ensure its production and supply of CHW meets the demand, as well as the competencies and skills' mix required.

HR policies should focus on the equitable distribution of these CHW cadres across the country, as well as developing and supporting their performance and productivity. (Actor: Government of Maldives)

Recommendation 6: **The evaluation recommends additional and ring-fenced allocations for promotive and preventative services at PHC level.** Strengthening and enhancing PHC services will also reduce the current pressures on secondary and tertiary facilities, as well as the financial burden of delivering such care at these levels. (Actor: Government of Maldives)

Recommendation 7: The role of the CHW and FHW cadres and public health functions were essential for effective PHC services, **and greater efforts should be made to make these jobs and careers more attractive.** Job satisfaction was a key factor in CHW effectiveness, and a number of issues were identified that influence this, including remuneration, career pathways, recognition of their work and the profession, job enrichment and decision-making authority. (Actor: Government of Maldives)

Recommendation 8: **While the curriculum for CHWs has been reviewed and revised in the last five years, the current curriculum should be more responsive and aligned with current needs.** The curriculum should also include content on adolescent health, NCDs, community engagement and behaviour change communication, gender equality and equity, as well as the use of mobile technologies and social media platforms for health promotion and education. (Actor: Government of Maldives)

Recommendation 9: Many CHWs and FHWs have been in their post for several years and **reinforcing and refreshing their initial basic education and training through a continuum of learning, including IST, mentoring and CPD is recommended.** The provision of more systematic and structured IST and CPD would also contribute to the improved maintaining and updating CHWs competencies, improving their performance and the quality of care provided as well as motivation and retention of these cadres. IST strategies and practices should also consider the gendered-specific needs and responsibilities of women, especially their family roles and obligations. (Actor: Government of Maldives, Development Partners)

Recommendation 10: It is recommended that adequate **resources and financing are allocated for effective monitoring and supportive systems and processes** and to ensure quality health care is delivered by CHWs. Improving the quality and frequency of supportive supervision processes to enable performance review and quality improvement was identified as a critical area for improvement. Increasing the availability and distribution of supervisors across atolls and islands, as well as strengthening their skills, competencies and attitudes to ensure supervisors are effectively and regularly conducting supervision and supporting health care providers in improving their performance were key recommendations. (Actor: Government of Maldives)

Recommendation 11: **The gendered dimensions of health workforce issues should be recognized and health workforce polices should ensure that gender disparities** in the remuneration, planning, recruitment, deployment, retention and motivation of these cadres and the overall PHC workforce **are well addressed.** (Actor: Government of Maldives)

Annex 1 Key informant interview guide for national level informants (Generic)

Potential informants: policy makers and national opinion leaders; officials from Ministry of Health and from other relevant community health, gender, women's' affairs line ministry officials; representatives from local government and civil service; professional association and regulatory bodies; development partners and donors/funders; representatives from international and local NGOs, private sector, and training providers.

Introduction

- Introduce yourself. Explain that the purpose of the interview is to collect the views and perspectives of stakeholders of policies and systems support for CHW programmes in the country in order to enhance the effectiveness of the health care system and strengthen health outcomes in the country.
- Ensure each participant has a copy of the information sheet. Obtain informed consent.
- Ensure key aspects from the information sheet are well-understood, primarily: (1) that the discussion will last a maximum of 45- 60 minutes; (2) that the content of the interview will remain confidential; (3) that the participant's name will not be used when reporting the findings; (4) that quotations will be anonymised; and (5) a voice recorder will be used, only to ensure that all the information from the interview is captured, and only if they agree to being recorded.

Materials

KII guide, KII log, notepad, pens, voice recorders, batteries, information sheets, consent forms, country specific CHW map, CHW definition; definition of support system; front cover and weblink for WHO CHW Guideline, WHO/UNICEF Operational Framework, and Astana Declaration; figure of WHO HS Framework; and country-specific desk review findings.

Please include the following details and participant profiles as part of the recording:

- Country of data collection
- Date of interview
- Post title of the participant
- Employer of the interviewee
- Sex
- Department/Unit/Organisation
- Number of months/years working in this position

For example: 'This is a key informant interview in the Maldives, it's the second of October 2019, the interview is with the Director of the Sexual and Reproductive Health Division, of the Ministry of Health'.

A. National CHW programmes and cadres

1. What is your role in CHW programmes in this country?

2. Are the following key CHWs, (*name cadre(s)*) identified for (name the country), correct? (*Provide agreed study CHW definition, if required)*
   a. If not, which cadres should be omitted or added? (For those added, probe for their roles in Q3 below)

3. Which of these CHW cadres or programmes are you most involved with or knowledgeable about and would be comfortable discussing today?

4. Could you please describe the key roles and responsi bilities of these cadres with respect to the provision of maternal, newborn, reproductive, and child health services?
   a. How would you describe the effectiveness of these CHWs currently in fulfilling their RMNCAH roles and responsibilities?

   Probe for:
   i. any other roles and responsibilities these RMNCAH CHWs might have: immunization/ polio, nutrition &/ECD, disease surveillance, WASH and/or disaster response, etc.
   ii. to determine if RMNCAH roles and responsi-bilities are spread across a number of cadres and how these cadres are coordinated.

   b. What factors facilitate and what factors constrain
   their effectiveness in fulfilling their RMNCAH roles and responsibilities?

   Probe for:
   i. What facilitating factors should be retained
   ii. Factors related to the individual CHW, the community and the health systems
   iii. Any gender related constraints to CHW effectiveness
   iv. Any other equity related constraints such as caste
   v. Any constraints related to competences and availability of supervisors
   vi. Recommendations to overcome these constraints.

Thoughts on how the RMNCAH roles and responsibilities of these CHWs might change in the next 10 years.

During our desk review we identified the following key findings related to health system support (explain/provide definition) for these CHW cadres. Do you agree with these?

and disaster response
iii. Community acceptability
iv. Effectiveness of CHWs in carrying out their roles and responsibilities
v. Access to training
vi. Discrepancies between prescribed coverage area/target population and what happens in practice due to HR/CHW shortages
vii. Work environment and safety
viii. Remuneration
ix. Senior/leadership roles
x. Career progression opportunities/criteria and constraints
xi. Overcoming potentially prohibitive cultural norms
xii. How other dimensions like caste, religion, ethnicity interact with gender in the work of these CHWs

2. Of the gender issues related to these CHWs that you have identified, how are these being addressed?

Probe for policies and specific system support

D. Financing and resource mobilisation

1. How are programmes related to these CHWs currently financed and/or resourced?

Probe for information on the following funding streams and proportion of funding from each:
i. Government financing
ii. Donor projects/programmes (off budget)
iii. Direct budget support from donors
iv. Community resources
v. Support from NGO and private not-for profit organisations
vi. Support from private-for-profit organisations

Request any documentation to support responses

2. Are there any changes planned to financing strategies for programmes related to these CHWs and/or to improve system support?

Probe for the following:
i. increased domestic or external funding;
ii. private sector support/involvement
iii. new mechanisms for health financing (user fees, health insurance,...),

Probe for availability of financing for CHW system support including:
i. drugs and medical supplies,
ii. remuneration
iii. job aids
iv. transport and logistics support
v. IT equipment for data collection
vi. supervision and mentoring
vii. refresher training

E. Private Sector Contribution to CHWs

1. What is the private sector's contribution to the production, use and management of these CHWs in this country?

Probe for:
i. Participation of contribution of not-for-profit and for-profit private sector organisations
ii. participation of private training institutions in training these CHWs
iii. participation of health professional societies in training these CHWs

2. How could the contribution from the private sector be enhanced?

Additional information:

- Which key stakeholders would you recommend we meet while we are in the country?
- Are there any key documents that we should review for this study?

Closure

- Ask if the participant would like to add further comments
- Bring the meeting to a close by summarising the main points
- Thank the participant for his/her time and active participation

Annex 2 Key informant interview guide on GENDER for national level stakeholders

Potential informants: Informants with a special knowledge/work area of gender and CHWs – including UNICEF CO gender focal person, any gender focal persons with different ministries involved with CHWs, gender focal persons from development partners, representatives from NGOs working on gender and health.

Introduction

- Introduce yourself. Explain that the purpose of the interview is to collect the views and perspectives of stakeholders on gender issues in policies and programmes related to CHWs.
- Ensure participant has a copy of the information sheet. Obtain informed consent.
- Ensure key aspects from the information sheet are well-understood, primarily: (1) that the discussion will last a maximum of 45- 60 minutes; (2) that the content of the interview will remain confidential; (3) that the participant's name will not be used when reporting the findings; (4) that quotations will be anonymised; and (5) a voice recorder will be used, only to ensure that all the information from the interview is captured, and only if they agree to being recorded.

Materials

KII guide, KII log, notepad, pens, voice recorders, batteries, information sheet, consent form, note on country-specific gender issues identified from desk review; front cover and weblink for WHO CHW Guideline, WHO/UNICEF Operational Framework, and Astana Declaration

Please include the following details and participant profiles as part of the recording:

- Country of data collection
- Date of interview
- Post title of the participant
- Employer of the interviewee
- Sex
- Department/Unit/Organisation
- Number of months/years working in this position

For example: 'This is an key informant interview in Maldives, it's the second of October 2019, the interview is with the Director of the Sexual and Reproductive Health Division, of the Ministry of Health'.

1. Please describe briefly your current position and your work, current and previous, related to gender and CHWs.
2. In your experience, in this country (name the country), how do you think gender impacts on the work of the CHW cadres we have identified in this country (name the cadres or provide list of the cadres we are referring to)?

   Probe for:
   - I. Gender issues faced by these CHWs
     - i. at family/household level
     - ii. in the community
     - iii. within the health system
   - II. Challenges faced by these CHWs in their work due to these issues
3. You spoke about how gender impacts the work of CHWs. How do other dimensions like caste, religion, ethnicity interact with gender in the work of these CHWs?
4. At the policy level how does gender play a role in policies related to these CHWs in this country (name the country)?

   Probe for:
   - I. Selection of CHWs for training
   - II. Division of roles/services between male and female CHWs
   - III. Remuneration
   - IV. Career progression
   - V. Work environment and safety
   - VI. any focus in CHW/PHC policy on gender issues related to other genders (apart from male/ female, eg. transgender) and any suggestions on how these can be included
5. At the programme level how does gender play a role in in the design and implementation of programmes related to these CHW cadres in this country (name the country)?

   Probe for:
   - I. Female and male CHW roles in the provision of RMNCHAH services by the health system and take up of services by communities
   - II. CHW selection criteria
   - III. Access to training
   - IV. Work environment and safety
   - V. Mobility
   - VI. Remuneration
   - VII. Senior/leadership/supervisory roles
   - VIII. Career progression
   - IX. Overcoming potentially prohibitive cultural norms
6. Have any specific policy measures been put in place to ensure that policies and programmes related to these CHWs are gender responsive/address issues related to gender?

If necessary, explain that gender responsiveness involves
considering gender norms, roles and inequalities, and measures to actively address them.

Refer back to issues raised as part of previous questions. Probe for answers from Q2 i, ii, iii, and Q3 if any solutions were given).

Probe for:

I. What are the key successes of these measures in addressing gender concerns in the CHW policies/programmes?
II. What are the key challenges of these measures in addressing gender concerns in the CHW policies/programmes?
III. Can you cite any specific examples of CHW programmes in the country where policies or programmes have been/have made efforts to be gender transformative?

If there are any issues identified in the desk review around gender for this specific country, refer to these and ask if anything has been done to address them.

7. If programmes related to these CHW in this country (name the country) were to be made truly gender transformative, what would you suggest should happen to achieve this?

If there are any issues identified in the desk review around gender for this specific country, refer to these and ask if anything has been done to address them.

Probe for:

I. Anticipated barriers, challenges and suggested solutions in implementing these suggestions
II. Equal pay
III. Equal access to training
IV. Equal access to promotion opportunities
V. Overcoming cultural norms/barriers

8. With regards to community health and/or PHC reforms being planned in this country (name the country), what are the measures being put in place to make programmes related to these CHWs responsive to gender concerns?

I. What would be your suggestions to make them more gender responsive?
II. Anticipated barriers, challenges and suggested solutions in implementing these suggestions

Additional information:

- Which key gender informed stakeholders would you recommend we meet while we are in the country (name the country)?
- Are there any key gender related documents that we should review for this study?

Closure

- Ask if the participant would like to add further comments
- Bring the meeting to a close by summarising the main points
- Thank the participant for his/her time and active participation

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Annex 4: Ethics Approval letter

LSTM
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Margaret Caffrey
Liverpool School of Tropical Medicine
Pembroke Place
Liverpool
L3 5QA

Friday, 30 August 2019

Dear Ms Caffrey,

Re. Research Protocol (19-037) ***Evaluation of South Asia's current Community Health Workers policies and system supports, and their readiness for Community Health Workers' expanding roles and responsibilities within Post-Astana national health care strengthening Plans***

Thank you for your letter providing the necessary in-country approvals for this project. I can confirm that the protocol now has formal ethical approval from the LSTM Research Ethics Committee.

The approval is for a fixed period of three years and will therefore expire on 30th August 2022. The Committee may suspend or withdraw ethical approval at any time if appropriate.

Approval is conditional upon:

- Continued adherence to all in-country ethical requirements.
- Notification of all amendments to the protocol for approval before implementation.
- Notification of when the project actually starts.
- Provision of an annual update to the Committee.
  Failure to do so could result in suspension of the study without further notice.
- Reporting of new information relevant to patient safety to the Committee
- Provision of Data Monitoring Committee reports (if applicable) to the Committee

Failure to comply with these requirements is a breach of the LSTM Research Code of Conduct and will result in withdrawal of approval and may lead to disciplinary action. The Committee would also like to receive copies of the final report once the study is completed. Please quote your Ethics Reference number with all correspondence.

Yours sincerely

Dr Jamie Rylance
Co Chair
LSTM Research Ethics Committee

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RECTEM010 v1.0
Release date: 14/07/2017 Issued by: RGEO

Country Report for Maldives

**UNICEF Regional Office
for South Asia (ROSA)**