HEALTH SECTOR ROADMAP 2012/2013

MINISTRY OF HEALTH AND FAMILY

SEPTEMBER 2012

ACRONYMS

ADR	Adverse Drug Reaction
CCHDC	Centre for Community Health and Disease Control
CHW	Community Health Workers
CSC	Civil Services Commission
DG	Director General
EML	Essential Medicines List
FHS	Faculty of Health Sciences
FHW	Family Health Workers
HIS	Health Information System
HIU	Health Information Unit
HR	Human Resources
HRH	Human Resources for Health
HSC	Health Service Corporation
IHR	International Health Regulations
MCH	Maternal and Child Health
MD	Managing Director
MFDA	Maldives Food and Drugs Authority
MoEd	Ministry of Education
MoFT	Ministry of Finances and Treasury
MoHF	Ministry of Health and Family
MVRs	Maldivian Rufias
NCIT	National Centre for Information Technology
NHA	National Health Accounts
NPO	National Professional Officer
NSPA	National Social Protection Agency
PPD	Policy and Planning Division
QAID	Quality Assurance and Improvement Division
STO	State Trade Organization
WB	World Bank
WHO	World Health Organization

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1.- Coordination at national and sub-national levels

Governance represents an important challenge for the health sector in Maldives, particularly with the substantial recent changes introduced aiming at moderating the initial strong decentralization move. The managing boards of the eight HSCs were dissolved and amalgamated in one central board which is a transitory structure towards a central Health Service Department (still under discussion) which will assume the management of health services at national level. The focal segment of the system will now be the Atoll level The new Minister of Health established a Health Advisory Committee composed of senior health experts working on voluntary basis that provide technical advice to him. Changes introduced have not always been accompanied by a solid dissemination and enforcement strategy which have often left institutions and staff disoriented and unclear. However stakeholders including health system managers and workers and also development partners are aware of this problem and are currently working on it.

1	Strategic approach	Action planned/recommended	Lead/Partners	Observations
1.1	* Roles and responsibilities	* In the area of HR definition of standards and policy development; All job descriptions have been revised, standard organizational structures and standard post establishment have been defined for each level of the system; * The process of transferring HRH to the Civil Service Commission is ongoing	* MoHF * CSC	* In order to ensure proper dissemination and adoption of the revised job descriptions it will need a strong communication campaign among all workers in the health system;
1.2		* Guidelines (SOPs) including roles and responsibilities of Atoll and Islands levels will be again disseminated. However a clear plan to implement this strategy is still undefined.	* MoHF/CCHDC/PPD	* PPD sent task to all atolls for dirtibution * It is advised to ask atolls to organize support sessions with islands under their coverage to ensure clear understanding
1.3		* In the area of social protection there is need to formally (in writing) clarify from the legal, functional and operational perspectives the role of NSPA and its relationship with Ashanda Pvt. Ltd. * Define specifically which are the roles and responsibilities in terms of management of the health insurance scheme and who is responsible for it (NSPA);	* NSPA/Ashanda/MoHF	* This is a recommendation included in the document WHO Duran, A. 2012 that needs to be adopted
	* Communication/coordination	* Regular meetings will be organized between central and atoll levels. Negotiations are ongoing with private telephone enterprises to facilitate installation of videoconference facilities in all Atoll Hospitals to facilitate these meetings.	* MoHF * Telephone companies * HSCs * Atoll Health Management Teams	
1.4		* To ensure appropriate coordination inter-ministerial meetings should be schedulled regularly between MoHF and MoFT, MoE and other ministries linked to the health sector in any of its areas	* MoHF * Other ministries	

2.- Health care financing

A mandatory universal non-contributory social health insurance (Ashanda) was introduced in January 2012. Coverage offers an annual benefit limit of 100,000 MRFs per beneficiary receiving services from any public or private service providers registered with NSPA. As a consequence the utilization of health services increased substantially and so did their cost which having already been steadily rising during the last years (from 1,500 MRFs per beneficiary in 2009 to 2,500 in 2011) seems to be spiralling without control in 2012. A recent assessment of HCF in the Maldives (WHO Duran, A. 2012) identified some issues with the supply side, the demand side and the insurer that may be contributing to this cost escalation. Payment of providers through fees for services ocurs within a weak regulatory environment with insufficiently balanced institutional arrangements, with an inappropriate attribution of roles and responsibilities and where supervision and inspection capacity are rather weak. This together with a devolution of power and responsibilities to HSCs with often limited resource management skills and the absence of incentives for cost control (e.g. lack of reference prices, absence of prescription control and lack of productivity monitoring in health services) contributed to this cost escalation. On the demand side beneficiaries are invited to over utilize services due mainly to poor information about the rational use of insurance benefits leading to the perception of Ashanda being a "100K MVRs pre-paid scheme" which together with the absence of gate-keepers in the system leads on the one hand to inefficient use of resources and on the other hand leaves the patient to decide which services are required which also pose some safety risks on patients who may end getting inadequate or innecesary services for their specific health problem. On the insurer side there is a rather poorly targeted package of services with prevalent diseases or more disadvantaged groups not being prioritised and insurer not selectively purchasing the best service providers but all of them.

2	Strategic approach	Action planned/recommended	Lead/Partners	Observations
2.1	* Cost control and containment Define and implement a strategy for cost control and containment assigning specific roles and responsibilities o each institution and professional involved	* Make it clear that data collected by Ashandha is the property of the Maldives Government (via NSPA) and that a strong, transparent monitoring and evaluation scheme needs to be set up immediately based on such data;	* MoHF * NSPA * Ashanda	* These are recommendations included in the document by Duran, A. 2012 that need to be adopted
2.2		* Direct the responsible agency (NSPA) and Ashandha Pvt Ltd, to immediately establish a publicly known, single schedule of fees and services;	* MoHF * NSPA * Ashanda	
2.3		* Require all providers of services to invoice using the official schedule and a standard form of invoice as prescribed by the responsible agency (NSPA). Ideally, this invoice form should include a provider registration number, should include the amount paid directly by the patient, and should be signed by the patient;	* MoHF * NSPA * Ashanda * Medical Council (?)	
2.4		* Direct the appointed responsible agency (NSPA) to immediately commence a process to make collection of statistical and financial data consistent with the approved schedule of fees and services to be used in setting up the future changes;	* MoHF * NSPA * Ashanda	
2.5		* Make it clear that the quantum of fees payable by the Ashandha Health Insurance Scheme must be approved by the Minister of Health.	* MoHF * NSPA * Ashanda	
2.6	* Provider payment Review of provider payments systems	* Strategy to implement "DRGs" and go for "casemix" based funding or any other relevant model which will bring in efficiencies to the system, as well accountbilities (this is a QAID suggestion and is not included among Duran's recommendations)	* MoHF * NSPA * Ashanda	
2.7		* Moving away from a pure fee-for-service model and towards an output/outcome, performance-related basis for payment for both outpatient and inpatient care, with clear standards and quality criteria and close-ended service indicative costs even beyond services covered under NSPA;	* MoHF/WHO * NSPA * MoFT	

2	Strategic approach	Action planned/recommended	Lead/Partners	Observations
2.8		* Establishing a rationale for any possible differences between the fees payable to public and private providers, both hospitals and outpatient providers; * Strategy for pharmaceutical cover "generics" or any other model (suggestion from QAID not included among Duran's recommendations);	* MoHF/WHO * NSPA * MoFT	* These are recommendations included in the document by Duran, A. 2012 that need to be adopted
2.9		* Including patient transport costs in the schedule of services covered, with a view to reducing out of pocket payments by patients;	* MoHF/WHO * NSPA * MoFT	
2.1	* National Health Insurance Act Review of the National Health Insurance Act	* Rewriting the HI Act in a clear and legally sound way that would remove the current ambiguities, voids and conflicting interpretations;	* MoHF/WHO * NSPA * MoFT	
2.11		* Giving statutory support to the role of NSPA and its overhauled managerial relationship with Ashandha Pvt Ltd	* MoHF/WHO * NSPA * MoFT	
2.12		* Promoting a basis for rationality in future decision making explicitly, to get the health system issues out of electoral politics in 2013;	* MoHF/WHO * NSPA * MoFT	
2.13		* Facilitating the pooling of funds for health care delivery under the umbrella of the Ministry of Health; the involvement of the Ministries of Finance & Treasury and Home Affairs (including LGA) will be integral to this aspect of the review;	* MoHF/WHO * NSPA * MoFT	
2.14		* Regulate quality level of providers both hospitals and individual doctors as a part of periodical (ideally annual) registration – unregistered providers will not be eligible for payment from the health insurance scheme;	* MoHF/WHO * NSPA * MoFT	
2.15	* Prepare future steps	* Progress towards establishing compulsory Provider Performance Reports that would give transparency to the activities of publicly funded hospitals, clinics and PHC centres;	* MoHF/WHO * NSPA	
2.16		* Introduce additional sources of funds ("sin taxes" on alcohol and tobacco, co-payments for certain pharmaceuticals and certain population groups, make contribution more aligned with income for formal sector employees -e.g. by increasing the contribution to the already compulsory payment to the pension fund or similar measure- or fasten the creation of a modern tax system, refining a VAT-like of tax, etc.);	* MoHF/WHO * NSPA * MoFT	

2	Strategic approach	Action planned/recommended	Lead/Partners	Observations
2.17		* Create additional pools of funds to provide a safety net for high-cost, low-frequency, high-complexity care not normally covered by the insurance system;	* MoHF/WHO * NSPA * MoFT	* These are recommendations included in the document by Duran, A. 2012 that need to be adopted
2.18		* Explore the feasibility of including under the public insurance selected services packages currently provided abroad (e.g. angiography) at much lower cost even when including transportation costs in order to maintain costs under control in the Maldives;	* MoHF/WHO	
2.19	* Communication	* Develop a communication plan with frequent presence in the media to make the updated terms of the Ashandha scheme and related issues as unambiguous as possible		
2.2		* Promoting a massive “health care quality awareness and improvement exercise” at national level, linked to the training of staff as necessary;	* MoHF/WHO	
2.21		* Paying specific attention to the population in Male;	* MoHF/WHO * NSPA * MoFT * Male Council	
2.22		* Increasing involvement of other stakeholders, specifically the medical profession;	* MoHF/WHO * NSPA * MoFT * Medical/Nursing Council	
2.23	* Efficiency gains	(See specific matrix) * Improve allocative efficiency in HRH * Centralisation of drug procurement and supply and introduction of "generics" policy * Introduction of gate-keepers policy * Rational use of service available (e.g. telemedicine) * Management and regulation of the social insurance scheme	* MoHF/WHO * NSPA * MoEd * CSC	

3.- Health workforce

Recent strategic changes in the health sector brought back responsibility for health workforce management to the MoHF. Health workers that were reallocated to the HSCs are now being transferred back to the CSC. There are some concerns about the fact that salaries paid by HSCs may have been higher than these paid by the Government and that this may have an impact on the motivation and consequently with potential turnover of employees from key professional groups. Salaries for some professional groups (e.g. Medical Specialists) paid by different HSCs were different sometimes even duplicating its value. Previous health system assessments identified weak management capacity across the system as an issue. Definition of cadres for different facilities is done according, among other criteria, to staff workload but recent evidence saw that these standards need to be revised. Despite having anecdotal evidence about low health worker productivity in some health facilities there is no monitoring mechanisms or process to substantiate this situation. There is a severe shortage of national health professionals, health sector managers and other support workers which is often addressed with recruitment of expatriate professionals. In 2010 more than half of the total workforce (51.2%) was expatriate with some categories going up to 81.7% like doctors or even to 100% like physiotherapists. International recruitment of health workers is expensive and has important implications for health service delivery. There is high turnover among expatriate staff and there is anecdotal evidence about problems of integration with the local communities. The process of recruitment of foreign professionals is outsourced to a recruitment agency with sometimes sub-optimal performance in terms of adherence to established minimum professional criteria. Not having a licensing process (exams) in place neither contributes to improve the situation in this regard. Maldivian students are sponsored to undertake medical and other professional pre-service and post-graduate training abroad. However the bonding system established to ensure that they return to work in the public sector is not properly enforced and despite bonding contracts being legally binding it is easy for them to pay back the amount that GoM spent on them and move to the private sector which represent an important lose for the public health system. There is some evidence about increasing trends of local professionals moving from the public to the private sector and also an incipient migratory move (brain drain) among key health professionals. However is difficult to substantiate this as information about the health workforce is fragmented and not always readily available.

Strategic approach	Action planned/recommended	Lead/partners	Observations
* Scale up the local workforce particularly in main and most affected professional categories	* Develop a workforce development plan aiming among others to progressively reduce international recruitment and scale up production of national HRs; * Increase sponsoring opportunities for students to go abroad for pre-service training in key professional disciplines; * Increase agreements with health professional schools to increase number of placements;	* MoHF/WHO * MoHF/HRDD (training) and MoHF/PPD (projects) * Bilateral aid (India supports 4 placements for medical training, Pakistan supports 1 for pharmacists, etc) * WHO scholarships for post-graduate education; * ADK Hospital sending students for medical training abroad	* These recommendations are included in a brief report of the rapid workforce assessment undertaken by the Consultant; * Terms of reference for technical assistance to support the development of a workforce development strategy have been defined by the Consultant.
* Rational allocation of HR	* Revised standard cadres (post establishment) for all health facilities;	* MoHF	
	* Replace medical doctors in small islands (500-1000 inhabitants) by CHWs and FHWs with extra training on clinical management (clinical officers) together with reinforcement of HSD at that level: .- Develop and introduce curriculum for CHW clinical officer at FHS (one year after Diploma level with 50% clinical placement); .- Define and implement clear referral protocols for patients from islands to Atoll level; .- Full roll out of the telemedicine services programme in every island with available facilities; .- Intensify and reorganize outreach programmes of specialists and GPs from regional and atoll hospitals to islands	* FHS * MoHF * MoEd	
* Ensure quality of health services provided by expatriate professionals	* Improve the recruitment and adaptation of expatriate doctors and nurses through introduction of licensing exams, rising of minimum professional standards for practicing in Maldives, introduction of orientation and adaptation programmes for expatriates, introduction of performance management procedures for expatriate staff	*MoHF * Profesisonal regulatory bodies (Nursing Council, Medical Council, etc.)	

Strategic approach	Action planned/recommended	Lead/partners	Observations
* Increase efficiency in Government sponsorship of health professional pre-service training abroad	* Establish agreement with national and international education institutions to create a system by which students completing training will be required to return to Maldives and work for a number of years for the public sector before getting their title or license to practice outside the public sector; * Increase the economic amount to be paid by students that decide to move to private sector immediately after completing courses;	* MoHF/HR Training	
* Transfer of staff in health facilities to MoH (Civil Service)	* The Central Board of HSCs needs to adopt a consolidated HR policy that eliminates operational differences and provide policy support for the change management in all the regional offices.	* HSC Board * MoHF * CSC	* All these recommendations are included in the report WHO Moosa, S. 2012 and are currently being implemented. Plan is to complete them by end of 2012.
	* MoH needs to appraise the HSCs Board and develop a working relationship to move the agenda for reform of health service delivery to CS and support change management.	* HSC Board * MoHF * CSC	
	* MOH and the HSC MD needs to communicate constantly, provide policy support and intervention to the HR management unit at HSC head office, regional offices and Atoll managers on a regular basis on the reform and progress towards reform.	* HSC Board * MoHF * CSC	
	* Consolidate the HR information system in the HSCs and identify differences in current job categories with that of approved categories in the CS together with any differences in remunerations.	* HSC Board * MoHF * CSC	
	* Prepare the recommended service list and organization chart for the health facilities with specific policy direction on outsourcing of services.	* HSC Board * MoHF * CSC	
	* Link with health facility service utilization data to develop workforce ratios and the HR requirement and skill mix.	* HSC Board * MoHF * CSC	
	* Develop health professionals' cadre for CS in consultation with Civil Service Commission * Consult with relevant health care professionals for revision of cadres (this suggestion comes from QAID and is not included among Moosa's recommendations).	* HSC Board * MoHF * CSC * Professional regulatory bodies	

4.- Health service delivery

Reallocation of roles and responsibilities for health service delivery introduced in recent years in the absence of strong dissemination strategies and weak monitoring and control mechanisms in place may have had some implications in terms of access, quality, coverage and safety of health services. However the recent consolidation of services under one board may provide a good opportunity to help all institutions and persons working in the health system to define, understand and assume their functions, responsibilities and terms of accountability. There are some regulatory gaps mainly due to great delays in the development and approval of key pieces of legislation such as the Public Health or the Tobacco Acts. Adherence to international health regulations is also poor. Introduction of universal social health insurance in January 2012 has caused an important increase in utilization of health services posing a serious strain on the system which in some cases, particularly in the private sector, leads to financially driven high workloads with very short consultation times and consequent poor quality of service provided. However underutilization has also been identified in recent health system assessments (e.g. Duran, A. 2012).

4.1	Strategic approach	Action planned/recommended	Lead/Partners	Observations
4.1	* Efforts in the area of HRH, defining and implementing policies and standards	* All job descriptions have been revised, standard organizational structures and standard post establishment have been defined for each level of the system;	* MoHF	
4.2	* Fully adhere to IHR 2005	* Continue progressing the implementation of IHR 2005;	* MoHF * WHO	
4.3	* Lobby new government to expedite the process of approval of important pieces of health legislation	* Minister will rise the issue of the importance of the different legal processes pending approval in the appropriate instances;	* MoHF	
4.4	* Improve HSD planning at sub-national levels	* Develop planning capacities at atoll and island levels	* MoHF * WHO	This is a recommendation included in Dr Shuey's, D. 2012 Mission Report. These recommendations needs to be revised and adapted according to new changes introduced in 2012;
4.5	* Improve HSD in small islands (< 1,000)	* Revitalize and fully roll out the telemedicine programme; * Introduce laboratory sample collection * Intensify outreach of GPs and specialist from regional and atoll hospitals * Strengthening of medical referral to higher levels (e.g. sea ambulances in strategic atolls, nurses trained on medical evacuation to be on call, improve communication systems, clear referral criteria as part of national treatment protocols, standards for medical evacuation, etc.)	* MoHF	

5.- Health information management system

The process of devolution followed by centralization of some elements of the system has left the HIS seriously fragmented. While data collection works well in many of the sub-systems (e.g. programmes, some health facilities, etc.), information sharing, dissemination and processing for use by policy makers is often not happening. Capacity at central level both qualitative (e.g. data analysis) and quantitative (e.g. number of staff assigned to HIS) is limited. At peripheral levels motivation to collect and process data is low which leads to, among other problems, poor timelines and completeness of HIS reports. As mentioned in some recent technical reports current deterioration of the HIS is at the moment alarming requiring immediate action to revitalize it.

5.1	Strategic approach	Action planned/recommended	Lead/Partners	Observations
5.1	* HIS integration	* Integration of the different elements the different programmes. All levels of the system will start collecting information integrating all aspects of the system (resources, operational information, etc.); * The first programme targeted will be MCH with support from UNICEF	.- MoHF/PPD/CCHDC .- WHO/UNICEF	* Hospital software development is a priority for MoHF but there is need for futher discussions with WHO Regional Adviser for Health Situation and Trend Assessment (HST)
5.2	* Standards, policies and regulation development and implementation	* In the first place, standards will be developed and during the year 2013 there will be training and piloting in different areas; Regulation such as the health Services Act which is currently being developed includes a section in Health Information which allow for the MoH to regulate areas such as access to information, confidentiality, etc;	* MoHF/PPD/CCHDC/QAID * WHO/WB	
5.3	* Coding	* There will be capacity building at different levels of the system for coders and certifiers (mainly doctors and CHWs); * Introduction of a coding quality monitoring system;	* MoHF * WHO	* Capacity building in HIMS is greatly needed. Development of a Diploma in HI has been proposed but this requires further discussion as it may not be efficient (other alternative could be to coordinate with NHIS Sri Lanka to adapt existing courses)
5.4	* Closing the gap between research and policy	* Launching of a periodical research bulleting is panned for 2013 including research undertaken in the country with the main objectives to offer evidence to policy makers and improve the decision making processes in the health sector; * A DHS is planned for 2013/2014 for which technical assitance will be required	* MoHF/PPD * WHO	Apart of this and in order to increase responsiveness and increase likelihood of evidence to be used it is recommended that: * Define a MoHF research agenda * Promote (funding) local research among academic and health professionals, * Get policy makers involved in research agenda setting, * Coordinate with FHS for research undertaken by students to cover areas included in the MoHF's research agenda

5.1	Strategic approach	Action planned/recommended	Lead/Partners	Observations
5.5	* Development of specific priority areas of the HIS	* Institutionalisation of National Health Accounts with a NHA Unit having been recently created with one trained person and dedicated full time;	* MoHF/Accounts/NHA Unit * WHO	* A consultant was recruited by WHO who is supporting the process of institutionalization through periodical visits,
5.6	* Revitalization of the HIS	* Accelerated recruitment of National Consultant on HIS	* MoHF/PPD * WHO	* These recommendations are included in the document by Fric, A 2012
5.7		* Revitalization of current health information system and strictly monitor completeness and timeliness of reports, particularly crucial public health indicators and health facility reports; formulate and sign Memorandum of Understanding between NCIT and MoHF on developing integrated health information system;	* MoHF/ PPD/ QAID/ CCHDC/ Atoll Hospitals/ Island Health Facilities	
5.8		* Organize regular HIS working group meetings (MoHF, NCIT and NSPA) and monitor progress in implementation of the Strategic Action Plan for Developing Integrated Health Information System	* MoHF/ NCIT/ NSPA	

6.- Medical products and technology

Medicines and medical material and technology are increasingly blamed for cost escalation of health care. Private sector comprises most of the pharmaceutical sector in the country except for a fraction of drugs which are procured and supplied by the State Trade Organization (public organization with 17% private share). While before introduction of universal health insurance (Ashanda) medicines were co-paid by patients (40 MVR per prescription), since January 2012 they are fully reimbursed. An essential medicines list (EML) exists but adherence by prescribers is very low with their choice open to around 2,900 registered drugs. Procurement and supply as mentioned earlier is mainly in the hands of the private sector. However there are currently discussions about the possibility of introducing a central procurement and supply system which in the view of the Consultant will face very strong resistance from private stakeholders and beneficiaries. In the absence of a proper system to monitor consumption it is almost impossible to forecast needs and ensure an adequate supply which leads to facilities including referral hospitals reporting stock ruptures and also wastage due to expiry of life saving drugs. Drug quality control is suboptimal with limited qualitative and quantitative testing capacity and poor inspection and control due mainly to insufficient staff. Regulatory framework for medicines is weak with important delays in legislative processes leaving the sector functionally unregulated in some important areas. There are problems identified also in the use of drugs by prescribers with polypharmacy and irrational use having been detected in recent assessments (WHO Holloway, K. 2011) which in the absence of national treatment guidelines and given the high proportion of expatriate prescribers with different backgrounds makes the situation even more complicated. Pharmacovigilance is incipient with only 3 ADRs reported in 2011.

6	Strategic approach	Action planned/recommended	Lead/Partners	Observations
6.1	* Strengthening regulatory frameworks	* Consultant currently revising regulatory framework trying to identify barriers for procurement and supply;	MFDA/WHO/UNOPS	
6.2	* Strengthening of procurement and supply systems	* UNOPS/WHO planning to start a collaboration with MoHF to strengthen the procurement and supply system;	MFDA/WHO/UNOPS	
6.3	* Strengthening quality control system	* Consultant currently training laboratory staff in quality control; * Agreement with MoF&T to organize national tenders for laboratory supplies; Equipment maintenance needs to be strengthened as well.	MFDA/WHO	
6.4	* Introduction of generic medicines	* Policy has already been drafted and will be implemented in 2013;	MFDA	
6.5	* Strengthening of pharmacovigilance system	* Training providers (medical staff) on identifying and reporting;	MFDA/WHO	

6	Strategic approach	Action planned/recommended	Lead/Partners	Observations
6.6	* Drug Supply and selection	* Monitoring of consumption be undertaken by slight adaptation and use of the drug import database and also requiring all importers to share their sales data with the MOH, including a breakdown by therapeutic class and by region. In this way the drugs most consumed may be identified and adherence to the EML monitored;		* All these recommendations are included in the report by WHO Holloway, K. 2011 and some of them are already being implemented. Given that the assessment by Dr Holloway was done in 2011 some recommendations have been adapted to the new situation of the health system. The recommendations should also be taken into account within the plans to create a new HSD and how the new organizational structure could affect each of the issues and solutions proposed.
6.7	* Drug use	* A unit dedicated to regular monitoring of medicines use and implementing strategies to improve use be created within the MOH, possibly the MFDA. Such a unit should be guided by a multidisciplinary statutory committee. Other interventions recommended include establishing Drug and Therapeutic Committees (DTCs) in all hospitals, developing clinical guidelines, distributing them and incorporating them into Continuing Professional Development (CPD) curricula, and developing public education programs on medicines use to be delivered through the existing CCHDC/MOH health promotion units;		
6.8	* Drug regulation	* The budget and staff be increased such that annual inspection of all pharmacies is possible, that the Standard Operating Procedures (SOPs) be revised for drug registration, inspection at the ports, structure and functioning of the Pharmaceutical Board and that a sensitization program on ADR reporting be instituted;		
6.9	* Coordination	* High level discussion be undertaken between the MOH, MOF, Ashanda and the Health Professional bodies concerning the roles and responsibilities of MOH, MOF and all the other stakeholders in monitoring and implementation of strategies to improve use of medicines.		

	AREA OF INTERVENTION	STAKEHOLDERS
1	Coordination at national and sub-national levels	.- Ms Aishat Saamiya (MoHF/PPD) .- Dr Sheeza (MoHF/DG Health) .- Ms Geela Ali (MoHF/PS) .- Dr.Fathimath Nazla Rafeeq (MoHF/CCHDC) .- Ms Maimoona Abubakooru (MoHF/CCHDC)
2	Health care financing	.- Ms. Fathimath Sahudha (NSPA) .- Mr. Ahmed Aslam (MoHF/Accounts division) .- Ms Aishath Fazliya (MoHF/Budget) .- Ms Aminath Nafha (MoHF/Budget/NHA Unit)
3	Health workforce	.- Ms Geela Ali (MoHF/PS) .- Ms Aminath Nashia (MoHF/Training division) .- Ms Soofeenaz (MoHF/HR Personnel) .- Ms Shaufeezan (HSC Central Board/HR) .- Ms.Thasleema Usman (MoHF/QAID) .- Ms Asiya Ibrahim (FHS/Nursing) .- Mr Ahmed Salim (FHS/PHC) .- Ms Aishath Ahmed Didi (FHS/PHC) .- PHC students (focus group) (FHS/PHC) .- Ms Ashya Rasheed (Nurs. Council) .- Ms Maryam Rasheed (Nurs. Assoc.)
4	Medical products and technology	.- Ms Shareefa Adam Manik (MoHF/MFDA) .- Ms Aishat Mohammed (MoHF/MFDA) .- Mr Alejandro Ruiz-Acevedo (UNOPS) .- Mr Ahmed Khaleel (NPO WHO/MoHF) .- Mr Truls Eriksen (WHO Consultant Pharm.)
5	Health information management system	.- Ms Aishat Saamiya (MoHF/PPD) .- Ms. Aiman Waheed (MoHF/PPD/HIMS)
6	Health service delivery	.- Dr Sheeza (MoHF/DG Health) .- Ms. Thasleema Usman (MoHF/QAID) .- Dr.Fathimath Nazla Rafeeq (MoHF/CCHDC) .- Ms Maimoona Aboobakuru (MoHF/CCHDC)

BIBLIOGRAPHY

Holloway, K. 2011. Pharmaceuticals in Health Care Delivery. Mission Report 30 January - 10 February 2011. 31 March 2011 WHO Reg. Office for the South East Asia.

Moosa, S. 2012. Assessment of the Human Resource Management System in the Health Services of Maldives. July 2012. WHO and Ministry of Health, Maldives.

Dwedney, J. and Rotem, A. 2001. National Health Workforce Plan. Republic of Maldives, 2001-2010. Male May 2001. Ministry of Health, Republic of Maldives.

Shuey, D 2011. Mission Interim Report: Support to decentralization and health sector reform in the Maldives. Janury 5th 2011. WHO CO Maldives

Fric, A. 2012. Strengthening Health Information System (HIS) in Maldives. 27 December 2011 - 26 March 2012. Final Report. WHO Country Office

Ministry of Health and Family 2011. Plan to Support Health System Decentralization in the Republic of Maldives 2012-2015. 25/12/2011 Ministry of Health and Family.

Ministry of Health and Family 2012. Review of Health Service Corporation, Maldives. 4 March 2012. MoHF

UNOPS 2012. Strengthening Health Sector Public Procurement and Supply Chain Management Capacities. Project Proposal. 29 August 2012 UNOPS