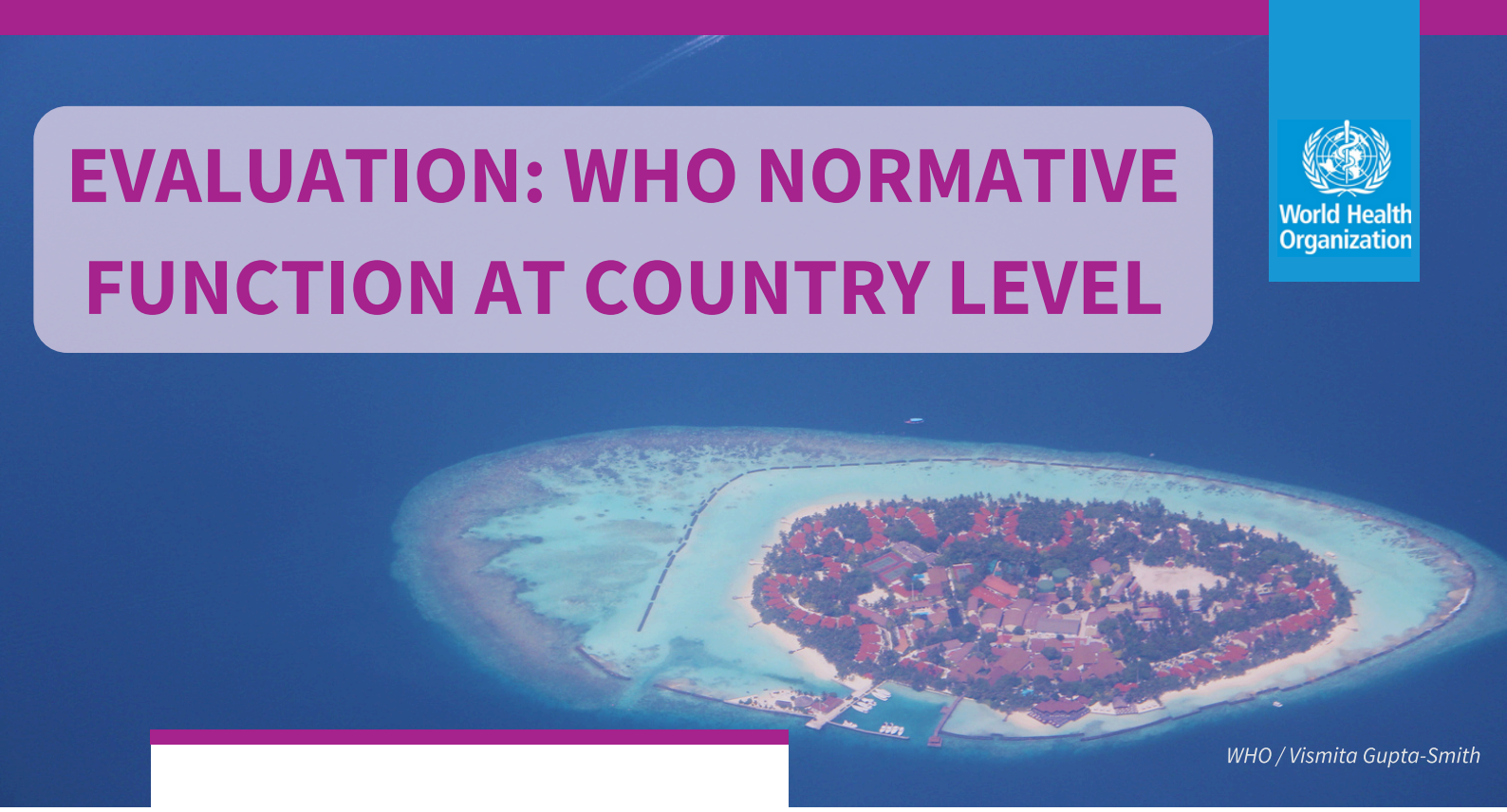
EVALUATION: WHO NORMATIVE FUNCTION AT COUNTRY LEVEL



WHO / Vismita Gupta-Smith

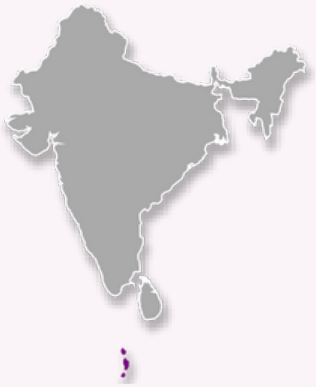
MALDIVES

COUNTRY CASE STUDY

INTRODUCTION

This is a a case study in Maldives conducted for the evaluation of WHO's normative function at the country level. The case study focused on four of six normative products identified for the evaluation, namely:

- **22nd WHO Model List of Essential Medicines 2021**
- **Guidance for conducting a country COVID-19 intra-action review (IAR)**
- **HEARTS: Technical package for cardiovascular disease management in primary health care**
- **mhGAP Intervention Guide**



COUNTRY CONTEXT

Development of the health system in Maldives has not kept pace with economic development. While overall health spending is high, spending efficiency is low with little spent on prevention and primary health care. According to Maldives Health Statistics 2020, almost two thirds of medical professionals were expatriates (724 of 1135, 64%) and 41% of nurses (1223 of 2987). Rates of staff turnover are high. Most health services are provided through government facilities. However, the referral system is not well developed, with many patients accessing secondary and tertiary facilities directly. The private sector is well developed, particularly in Male. There is a national health insurance scheme, Aasandha. There is, however, no comprehensive national health information system. There are separate fragmented systems in Aasandha, secondary and tertiary hospitals and in national programmes. Some of these systems use proprietary software. All required medicines in the Maldives have to be imported. The Ministry of Health (MOH) does not procure medicines directly but through an MOU with the State Trading Organisation.

UHC coverage Index:
61.42 (GHO, 2021)

Medical doctors per 10,000:
21.61 (GHO, 2019)

Current Health Expenditure as % of GDP:
11.35 % (GHO, 2020)

NORMATIVE GUIDANCE IN GENERAL

In general, WHO standards and normative guidance are highly respected in Maldives, particularly within MOH, which has a strong and longstanding relationship with WHO. The WHO country office and MOH are co-located. Guidance issued by WHO is primarily relevant to the public sector with less relevance to the private sector. The technical quality and global perspective of the guidance are valued. However, there are concerns that the guidance may be too theoretical and may not lead effectively to change in Maldives without a clear programme for implementation, resources to promote change and a monitoring system to assess the use and impact of the guidance.

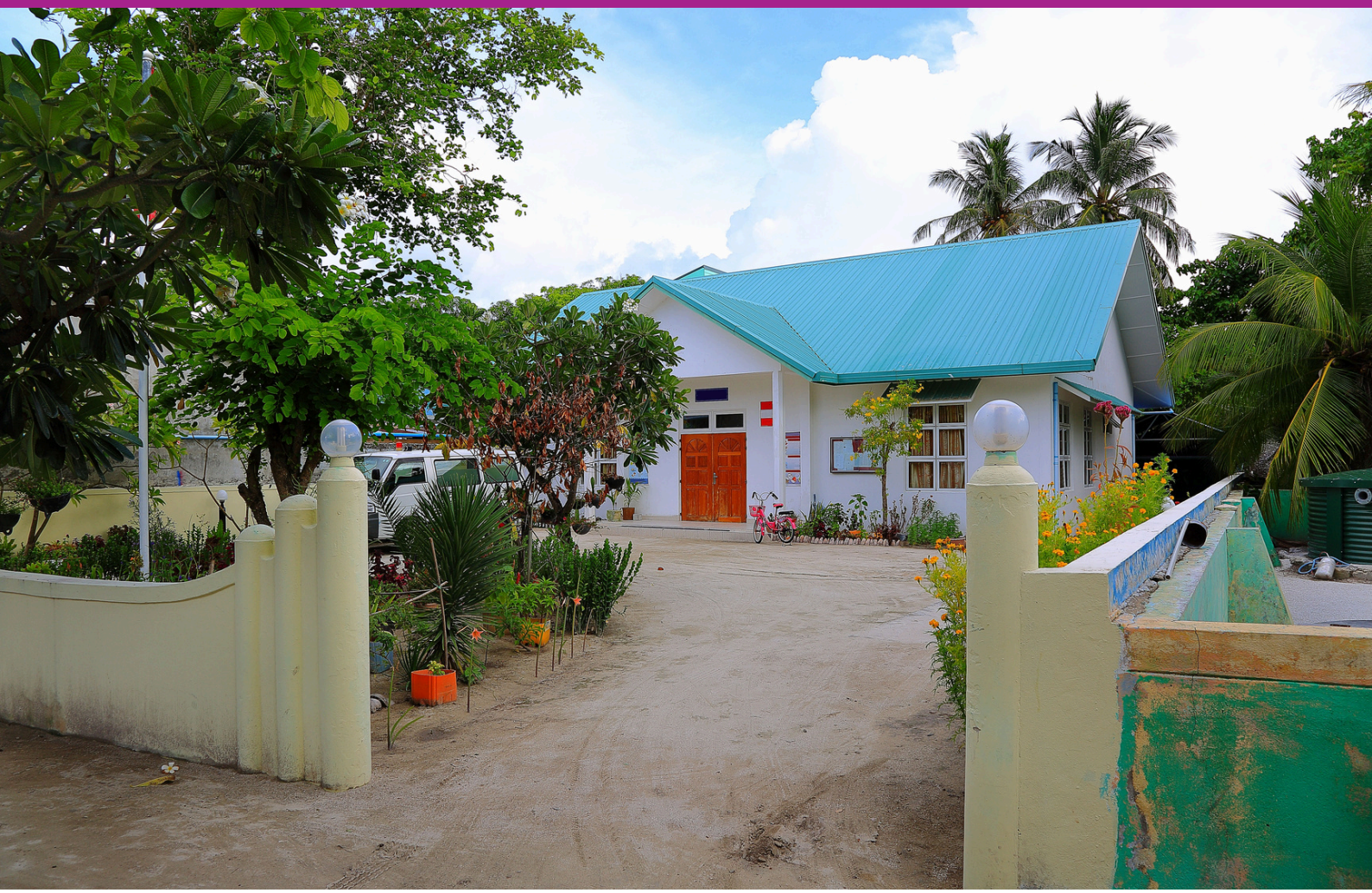
22ND WHO MODEL LIST OF ESSENTIAL MEDICINES

WHO has produced an Essential Medicines List (EML) since 1977 with the current version produced in 2023. Based on 2017 data, WHO has a global database of essential medicines which gives the number of essential medicines on the national list and the percentage that are on the WHO EML. However, there is no system to regularly update this database. According to this database, there were 535 medicines on the Maldivian EML of which only 243 (45%) were on the WHO EML.

The Maldives Food and Drug Administration (MFDA) produces a national EML based on the WHO EML. Medicines which are on the WHO EML can be approved for use in Maldives using an approach that is simpler and cheaper than full registration. This is important given that Maldives constitutes a relatively small medicines market. The evaluation team compared national EML with the WHO EML and found that just over half of the medicines on the WHO list (254 of 479, 59%) appear in the Maldivian EML. A slightly higher proportion (254 of 427; 59%) of medicines on the Maldivian EML are on the WHO EML. There are particular issues with antibiotics with some classified differently on the AWaRe system in the WHO EML and in the Maldivian EML.

While there is the prospect that the WHO EML could contribute to improved health outcomes by ensuring essential medicines are procured and prescribed, this is largely not happening. A 2014 Situational Analysis of Medicines in Health Care Delivery concluded that, although there is a national EML, "it is not actively used or promoted". The main problems are:

- **There is poor congruence between the WHO EML and the NEML in Maldives. Only just over half the medicines are on the WHO NEML and vice versa.**
- **There are few, if any, mechanisms to use the NEML as a basis for rational procurement and prescription of medicines in Maldives. There is an expectation that pharmacies stock essential medicines but there is no requirement that doctors prescribe essential medicines or that Aasandha reimburses essential medicines only. There has been little, if any, training of doctors on the use of essential medicines and national treatment protocols exist for few, if any, conditions. Attempts by MFDA to introduce generic prescribing and maximum price levels have been unsuccessful.**
- **There is no system in Maldives to monitor the extent of use of essential and non-essential medicines.**



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GUIDANCE FOR CONDUCTING A COUNTRY COVID-19 INTRA-ACTION REVIEW

In July 2020, WHO published guidance on conducting a COVID-19 IAR which included ten tools. A supplement to the guidance was issued in April 2021. Maldives has conducted two pillar-specific IARs. The first took the form of a COVID-19 vaccine post-introduction review (c-PIE) while the second focused on laboratory services. The reviews did draw from the WHO guidance but found the length and number of questions overwhelming. The approach they took of conducting a SWOT analysis yielded responses to a large number of questions in an efficient manner.

The c-PIE proved extremely useful making recommendations in five main areas – human resource gap, cold chain, digital data reporting, SOPs and guidelines, and waste management. Respondents identified concrete actions taken to address each of these recommendations, for example adding two permanent staff including a cold chain manager, replacement of all domestic fridges in health facilities, and expanding the electronic data reporting system beyond COVID-19 to cover other forms of vaccination. The review of laboratory services was used to inform a funding application to EIB for a new national laboratory

One concern is that the first review focused on an area, vaccination, where Maldives was considered to be doing well, while the second review was conducted as a requirement for consideration of a funding application for a national laboratory. This is not to say that these reviews were not valuable but rather to question whether opportunities to review other important areas, including those where progress has perhaps been less strong, have not yet been taken. Another concern relates to the size and frequency of reviews. The 2021 addendum argues that intra-action reviews should be relatively small, frequent affairs. However, other elements of the guidance (the number of questions to choose from, the number of pillars to review and the push to involve a diversity of stakeholders) all promote a larger, less frequent undertaking. These latter factors have shaped the reviews in Maldives. For example, the c-PIE involved a very large team.

HEARTS: Technical package for cardiovascular disease management in primary health care

HEARTS is a technical package providing a strategic approach to improve cardiovascular health. The original manual consisted of six modules with a seventh, on diabetes, added in 2020. HEARTS is being promoted in WHO's South-East Asia Region as part of SEAHEARTS, which also includes initiatives on tobacco control and elimination of industrially-produced trans fats. A 2021 stepwise survey identified NCDs as major causes of mortality in Maldives.

- **The major challenge facing Maldives in relation to the prevention, diagnosis and management of NCDs is that the primary health care (PHC) system is not organized in the country. As a result, levels of community trust in PHC services are low with many people going directly to secondary and tertiary services, particularly in Male. In addition, there is currently no comprehensive HMIS in Maldives. Although elements of such a system do exist, they are very fragmented and they link poorly with each other.**

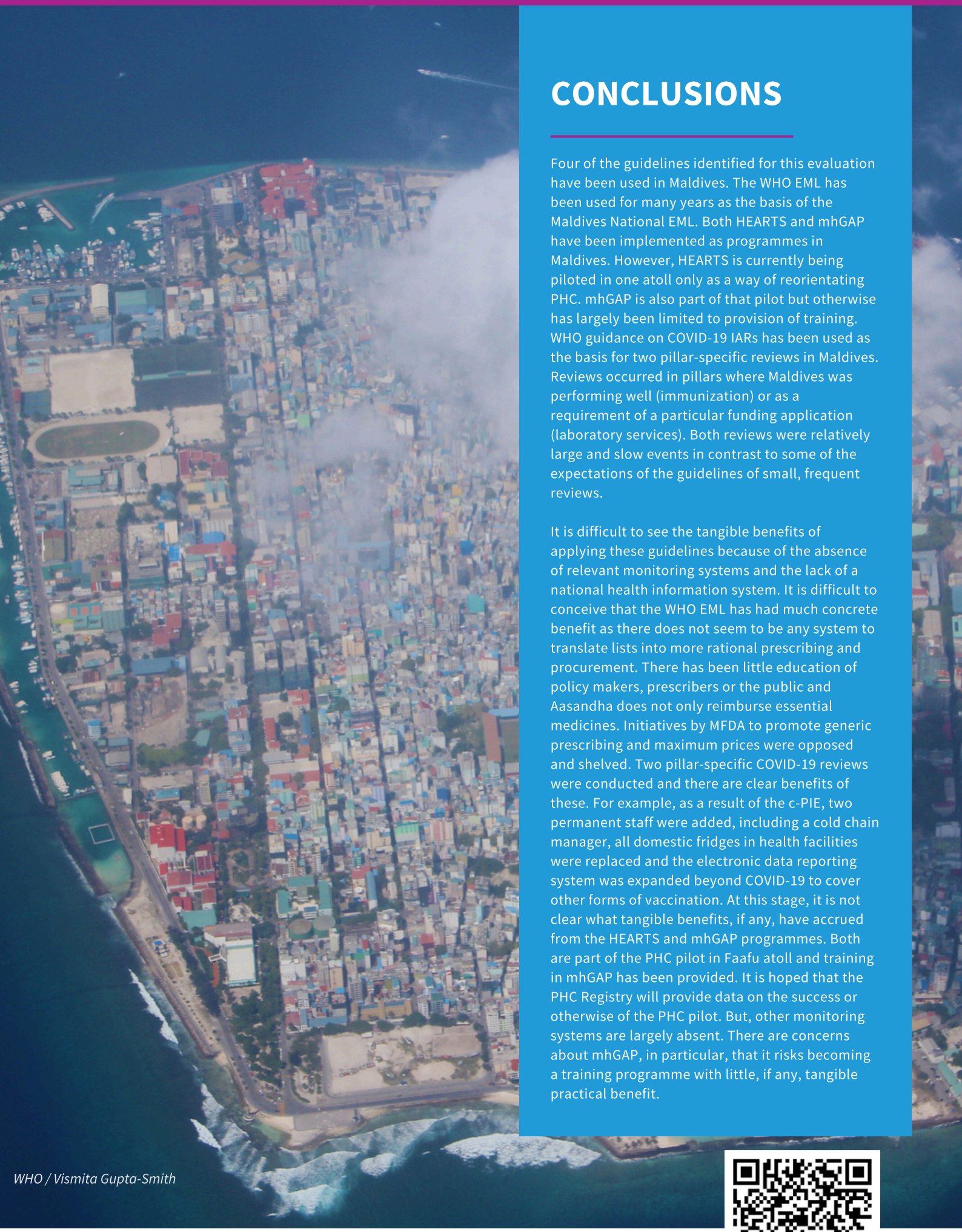
- **Therefore, WHO is supporting MOH to reorientate the health system towards primary health care. This approach is being piloted in Faafu atoll and includes elements of HEARTS and mhGAP. One challenge is that Maldives does not have a well developed, interconnected health information system. So, part of the pilot is to introduce a PHC registry. However, given the early stage of implementation of this programme, it is not possible to assess definitively how well this will work out in practice at this stage.**

mhGAP Intervention Guide

The WHO Mental Health Gap Action Programme(mhGAP) aims to scale up services for mental, neurological and substance use disorders, particularly in low- and middle-income countries. A WHO report documented its use in more than 100 countries. mhGAP-related training started in Maldives in 2014 as an initiative by the NGO, the Mental Health Awareness Foundation (MHAF) Maldives. Although this initiative was not sustained, the training was reintroduced by MOH from 2019. This initiative was strongly supported by the Centre for Mental Health at Indira Gandhi Memorial Hospital as part of an overall aim of extending mental health services across Maldives.

However, progress has been relatively slow. The mhGAP material is reported to be very content heavy, with limited focus on key issues, such as how to deliver training and how to integrate mental health into PHC in practice. In addition, elements of the material were not considered very relevant to the Maldives. Considerable time and effort has been needed to try to contextualize the material. While technical assistance from WHO has been useful overall, some has been less useful than it might have been, e.g. the provision of "master training" using consultants from the South-East Asia Region. Attempts to build a cadre of mhGAP trainers have had relatively limited success. Factors include time gaps between training initiatives, a limited pool of people with any training experience and a high turnover of people trained.

The greatest concern regarding mhGAP in Maldives is that it will simply be a training programme with few, if any, tangible benefits in practice. It is difficult to know if this is or is not the case as there is no clear system planned or in place, for monitoring mhGAP beyond the number of people trained. Measures to address this concern might include adjusting the training provided to focus more on the practicalities of how mental health might be introduced into PHC by the people being trained in the places that they work. It would be essential to have some form of follow-up to the training including visits for supportive supervision. Currently, these elements are not part of the programme.



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CONCLUSIONS

Four of the guidelines identified for this evaluation have been used in Maldives. The WHO EML has been used for many years as the basis of the Maldives National EML. Both HEARTS and mhGAP have been implemented as programmes in Maldives. However, HEARTS is currently being piloted in one atoll only as a way of reorientating PHC. mhGAP is also part of that pilot but otherwise has largely been limited to provision of training. WHO guidance on COVID-19 IARs has been used as the basis for two pillar-specific reviews in Maldives. Reviews occurred in pillars where Maldives was performing well (immunization) or as a requirement of a particular funding application (laboratory services). Both reviews were relatively large and slow events in contrast to some of the expectations of the guidelines of small, frequent reviews.

It is difficult to see the tangible benefits of applying these guidelines because of the absence of relevant monitoring systems and the lack of a national health information system. It is difficult to conceive that the WHO EML has had much concrete benefit as there does not seem to be any system to translate lists into more rational prescribing and procurement. There has been little education of policy makers, prescribers or the public and Aasandha does not only reimburse essential medicines. Initiatives by MFDA to promote generic prescribing and maximum prices were opposed and shelved. Two pillar-specific COVID-19 reviews were conducted and there are clear benefits of these. For example, as a result of the c-PIE, two permanent staff were added, including a cold chain manager, all domestic fridges in health facilities were replaced and the electronic data reporting system was expanded beyond COVID-19 to cover other forms of vaccination. At this stage, it is not clear what tangible benefits, if any, have accrued from the HEARTS and mhGAP programmes. Both are part of the PHC pilot in Faafu atoll and training in mhGAP has been provided. It is hoped that the PHC Registry will provide data on the success or otherwise of the PHC pilot. But, other monitoring systems are largely absent. There are concerns about mhGAP, in particular, that it risks becoming a training programme with little, if any, tangible practical benefit.

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