
A PROCESS AND SYSTEMS EVALUATION OF THE DRUG TREATMENT AND REHABILITATION SERVICES IN THE MALDIVES

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EXECUTIVE SUMMARY

Despite high levels of drug use, and associated social and criminal costs, the Maldives to date has avoided major health harms and costs that are linked with drug use in other parts of South Asia, and HIV/AIDS in particular. The main task in the Maldives is to reduce the impact of use of heroin and problematic drug use by better prevention and treatment. Good prevention and treatment will help prevent HIV and other adverse health, social and criminal consequences of drug use.

There are a number of structural conditions that will need to be addressed through engagement with multiple governmental ministries and departments. The main conclusions of this report will require collaboration and coordination within government and between government, civil society and the drug using (active and in recovery) community.

- *There is a need to differentiate in law and policy and practice between different types of drug use in terms of potential harm to the individual and society.*
- *There needs to be greater separation of criminal justice and therapeutic interventions.*
- *Penalties for drug offenses are high and inflexible.*
- *Too many drug users are in prison to no obvious gain to the community – either in terms of deterrence or rehabilitation.*
- *Drug users get trapped in a penal and rehabilitation system that has the unintended consequence that rehabilitation is made harder.*
- *The lack of job opportunities for recovering drug users is a major obstacle to reintegration, across all services.*
- *There is sufficient positive evidence now to roll out the methadone maintenance programme to other community sites.*
- *It is imperative the reported low level of injecting does not increase.*

A cost-effective system will bring economic benefit by the avoidance of health care costs (for example in the prevention of HIV and HCV infection, avoiding treatment costs, and the high welfare costs of drug use), a reduction in crime, a reduction in costs of the criminal justice system, and improved employment prospects.

- Many of the components of a good treatment and rehabilitation system are in place
- There is a lack of coordination which has a negative impact on helping people to become abstinent
- Some people are being ‘recycled’ through prison and the treatment and rehabilitation system with no clear exit
- Too many drug users are in prison to no obvious gain to the community – either in terms of deterrence or rehabilitation.
- The lack of job opportunities for recovering drug users is a major obstacle to reintegration, across all services
- Some services are operating at below capacity and are not cost-efficient
- The links between the criminal justice system and treatment may work against recovery
- Administrative systems make innovation difficult
- There are many small changes that could make a big difference – e.g. relapse prevention, job training, work opportunities

As we have made clear, the development of a robust, effective and rights-based treatment and rehabilitation system depends on changes within those services, and adjustments in other services

and organisations. Overall, the changes will require political and public dialogue to ensure that the Maldives can reduce the level of drug use and the current and potential consequences of drug use.

We have made numerous operational recommendations in this report. The following table summarises our recommendations and attempts to prioritise the recommendations that may be useful to the government, NGOs and development partners involved in funding, coordinating, regulating and implementing drug prevention, treatment and rehabilitation programmes and HIV prevention programmes among drug using populations. Our analysis did not cover financial performance and we were unable to undertake any unit cost analysis or other methodologies to assess the cost effectiveness of the current programmes or the financial impact of our recommendations.

TABLE 1: RECOMMENDATION MATRIX

	Urgent	Important	Good to consider if funding available
Policy	<p>Contract culture and benchmarking:</p> <ul style="list-style-type: none"> i) Introduce performance measures and benchmarks for government, private and NGO services. ii) Ensure that benchmarks and standards are in place before privatisation of any service. iii) Work with Ministry of Human Resources, Youth and Sports to learn lessons and experiences from their contracting out of youth centres. <p>Employment of ex-drug users:</p> <ul style="list-style-type: none"> i) Encourage and support the formation of new NGOs that employ recovering drug users; ii) Remove barriers to employment. iii) Consider the development of an Enterprise Fund to allow recovering users to establish new businesses and private sector development. iv) Engage with the private sector and provide financial incentives to create employment opportunities for recovering drug users within existing businesses. v) Explore other services that would benefit from public-private partnerships. (e.g. The Works Corporation pilot) 	<p>Review the Treatment Board policies for entry into rehabilitation programme and lessen the requirements to enable more incarcerated drug users the opportunity to enter the DRC.</p> <p>Allow greater freedom for voluntary drug users who may relapse during DRC and CRC programmes to avoid entering into the mandatory system. This will make voluntary admission into the system more attractive and reduce costs</p> <p>Strengthen the policy environment for rolling our evidence based drug treatment and rehabilitation, including the development of a more enabling environment for effective drug prevention, treatment and care.</p>	<p>Establish a platform for knowledge exchange and develop linkages to share experiences with other countries with similar socio cultural and religious contexts.</p>
Programme development	<p>Establish more NGOs led by recovering drug users and others.</p> <p>DDPRS & NAP need to align donor and UN projects based on gaps/national priorities. Move from project to programme based funding of all HIV and drug programmes. Ensure coordination of UN agencies to avoid duplication and harmonise HIV (Global Fund, WHO, UNICEF) and drug programmes (UNODC).</p> <p>Scale-up methadone maintenance treatment services, incorporating lessons learned from the pilot to achieve higher enrolment and retention rates.</p> <p>Encourage recovering drug users who have completed mandatory or voluntary treatment gain employment to work as drug counsellors.</p>	<p>Develop a continuum of care from prevention through to rehabilitation that provides options for active drug users who wish to reduce/abstain from drug use including other treatment options other than residential treatment and MMT.</p> <p>Develop a standardised set of IEC materials for active drug users that can be used across all sectors and ministries.</p> <p>Establish standard operating procedures for counselling both in clinic and with NGO partners</p>	<p>Establish a clinical centre of excellence for the treatment of addictions at Greenge to train medical and health personnel in the Maldives.</p> <p>Expand the youth health café concept to other islands.</p> <p>Explore the feasibility of using mobile detoxification camps as a cost-effective and more accessible alternative to static detoxification centres.</p> <p>Establish a specialised drug counselling curriculum and training programme as a joint venture between Ministry of Education and NGOs. Professionalise counselling and provide opportunities for career development.</p>

	Include drug awareness components in the MoE life skills modules for children from 11 upwards. Establish a working group with MoE, DDPRS and NGOs to review the current modules being developed by MoE.		Develop a support mechanism for counsellors to avoid burn out, discuss difficult cases etc. Develop an alcohol awareness, harm reduction, treatment and recovery programme.
Advocacy	Engage with parliamentarians and establish a specific awareness programme for current and future parliamentarians to ensure decisions at the policy level are taken based on evidence and best practice and embedded within the improvement of public health for all citizens.	Consider a national consultation on drug use and its consequences for future generations of Maldivians involving government, civil society, private sector and the international community. Analyse progress made since the Future Search conference, and develop a multi-sectoral awareness campaign involving all stakeholders coordinated by Vice President's office.	Consider sending a delegation to attend the 2011 International Harm Reduction Conference in Beirut, Lebanon.
HIV Prevention	People who continue to inject should receive explicit advice on the avoidance of blood-borne viruses, other infections, STIs and overdose including on the use of sterile injecting equipment and sterile injection procedures and condoms. Coverage of voluntary confidential testing and counselling (VCT) for HIV, and HCV testing, for people who use drugs, and especially people who inject drugs should increase from the current low levels, and injectors encouraged to have repeat tests with confidentiality ensured. Careful consideration must be given to the location and operation of VCT sites to ensure that clients trust that it is truly voluntary and confidential and the staff are sensitive to the stigma faced by drug users.	Consideration should be given to a social marketing programme (similar to condom distribution) using private sector pharmacies to distribute and collect injecting equipment. The use of drugs by injection should be discouraged among people who are vulnerable to injection and current injectors should be advised not to introduce others to injecting.	Contingency plans should be made for the swift introduction of a specialist needle and syringe programme if the number of injectors increases or cases of HIV and HCV among injectors are identified. The situation needs to be kept under active review
Drug Rehabilitation Centres	The rules on positive urine testing should be relaxed. Instead of using urine testing as a punitive/control mechanism, counsellors should have more flexibility to make decisions on a case-by-case basis. Provide additional counselling and support during key festivals and holidays when relapse is common. Develop a work training and reintegration programme.	Review the Treatment Board policies for entry into rehabilitation programme and lessen the requirements to enable more incarcerated drug users the opportunity to enter the DRC. Develop relapse prevention strategies at key stages in the programme. Consider using detoxification services for clients who have positive urine tests instead of returning to DRC.	Allow residents at the DRC to be trained in basic skills such as cookery and have work skills training to reduce costs and generate income. Introduce a case management approach for all recovering drug users.
Detoxification Centres	A review of the cost-effectiveness of the two detoxification centres should be undertaken.	The center at Villimale' needs expansion and better premises in order to deliver a high quality service to more	Consider relocation of detoxification centre from S. Hulhumeedhoo to S. Hithadhoo for

	<p>An after care system urgently needs to be introduced including relapse prevention</p> <p>There should be access to detoxification for females</p>	<p>people Detoxification centres and NGOs should develop a protocol or 'toolkit' for home detoxification, with or without support of medication</p> <p>Improve safety and security: search clients for drugs before entering; ensure centres have full resuscitation equipment including ambubags, and a safe for controlled medicines</p>	<p>improved accessibility and lower cost for the client</p> <p>Explore the possibility of general medical staff undertaking detoxification in general hospitals</p>
Methadone Maintenance Therapy	<p>Better explanation is needed to all stakeholders (e.g. parliamentarians, government, treatment services, drug users and parents) about the aims of MMT and its cost-effectiveness, especially that it is a long-term treatment with both individual and community benefits.</p> <p>Identify influential champions who can mobilise parliamentarians, ministries, religious leaders, prison authorities and civil society leaders to understand the importance of MMT and it's scale-up as a public health priority in terms of HIV prevention and improved drug treatment outcomes.</p> <p>Agencies providing counselling for MMT patients should be contracted direct by MMT or to have a memorandum of understanding with MMT to ensure that the counselling content complements MMT, and to include peer counsellors.</p> <p>It is important to incorporate work training and explore employment opportunities for patients.</p>	<p>The programme in Male' should now be expanded. A second MMT site should be developed on another island, with high levels of heroin use, possibly determined by the mapping and size estimation surveys, and that is comparatively accessible (distance, cost etc.) from other islands, using the experience gained in Male', and giving attention to the lessons learned from the pilot.</p> <p>The rules for enrolment into the MMT programme need to be simplified. The decision should be a clinical one in accordance with an agreed protocol.</p> <p>Psychosocial counselling needs to be improved: counselling protocols need to be developed that are consonant with the aims of the MMT.</p>	<p>Staff retention: the clinic needs to ensure that the current clinical expertise is retained.</p> <p>Staff and others need to learn from the experiences in other countries in implementing MMT, to exchange knowledge and implementation experiences, and learn from best practices, including reciprocal study tours for clinic staff, and also for parliamentarians and decision makers.</p>
M&E	<p>Establish a drug strategy information system to monitor the drug situation, including an "early warning" system, and</p> <p>Standardise and computerise agency records across government and NGO sectors.</p> <p>Questions on drug use and contact with services should be included in the Maldives Demographic and Health Survey.</p>	<p>Improve national research capacity on drugs and HIV. Strengthen both the Research Council and the Decision Support Services and Health Research Unit within MoHF. Encourage publications in peer reviewed journals and dissemination through International Conferences.</p>	<p>Develop capacity to undertake research, especially on the effectiveness of interventions, possibly in collaboration with an external university.</p> <p>Undertake a full cost-effectiveness study of the mandatory and voluntary drug treatment systems to inform planning and scaling up options including privatisation models, more direct involvement with recovering drug users through employment in the treatment system</p>

			and to identify gaps for potential private sector and development partner investment.
NGOS	<p>Outreach to have clear messages (e.g. avoidance of injection, referral to help)</p> <p>Encourage recovering drug users to apply for positions within NGOs, particularly as peer counsellors and outreach workers.</p>	<p>Refocus outreach teams to better utilise active drug user networks for cascading information and awareness among active drug users</p> <p>Explore – with the National AIDS Programme – the establishment of an active drug user network. All NGOs involved in drug programmes are in recovery and this is not attractive to current users.</p>	Explore the establishment of a legal defence fund to provide legal representation for drug users arrested for possession and/or use of drugs.

1 MISSION AND WORKING METHODS

We were invited by the Ministry of Health and Family of the Government of the Maldives to undertake an evaluation of the treatment and rehabilitation services provided by the Department of Drug Prevention and Rehabilitation Services (DDPRS) in the Ministry of Health and Family.

The objective was to gather evidence on programme implementation and treatment results in order to inform strategic policy and delivery options for the scaling up of comprehensive treatment and rehabilitation service for people using drugs in the Maldives.

The context for this request is the high level of drug use in the Maldives, the potential for spread of HIV infection, and the government objective to treat the drug user as someone in need of help and rehabilitation, rather than as a criminal.

The specific tasks were to:

1. Review drug treatment and rehabilitation services currently offered to clients at the treatment and rehabilitation centres under DPPRS.
2. Evaluate the quality of the treatment and rehabilitation programme, including in retaining clients through the full treatment regimen.
3. Assess the long term effectiveness, feasibility and appropriateness of the treatment and rehabilitation services in the Maldives including reduction in injecting drug use, adherence to opioid substitution therapy (MMT), influences on criminal behaviour and educational or career progress; and to
4. Develop strategic options for service delivery and a monitoring and evaluation plan for the services to be provided.

The lack of systematic data available in a readily analysable form (with the partial exception of the Methadone Maintenance Treatment clinic (MMT)) meant that a formal evaluation of the implementation and impact of the services was difficult. It was also apparent that difficulties relating to the development of the services are linked to the broader context of drug use and the response to it in the Maldives.

We therefore collected **process** information on the services where available, but also investigated the impact of the wider **system** on the ability to deliver an effective drug prevention, treatment and rehabilitation service.

The main sources of information, which we used, were:

1. Site visits to treatment and rehabilitation services, detoxification centres, non-governmental organizations, and prison (listed in Annex 1).
2. Meetings with government ministers and senior civil servants, staff of organisations involved in treatment and rehabilitation, and UN staff (listed in Annex 1) – a total of 72 individuals.

3. Interviews with drug users in the community and in treatment and prisoners. We had individual and group discussions with over 40 drug users and ex-drug users ¹.
4. Examination of record keeping systems.
5. Documents and reports (listed in Annex 2).

The visit was funded through World Bank (South Asia) and took place from 25th October to 8th November 2010.

¹ We talked with drug users individually or in groups at Journey (21), Aseyri Prison (approx. 9), District Rehabilitation Centre (2), Open Hand (8), and the Community Service Favamulah (1).

2 BACKGROUND TO DRUG USE AND DRUG PROBLEMS IN THE MALDIVES

The population of the Maldives is predominantly young, with an estimated 43% (133,513/314,542) aged between 15 and 34². Unemployment is high at 14% of the 15+ labour force. Youth participation in work is very low compared with other South Asian countries³. Many young people are reluctant to participate in the labour market and the migrant labour force exceeds one fourth of the total population of the Maldives. Those who leave school at 16 are unable to work in many occupations until they are 18. Many school children come to Male' at age 13 for further education, staying with relatives. Housing is in short supply and there is considerable overcrowding in Male'.

Drug use is reputedly extensive among young people in the community, although hard data are lacking. Informal estimates that suggest that between 10,000 and 30,000 young people are using drugs should be treated with caution: these estimates would mean that between 8% and 23% of young people use drugs. The estimates are however plausible in comparison with estimates of drug use among young people in Europe⁴. North America and Australia

It is commonly reported that most Maldivian extended families have at least one active drug user. In one group of drug users we interviewed, 32% of their siblings - including themselves - used drugs.

Greater clarity is needed in describing the prevalence of drug use: whether people are referring to current or previous use, to what types of drugs, and whether the person might be considered to be a casual or more serious user. Viewing all drug users as 'addicts' or 'abusers' in need of help or rehabilitation does not help accurate epidemiological assessment or the development of appropriate interventions nor the appropriate response to different kinds of drug users and drug problems.

Drugs used are mainly hash oil and heroin, along with a wide variety of pharmaceutical preparations⁵. Many problem drug users use a variety of preparations. Use of amphetamine is rare in comparison with neighbouring countries – only five of 275 injectors in the Biological and Behavioural Survey (BBS)⁶ survey reported having used it. More detail on drug use including injecting among school children aged 13-15 in 2009 was collected in the 2009 Global School-based Student Health Survey⁷.

Age of first drug use is typically young – with many drug users starting during school age – though there is wide variation. Age of those in treatment and recovery is typically in the mid to late twenties – though again with wide variation.

²The Maldives Health Statistics, Ministry of Health & Family, Republic of Maldives, 2009

³ Rapid Assessment of the Employment Situation in the Maldives, Human Rights Commission of the Maldives, 2009

⁴ Annual Report on the State of the Drugs Problem in Europe. EMCDDA, Lisbon, November 2009

⁵ Voices from the Shadow, UNICEF and Journey, 2007

⁶ Biological and Behavioral Survey on HIV AIDS, UNDP, November 2008

⁷ 2008 Maldives and Male' Global School-Based Student Health Survey Questionnaire, Ministry of Education

The BBS estimated that there was a total of 375 injectors in Male' and Addu in mid-2008. In the 2003 rapid assessment, 8% of drug users had injected, but the frequency of injecting was not reported⁸. In 2006 a rapid assessment conducted by the NGO Journey⁹, found that 28% reported having injected at some time. In Male' there do not appear to be regular drug congregation sites and most drug use reputedly takes place indoors. The National AIDS Programme is currently undertaking a social risk mapping and size estimation of most-at-risk populations for HIV and will include data on injecting drug use.

Most people who have injected do so infrequently. In the Journey survey, 6.5% had injected once, 15.5% sometimes, and 6% nearly always. The 2008 BBS¹⁰ which recruited 147 people who inject drugs in Male', and 128 in Addu, found that less than half (46%) had injected in the last 30 days (Male' 43%, Addu 50%). In total, 16% (44/275) were injecting every day, and these were mainly older drug users. Our interviews suggested that injecting remains rare, and that frequent injectors are rarer. In Male', 22% had shared a needle or syringe the last time they injected, and 25% in Addu.

- ***Heroin is typically smoked and injecting remains rare and is mainly infrequent***

Doctors rarely see injection-related infections, such as abscesses and septicemia. Drug users in Male' and Addu are generally healthy (apart from drug dependence) and do not show signs of severe ill health and physical damage (such as venous damage, neural damage, extreme low weight, teeth loss) that are typical of many people who inject in South Asia. Overdose rates are low (1 overdose death in 2007, 3 in 2008, 2 in 2009) – as would be expected if most heroin users do not inject. There has been an increase in deaths by suicide – 11 in 2009, 9 by hanging and 3 by overdose. The total number of drug-related deaths in 2009 was 19¹¹.

There has been a cumulative 14 cases of HIV infection among Maldivians, of which three are living, and none are injectors. The BBS survey reports no cases of Hepatitis B, which is unsurprising given the high level of HBV vaccination coverage - rising from 90% in 1999 to 98% in 2008¹². The BBS found one case of Hepatitis C infection in Male' and one in Addu, and no HIV infection amongst injectors. Levels of testing are low with only 18% of injectors in Male' and 16% in Addu have ever had an HIV test. HCV is a good indicator of the spread of blood-borne infections.

- ***It is imperative the level of injecting does not increase***

Recommendations:

- The use of drugs by injection should be discouraged among people who are vulnerable to injection.
- Current injectors should be advised not to introduce others to injecting.
- People who continue to inject should receive explicit advice on the avoidance of blood-borne viruses, other infections, STIs and overdose including on the use of sterile injecting equipment and sterile injection procedures and condoms.

⁸ Rapid Situation Assessment of Drug Abuse in Maldives, Narcotics Control Board, Republic of Maldives, 2003

⁹ Rapid Assessment Survey, Journey, 2006

¹⁰ Biological and Behavioral Survey on HIV AIDS, UNDP, November 2008

¹¹ Drug use, death and mental health in the Maldives. Jonathon Dewhurst and Jennifer Drife, June 2010

¹² The Maldives Health Statistics, Ministry of Health & Family, Republic of Maldives, 2009

- There should be a relaxation on any prohibition on or reluctance of pharmacists to sell sterile equipment to people who inject. Consideration should be given to a social marketing programme (similar to condom distribution) using private sector pharmacies to distribute and collect injecting equipment. A specialist needle and syringe exchange service is probably not cost-effective at this time. Contingency plans should be made for the swift introduction of this if the number of injectors increases or cases of HIV and HCV among injectors are identified. The situation needs to be kept under active review (see Ch.5 on monitoring and evaluation).
- Coverage of voluntary confidential testing and counselling (VCT) for HIV, and HCV testing, for people who use drugs, and especially people who inject drugs should increase from the current low levels, and injectors encouraged to have repeat tests with confidentiality ensured. Careful consideration must be given to the location and operation of VCT sites to ensure that clients trust that it is truly voluntary and confidential and that the staff are sensitive to the stigma faced by drug users.

3 RESPONDING TO DRUG USE AND DRUG PROBLEMS

TREATMENT AND REHABILITATION

The Department of Drug Prevention and Rehabilitation Services is within the Ministry of Health and Family. It is responsible for planning, delivering and monitoring drug treatment and rehabilitation, and drug prevention services.

Within DDPRS, the Division of Drug Prevention and Harm Reduction Services is responsible for Laboratory Services, the MMT, and Prevention and Awareness Services. The Division of Treatment and Rehabilitation Services is responsible for residential services (Drug Rehabilitation Centres) and Community Services¹³.

Treatment and rehabilitation services comprise the Drug Rehabilitation Centre (Hinmafushi); the Regional Drug Rehabilitation Centre (Addu) (currently closed), the Community Services in Male', Addu and Fuvamulah; the Methadone Maintenance clinic in Male', and detoxification centres in S.Hulhmeedhoo in Addu atoll, and K. Villimale'. The Treatment Board decides which people may go to DRC.

NGOs providing services for drug users are Journey, Hand in Hand, the Society of Women Against Drugs (SWAD) and Society for Health Education (SHE), all in Male'; and Open Hand in Fuvamulah.

RELEVANT MINISTRIES AND COMMITTEES

MINISTRY OF HOME AFFAIRS - MoHA

The MoHA is responsible for the coordination of many aspects of the Criminal Justice System, CJS, including the police, prisons, juvenile justice and the parole board. The Ministry is currently collaborating with the UNDP Access to Justice project to develop an integrated database to strengthen and improve the information management across all departments involved in the CJS.

Drug related offences are a significant part of the MoHA workload and the MoHA is working closely with the Ministry of Health and Family to align policies that are based upon the public health priorities of reducing harms and creating more acceptance of drug use and drug users as victims rather than criminals.

A recent initiative by the Works Corporation employed 14 recovering drug users for eight months. This pilot project has been considered a success with 71% (n=10) successfully completing the programme and remaining drug free. The 10 graduates received clemency from the President.

¹³ Organogram, Department of Drug Prevention and Rehabilitation Services, 2009

The MoHA is very interested and willing to expand this employment programme to many more recovering drug users who have successfully completed the DRC programme and to possibly integrate employment programmes as part of the CSC package of services in collaboration with the DDPRS. The MoHA is able to provide funding and infrastructure to develop employment opportunities for recovering drug users and have recognised that the lack of opportunity for employment is one of the primary causes of relapse for many recovering drug users who have successfully completed treatment and rehabilitation.

MINISTRY OF HEALTH AND FAMILY, MOHF: NATIONAL AIDS PROGRAMME

The NAP is the coordinating body for all HIV & AIDS programmes implemented by government and NGOS. A representative from the NAP is a member of the parole board. Funding is provided by the GFATM and there are seven staff. However, the majority of staff are administrative and there are no technical experts except for the NAP manager. The MMT programme is a vital component in the HIV response and the NAP will work with the DDPRS to develop a plan to scale up services once the MMT has been evaluated.

The NAP and DDPRS meet quarterly with NGOs to:

- Discuss implementation challenges
- Avoid duplication of activities
- Share information and reports

The NAP does not implement any major prevention programs targeting IDUs and instead has targeted parliamentarians and others during key events such as World AIDS Day. Most prevention activities are focused on. To improve the outreach, NAP is currently undertaking a mapping and size estimation survey of most at risk populations, including injecting drug users, supported financially by World Bank and undertaken by the University of Manitoba. A priority will be to modify the existing costed strategic action plan for HIV prevention based upon the information and data from the mapping and size estimation surveys.

The NAP has also identified the need to support the development and diversity of new NGOs, particularly employing recovering drug users, and including an NGO or network that is involving active drug users.

MINISTRY OF ISLAMIC AFFAIRS, MOIA

The MoIA is responsible for coordinating and maintaining the 700 Mosques throughout the country. The MoIA employs all Imams and the Huthubaa is written by the MoIA and distributed every week to the Mosques. A programme of Mosque construction is nearly completed and 23 new Mosques have been built on islands with 10 remaining. Each new Mosque costs between Rf 5 – 6,000,000. All laws in the Maldives are aligned with Islamic principles and laws.

Aside from providing coordination and management of Mosques, the MoIA also runs television and radio programmes that address social issues.

The MoIA is very concerned about the level of drug use in the country, particularly among adolescents and youth. The Ministry works very closely with the MoHF and the WHO and would like to develop a more holistic approach to drug treatment and rehabilitation that includes spiritual development of recovering users. Currently there are no dedicated services for spiritual education in prisons or the DRC aside from the regular daily prayer attendance

five times daily, along with the Friday Huthubaa as observed by all Muslims. The MoIA will only provide workshops and/or seminars if invited.

The MoIA recognises the importance of public health interventions for drug users and supports the MMT as an important contribution to support drug users in their recovery. HIV & AIDS is also considered a serious threat and the MoIA will continue to support the MoHF to develop new programmes for HIV prevention and treatment.

Ministry of Human Resources, Youth and Sports, MHRYS

The MHRYS serves on both the Parole Board and the Narcotics Control Council.

The MHRYS has several awareness programmes for both at-risk youth and the general population. They have 21 youth centres throughout the country and have begun a programme of privatisation whereby NGOs are contracted to manage the centres according to set benchmarks monitored by the Ministry. To date five centres have been contracted out since March 2010. Each privatised centre is paid Rf. 32,000 for running costs and anecdotal evidence suggest that the centres are run more effectively and more accessible to youth if NGOs are managing the centres. The contracts are for 5 years.

The MHRYS also supports the SWAD DIC and have established a “Youth Health Café” with support from UNFPA. The Health Café is a safe place for youth to access HIV prevention information and includes a clinic staffed by a nurse who is able to provide STI screening and reproductive health advice. The approach of embedding HIV awareness programmes within a social setting acceptable to youth is reportedly successful and client numbers have increased since the establishment of the health clinic. A limitation is that the café is only meant to provide services to youth and is not accessible to adolescents who also require such services.

Drug awareness is an important area for the Ministry and plans are being developed to establish a crisis hotline where at-risk youth can receive anonymous counselling over the phone. A major barrier is the lack of opportunity for recreational and social mechanisms that can be accessed by youth. In addition there are no programmes designed specifically for youth who are incarcerated.

Ministry of Education, MoE

The MoE is responsible for the management and coordination of all 230 schools in the country as well as colleges of further education.

The School Health and Safety Section of Educational Supervision and Quality Improvement Division is responsible for developing a new life skills curricula that will focus on health and well being including drug awareness and education. It will be implemented directly by teachers and is supported by the Colombo Plan and UNICEF.

The MoE acknowledge that drugs are both available and used by children and the Global School-based Student Survey 2009 confirmed that relatively high levels of drug use is found across the country. A significant challenge for the MoE is to identify at-risk and vulnerable children who can be referred to specialist agencies. There are a limited number of school counsellors who can provide expert counselling for children and teachers lack the skills and have a heavy existing workload to be able to identify at-risk and vulnerable children.

It is not possible for children to access services provided by NGOs such as Journey and SWAD and there are no NGOs who work directly with active young drug users.

RELEVANT INTERNATIONAL ORGANIZATIONS ACTIVE IN MALE'

UN organizations active in drugs and or HIV/AIDS include UNODC, UNICEF, UNDP, WHO and the World Bank. Details of their work will be found in Annex 3.

The Global Fund to fight AIDS, TB and Malaria is a major external funder of HIV prevention programmes and projects.

4 ORGANISATIONAL PERFORMANCE

OVERVIEW OF SERVICES AND ORGANISATIONS RELEVANT TO TREATMENT AND REHABILITATION

This chapter examines the characteristics, operation and performance of components of the drug treatment and rehabilitation services.

There are two potential routes through treatment and rehabilitation in the Maldives. As the boxes below show, the treatment trajectories are shaped by legal requirements and the availability of different types of services.

These are 'schematic' routes – not everyone who needs help will follow these routes and they are not always fully functional or followed by either providers or drug users. For example, many people seek treatment in other countries, on many islands people do not have access to treatment, and there are many circumstances that can result in release from prison ahead of time.

The Compulsory Treatment System

Arrest. If a person is found in possession of an illegal drug a charge is made and a urine test conducted at the police station. If illegal narcotic or psychotropic substances are detected additional charges for drug use may also be filed.

Judicial System. Once a case has been filed with the Prosecutor General the accused will be sent to the lower court for a hearing and a verdict. There are three categories for drug offences; use, possession and trafficking depending upon the amount found in possession. In most drug possession and use cases a defense lawyer is not provided. If the accused is found guilty a judge will hand out a sentence based upon the 1997 drug law. First time offenders are eligible for transfer to the Drug Rehabilitation Centre provided there are no pending cases within the judicial system.

Prison. The offender will be sent to one of three prisons to serve out their sentence. Parole can be applied for once 1/3 of their sentence has been served. Alternatively a drug offender can apply to the Treatment Board for enrolment into the Drug Rehabilitation Centre.

Drug Rehabilitation Centre. Based upon the Therapeutic Community modality. Residents must complete a three-phase programme for 6-8 months and remain drug free during their stay and are monitored by regular urine testing. Positive urine tests for drugs will mean removal and return to prison to finish the original sentence. Release from the DRC depends upon approval from the Treatment Board.

Community Service Centre. Release from the DRC is followed by an 11-month community service order. A system of regular signing-in, urine testing and counselling are the main components. If tested positive twice for drug use the individual will be sent back to the DRC for a second time.

Reintegration. Following completion of the CSC the individual is able to resume an unsupervised life outside of the Criminal Justice System (CJS). Regular contact with recovery groups is encouraged. A major barrier to reintegration is the opportunity to find employment.

The Voluntary Treatment System

Awareness & Decision. Usually through a referral from a family member, peer or contact with an NGO, an active drug user may take the decision to stop using drugs.

Detoxification. Depending upon the type of drug dependency and severity of dependency the detoxification process can take from seven days to one month. There are two options available: a residential detoxification managed by the DDPRS in two locations in S. Hulhumeedhoo and K. ViliMale'. The detoxification programme is semi-structured and lasts 21 days. The other option is to self-detoxify at home without medical support. There is no follow-up after medical detoxification.

Drug Rehabilitation Centre. People can go voluntarily to DRC. They are then subject to the same rules as those who have entered the programme via the CJS.

Methadone Maintenance Therapy. A dispensing clinic is located at the main DDPRS facility in Greenge, Male'. Volunteers need to obtain clearance for entry from five different government departments to ensure no criminal cases are being processed before enrolment. The DDPRS has reviewed this requirement and in most cases is now waived. Methadone is dispensed daily and flexible dosing is managed by the clinician in charge. Counselling services are provided by both the DDPRS counsellors and the NGO Journey who have a DIC and recovery support group located in the same compound as the MMT clinic. There are no time limits to staying in the programme. If relapse is followed by a residential stay at the DRC the volunteer is required to follow the same rules as others who are ordered to undergo treatment via the CJS.

Reintegration. A voluntary decision to leave the MMT programme is discussed with the clinician and the individual is able to withdraw from the MMT even if against medical advice. If the individual does not have a criminal record there are opportunities available for employment not available to those recovering drug users who have completed their mandatory treatment.

1 THE COMPULSORY TREATMENT SYSTEM

The compulsory treatment system comprises the Treatment Board, the Drug Rehabilitation Centre, the Regional Drug Rehabilitation Centre and the Community Service

DRUG REHABILITATION CENTRE

The DRC was established on Hinmafushi in 1989. To date, it has admitted 2,597 people, an average of about 207 per full operating year. The optimum capacity is 150 with a maximum of 250. There is a dormitory for up to 20 women. It costs \$20 - \$25 per person per day.

Staff include a counselor in charge of the facility, a senior administrator in charge of services, seven counsellors, and security staff. Most of the counselling staff are young and female. The facilities and compound are spacious, and residents live in dormitories. The intake room is small and needs to be refurbished.

The DRC is based on the US Daytop modality, that has been modified to adapt to the Maldivian context in terms of culture, beliefs and Islamic principles, with a structured programme delivered by residents, with stages and progression in status and responsibility as the residents progress through intake (with some patients in withdrawal), primary treatment and re-entry; and 'punishment' for rule-breaking. In addition counselling is provided by DRC counselling staff. There are facilities for recreation and skills development.

There are currently 69 resident clients, 12 in intake and 8 in re-entry. Standard length of treatment is six to eight months, but some stay longer. Patients are discharged on recommendation to and agreement of the Treatment Board.

The programme is difficult to evaluate due to absence of standardised measures, a computer based information system, or means to monitor resident throughput and success.

Relapsed residents are defined as those who are referred back by the Community Service, usually as a result of failed urine tests in the community treatment phase. It is difficult to calculate relapse rates, but between from 2002 to end of 2009 there were 500 relapsed residents admitted out of 1,980 total residents in the period. The relapse rate would appear to be between 25% and 33%. This rate would likely be higher if residents were followed in the post CS phase.

The facility is currently operating at below capacity, apparently because of the strict eligibility criteria of the Treatment Board.

Recommendations:

- Review the Treatment Board policies for entry into rehabilitation programme and lessen the requirements to enable more incarcerated drug users the opportunity to enter the DRC.
- Increase the current capacity of seven counselling staff to a minimum of 10.
- Allow residents at the DRC to be trained in basic skills such as cookery and have work skills training to reduce costs and generate income.

REGIONAL DRUG REHABILITATION CENTRE, S. GAN

The RDRC was established in 2004 and based on the same model as the DRC. It is non-operational since October 2009, but former residents are seen by the Community Services. It had 74 clients in 2006, 88 in 2007, 63 in 2008, and 28 up to closing in 2009.

COMMUNITY SERVICES: MALE', GN. FUVAMULAH, AND S. HITHADHOO

Clients leaving the DRC and RDRC then attend the Community Service for the next 11 months. The five-phased programme includes signing in and urine testing, on a decreasing frequency over time. If the client fails two urine tests they are sent back to DRC. Clients receive individual counselling.

Counsellors are trained in generic counselling at the Faculty of Health Sciences in Male'. They do not receive drug awareness and drug counselling training, and learn this on the job or abroad. Counsellors are mainly young and virtually all are female. They also conduct family counselling.

In Male' Community Service there are currently approximately 100 clients, and 7 counsellors. The average caseload is 16.

CS also conducts initial screening before clients are admitted to DRC, and makes recommendations to the Treatment Board about release of clients from DRC and CS.

Non-Male' residents need to reside in Male' at own or family cost.

Fuvamulah Community Service is based in the southern Maldives and is the Community Service for residents treated at the former District Community Rehabilitation Service on Addu, and for people treated at the DRC. It has two counsellors and nine clients.

Addu Community Service has 27 clients, five counsellors, one administrator and 12 security staff (retained after the closure of the RDRC). Counsellors also provide family counselling. It follows the same model as the DRC for signing in and urine testing.

- ***The lack of job opportunities for recovering drug users is a major obstacle to reintegration, across all services.***
- ***There is a huge reserve of untapped experience and skills within the recovering community that could be directed toward more recovering drug users entering counselling training programmes and being employed by NGOs***

Recommendations:

- Explore the possibility of training male recovering drug users as peer counsellors in DRC and CSC.
- The rules on positive urine testing should be relaxed. Instead of using urine testing as a punitive/control mechanism, counsellors should have more flexibility to make decisions on a case-by-case basis.
- Introduce a case management approach for all recovering drug users.
- Develop relapse prevention strategies at key stages in the programme.
- Provide additional counselling and support during key festivals and holidays when relapse is common.
- Consider using detoxification services for clients who have positive urine tests instead of returning to DRC.
- Develop a work training and reintegration programme.

2. THE VOLUNTARY TREATMENT SYSTEM

DETOXIFICATION CENTRES

There are two detoxification centres, at K.Villimale' and at S.Hulhumeedhoo. Detoxification is voluntary.

Villimale' detoxification centre was established in July 2009 and has capacity for 12 men, with 11 resident when we visited. The buildings and compound are overcrowded and in poor condition. Residents sleep on mattresses on the floor. There is no counselling or group session room. There is one doctor, three counsellors, two staff nurses, an administrator and security staff.

Patients are referred by Journey, SWAD and MMT, via a referral letter from DDPRS. Admission can be the same day if there is space.

There have been 171 admissions to date. Of the 40 admitted in the first six months 29 completed the programme. There were 50 counselling sessions, 80 group sessions and 36 family sessions. The clinic uses a 21-day detoxification supported by medications in the first week. The protocol was developed by DDPRS medical staff. There is no after care.

Hulhumeedhoo detoxification centre opened in December 2009 and has had 7 patients and none when we visited. The facility is of high quality. Security of controlled medicines needs to be improved. There is one doctor, one counsellor (a recovering drug user and graduate of DRC), one nurse and security staff. Patients are referred by the Regional Drug Rehabilitation Centre. The clinic uses the same 21-day detoxification programme, and was initiated by DDPRS medical staff.

Of the seven admissions to date, three were heroin users and the others using a variety of other drugs. Three successfully completed the detoxification programme. There is no after care. Hulhumeedhoo is operating well below capacity and is unlikely to be cost-effective or provide value for money for both clients and government.

Among drug users we spoke to there is a clear demand for detoxification, with many self-detoxifying at home. Detoxification without social support and after care has a poor success rate and is not cost-effective. Research studies show that about 80% of patients relapse within 12 months of detoxification, less if the aftercare is supported by Naloxone or psycho-social treatment. Detoxification in itself does not constitute treatment for substance use disorders. Comprehensive treatment entails rehabilitation and recovery services¹⁴.

Two centres to serve the whole of the Maldives is insufficient: staff were not positive about the potential to undertake detoxification in general hospitals due to resistance by hospital staff and patients, or in the community (as is the case in many countries), but there seems to be little option but to explore this further if services are to reach those in need and be sustainable.

Recommendations:

- A review of the cost-effectiveness of the two detoxification centres should be undertaken.
- An after care system urgently needs to be introduced including relapse prevention.
- Consider relocation of detoxification centre from S. Hulhumeedhoo to S. Hithadhoo for improved accessibility and lower cost for the client.
- The centre at Villimale' needs expansion and better premises in order to deliver a high quality service to more people.
- Explore the possibility of general medical staff undertaking detoxification in general hospitals.
- Detoxification centres and NGOs should develop a protocol or 'toolkit' for home detoxification, with or without support of medication.
- There should be access to detoxification for females.
- Improve safety and security: search clients for drugs before entering; ensure centres have full resuscitation equipment including ambubags, and a safe for controlled medicines.

METHADONE MAINTENANCE CLINIC

The Methadone Maintenance Clinic was established in October 2008 with the aim of reaching 60 patients. 12 patients were recruited in the first four days, and a total of 47 patients were recruited by June 2009. The initial service was restricted to people who inject, and was later expanded to people using heroin by other routes. After a cessation of new recruitment and a decline of patient numbers to 10, recruitment restarted in October 2010 and 18 patients came into the service in the first few days.

Treatment is voluntary, but patients are required to obtain permission to participate from a number of government departments. Even with this need for legal clearance, the waiting times for entry to the programme are relatively short in comparison with other countries.

¹⁴ Factors affecting detoxification readmission: Analysis of public sector data from three states, 07 September 2006 Tami L. Mark, Rita Vandivort-Warren, Leslie B. Montejano, Journal of Substance Abuse Treatment December 2006 (Vol. 31, Issue 4, Pages 439-445)

Training for staff and the development of treatment protocols was assisted by an external consultant.

The service faced a number of significant problems that have affected its ability to operate at optimal level. This included loss of methadone in a fire and stock shortages, changes in opening hours, administrative problems regarding the number of hours worked by staff and consequently their remuneration, extended periods with no urine testing available, and rescheduling of dispensing during Ramazan.

Patients have received counselling in the clinic, at Journey (which is adjacent) and from SWAD and SHE. Although potentially a good use of resources, and an opportunity to involve other stakeholders, the variety of organisations involved possibly made the delivery of the counselling services less than optimal and confusing.

There have also been difficulties regarding the perception of the programme by other stakeholders.

Despite these implementation problems, when compared against international criteria, the MMT is operating well for a new service, including:

- Enthusiastic, experienced and knowledgeable staff.
- Clear treatment contracts with patients.
- Rapid induction of patients – once legal clearance obtained.
- Appropriate clinical examination for dependence and mental state.
- Appropriate security for controlled drugs.
- Dose levels at an appropriate range by international standards at induction, and increasing until stabilization¹⁵, and flexible dosing¹⁶.
- Daily supervised dispensing.
- Maintenance dose levels which are in the appropriate dose range by international standards – ranging between 60mg and 120mg per day – (60mg per day is recommended as the minimum effective maintenance dose for most patients in a consensus statement from the US National Institutes of Health).

Good clinical outcomes are related to retention in methadone maintenance. The international literature shows that methadone is able to retain patients in treatment better than the drug-free alternatives¹⁷. The clinic retained 77% at three months: this is in the same region as many studies in the international literature¹⁸. The UK benchmark for MMT is 75% at three months.

¹⁵ Analysis of clinic data by GVS

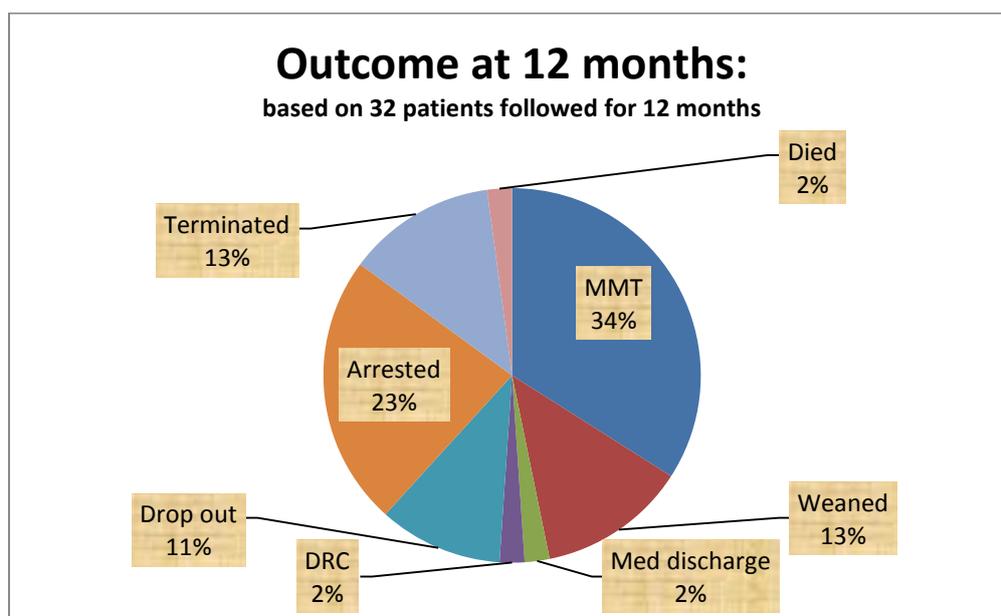
¹⁶ A Meta-Analysis of Retention in Methadone Maintenance by Dose and Dosing Strategy. Yan-ping Bao; Zhi-min Liu; David H. Epstein; Cun Du; Jie Shi; Lin Lu' 2009, The American Journal of Drug and Alcohol Abuse, online, Jan 2009; Department of Health (England) and the devolved administrations (2007). *Drug Misuse and Dependence: UK Guidelines on Clinical Management*. London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive

¹⁷ Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. Mattick R.P., Breen C., Kimber J. et al. Cochrane Database of Systematic Reviews: 2009, 3, Art. No.: CD002209.

¹⁸ A Meta-Analysis of Retention in Methadone Maintenance by Dose and Dosing Strategy. Yan-ping Bao; Zhi-min Liu; David H. Epstein; Cun Du; Jie Shi; Lin Lu' 2009, The American Journal of Drug and Alcohol Abuse, online, Jan 2009.

Retention was 62% at six months, 43% at nine months, and 32% at 12 months¹⁹. By comparison, 12-month retention in other countries tends to range between 36 and 60%. Some patients who ceased treatment did so at their own request. Taking together successful retention in treatment plus positive discharges (withdrawn from drugs at own request, medical discharge, referral to DRC) over 50% of patients had good outcomes at 12 months.

The main reason for treatment disruption and cessation was arrest, followed by disciplinary termination. It was not possible in the time available to explore the reasons behind these terminations, and such a review should be undertaken in order to improve retention rates.



Patients retained in treatment made good progress as measured comparing baseline with status at 9 months²⁰ (as measured by the Addiction Severity Index). Injecting ceased. There was 87% drop in self-reported heroin use (however only a 66% drop based on urine tests). Use of other drugs did not disappear and urine tests showed that at nine months 47% had positive urines for drugs other than heroin. There was an almost 100% reduction in physical illness, and a 90% reduction in psychological illness. There were major improvements in family relationships. There were modest improvements in sexual risk behavior, reductions in borrowing money, illegal income and criminal engagement. Levels of psychological depression, anxiety and stress decreased significantly²¹.

The numbers in treatment are small, but all indicators are in the right direction and consistent with international experience and international research evidence²².

Problems, in addition to those outlined above, include:

- Patients need to obtain clearance from five different government departments before being accepted onto the programme to ensure no criminal cases are pending.

¹⁹ Analysis of clinic data by GVS

²⁰ Methadone Maintenance Therapy (MMT) in Maldives, UNODC, Regional Office for South Asia. 2010

²¹ Drug use, death and mental health in the Maldives. Jonathon Dewhurst and Jennifer Drife, June 2010

²² A Meta-Analysis of Retention in Methadone Maintenance by Dose and Dosing Strategy. Yan-ping Bao; Zhi-min Liu; David H. Epstein; Cun Du; Jie Shi; Lin Lu' 2009The American Journal of Drug and Alcohol Abuse, online, Jan 2009.

- There is consensus among MMT staff and NGOs that a major weakness is the quality of the psychosocial support.
- There are different views on the aims of MMT, held by other some treatment staff outside of MMT
- There is a lack of counselling protocols and contradictions between the philosophies of the MMT and some agencies providing counselling.
- Lack of exposure of MMT staff to MMT in other countries.

Despite inevitable problems in introducing a new service the evidence is that the MMT functions well, but that it could function better.

❖ ***There is sufficient positive evidence now to roll out the methadone maintenance programme to other community sites.***

The clinic could have operated better if not for a number of implementation and external factors. A number of important lessons have been learned from the first phase of the implementation, which should make the second 'renewed' phase in Male' operationally more effective, and which provides lessons for a roll out elsewhere in the Maldives.

Recommendations:

- Better explanation is needed to all stakeholders (e.g. parliamentarians, government, treatment services, drug users and parents) about the aims of MMT and its cost-effectiveness, especially that it is a long-term treatment with both individual and community benefits.
- The rules for enrolment into the MMT programme need to be simplified. The decision should be a clinical one in accordance with an agreed protocol.
- Psychosocial counselling needs to be improved: counselling protocols need to be developed that are consonant with the aims of the MMT.
- Agencies providing counselling for MMT patients should be contracted direct by MMT or to have a memorandum of understanding with MMT to ensure that the counselling content complements MMT, and to include peer counsellors.
- It is important to incorporate work training and explore employment opportunities for patients.
- Staff retention: the clinic needs to ensure that the current clinical expertise is retained.
- Staff and others need to learn from the experiences in other countries in implementing MMT, to exchange knowledge and implementation experiences, and learn from best practices, including reciprocal study tours for clinic staff, and also for parliamentarians and decision makers.
- The programme in Male' should now be expanded. A second MMT site should be developed on another island, with high levels of heroin use, possibly determined by the mapping and size estimation surveys, and that is comparatively accessible (distance, cost etc) from other islands, using the experience gained in Male', and giving attention to the lessons learned from the pilot.

EXPANSION OF MEDICAL TREATMENT OF ADDICTION

There is a growing level of expertise in the medical treatment of addiction in the Maldives, and the experience that has been gained should be utilised to increase the numbers who are competent to manage drug-related problems, including the management of withdrawal, and the provision of MMT. If the medical treatment of addiction in the Maldives is to expand, then the consideration should be given to the creation of a centre for clinical excellence in addiction treatment. This centre would be responsible for the development and updating of

treatment protocols; training of medical staff in addictions; design and first phase introduction of services in other islands; training of general medical staff and health care workers in the management of addiction including the medical management of detoxification in hospitals, in other care settings, and in the home, throughout the Maldives. There are 332 general practitioners, 220 specialist doctors and 1,539 nurses. Consideration should be given to training some of them in the medical management of addiction.

3. NON GOVERNMENTAL ORGANISATIONS

JOURNEY

Established in 2005 in Male', Journey has grown into a large NGO that is managed and governed by recovering drug users. It was formed out of the need for recovering drug users to create not only a safe place to help support their individual and collective recovery, but also to create employment opportunities for recovering drug users as an incentive to remain drug free.

The main activities are managing a DIC and Outreach teams and have also recently added VCT to their package of services. The VCT centre is the only facility for testing and counselling for HIV that is outside of the public health system and the service is available to both drug using and non-drug using populations. Journey staff are also engaged in many collaborative research activities including participation in the IDU mapping currently implemented by the University of Manitoba.

Central to Journey's philosophy is that self-help groups provide the best chance to continue recovery. Many of the clients using the services have relapsed at least twice before and the DIC provides a safe place for recovering drug users to access services and support. Journey is also providing services to active drug users, mainly through outreach programmes.

The majority of clients regularly attending the Journey DIC are following the Narcotics Anonymous 12 step approach to recovery. However, Journey are also supported by UNODC to provide counselling and support services for all the enrolled MMT clients and they provide a range of recovery options for drug users without any ideological or moral pressures to follow a particular approach to recovery. As the NGO has matured, its leadership has become more accepting of recovery options beside abstinence and the 12-step programme. The majority, 95%, of Journey's clients are in one form or another of recovery.

Journey would like to establish more projects for active drug users but acknowledge that they are known primarily for providing services to recovering drug users that is not seen as attractive to many current and active drug users.

SOCIETY FOR WOMEN AGAINST DRUGS - SWAD

Established in 2006 in Male', SWAD came into existence out of concerns of Mothers and Sisters of drug users. It was initially formed by 100 women who had been directly affected by drug use within their families. There are now 270 mothers/sisters who are members of SWAD and 70% are single mothers.

SWAD have mainly focused on drug demand reduction but are now expanding their programmes to include drug prevention components. They provide a range of training and support services but are also actively involved in public advocacy and have held demonstrations and organising petitions to raise awareness among the public and with policymakers. SWAD were key informants in the drafting of the new drug bill that is currently waiting for debate and approval in Parliament.

Most clients are referred through family networks and deliver their services at a DIC. The DIC does not offer any medical services for recovering users. SWAD were initially involved in the development of the MMT programme but felt it was not a service that they could provide without additional funding for support services and better coordination between DDPRS, Journey and other agencies involved in the programme. UNODC, the Colombo Plan and philanthropic donors fund SWAD.

SOCIETY FOR HEALTH EDUCATION - SHE

SHE are based in Male' and have been providing services for 22 years and are one of the most established NGOs in the country. They provide a range of health services including sexual and reproductive health and operate a clinic and laboratory from within their premises. They regularly organise health camps for the general population and have included modules on drug use and other risk behaviours for HIV in these one-day events.

The NGO is currently working on its next strategic plan and have identified HIV and drug prevention as a priority. A VCT centre will be opened on December 1 2010 as part of the GFATM grant in collaboration with CCHDC.

Their operating philosophy is to focus on the personal development of recovering drug users and have a life-skills programme for MMT clients that is jointly coordinated with Journey and funded by UNODC.

HAND IN HAND

Hand in Hand are based in Male' and were established in 2008 and have experience and capacity working and training youth and parents. They have focused much of their drug programmes on prevention, as they believe it will be a more effective and sustainable solution than the current options available for drug treatment and rehabilitation.

Their education programme is based upon "Living Values Education" that is a structured life-skills programme adapted from a USA based programme. They are now implementing a drug prevention and awareness module and are the Maldives affiliate of the Living Values organisation. The materials have been developed in the USA but adapted by Hand in Hand to ensure cultural acceptability. They are planning to launch the Living Values nationally in January.

They focus their drug work on aftercare and have established referrals with both the DRC and CSC and provide services for recovering female drug users.

A recent innovation has been the development of a radio programme that is broadcast every Friday targeting parents. The show lasts one hour and includes a phone-in where concerned parents can ask questions.

OPEN HAND

Open Hand are based in Fuvahmmulah and were officially registered in 2008 by a group of recovering drug users to provide mutual and peer based support to enhance their chances of remaining drug free. Their funding comes from the Colombo Plan. They have three objectives:

- To develop a supportive environment for recovering drug users to rebuild their lives and become productive members of the community.

- To create awareness among the community through outreach and education.
- To conduct awareness campaigns that prevent adolescents and youth to begin using drugs.

The DIC, opened on 15th October 2010, provides a range of services for active and recovering drug users. Their recovery programme is a structured programme following the principles of Narcotics Anonymous 12 step programme. The programme has a mix of counselling, recreation, life-skills and spiritual components. They also have a crisis intervention component to provide support to individuals at risk of relapse.

Open Hand also works with parents and youth and has established an outreach team working in the community.

There are currently 32 active members in the NA programme, of which eight have relapsed. Members of the programme firmly believe that regular urine testing is an essential component to help prevent relapse and are working with the DDPRS to ensure a regular supply of kits.

Recommendations for NGOs

- Refocus outreach teams to better utilise active drug user networks for cascading information and awareness among active drug users.
- Encourage recovering drug users to apply for positions within NGOs, particularly as peer counsellors and outreach workers.
- Outreach to have clear messages (e.g. avoidance of injection, referral to help)
- Explore – with the National AIDS Programme – the establishment of an active drug user network. All NGOs involved in drug programmes are mainly focused on recovery and this is not attractive to current users.
- Explore the establishment of a legal defence fund to provide legal representation for drug users arrested for possession and/or use of drugs.

4. THE LAW ON DRUGS AND THE CRIMINAL JUSTICE SYSTEM

Drugs are controlled under law 77/1997 as amended in 1995 and 2003²³. The law includes inter alia offenses for drug use, drug possession and drug trafficking. The mandatory sentence for drug possession or drug use is 5 to 12 years, and for drug trafficking is 12 to 25 years. Possession of any drug of less than 1g is considered to be use, and 1g and over is considered trafficking. There is no distinction between different types of drugs. The law provides for compulsory and voluntary rehabilitation but does not specify the form that this should take.

❖ Penalties for drug offenses are high and inflexible

Offenders under the age of 18 have mandatory rehabilitation with one third of their sentence waived, and are monitored for three years after rehabilitation.

According to the Prosecutor General's Office, the sentencing trend has been as follows;

²³ Law on narcotic drugs and psychotropic substances, Law number 17/77, Republic of Maldives, 19 December 2007

- Drug use, first time offender: 5 years imprisonment with possibility of rehabilitation opportunity provided there is no other criminal prosecution.
- Drug use and possession less than 1gram: 5 years imprisonment with possibility of rehab opportunity provided there is no other criminal prosecution.
- Drug use, prior drug conviction: 12 years imprisonment, no rehabilitation opportunity through state.
- Drug use and possession less than 1 gram with prior drug offence: 12 years imprisonment, no rehabilitation opportunity through state.

Those serving sentences for use or possession are eligible for parole after one third of the sentence has been served, and after 50% in the case of those convicted of trafficking.

The lower court has determined that in the case of any drug sample, which, on analysis, is found to comprise more than one drug, then each drug counts as a separate offense²⁴. For example, someone who is found in possession of a sample of heroin, which also contains a benzodiazepine, can be charged with possession of two drugs, and if a urine test is positive for both these drugs then that is two further charges. If the quantity of the benzodiazepine is more than the medical daily dose (although under 1 gram) this counts as a trafficking offence. Such a person would receive a sentence for each offense, hence cumulatively could receive a sentence of greater than that of a trafficker (e.g. in the region of 40 years). Most defendants do not have legal representation.

The Prosecutors office, with a staff of 30 lawyers, processed approximately 4000 cases in 2009, of which 60-70% were drug-related cases.

❖ ***The criminal justice system is overburdened with drug cases***

❖ ***There is a need to differentiate in law and policy and practice between different types of drug use in terms of potential harm to the individual and society.***

We were unable to gain statistics on arrests and convictions as so we were unable to verify the numbers being processed through the CJS, for which offences and the sentences they received. Our understanding is that the Ministry of Home Affairs is developing a CJS record system with help from UNDP under a governance programme. According to the police, 83% of crimes are committed by drug users.

PRISONS

The current daily prison population is approximately 800. The Maldives ranks 23rd highest globally with a population prison rate of 343 per 100,000 population. It has the highest rate in South Asia; it is twice as high as Sri Lanka (at 153/100,000). In Singapore, the rate is 273/100,000, in Malaysia it is 130/100,000, in Bangladesh 51/100,000, and in India 21/100,000²⁵.

❖ ***Too many drug users are in prison to no obvious gain to the community – either in terms of deterrence or rehabilitation.***

²⁴ Prosecutor General's Office

²⁵ Prison Brief - Highest to Lowest Rates. International Centre for Prison Studies, King's College London, online October 2010

The three prisons are in Male' (300), Aseyri (125) and Mafushi (400+). It is estimated that 80-90% of prisoners are serving sentences for drug offences or drug-related offences. We visited Aseyri prison, a low security prison with a capacity of 200. The current inmate population of 125 includes 21 foreigners sentenced for drug trafficking, mainly from Sri Lanka, Pakistan, Bangladesh and India. Nearly all inmates are serving sentences for drug offences. There are 35 guards, senior staff and administration staff. 90% of prisoners are drug users. There appears to be little or no drug use within the prison: according to prisoners the prison conditions are good and they do not wish to risk being returned to other prisons. There is conjugal visiting. Prison dormitories are relatively new and house 16 – 20 inmates per room. Inmates have television, recreation and skills facilities, and some education. There is no drug treatment.

- ❖ ***There needs to be greater separation of criminal justice and therapeutic interventions***
- ❖ ***Drug users get trapped in a penal and rehabilitation system that has the unintended consequence rehabilitation is made harder***

DRAFT DRUGS BILL

The drugs laws have been reviewed and a draft Drugs Bill has been presented to Parliament. We understand that it will make a greater distinction between users and traffickers, and differentiate between different drugs. There may also be provision for a Drug Court. We were unable to get a copy translated into English.

5 MONITORING AND EVALUATION

Despite apparently high levels of drug use, the Maldives has avoided some of the highly problematic patterns of drug use and associated health problems that have been experienced in some other South Asian countries. As we have shown elsewhere in this report, it is important to improve the drug treatment and rehabilitation services, and this will be a good return on investment, in terms of avoidance of morbidity and mortality, and a reduction in crime and costs of the criminal justice system.

- ❖ Policy makers and drug services need information about the state of and changes in drug use in the Maldives (such as increased use of amphetamine, or a switch to injecting), and about the activity and effectiveness of the different services that are delivered. ***The Maldives does not have a drug strategy information system, or systematic information about different programmes (e.g. treatment) or specific interventions (e.g. detoxification).***

The dearth of systematic, standardized computer based records means that it is difficult to assess progress towards government objectives, and the effectiveness of different interventions. There appear to be several interventions that are operating well below optimum and are not cost-effective. It is important to develop an information system, probably working alongside others working on health systems and activity analysis.

CURRENT INFORMATION GATHERING

Information on drug use has also been collected in a number of research studies and surveys including the:

- Biological and Behavioural Survey (BBS) which focuses on most at risk populations
- 2008 Maldives and Male' Global School-based Student Health Survey
- Two rapid assessment studies, and
- A mapping study currently being undertaken funded by World Bank and undertaken by the University of Manitoba, which will estimate the number of injecting drug users and their location.

Maldives routine health activity systems do not report on drug use and drug problems.

The Maldives Demographic and Health Survey of 2009²⁶ did not include drug use.

RECORD SYSTEMS HELD BY AGENCIES

Most of the record systems that we examined were paper based and completed in hand in ledger books or typed. Summary reports (e.g. on the number of patients) are produced apparently manually.

²⁶ Maldives Demographic and Health Survey 2009, Preliminary Report, Ministry of Health & Family, Republic of Maldives, 2009

For example, the DRC has a client case file which includes the initial screen and recommendation by the CS, consent document, signed rules and regulations document and a medical status report, a treatment plan, and an ongoing record of counselling sessions. On discharge to the CS the file includes a narrative record of family structure and client details, duration of stay, behavioural change and motivation, and a recommendation to the Treatment Board.

The Community Service includes a ledger-based record of patient's signing in and urine test results, and records of counselling sessions. The system is mainly designed around monitoring clients' compliance with CS rules and identifying infringements, and recording counselling sessions, along with information that is used to make a recommendation to the Treatment Board. Although much of the information is potentially useful for monitoring agency performance, the lack of systematic data collection and computer based client records makes it difficult to do so.

The MMT has more systematically collected information. In addition to case-notes information on clients' behavior and mental and physical health is collected using the international standard questionnaires such as the Addiction Severity Index, and urine tests. There is also a computer record of methadone doses and reasons for termination of treatment.

In most cases, activity reports to DDPRS (e.g. the number of patients seen) are generated manually, or from ad hoc excel files developed by individual staff and which differ from site to site.

Most agencies appear well equipped with computers, and people use them.

MONITORING AND EVALUATION – INFORMATION TO INFORM STRATEGIC DEVELOPMENT

M & E helps measure progress towards strategic objectives, including the activity of different programmes and interventions.

The information should be used to:

- Provide better understanding of the drug use problem and changes over time.
- Provide early warning of negative developments – e.g. outbreak of HIV infection, new drugs being used.
- Assess consequences of drug use including HIV/AIDS, hepatitis and other infections, overdose and death, and crime.
- Enable an assessment of programme coverage – e.g. the proportion of injectors in contact with helping agencies or receiving advice on HIV prevention.
- Enable decision-making for planning by identifying progresses and gaps.
- Allow government to assess programme and intervention performance to ensure value for money and adjust resource allocation.
- Enable better coordination among agencies involved in planning and delivering drug prevention, treatment and rehabilitation interventions.
- Improve the operation of the different programmes and interventions.
- Ensure that programmes are functioning as planned, and the resources are used efficiently.

Ideally, an M & E system should be able to monitor and evaluate the whole system i.e. the:

- The resources used (the costs of the different programmes and interventions – e.g. staff, facilities).
- Activities (what they do – e.g. detoxify).
- Outputs (what they deliver – e.g. number of patients successfully detoxified).
- The impact (the result – e.g. the number of people who maintain abstinence after detoxification).

Resources > activities > outputs > impacts

In practice, resources for M & E will rarely be sufficient for this. For example, measures of impact often need a research design, and often require follow-up of patients after they have left treatment.

The aim however is to produce information that is useful for decision makers, planners and managers, and for programme staff.

Recommendation:

- It is important that the Maldives establishes a drug strategy information system

COMPONENTS OF A DRUG STRATEGY INFORMATION SYSTEM.

A drug strategy information system would have several inter-related objectives and components:

1. To **monitor** the drug situation in the Maldives and how it changes over time, including an early warning system.
2. To **assess** the activity of different services e.g. the number of patients seen, their characteristics and outcomes, changes in types of patients seen over time.
3. To **evaluate** agency performance – for example agencies might have performance benchmarks as part of their contracts or service agreement – e.g. the number of clients reached, the number of successful detoxifications.
4. To assess the **coverage** of interventions – the proportion of the population in need that is helped.
5. To identify **research** needed on specific issues that cannot be covered within routine monitoring.

It would be designed so that information collected would serve several purposes: for example information collected in an agency would be used for client management, would be used to generate information on agency activity and performance, and could also be used to monitor the overall situation of drug use in the Maldives. The information would thus be useful for agency staff, agency managers, DDPRS, and NCC and others.

Patient details > client management > agency activity and performance > drug situation and early warning system

Below we suggest a possible framework for data collection and examples of the kinds of data that could be collected. The specific details of the system would need further elaboration. Which interventions to include in the M & E system, and the specific information to be collected needs further discussion and elaboration once a decision is made to develop an information system?

1 MONITOR THE DRUG SITUATION IN THE MALDIVES AND HOW IT CHANGES OVER TIME, INCLUDING AN EARLY WARNING SYSTEM.

The monitoring and early warning system would track changes in drug use and risk behaviours, and would collate information from a variety of sources, examples of which are as indicated in the table. In particular, it is important that questions on drug use are asked in the Maldives Demographic and Health Survey in order to get population level estimates of drug use as a denominator to interpret other data (such as the numbers being treated, the numbers being tested for HIV and HCV). The evidence from many countries is that the drug situation can change rapidly, therefore information from the early warning system needs to be actively reported and discussed at high-level HIV/AIDS and drugs coordinating meetings.

Objective	Information needed	Measures
Assess levels of HIV and HCV infection. Early warning of change in epidemic	Anonymised data from Voluntary Counselling and Testing for HIV and HCV, and or anonymised samples of blood collected from other epidemiological surveillance systems (e.g. Thalassaemia)	Number of tests conducted, risk exposure and results
Assess changes in drug use over time, and in prevalence of injecting	Repeated survey of school children Maldives Health survey Mapping study – possibly repeated, depending on first study results	Different drugs used, ever, last year and last month, and route of administration
Early warning and of changes in drugs used e.g. stimulants; changes in occurrence of injecting; changes in adverse events such as overdose, physical complications	Police and customs reports Laboratory analyses of seized drugs Reports from drug treatment and outreach services Hospital emergency service Mortality reports Mapping study	Drugs being used Prices and purity Routes of administration Overdose and other drug-related deaths

2 ASSESS THE ACTIVITY OF DIFFERENT SERVICES

Each service or intervention will need its own specific monitoring system oriented to the aims of the intervention and agreed with staff and managers. This will include information required to assess and manage clients, and where relevant, to track changes in them over time. For example:

- Methadone maintenance – e.g. client characteristics, time to gain access to treatment, doses provided, treatment retention, patient health and behavior change over time.
- Drop-in centre – e.g. numbers of individual clients seen and their characteristics, number of client contacts, number of sessions.

- Outreach – e.g. number of different individuals reached over time and their characteristics; number of outreach contacts made over time; what information is provided to contacts; referrals.
- DRC – number and characteristics of clients, length of time to pass through treatment stages, time in treatment, numbers referred to CS or other outcomes.

However, all treatment and community services should be encouraged to use a common core data set at intake. Reference should be made to the recommendations being compiled by WHO on a core dataset for drop-in centres, which should also be considered for use in DPPRS and other services.

An example of the kind of data that might be collected in an outreach programme are given in the table. Measures of agency activity provide information on how well the agency is working, and allows changes in plans – e.g. targeting new groups, changing the information provided.

Outreach - agency objective	Information needed	Measures
Provide information to drug users through outreach on risk of injecting drugs	Activities of outreach workers	Times of day and location worked Number of individual drug users reached and their characteristics; Number of face to face contacts Information provided to clients Referrals to services

3 EVALUATE AGENCY PERFORMANCE

Agencies need to be able to show what they are doing. This includes whether they are reaching the right people (e.g. are the people coming into treatment those who will most benefit?); what is actually delivered by the agency (e.g. the number and nature of counselling sessions provided); how quickly do people process through different stages of treatment; how does their mental and physical health change during treatment; how many people graduate successfully; what are the outcomes of treatment including how many graduate successfully, how many drop out or have other outcomes.

An example is given for detoxification.

Objective	Information needed	Measures
Detoxify patients	How well the agency is delivering detoxification services, compared to agreed benchmarks	Numbers who seek and enrol for detoxification, from where referred and their characteristics Length of time in

		treatment Reasons for discharge Numbers who successfully complete detoxification Numbers who are referred on for social support (and ideally, how many maintain abstinence at 3 months after discharge)
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4 TO ASSESS COVERAGE

Wherever possible, surveys and other information collection systems, including the Mapping Study, should also record whether or not people have been in contact with other services. This is particularly important in the case of population and community surveys, since this information can be used to assess programme coverage – i.e. the number of people reached by services. For example, a community survey of drug users should assess what proportion has had any help, information or advice. Such questions should also be asked in population surveys.

Recommendation:

- Questions on drug use and contact with services should be included in the Maldives Demographic and Health Survey.

5 RESEARCH

Some questions - for example about the behavior of drug users not reached by services, the impact an educational programme, the comparative advantage of different detoxification regimes, the long term impact of treatment - can only be answered through specific research studies: for example, the effectiveness of DRC or detoxification can really only be assessed by studies that follow patients for some time after they return to the community.

The Maldives makes for a unique natural laboratory. There might be considerable national and international gain by establishing research capacity, possibly through links with a University. There are many possibilities for research of domestic and international significance, including for example on the cost-effectiveness of interventions, and operations research on job creation.

This would build on the unique position of the Maldives.

Recommendation:

- Develop capacity to undertake research, especially on the effectiveness of interventions, possibly in collaboration with an external university.
- Undertake a full cost-effectiveness study of the mandatory and voluntary drug treatment systems to inform planning and scaling up options including privatisation models, more direct involvement with recovering drug users through employment in

the treatment system and to identify gaps for potential private sector and development partner investment.

REQUIREMENTS FOR EFFECTIVE M&E SYSTEM

An M&E system would not be difficult to implement. Much of the information is already collected, but not in a readily usable form. It would require initial investment to modify existing collection systems, and ongoing analytic capacity. Data collection should be part of the basic service specification, especially if there is a move to contracting of services. Establishing an M&E system requires:

- Policy level commitment and perceived utility of the information.
- Operational level commitment and perceived utility of the information.
- Resources required to design, implement and operate the M & E system.
- Agreement on core indicators and information across interventions.
- Training and motivation of staff.
- Computerised record systems.
- Integration into agency record systems (avoid duplication).
- Analytic and reporting capacity.

6 STRATEGIC RECOMMENDATIONS

As external observers, the points that are most striking are that:

- Many of the components of a good treatment and rehabilitation system are in place
- There is a lack of coordination which has a negative impact on helping people to become abstinent
- Some people are being 'recycled' through prison and the treatment and rehabilitation system with no clear exit
- Too many drug users are in prison to no obvious gain to the community – either in terms of deterrence or rehabilitation.
- The lack of job opportunities for recovering drug users is a major obstacle to reintegration, across all services
- Some services are operating at below capacity and are not cost-efficient
- The links between the criminal justice system and treatment may work against recovery
- Administrative systems make innovation difficult
- There are many small changes that could make a big difference – e.g. relapse prevention, job training, work opportunities

We have made numerous operational recommendations in this report.

As we have made clear, the development of a robust, effective and fair treatment and rehabilitation system depends on changes within those services, and adjustments in other services and organisations. Overall, the changes will require political and public dialogue to ensure that the Maldives can reduce the level of drug use and the current and potential consequences of drug use.

Despite high levels of drug use, and associated social and criminal costs, the Maldives to date has avoided major health harms and costs that are linked with drug use in other parts of South Asia. The main task in the Maldives is to reduce the impact of use of heroin and problematic drug use by better prevention and treatment. Good prevention and treatment will help prevent HIV and other adverse health, social and criminal consequences of drug use.

A cost-effective system will bring economic benefit by the avoidance of health care costs (for example in the prevention of HIV and HCV infection, avoiding treatment costs, and the high welfare costs of drug use), a reduction in crime, a reduction in costs of the criminal justice system, and improved employment prospects.

We have a number of cross cutting recommendations below. The suggestions that we make are consistent with policy direction in the Maldives including:

- The manifesto of the Maldivian Democratic Party ²⁷ which has the prevention of narcotics abuse and trafficking as one of the 5 key policy goals, with a policy to 'treat the abuser as a victim, prioritise rehabilitation and bring addicts back to society instead of treating substance abuse as a criminal offense'.

²⁷ "Anneh Divehi Raajje": The Other Maldives, Manifesto of the Maldivian Democratic party – Alliance, 2008

- A rights based constitution²⁸.
- The Maldives Health Master Plan 2006-2015²⁹ has several relevant policy goals including: (i) to ensure that people have the appropriate knowledge and behaviours to protect and promote their health; (ii) to ensure safe and supportive environments are in place to promote and protect health and well being of the people; (iii) to prevent and reduce the burden of disease and disabilities; (v) to ensure that all citizens have equitable and equal access to health care; and (vii) to build partnerships in health service.
- The need to involve NGOs.
- The drive to develop a contract driven and sustainable service culture.

CROSS CUTTING RECOMMENDATIONS

Policy

Contract culture and benchmarking: introduce performance measures and benchmarks for government, private and NGO services. Ensure that benchmarks and standards are in place before privatisation of any service. Work with Ministry of Human Resources, Youth and Sports to learn lessons and experiences from their contracting out of youth centres.

Review the Treatment Board policies for entry into rehabilitation programme and lessen the requirements to enable more incarcerated drug users the opportunity to enter the DRC. Allow greater freedom for voluntary drug users who may relapse during DRC and CRC programmes to avoid entering into the mandatory system. This will make voluntary admission into the system more attractive and reduce costs

Employment of ex-drug users: encourage and support the formation of new NGOs that employ recovering drug users; remove barriers to employment. Consider the development of an Enterprise Fund to allow recovering users to establish new businesses and private sector development. Conduct a market gap analysis and provide training and mentoring for newly established businesses and enterprises. Engage with the private sector and provide financial incentives to create employment opportunities for recovering drug users within existing businesses. Explore other services that would benefit from public-private partnerships. For example, the drug strategy could build upon the pilot project implemented by the Works Corporation and expand the programme to give opportunities for more recovering drug users to enroll. 71% of initial participants graduated and were granted clemency.

To strengthen the policy environment for rolling our evidence based drug treatment and rehabilitation, including the development of a more enabling environment for effective drug prevention, treatment and care. Establish a platform for knowledge exchange and develop linkages to share experiences

²⁸ Constitution of the Republic of Maldives, 2008 Translated by Ms. Dheena Hussain at the Request of Ministry of Legal Reform, Information and Arts

²⁹ Health Master Plan, Ministry of Health, Republic of Maldives, 2006

with other countries with similar socio cultural and religious contexts. The World Bank sponsored visit to Malaysia by senior policy makers is a starting point and similar exchanges could be developed with other critical stakeholders including clinical staff, recovering drug users and civil society.

Identify influential champions who can mobilise parliamentarians, ministries, religious leaders, prison authorities and civil society leaders to understand the importance of MMT and it's scale-up as a public health priority in terms of HIV prevention and improved drug treatment outcomes.

Coordination

DDPRS & NAP need to align donor and UN projects based on gaps/national priorities. Move from project to programme based funding of all HIV and drug programmes. Ensure coordination of UN agencies to avoid duplication and harmonise HIV (Global Fund, WHO, UNICEF) and drug programmes (UNODC).

Better understanding and communication is needed between all agencies at managerial and operational level.

Scaling up

Establish a clinical centre of excellence for the treatment of addictions at Greenge to train medical and health personnel in the Maldives.

Scale-up methadone maintenance treatment services, incorporating lessons learned from the pilot such as improved and more appropriate counselling, incorporation of life-skills training and adjunct services and improved case management to achieve higher enrollment and retention rates, and establishing a fully functional MMT program with peers, permanent and motivated staff, integral support and counselling, good M&E, and evidence based planning.

Establish more NGOs led by recovering addicts and others.

Explore the feasibility of using mobile detoxification camps as a cost-effective and more accessible alternative to static detoxification centres.

Expand the youth health café concept to other islands.

Operational

Develop a continuum of care from prevention through to rehabilitation that provides options for active drug users who wish to reduce/abstain from drug use including other treatment options other than residential treatment and MMT.

Encourage recovering drug users who have completed mandatory or voluntary treatment gain employment to work as drug counsellors.

Include drug awareness components in the MoE life skills modules for children from 11 upwards. Establish a working group with MoE, DDPRS and NGOs to review the current modules being developed by MoE.

Develop a standardised set of IEC materials for active drug users that can be used across all sectors and ministries.

Establish a specialised drug counselling curriculum and training programme as a joint venture between Ministry of Education and NGOs. Professionalise counselling and provide

opportunities for career development. Develop a support mechanism for counsellors to avoid burn out, discuss difficult cases etc.

Establish standard operating procedures for counselling both in clinic and with NGO partners.

Develop an alcohol awareness, harm reduction, treatment and recovery programme.

Monitoring and information

Establish a drug strategy information system to monitor the drug situation, including an “early warning” system, and standardise and computerise agency records.

Improve national research capacity on drugs and HIV. Strengthen both the Research Council and the Decision Support Services and Health Research Unit within MoHF. Encourage publications in peer reviewed journals and dissemination through International Conferences.

Advocacy and public opinion

Consider a national consultation on drug use and its consequences for future generations of Maldivians involving government, civil society, private sector and the international community. Analyse progress made since the Future Search conference, and develop a multi-sectoral awareness campaign involving all stakeholders coordinated by Vice President’s office.

Engage with parliamentarians and establish a specific awareness programme for current and future parliamentarians to ensure decisions at the policy level are taken based on evidence and best practice and embedded within the improvement of public health for all citizens.

Consider sending a delegation to attend the 2011 International Harm Reduction Conference in Beirut, Lebanon.

FINAL NOTE

We have been unable in the time available to assess the feasibility of these suggestions or cost implications. We are aware that the NAP did an initial prioritisation and costing of HIV prevention among Injecting Drug Users and other vulnerable and high risk groups which could be used as a model process for addressing and incorporating the recommendations in this report, including costing of the scaling up of an improved MMT and other recommended priority actions. Some are easy to implement, others require longer planning and implementation over time. Each of them alone will have some impact on improving and strengthening the drug treatment and rehabilitations services in the Maldives, and the overall ability of the country to reduce the impact of drug use on the individual and society.

ANNEX 1: LIST OF ORGANIZATIONS AND INDIVIDUALS VISITED AND CONSULTED

GOVERNMENT MINISTRIES, DEPARTMENTS AND CENTRES

Organization		Name	Designation
PRESIDENT'S OFFICE	1	Dr. Mohamed Waheed Hassan Manik	Vice President
	2	Ms. Aishath Shuweikar	Deputy Under Secretary
MINISTRY OF HEALTH AND FAMILY	3	Dr. Ibrahim Yasir Ahmed	Director General of Health Services
	4	Ms. Saleema Hameez	Assistant Planning Officer
MINISTRY OF HOME AFFAIRS	5	Mr. Ahmed Adil	Minister of State for Home Affairs
MINISTRY OF HUMAN RESOURCES YOUTH AND SPORTS	6	Ms. Aishath Rasheed	Director
MINISTRY OF EDUCATION	7	Ms. Fathimath Azza	Director
	8	Ms. Aishath Shifa	Educational Supervisor
MINISTRY OF ISLAMIC AFFAIRS	9	Mr. Mohamed Shaheem Ali Saeed	Minister of State for Islamic Affairs
	10	Mr. Mohamed Didi	Permanent Secretary
PROSECUTOR GENERAL'S OFFICE	11	Ms. Uzaa Dheebanaaz Fahmy	S. Assistant Public Prosecutor
	12	Mr. Uz. Hussain Nasheed	Assistant Public Prosecutor
DEPARTMENT OF PENITENTIARY AND REHABILITATION SERVICES (DPRS)	13	Mr. Mohamed Rasheed	Director General
ASEYRI JAIL AT K.HINMAFUSHI	14	Mohamed	Prison - in-charge
NATIONAL AIDS PROGRAMME, CENTRE FOR COMMUNITY HEALTH AND DISEASE CONTROL	15	Mr. Abdul Hameed Hassan	Senior Public Health Programme Officer
DRUG ENFORCEMENT DEPARTMENT, MALDIVES POLICE SERVICE	16	Mr. Rilwan Shareef	Drug Operation In-charge
MAPPING TEAM, NATIONAL AIDS PROGRAMME, CENTRE FOR COMMUNITY HEALTH AND DISEASE CONTROL	17	Ms. Mirfath Ahmed	Programme Manager
	18	Ms. Aishath Zahira	Programme Assistant
	19	Ms. Aminath Nawal	M & E Associate

CENTRES AND DIVISIONS UNDER DEPARTMENT OF DRUG PREVENTION AND REHABILITATION SERVICES

Organization		Name	Designation
DEPARTMENT OF DRUG PREVENTION AND REHABILITATION SERVICES (DDPRS)	20	Ms. Aminath Zeeniya	Director General
	21	Ms. Mamdhooa Shujau	Deputy Director
GAGAN METHADONE MAINTENANCE CLINIC (MMT)	22	Ms. Aishath Ibrahim	Director, DDPRS
	23	Dr. Chengappa Monnanda Nanjunda	Medical Officer
	24	Ms. Reyma Narayanan	Staff Nurse
	25	Ms. Shahuna Ahmed	Counselor
	26	Ms. Shifna Waheed	Counselor
	27	Dr K V Bhaskar	Psychiatrist
PREVENTION DIVISION (DDPRS)	28	Mr. Muhammed Azim Abdul Hadhee	Director
COMMUNITY SERVICE CENTRE AT DDPRS MALE'	29	Ms. Mibsam Nasheed	Senior Counselor
	30	Ms. Shifana Ali	Counselor
	31	Ms. Ratheeba Mohamed	Counselor
	32	Ms. Shiyaza Mohamed	Assistant Counselor
	33	Ms. Safiyya Hussain	Assistant Counselor
COMMUNITY SERVICE CENTRE AT S.HITHADHOO	34	Ms. Aminath Zeena	Counselor
HULHUMEDHOO DRUG DETOXIFICATION CENTRE	35	Dr Mohammed Shihabandheen Kappan	Medical Officer
	36	Mr. Mohamed Ayoob	Counselor in charge
COMMUNITY SERVICE CENTRE AT GN. FUVAMULAH	37	Ms. Rasheedha Abdulla	Assistant Counselor
	38	Ms. Samha Naseer	Assistant Counselor
DRUG REHABILITATION CENTRE AT K. HINMAFUSHI	39	Mr. Abdulla Faseeh	Senior Counselor
	40	Ms. Aminath Shahuza	Counselor
	41	Ms. Fathimath Shifaza	Counselor Assistant
	42	Ms. Shifaza Mohamed	Counselor Assistant
	43	Ms. Aminath Riyaza	Counselor Assistant
VILIMALE' DETOXIFICATION CENTRE	44	Dr. Sohail Ahmed Bijarani	Medical Officer
	45	Mr. Ahmed Firaag	Counselor
	46	Ms. Shifaza Abdulla	Counselor Assistant

UN AGENCIES

Organization		Name	Designation
THE WORLD BANK, HIV/AIDS Human Development, South Asia Region	47	Dr Mariam Claeson	Coordinator
UNITED NATIONS DEVELOPMENT PROGRAMME, HIV/AIDS -Global Fund Programme Management Unit, UNDP-Maldives	48	Ms. Ivana Lohar	Programme Manager
WORLD HEALTH ORGANIZATION (WHO)	49	Dr. J.M. Luna	Country Representative
UNITED NATIONS OFFICE ON DRUGS AND CRIME (UNODC)	50	Ms. Cristina Albertin	Representative
	51	Mr. Kunal Kishore	Interim Coordinator
UNICEF	52	Mr. Mohamed Naeem	Child protection Specialist

NON-GOVERNMENTAL ORGANIZATIONS

Organization		Name	Designation
JOURNEY	53	Mr. Ahmed Adam	Chair Person
	54	Mr. Mohamed Shuhaib	Vice Chair Person
	55	Mr. Ahmed Nazim	Staff
	56	Mr. Mohamed Faseen	Board Member
SOCIETY FOR WOMEN AGAINST DRUGS(SWAD)	57	Ms. Fathimath Afiya	Chair Person
	58	Ms. Aishath Rishtha	Programme Manager
SOCIETY FOR HEALTH EDUCATION (SHE)	59	Ms. Fazna Shakir	Assistant Executive Director
	60	Ms. Mariyam Shifneeza	Programme Assistant
	61	Ms. Thoma Abdul Samad	Counselor
HAND IN HAND	62	Ms. Rizha Ibrahim Manik	Ass. Executive Director
	63	Ms. Aminath Ismail	Executive Director
OPEN HAND (GN.FUVAMULAH)	64	Mr. Ismail Ali	President/Coordinator
	65	Mr. Shamsul Jabeen	Outreach worker/Vice President
	66	Mr. Nasrulla Ali	Outreach Worker
	67	Mr. Ahmed Wanood	Admin/Finance Officer

68	Mr. Althaf Ahmed	Facility Manger
69	Mr. Mohamed Sameen	Admin/Finance Officer
70	Mr. Ibrahim Arfath	Facility Supervisor
71	Mr. Mohamed Ayaam	Member
72	Mr. Abdul Rahman Fahud	Member

ANNEX 2: DOCUMENTS EXAMINED

"Anneh Divehi Raajje": The Other Maldives, Manifesto of the Maldivian Democratic party – Alliance, 2008

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ANNEX 3: UN AGENCIES ACTIVE IN THE FIELD OF DRUGS AND HIV/AIDS IN THE MALDIVES

UNITED NATIONS DEVELOPMENT PROGRAMME, UNDP

The UNDP is currently the Principal Recipient (PR) for the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) Round 6 grant. The grant is currently in phase 2 with the DDPRS and the Centre for Community Health and Disease Control (CCHDC) as the two government Sub-Recipients. Part of the current GFATM grant is targeted toward drug demand reduction and creating an enabling environment through the development and strengthening of peer education approaches and establishing outreach programmes with the Society for Health Education (SHE) as a Sub-Recipient and Journey as a Sub-Sub-Recipient. An HIV Voluntary Counselling and Testing Centre has been established at the Journey Drop-In Centre (DIC). The grant has also focused on high-level advocacy with Parliamentarians to raise awareness of the issues around HIV and the linkage with drug use.

A GFATM Round 10 application has been submitted that will focus on Most At Risk Populations (MARPS) including Injecting Drug Users (IDU), Males who have Sex with other Males (MSM), Female Sex Workers (FSW), prisoners and youth. The UNDP will be a joint PR with government

Aside from activities relating to HIV prevention, the UNDP also implements an access to justice programme in collaboration with the Ministry of Home Affairs. The UNDP is also collaborating with the Maldives Chamber of Commerce to encourage a more focused Corporate Social Responsibility (CSR) from the private Sector to provide more opportunity for recovering drug users and other MARPs.

In addition the UNDP is responsible for the coordination of the United Nations Development Assistance Framework (UNDAF) 2011 – 2015 that all UN agencies will use for the development of the individual agency strategies and work plans. It has been agreed that a Joint UN Team on AIDS (JUNTA) will be established and a unified budget and work plan for two years will be developed with support from the UNAIDS country office in Sri Lanka.

WORLD HEALTH ORGANISATION, WHO

The WHO is increasing its support to HIV and drug prevention & treatment programmes and is interested in supporting efforts to develop the capacity of NGOs to increase the number of NGOs who can provide prevention, treatment and rehabilitation to drug users who are at risk from HIV. The Ministry of Health and Family is the counterpart Ministry for WHO and the Maldives office of the WHO is relocating to premises within the MoHF. Additionally the WHO is working closely with other relevant Ministries including the Ministry of Islamic Affairs.

Recently the WHO published a technical report on social disparities in health in the Maldives³⁰, and is the first time data on the linkages between social inequality and health status has been analysed in the Maldives.

The priorities of the WHO under UNDAF 2011 - 2015 will include:

- Strengthening the capacity of counselling training and the development of specialist counsellors for HIV prevention and drug treatment and rehabilitation.
- Supporting improved data collection, monitoring and data analysis of NGOs working with recovering drug users.
- Increasing the research capacity of the MoHF decision and support services and health research unit. The WHO has also been working with the newly formed Research Council and is providing technical assistance to enable the Research Council to publish research and data.
- High-level advocacy with parliamentarians and influencers to sensitise key decision makers on the public health benefits of improved and coordinated services for drug users.

UNITED NATIONS OFFICE ON DRUGS AND CRIME, UNODC

The UNODC has been providing support to the Maldives in relation to HIV prevention among drug users mainly through the AusAID funded “Prevention of Transmission of HIV among drug users in SAARC countries – H13”. The project is providing technical assistance and funding to NGOs and is a key partner of the DDPRS in the development of the MMT clinic in Greenge, Male’. With additional resources from the DDPRS, the UNODC has provided financial support for the procurement of methadone, equipment and refurbishment of the dispensing clinic and extensive technical support to develop operating guidelines, protocols and management support.

The European Commission is providing a \$2m through the UNODC to establish and scale-up community treatment and rehabilitation centres and additional services for recovering drug users.

Until recently most of the support to the Maldives has been provided from the UNODC Regional Office for South Asia (ROSA) based in New Delhi, including management and oversight functions. A local national officer has recently been recruited and an International expert is planned to arrive in January 2011. The UNODC is planning to increase its projects for HIV and drug use prevention, treatment and rehabilitation.

United Nations Children’s Fund, UNICEF

Since 2008 UNICEF have been providing financial and technical support to ensure increased child protection services. The programme has three components:

- Child Protection in partnership with MoHF
- Juvenile Justice in partnership with the police, Attorney General’s Office and Ministry of Home Affairs

³⁰ Social disparities in health in the Maldives: an assessment and implications. Technical report. World Health Organization, Regional Office for South East Asia, 2010

- Drugs and HIV among adolescents and youth aged 10 - 19 in partnership with the DDPRS and Journey. The project aims to develop an integrated package of prevention, rehabilitation and reintegration services for this age group.

Data from the Global School-based Student Health Survey 2009 and informal surveys conducted by the evaluation team indicate that age of first drug use can be as young as 11 years old. There are no integrated prevention, rehabilitation programmes available to adolescents or youth who are active drug users but wish to stop using drugs.

UNICEF'S priorities under the JUNTA will be prevention of HIV and drug use and will develop strategies, plans and programmes to build capacity and also identify leaders from within youth and adolescent groups and networks. A specific priority will be to develop in partnership with the DDPRS and the Juvenile Justice unit the feasibility of establishing an adolescent detoxification centre.

UNICEF are also working with the Faculty of Health Sciences and the University of Newcastle, Brisbane, Australia to expand the one year advanced training certificate for Social Workers and will prioritise the enrolment of males to ensure a gender balance of Social Workers.

A barrier to providing effective child protection services has been the management of data. A collaboration with the Prosecutor General, Juvenile Justice and Child Protection departments at the Ministry of Home Affairs has resulted in the development of the Maldives Child Protection database that will be launched via the government e-letter system on November 25 2010. The database aims to store relevant data from all government departments and NGOs involved in child protection issues to ensure data is shared and stored centrally in a single database.

The World Bank

Aside from this evaluation, the World Bank has supported (i) the costing of a strategic action plan for HIV prevention among IDUs; (ii) the current social risk mapping of drug users and other high risk groups; and (iii) an upcoming high level government to government exchange with Malaysia on comprehensive harm reduction, MMT and the role of an enabling policy and legal environment for effective outreach of harm reduction, including MMT.