Health Resource Facility
for Australia's Aid Program

Options for Australian and New Zealand development assistance in health, Kiribati

Concept Note

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Acronyms

A$	Australian dollar
AUT	Auckland University of Technology
BMI	Body mass index
BNPL	Basic needs poverty line
CI	Confidence interval
CNS	Clinical Nurse Specialist
CSO	Civil society organisation
DEN-3	Dengue virus type 3
DFAT	Department of Foreign Affairs and Trade, Australia
DP	Development partner
DTP	Diphtheria-tetanus-pertussis vaccine
FNU	Fiji National University
FPNZ	Family Planning New Zealand
FSMed	Fiji School of Medicine
GAVI	Global Alliance on Vaccines and Immunisation
GDP	Gross domestic product
GNI	Gross National Income
GOK	Government of Kiribati
HIU	Health Information Unit
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
HRH	Human resources for health
HSCG	Health Sector Coordination Group
I$	International dollar
IMR	Infant mortality rate
IPPF	International Planned Parenthood Federation
KANI	Kiribati-Australia Nursing Initiative
KDP	Kiribati Development Plan
KiFHA	Kiribati Family Health Association
KiriCAN	Kiribati Climate Action Network
KIT	Kiribati institute of Technology
KSON	Kiribati School of Nursing
LMIC	Lower middle income country (World Bank classification)
MDG	Millennium Development Goal
MFAT	Ministry of Foreign Affairs and Trade, New Zealand

MFEM	Ministry of Finance and Economic Management
MHMS	Ministry of Health and Medical Services
MMed	Master of Medicine
MMR	Maternal mortality ratio
MNCH	Maternal, newborn and child health
MPH	Master of Public Health
MTC	Marine Training Centre
MTS	Medical Treatment Scheme
NCD	Non-communicable disease
NGO	Non-government organisation
NHSP	National Health Strategic Plan
O&G	Obstetrics and gynaecology
OPV	Oral poliomyelitis vaccine
PEN	Package of Essential NCD interventions
PGDip	Postgraduate Diploma
PHRHA	Pacific Human Resources for Health Alliance
PIC	Pacific Island country
POLHN	Pacific Open Learning Health Net
PPP	Purchasing power parity
RACS	Royal Australasian College of Surgeons
RERF	Revenue Equalisation Reserve Fund
SDH	Social determinants of health
SGBV	Sexual and gender-based violence
SMC	Senior Management Committee, MHMS
SPC	Secretariat of the Pacific Community
STI	Sexually transmissible infection
TB	Tuberculosis
TCH	Tungaru Central Hospital, Nawerewere
TOR	Terms of reference
TVET-SSP	Technical and Vocational Education and Training Sector Support Program
U5MR	Under-five mortality rate
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children’s Fund
UNFPA	United Nations Population Fund
US$	United States Dollar
WHO	World Health Organization

Acknowledgements

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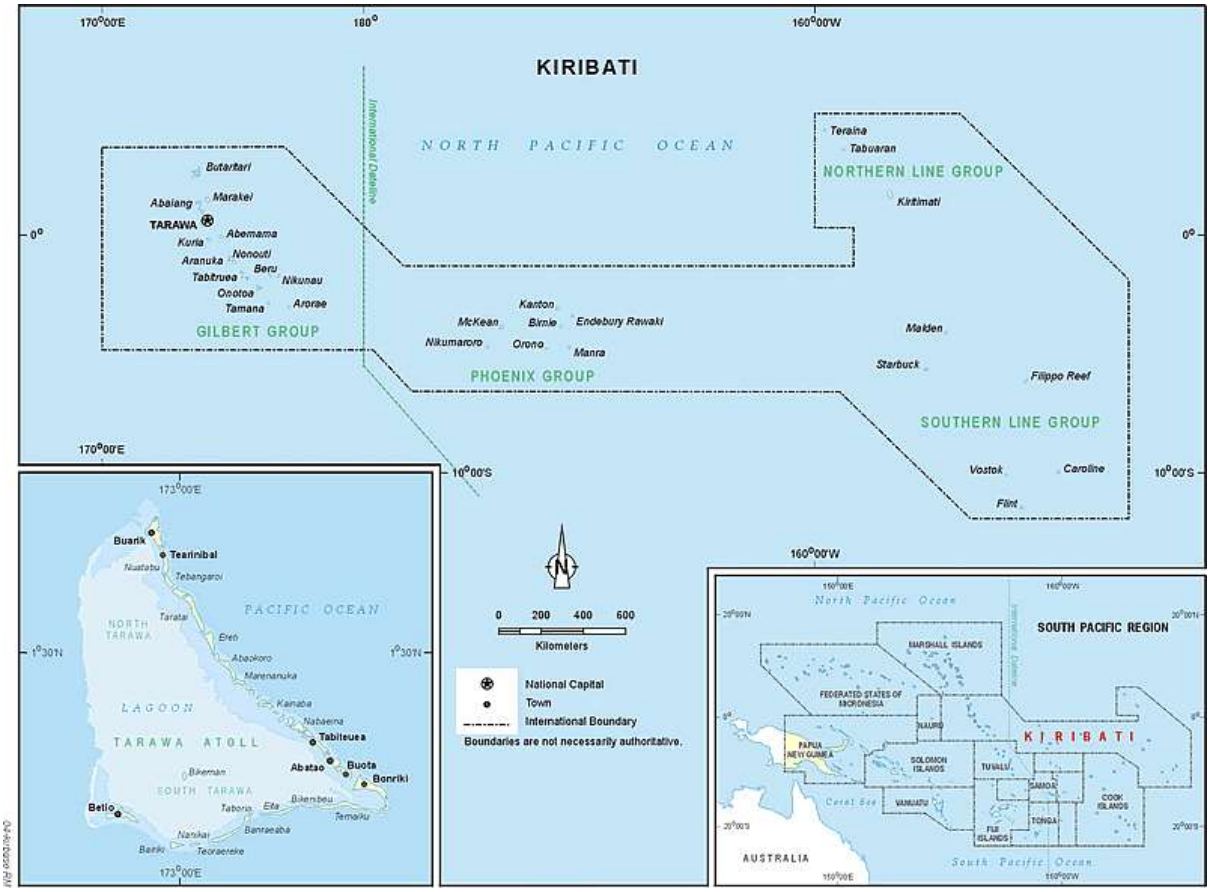
Map of Kiribati



The Republic of Kiribati consists of 33 atolls and islands situated in the central Pacific Ocean around where the Equator intersects the International Date Line (small map, lower right).

The Gilbert Islands include 16 atolls, the Phoenix Islands eight atolls and coral islands, and the Line Islands eight atolls. The western-most Island of Banaba (formerly known as Ocean Island) is the only true island; it is not visible on the map, but is located south-west of Tarawa and due west of Nonouti. Kiritimati (Christmas) Island in the Line Islands is the world's largest atoll.

Of the 33 atolls and islands, just 21 are inhabited. At the 2010 national population census, the total population was recorded as 103,058.

The distance from the western end of the country to the eastern end is more than 5,000 kilometres. The total area within Kiribati's maritime boundaries is more than 3.5 million square kilometres, but the total land area is just 811 square kilometres.[1]

The capital and seat of government is located at Bairiki on Tarawa atoll (small map, lower left).

[1] To put this in context, the total territorial area of Kiribati is slightly bigger than that of India and, east-to-west, spans approximately the same distance on the Earth's surface as China. However, the total land area is no more than that occupied by Canberra city and suburbs.

Executive summary

Background

In view of the numerous health challenges facing the Republic of Kiribati, the Governments of Australia and New Zealand have begun to explore options for potential support to the health sector and other sectors that may influence health outcomes.

A scoping mission to Fiji and Kiribati was undertaken in December 2013 to: (a) consult with Government, development partners and other stakeholders; (b) test ideas for future development assistance in health and related sectors; and (c) explore the operational context. This *Concept Note* presents a range of options that Australia and New Zealand may consider supporting.

Development context

Kiribati is one of the poorest countries in the Pacific, and one of the most geographically isolated in the world. It has a fragile environment, rapidly growing urban population and uncertain economic growth, and is susceptible to a rise in mean sea level and extreme weather events (for example, as a result of climate change); two-thirds of the population are classified as poor or vulnerable to poverty.

Domestic overcrowding and poor quality housing – particularly on South Tarawa – and limited access to safe water supply, nutritious food and adequate sanitation all present risks to health outcomes.

Some windfall profits from offshore fishing licences and good management of the sovereign wealth fund have seen the World Bank re-classify Kiribati as a lower middle income country. This is not an accurate reflection of the low level of human development and limited opportunities in the country.

Health status and outcomes

Kiribati is drifting off track in relation to many of its health-related Millennium Development Goal targets. Its under-five mortality rate (47 per 1,000 live births) is the highest among the Pacific Island countries (PIC) [2] – due mainly to neonatal mortality (19 per 1,000 live births), malnutrition and common, life-threatening infections (pneumonia, diarrhoea). Immunisation rates vary greatly between islands, and overall coverage is likely to be lower than the reported 90-99 per cent; neither rotavirus nor pneumococcal conjugate vaccines are currently included in the national schedule.

There are significant levels of sexual and gender-based violence, including directed towards adolescents and children. Only two-thirds of babies are born in a health facility, and six maternal deaths were reported in 2012 (estimated maternal mortality ratio 202 per 100,000 live births; 95 per cent CI 92.6–439.9 per 100,000).

A non-communicable diseases (NCD) crisis is unfolding rapidly. Almost three-quarters of the adult population have personal NCD risk factors (elevated blood pressure and/or serum cholesterol, smoking, insufficient exercise, overweight and obesity), and one quarter of adults over the age of 25 years are pre-diabetic or already on treatment for diabetes. Lower limb amputation as a result of diabetes and smoking is the most rapidly increasing reason for surgical admission at the national hospital and contributes significantly to the national burden of disability.

There is a high incidence and prevalence of tuberculosis (TB), leprosy and sexually transmissible infections (STIs) and ongoing vulnerability to infectious disease outbreaks (for

[2] Excluding Papua New Guinea (which has a reported under-five mortality rate 58 per 1,000)

example, dengue, diarrhoeal disease). Diabetes is a major driver of the TB epidemic. Human immunodeficiency virus (HIV) infection is present but numbers are small.

Health system

Real health expenditure *per capita* is not keeping pace with population growth, despite an overall increase in the health budget (in nominal terms). Clinical hospital services and curative care receive 52 per cent of the health budget, with 16 per cent allocated to primary care and public health.

The suspected rapid increase in prevalence of NCDs and a 65 per cent increase in offshore referrals for medical and surgical treatment in 2013 (at a cost of about A$ 1 million) represent major emerging threats to the health budget.

The health workforce (3.3 trained local doctors, nurses and midwives per 1,000 population) is barely sufficient to deliver the services needed by multiple, widely dispersed islands and communities. A large number of nursing vacancies on the staff establishment continue to be filled by retirees on contract. The capacity of the Kiribati School of Nursing (KSON) to train the required number of nurses, medical assistants and midwives to address the shortfalls is extremely limited.

The progressive return of 31 Cuban-trained medical graduates over the next four years will help to address the shortage of frontline medical officers.

Central human resources for health management and a workforce database are lacking. A new national Health Workforce Plan is due to be developed in the first half of 2014.

Proposed Australian and New Zealand assistance in health

External funding currently makes up just 16.9 per cent of health expenditure – a lower proportion than in many PICs.

Within the National Health Strategic Plan (NHSP), there are four priority areas that any new Australian and New Zealand support should focus on: 1) population and reproductive health; 2) health workforce; 3) maternal, neonatal and child health (MNCH); and 4) NCDs. Additional technical support for communicable diseases (HIV, TB) may also be maintained through regional mechanisms.

Population, reproductive health and MNCH would potentially be addressed through partnerships with UN agencies (e.g. through a proposed Joint UN Program) and domestic and international NGOs. Australia, UNICEF and WHO should use their links to the board of the GAVI Alliance to encourage review of Kiribati's eligibility for funding for rotavirus and pneumococcal conjugate vaccines.

Support for human resources should align with the new national Health Workforce Plan. Assistance would focus on improving the capacity, quality and throughput at KSON through: refurbishment and extension of the School's physical infrastructure; updating some equipment and teaching aids; and strengthening the capacity and standards of KSON teaching staff through technical partnerships with nursing faculties in Australian, New Zealand and Fijian universities. Continuing donor and technical support for the new medical Internship Program will be needed to ensure quality of care and to keep career pathways open; this will complement expected continuing investments by Cuba and Taiwan. Additional pre-service and community cadres of health worker might be developed using a labour market model with multiple exit points, aligned with domestic needs and regional accreditation standards.

The focus on health workforce would address a parallel agenda in strengthening the quality of health service delivery.

The approach to NCDs should focus on: a) primary prevention through behaviour change and promotion of healthy lifestyles (which could be closely linked to the Australian-funded community Sports Outreach Program) and nutrition (including domestic vegetable production

supported through the Kiribati Climate Action Network); and b) secondary prevention through continued implementation of the Package of Essential NCD ('PEN') interventions being promoted by WHO. The most appropriate mechanism of funding and managing health sector aspects of this support is not yet clear.

Two supportive elements are also included for consideration: 5) Technical support for health system analytical work; and 6) Inter-sectoral collaboration on social determinants of health and other factors outside the health sector that have a bearing on health outcomes. Health finance and policy analysis would be useful to guide efficient use of limited resources and equitable access to services, and could be provided by Australian or New Zealand academic institutions or the World Bank under the overall guidance of the Health Sector Coordination Group.

Support for people with disabilities, sexual and gender-based violence and non-health sector determinants of health outcomes (e.g. improved water and sanitation) would be maintained through active inter-sectoral collaboration, in parallel with the clear health sector priorities.

Modality of support, budget and program management

Modalities of support will need to be determined following careful consideration and frank discussion between funding agencies, Government of Kiribati and potential implementing partners. They would most likely include a mixture of core funding support for distinct programs, implementation by UN partners and/or local and international NGOs, and directly contracted technical assistance.

It is estimated that a budget of around A$ 10 million would be needed for the first three years of a longer term program of coordinated Australian and New Zealand support.

As the proposed program is aligned with current national health priorities and the NHSP, primary responsibility for oversight and monitoring would rest with the Ministry of Health and Medical Services and the Health Sector Coordination Group.

1. Introduction, objectives and activities

1.1. Background and rationale

1) **Kiribati faces a great number of health and development challenges** – mainly related to its fragile environment, uncertain economic growth, rapidly growing population, and limited capacity in the health sector and for public financial management and donor coordination.

2) **The Governments of Australia and New Zealand have both begun to explore options for potential support to the health sector and other sectors influencing health outcomes in Kiribati.** Health is not yet a priority sector for the *Australia-Kiribati Partnership for Development* (although it remains a standing agenda item in annual bilateral talks). Health and human development have recently been included as priority outcomes in the *Kiribati-New Zealand Joint Commitment for Development*;[3] specifically, New Zealand has undertaken to support Kiribati's efforts to address: population-related problems (including population growth and urban migration to South Tarawa); awareness and use of family planning; health practices that will reduce the incidence of communicable and non-communicable diseases (NCDs); and treatment through community- and facility-based health providers.

1.2. Objectives

3) Dr Rob Condon (consultant Public Health Physician) undertook a **scoping mission to Fiji from 3-4 December and to Kiribati from 5-11 December 2013**. The purpose of the visit was to: (a) consult with Government, bilateral and multilateral development partners (DP) and non-Government stakeholders; (b) test ideas for future development assistance in health and related sectors; and (c) explore the operational context and factors that may influence programming models for any future support. Terms of reference (TOR) for the visit are included at Annex 1.[4]

4) **The principal output of the scoping mission is this revised *Health Concept Note***, which updates a similar document developed in 2011. The present document explores how the Governments of Australia, New Zealand and Kiribati (GOK) might jointly tackle prevailing and emerging health concerns. This, in turn, will inform the Australia–Kiribati Partnership talks, which are scheduled for February 2014 and may pave the way for new Australian investments in health from 2015 onwards.

1.3. Consultations with partner Government and other stakeholders

5) The **list of partners and stakeholders consulted in Fiji and Kiribati** is included at Annex 2. In Fiji, they included: World Health Organization (WHO; health systems, Pacific Human Resources for Health Alliance [PHRHA] and Pacific Open Learning Health Net [POLHN] focal points), United Nations Population Fund (UNFPA), International Planned Parenthood Federation (IPPF) and the Fiji School of Medicine (FSMed), Fiji National University (FNU). In Kiribati, they included: Ministry of Health and Medical Services (MHMS); visits to health facilities and discussions with health workers and managers – Tungaru Central Hospital (TCH) and mental health unit, Kiribati School of Nursing (KSON), Betio Hospital, and Eita

[3] The *Kiribati-Australia Partnership for Development 2009-15* addresses the following priority outcome areas: basic education, workforce skills development, growth and economic management, and infrastructure. Other sectors addressed by the *Kiribati-New Zealand Joint Commitment* include: public and private sector economic performance, and water, sanitation and housing (improved quality of urban water supply and sanitation, solid waste management, land use and housing).

[4] Briefing Papers: TOR 4.4 was subsequently changed to: a) providing written input into a single Partnership Briefing Paper; and b) a written assessment of the Joint UN RMNCAH Proposal (see paragraphs 47-48, 52-53).

Health Centre;[5] UN and other DPs represented in-country (WHO, United Nations Children's Fund [UNICEF], New Zealand High Commission, Cuban Embassy, Embassy of the Republic of China, Taiwan); Domestic Violence and Sexual Offences Unit, Kiribati Police Service; and two non-government organisations (NGO) – Kiribati Family Health Association (KiFHA) and their Family Planning New Zealand (FPNZ) partners, and Kiribati Red Cross. Dr Iobi Batio (Senior Program Manager) and Ms Erimeta Barako (Assistant Program Manager) from the Health, Gender and Disability team joined the mission from the Australian Department of Foreign Affairs and Trade (DFAT) aid program office in Tarawa.

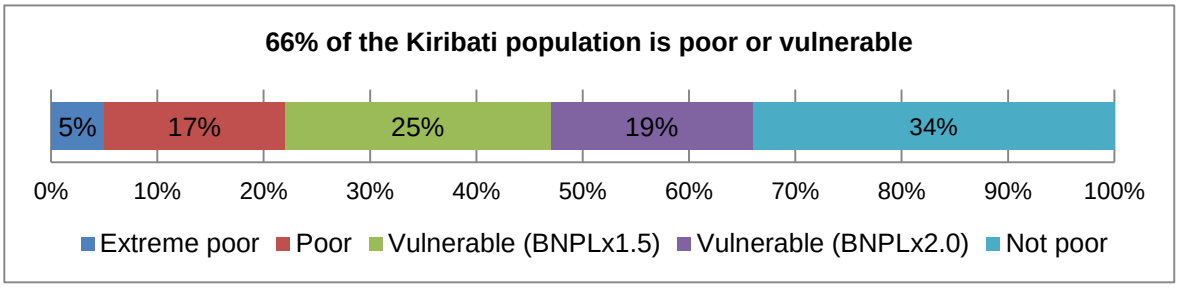
6) **The principal findings and recommendations of the scoping visit were discussed at the Health Sector Coordination Group (HSCG) meeting**, and were also presented at the weekly DFAT staff development forum in Tarawa – both on 11 December; the New Zealand Ministry of Foreign Affairs and Trade (MFAT) was represented at both meetings. Further discussions were held with DFAT in Canberra on 17 December, and an *aide memoire* was circulated to relevant country and head office officials within DFAT and New Zealand MFAT.

2. Population, political economy and development context

7) **Kiribati is a lower middle income country (LMIC) located in the central Pacific. It is one of the most remote and geographically dispersed countries in the world**, comprising 33 islands spread over 3.5 million square kilometres. It is located in the arid equatorial oceanic climatic zone: fresh water resources are fragile and most islands are vulnerable to prolonged periods of drought. Agricultural activity is limited by the alkalinity and low organic and nutrient content of the sandy soil . Most of the country is low-lying and is thought to be vulnerable to the long term effects of climate change on the average sea level.

8) **Kiribati is one of the poorest countries in the Pacific**, with a human development index of 0.629 (global ranking 121 of 186 ranked countries) and a gross national income (GNI) *per capita* of US$ 2,311. About 22 per cent of the population is rated poor or extremely poor, and another 44 per cent is rated vulnerable (Figure 1). The most recent available socioeconomic development data are summarised in Table 1.

Figure 1: Proportion of population classified as poor or vulnerable in relation to basic needs poverty line, Kiribati, 2006



Source: DFAT (Kiribati Program Poverty Assessment [Draft], 2013)

BNPL = basic needs poverty line: A$ 16 per person per week nationally, A$ 24 in South Tarawa, A$ 13 elsewhere in the Gilbert Islands and A$ 20 in the Line and Phoenix Islands (UNDP: Household Income and Expenditure Survey, 2006)

[5] The short time available in Kiribati did not allow visits to any sub-national hospital or outer island health centre or community. It would be useful to include this in the schedule for any subsequent visit, prior to finalising areas and modalities for support.

Table 1: Summary of selected socioeconomic development indicators, Kiribati

Overall human development		
Human development index (2012)		0.629
Economy and income		
Gross National Income *per capita* (2012)		US$ 2311
Gross Domestic Product (2012; current US$)		US$ 169.7 million
Demographics		
Total population (2010)		103 058
Population growth rate (2013, projected)		2.2%
Median age of population (2011, projected)		22 years
Life expectancy at birth (2013, projected)	Total Males Females	67 years 65 years 71 years
Total fertility rate per woman (2010)		3.9
Proportion of population residing in urban / rural areas (2010)		54% / 46%
Social determinants of health (non-health sector) [6]		
Total adult literacy rate (2005)		92%
Gross primary school enrolment (2010)	Boys Girls	84% 87%
Use of improved drinking water sources (2012)	Total Urban Rural	63% 77% 53%
Use of improved sanitation facilities (2012)	Total Urban Rural	34% 49% 22%

Sources: SPC (Pacific Island Populations 2011), WHO (World Health Statistics 2013), World Bank (World Development Indicators 2013), WHO-MHMS (Health Service Delivery Profile, 2012), GOK (Kiribati Development Plan, 2012-15)

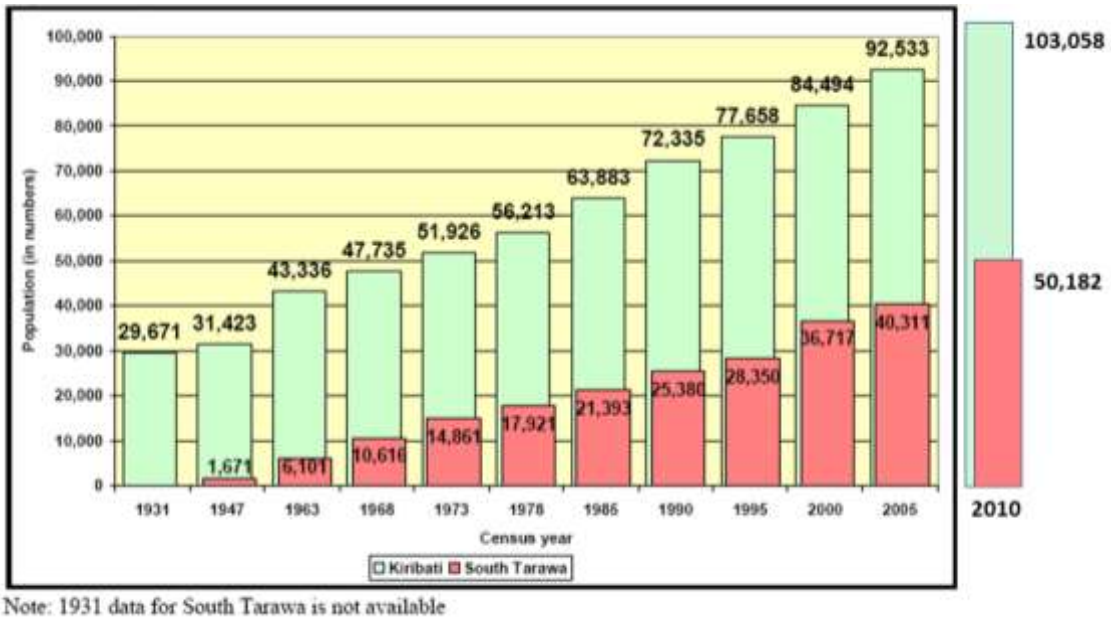
9) **The population of 103,058 is young and increasingly urban** (Figure 2). Life expectancy at birth is 67 years. The median age is 22 years, with 34.9 per cent of the population aged 0-14 years and just 5.6 per cent aged 60 or above. The South Tarawa atoll has become the most densely populated in the Pacific, with more than 50,000 people living on a total land area of 16 km^2.

10) **Rapid population growth and drift to the urban areas of South Tarawa and Betio give rise to many factors that may compromise health outcomes: domestic overcrowding, poor quality housing, and poor access to safe water supply and sanitation.** Typical household size on South Tarawa is seven people and, on the outer islands, five people. About three-quarters of the population of Tarawa and half of the population on the outer islands have access to an improved water source. Less than half of the urban population and one-quarter of those on outer islands has access to improved

[6] The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. (Source: http://www.who.int/social_determinants/en/)

sanitation. The build-up of solid and container waste in urban areas poses further threats to health (through contamination of groundwater supplies, and as larval breeding sites for dengue vector mosquitoes).

Figure 2: Population growth by census year, Kiribati and South Tarawa, 1931-2010



Note: 1931 data for South Tarawa is not available

Source: MHMS; National Statistics Office, MFEM

11) **The Kiribati economy is volatile and extremely vulnerable to external financial influences.** It is highly dependent on official development assistance (amounting to 27 per cent of current gross domestic product [GDP]), the sale of fishing licenses to foreign fleets (23 per cent), earnings from the Revenue Equalisation Reserve Fund (RERF; 21 per cent),[7] and offshore remittances (variable; recent range 8-18 per cent). Export earnings (mainly from copra) are equivalent to less than 5 per cent of GDP. Many staples – including food, water and fuel – are imported.

12) **As traditional lifestyles transition to a consumer economy, there is an increasing need for cash** (e.g. to pay for imported food and childhood education). The population on the outer islands has less access to the cash economy and remittances than the more urbanised population on South Tarawa.

3. Health risk factors and outcomes

13) **Kiribati is drifting off track to achieve many of its health-related Millennium Development Goal (MDG) targets.** Selected health output and outcome indicators are summarised in Table 2.

14) **Overall neonatal and child health outcomes in Kiribati remain poorer than in many other Pacific Island countries (PIC), and progress towards MDG 4 targets has stalled** (Figures 3 and 4). The under-five mortality rate (U5MR) has fallen from 88 per 1,000 live births in 1990 (the MDG baseline year) to 65 in 2000 and 47 in 2011, but is still the highest in the Pacific. The infant mortality rate (IMR) fell from 64 to 38 per 1,000 over the same period. Newborn deaths (i.e. occurring during the first 28 days of life) account for half of

[7] The RERF is the GOK sovereign wealth fund. It was created in 1956 to act as a financial buffer fund using the country's historic earnings from phosphate mining on Banaba (Ocean) Island (commercially viable phosphate deposits on Banaba had been exhausted by the time of independence from Britain in 1979).

all infant deaths (19 per 1,000 live births). Other common causes of childhood death include severe malnutrition and common, life-threatening infections that are commonly associated with poor sanitation and hygiene (Figure 5).

Table 2: Summary of selected health indicators, Kiribati

Neonatal, infant and child health		
Immunisation coverage among one-year-olds (DTP^3, 2011)		99%
Immunisation coverage among one-year-olds (OPV^3, 2011)		95%
Immunisation coverage among one-year-olds (measles, 2011)		90%
Neonatal mortality rate per 1,000 live births (2011)		19 per 1,000
Infants exclusively breastfed for first 6 months of life (2007-11)		69%
Infant mortality rate per 1,000 live births (2011)		38 per 1,000
Under five mortality rate per 1,000 live births (2011)		47 per 1,000
Pneumonia: % seeking care for suspected pneumonia (2007-12)		81%
Diarrhoea: % treated with oral rehydration solution (2007-12)		62%
Maternal health		
Antenatal care from a skilled provider (doctor, nurse and/or midwife), % with at least one visit (2007-12)		88%
Number of live births (2011)		2971
Births attended by a skilled provider (doctor, nurse and/or midwife), % of total births (2007-12)		80%
Births taking place in a health facility, % of total births (2007-12)		66%
Maternal deaths per year (2008-12, range) [8]		1-6
Relative burden of communicable and non-communicable disease		
Communicable, maternal, perinatal and nutritional conditions as % of total deaths, all ages (2008)		29%
TB case notification rate per 100,000 (2011)		334
TB treatment success rate (2010)	All forms	92%
	Sputum smear positive	97%
NCDs as % of total deaths, all ages (2008)		69%
Proportion of population aged 25-64 years with ≥3 NCD risk factors		72.7%
Proportion of population who are overweight (BMI ≥ 25 kg/m^2)		81.5%
Proportion of population with elevated fasting blood glucose (≥ 6.1 mmol/L) or currently on diabetes medication		28.1%

Sources: WHO (World Health Statistics 2013, Country Health Information Profile, NCD Country Profiles, STEPS survey), World Bank (World Development Indicators 2013), UNICEF (Kiribati Statistics)

Abbreviations: DTP^3 = diphtheria-tetanus-pertussis (3rd dose); OPV^3 = oral poliomyelitis vaccine (3rd dose); TB = tuberculosis; BMI = body mass index.

[8] Small population and low numbers mean that rates are volatile with a wide margin of error. In particular, calculations of maternal mortality ratio (MMR) lack the precision to reflect trends, which are more accurately monitored using absolute numbers of events (i.e. numerator data). To put this in perspective, the NHSP target of two maternal deaths per year represents a MMR of 67.3 per 100,000 live births, but the 95% confidence interval (CI) would be 18.5 – 245.1 per 100,000; the MMR for six maternal deaths would be 201.9 per 100,000 live births (95% CI 92.6 – 439.9 per 100,000).

Figure 3: Under-5 mortality rates per 1,000 live births (most recent estimates), Kiribati and other PICs

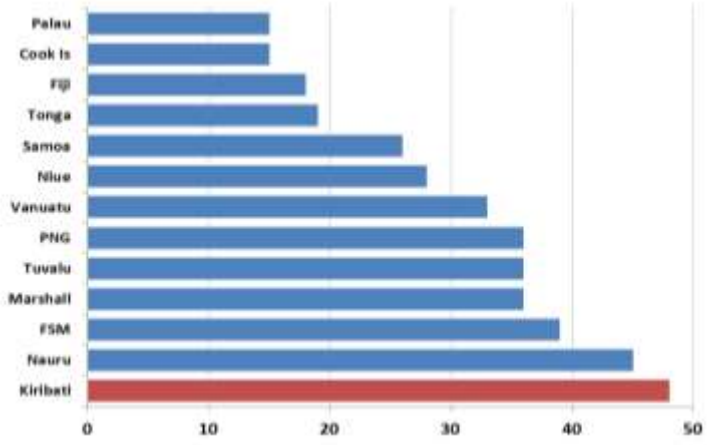
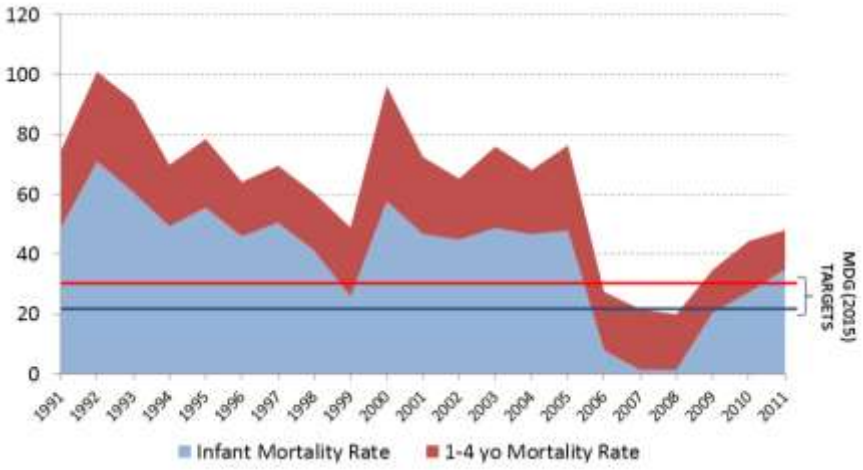
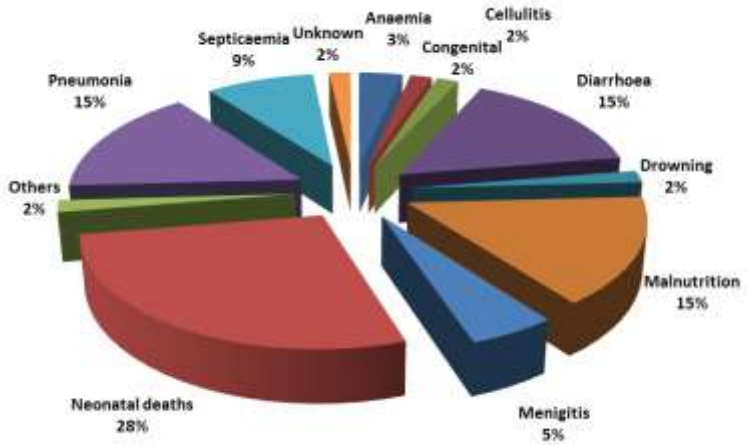


Figure 4: Trends in infant and under-5 mortality rates per 1,000 live births, Kiribati, 1991-2011



Source: MHMS. Poor data quality in 2006-09 means that infant and U5MR may have been under-estimated during those years

Figure 5: Causes of under five deaths, Kiribati, 2011



Source: MHMS

15) **The two most common infectious diseases of childhood – acute respiratory infection and diarrhoeal disease – are potentially preventable with new vaccines** against rotavirus and pneumococcal infection. However, good management of the RERF and some windfall profits from offshore fishing licenses have seen the World Bank re-classify Kiribati as a LMIC;[9] this currently prevents Kiribati from accessing funding support for rotavirus vaccine and pneumococcal conjugate vaccines through the GAVI Alliance. An outbreak of confirmed rotavirus diarrhoea in mid-2013 was responsible for more than 800 cases and six deaths (all in children under five years of age).

16) **Although overall vaccine coverage is reported to be well above 90 per cent nationally (Table 2), estimates of coverage fluctuate widely by location** (generally within the range 0-200 per cent). This suggests there may be great variation in demand (health-seeking behaviour) and data quality. DPs have assisted Kiribati to respond to vaccine 'cold chain' crises twice over the last 10 years.

17) **Maternal outcomes are also fragile, and the likelihood of achieving MDG 5 targets is uncertain: women continue to die in childbirth, and the six maternal deaths in 2012 went un-investigated**. Six maternal deaths are well above the National Health Strategic Plan (NHSP) and MDG target of no more than two maternal deaths per year. Further improvement will depend on the ability to increase access to skilled birth attendants, and will be vulnerable to quality of service delivery, referral pathways, and underlying fertility and access to contraception.[10]

18) **There is some gender difference in life expectancy (males 65, females 71 years) and U5MR (males 50, females 45 per 1,000 live births), and significant levels of domestic, sexual and gender-based violence (SGBV; including directed towards adolescents and children)**. These are well documented in the landmark *Kiribati Family Health and Support Study* (2010). Significant risk behaviour and vulnerability to HIV infection and sexually transmissible infections (STI) among adolescents and young adults are described in *Risky Business Kiribati* (2010) and several other studies.

19) **A large proportion of the adult population has personal risk factors for NCDs**, including elevated blood pressure and/or serum cholesterol, smoking, insufficient exercise, and overweight and obesity (Table 2). Almost one in five adults over 25 years of age has an elevated blood sugar level (or is already on treatment for diabetes), and lower limb amputation due to the combined effects of diabetes- and smoking-related peripheral vascular disease is the most rapidly growing reason for surgical admission at the TCH. Re-surfacing of the main road through South Tarawa may increase traffic speed and the risk of pedestrian injuries.

20) **The high incidence and prevalence of tuberculosis and leprosy, an imminent, major NCD crisis and recently recognised strong 'co-morbidity' effects between diabetes and TB all present a risk of reversal of progress relative to MDG 6**. Most years, the TB prevalence is either the highest or the second-highest in the Pacific (exacerbated by domestic overcrowding, especially on South Tarawa). With support from Australia, the Global Fund and the Secretariat of the Pacific Community (SPC), the TB case detection rate and treatment success rate have improved, but it will be many years before a stable reduction in transmission can be achieved. SPC estimates that the additional burden of TB attributable to diabetes is around 25 per cent. The prevalence of HIV infection is stable

[9] The World Bank's classification of national economies is based on Gross National Income (GNI) *per capita*. Lower middle income countries are currently classified as those with a *per capita* GNI for 2011 between USD 1,026 and USD 4,035.

[10] UNICEF reports a contraceptive prevalence rate of 22 per cent among women of reproductive age (15-49 years) in 2007-12. The population is predominantly Roman Catholic (55 per cent), which may influence contraceptive uptake; the second most common religious affiliation is Congregationalist Protestant (36 per cent). UNFPA reports an unmet need for contraception of above 25 per cent.

and very low, but high rates of STIs (up to 15 per cent among antenatal mothers) and SGBV confer ongoing risk and vulnerability.

21) **Outbreaks of dengue fever are reported about every two to four years, affecting mainly the more urban communities.** Again, this is related to: a) poor urban sanitation that facilitates mosquito breeding; and b) occupational mobility providing opportunities for importation from other PICs or Asia. An outbreak of dengue type 3 (DEN-3) occurred recently in South Tarawa with 89 suspected or confirmed cases and four hospitalisations but no severe or haemorrhagic presentations and no deaths.[11]

22) **Health status and outcomes in Kiribati are strongly related to the social determinants of health (SDH) described above**. Health cannot be viewed only from a health sector perspective in isolation from the broader intersectoral determinants of health status and outcomes.

4. Health system analysis

4.1. Health policy, strategy and governance

23) **The NHSP for 2012-15 was endorsed in 2013 and is guiding the work of the health sector; subsidiary and supportive plans (e.g. for HIV and STIs, NCDs and the elimination of SGBV) are also in place.** The NHSP identifies six priority areas, each with a related strategic objective:

- Population growth and family planning
- Maternal, newborn and child health (MNCH)
- Communicable diseases
- NCDs
- Health service delivery and the health system
- SGBV and youth issues.

The first five of these are aligned with the Kiribati Development Plan 2012-15 (KDP), which includes a strong commitment to the MDGs. The capacity of the MHMS to implement, monitor and report on progress relative to these strategies is currently limited.

24) **The MHMS Senior Management Committee (SMC) meets approximately monthly and is responsible for monitoring the implementation of the NHSP.** The Health Sector Coordination Group meets approximately six-weekly and provides a mechanism to support the planning and delivery of health services in Kiribati and to coordinate additional technical and financial support.[12]

4.2. Health financing

25) **Total health expenditure is around 10 per cent of GDP which although above average for the region, has been declining slowly since 2007; more significantly, real health expenditure *per capita* is not keeping pace with population growth, despite an overall increase in the health budget (in nominal terms)** from A$ 14.1

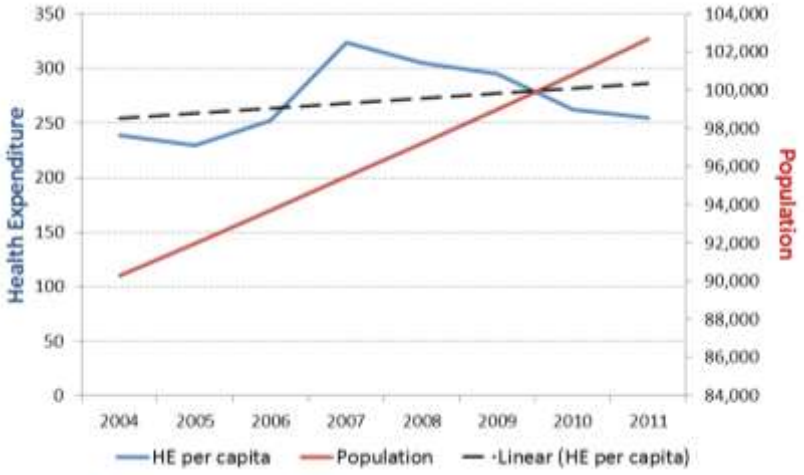
[11] DEN-3 is a commonly circulating strain in the Pacific but has not previously been reported before in Kiribati. This means that close to 100 per cent of the population would be expected to be susceptible, with the potential for an explosive outbreak.

[12] The HSCG comprises the SMC plus representatives from Australia, New Zealand, Japan, Taiwan, KiFHA, UNICEF and WHO. Visiting technical specialists (e.g. from FSMed or visiting consultants or clinical teams) may also be invited to participate.

million in 2012 to A$ 14.8 million in 2013-14 and a projected A$ 15.1 million in 2015 (Figure 6 and Table 3).

However, it will be difficult for the GOK to increase its health spending further. There is limited capacity in both the MHMS and the Ministry of Finance and Economic Management (MFEM) to undertake detailed, structured health policy and financial analysis to guide decision-making.

Figure 6: Health expenditure *per capita* in "real terms" (PPP, constant 2005 international $) relative to population, Kiribati, 2004-11



Source: World Bank (World Development Indicators 2013), SPC (PIC Population Projections, 2013)

Table 3: Summary of selected health financing indicators, Kiribati

Health financing and expenditure	
Total health expenditure as % of GDP (2011)	10.1%
Private health expenditure as % of GDP (2011)	2.0%
Public (i.e. GOK + DP) health expenditure as % of total health expenditure (2011)	80.0%
General government expenditure on health (including external resources) as % total government expenditure (2010)	10.0%
External resources for health as % total health expenditure (2010)	16.9%
Per capita total health expenditure, current US$ (2011)	US$ 177
Per capita total health expenditure, PPP (2011) [13]	I$ 255

Sources: WHO (World Health Statistics 2013), World Bank (World Development Indicators 2013)

[13] PPP (purchasing power parity) methods are designed to avoid distortions caused by variations in exchange rates and the costs of goods and services being lower in one country compared to another (where the actual "purchasing power" of the local currency may differ from other currencies). PPP uses a notional "international dollar" (I$) rather than the US dollar.

26) **External funding makes up just 16.9 per cent of health expenditure in Kiribati** (relatively modest compared with some PICs).[14]

27) **Clinical hospital services and curative care receive the largest share of overall health expenditure** (52 per cent), followed by pharmaceuticals (17 per cent), primary care and public health (16 per cent) and administration (15 per cent). The World Bank has begun to quantify the unsustainable economic impact of NCDs in other PICs (Samoa, Tonga and Vanuatu); similar effects may be anticipated in Kiribati. Out-of-pocket spending on health is minimal as Government healthcare services are provided free of charge to all Kiribati citizens and residents.

4.3. Health service delivery

28) **Government health services in Kiribati are delivered through a four-tier system: one national referral hospital** located in South Tarawa (TCH; which receives referrals from other hospitals and health centres); **three district hospitals** located in Kiritimati Island (serving the Line and Phoenix Island Groups), at Tabiteuea North (serving the southern Gilbert Islands) and a community hospital in Betio (serving the local community); **30 Health Centres** (staffed by Medical Assistants and Community Midwives); and **75 Health Clinics** (also referred to as dispensaries, and staffed by Community Nurses and Nurse Aides). Non-government clinics are run by KiFHA and at the Marine Training Centre (MTC). There are no private medical practitioners.

29) **Per capita outpatient attendance at Government facilities is 3.89 visits per year.** This is twice the level of health service utilisation in many other PICs.

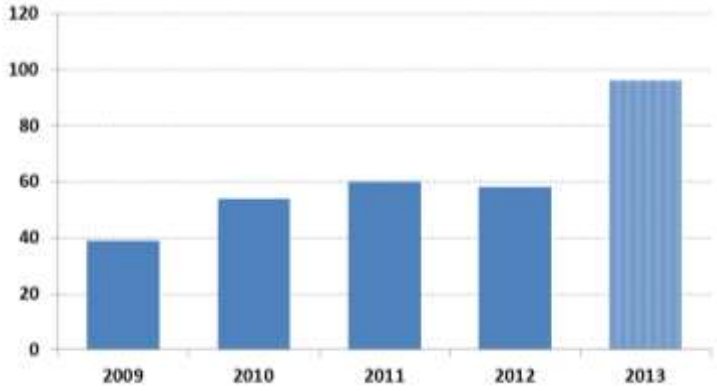
30) **In parallel with the Government system, there is a network of traditional healers and traditional birth attendants** who provide local medicines, massage and antenatal, delivery and postnatal care (note the lower proportion of women delivering in facilities compared with those who attend for antenatal care; Table 2). Most people use both systems. There is no coordination mechanism between the two systems and traditional healers are not included in health legislation or regulations.

31) **The 120-bed TCH is reported to be running at approximately 120 per cent occupancy and, after 20 years, physical infrastructure is deteriorating.** Against a significant and increasing burden of disability, the European Union-funded Rehabilitation Centre was destroyed by fire in October 2012. The Mental Health Unit at Bikenibeu is also overcrowded and in considerable disrepair, and it is difficult to segregate male and female patients.

32) **An increase in offshore referrals for medical and surgical treatment represents an emerging threat to the health budget.** Referrals for international medical treatment almost doubled (from 58 to 96) between 2012 and 2013 (Figure 7), at a gross cost of approximately A$ 1 million for 2013.

Figure 7: International medical referrals from Kiribati, 2009-13

[14] For example, in Vanuatu and Solomon Islands, financial support from development partners heavily underpins the health budgets. In 2012, the Government of Vanuatu provided about two-thirds of total health expenditure and DPs about one-third; in Solomon Islands, the DP-funded proportion was about 40 per cent.



Source: MHMS (2013 data provisional to 9 December)

The principal destinations include Taiwan and India; a relatively small proportion of patients are referred to Fiji, and even fewer go to New Zealand and Australia. There is a significant risk of importation of multi-drug resistant strains of bacteria (which are prevalent in most Indian hospitals) following invasive procedures or other treatments that require long-term in-dwelling cannulae and catheters.

4.4. Health workforce

33) **Kiribati has 3.3 trained local doctors, nurses and midwives per 1,000 population overall.**[15] **The dispersal of the population across multiple islands and throughout the extended urban villages of South Tarawa means that this is barely adequate to cover core service delivery requirements, let alone provide adequate mentoring and supervisory outreach to maintain the quality and standards of care.** Out of 833 health sector employees, there are 732 clinical and public health workers and 101 managerial, administrative and support staff (Table 4). There are currently 156 vacancies on the MHMS staff establishment (about 40 per cent of them for nurses); these positions are often filled on contract by retirees.

34) **Central human resources for health (HRH) management and a workforce database are lacking.** Background analysis for a new national Health Workforce Plan was undertaken in 2013 and the Plan itself will be developed in the first half of 2014.

35) **The capacity of the Kiribati School of Nursing (KSON) and the MHMS to train the required number of nurses, Medical Assistants and midwives to address these shortfalls is extremely limited**. The KSON building remains in disrepair; teaching facilities are cramped, and inadequate to manage the School's efforts to increase the size of its annual nursing cohort from 20 to 40 in 2013. Only two of the 11 teaching staff have postgraduate qualifications in nursing or received some additional 'up-skilling' in nursing education through previous partnerships with Taiwanese institutions and the Auckland University of Technology (AUT). For most other cadres of health worker (including the other nurse educators), there is an over-reliance on informal, on-the-job training. There are two POLHN computer laboratories – one for the use of KSON students and staff and one for the rest of the MHMS.

36) **Fourteen Cuban-trained medical graduates have just returned to Kiribati to commence a new, competency-based Internship Program (funded by Australia through FSMed, with additional technical support provided through WHO).** Another

[15] WHO regards a health worker to population density of 2.3 doctors, nurses and midwives per 1,000 as the minimum needed to provide 80 per cent coverage of basic essential services, e.g. skilled birth attendance and childhood immunisation. Countries below this threshold, including several PICs, are considered to have a critical health worker shortage. By comparison, in Australia the ratio is 13.4 per 1,000 and in New Zealand it is 13.6 per 1,000.

17 trainees will return between 2014 and 2017, enabling Kiribati to eventually address not only the 15 vacant medical officer positions currently on the staff register but to increase the overall doctor-to-population ratio towards 1:2,000. The Program's feasibility and design study identified a critical shortage of medical specialists in Kiribati – not only for clinical service provision but also to supervise junior medical staff (Figure 8); this will be addressed in the short term through three recruited specialists under the Internship Program, through long-term targeted placement of rotating Cuban specialists, and through short-term teams of visiting Australian, Taiwanese and New Zealand specialists. By the end of 2016, postgraduate trainees returning from FSMed should be sufficient to provide the required level of supervision.

Table 4: Current numbers of health workers and density per 1,000 population, Kiribati, 2013

Health Professional Group/Cadre	Total	Rate per 1,000 population
Generalist medical practitioners	8	0.07
Specialist medical practitioners	14	0.13
Medical assistants	44	0.41
Health assistants	2	0.02
Graduate/registered/professional nurses	301	2.79
Nurse aides	198	1.84
Dentists, technicians and assistants	25	0.23
Pharmacists, technicians and assistants	15	0.14
Medical and pathology laboratory technicians	20	0.19
Medical imaging and equipment technicians	16	0.15
Physiotherapists and assistants	4	0.04
Nutritionists and dieticians	2	0.02
Biomedical engineers	2	0.02
Medical and dental prosthetic technicians	2	0.02
Environmental health and hygiene professionals	7	0.06
Health professionals not elsewhere classified	14	0.13
Ambulance workers	23	0.21
Personal care workers not elsewhere classified	35	0.32
Total clinical, support and public health workers	**732**	**6.79**
Medical students in training *(additional to above)*	**31**	**0.29**
Health service managers	7	0.06
Medical records and health information technicians	4	0.04
Service and sales workers	36	0.33
Clerical support workers	16	0.15
Domestic and ancillary support workers	22	0.20
Non-health professionals not elsewhere classified	16	0.15
Total managerial and non-clinical staff	**101**	**0.94**

Source: WHO and University of New South Wales (Draft HRH Country Profile – Republic of Kiribati, 2013)

Medical practitioner numbers exclude international medical staff.

37) **Nauru and Tuvalu have expressed interest in their own foreign-trained medical graduates also completing the Kiribati Internship Program**, and participated in peer review towards the end of the Program's development in early 2013. Nineteen Tuvaluan graduates and seven from Nauru would enter the Program between 2015 and 2019 (Figure 9).

Figure 8: Phased increase in supervisory capacity by clinical rotation, Kiribati Internship Program, 2013-17

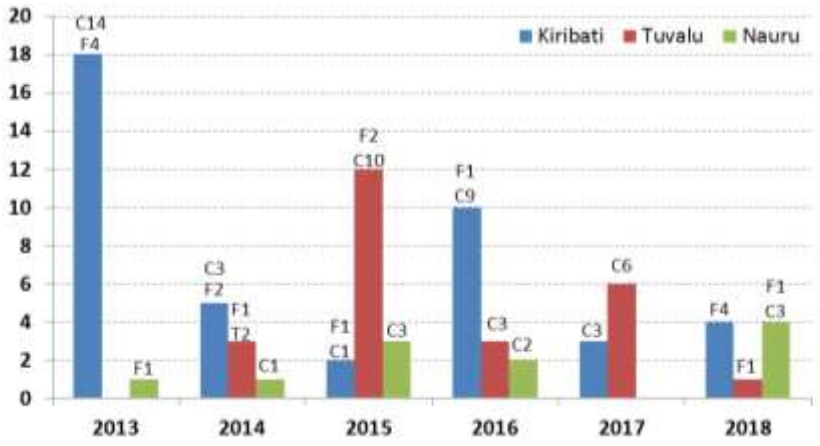
	2013	2014	2015	2016	2017
Medicine	1 PGDip	1 PGDip	1 PGDip	3 PGDip	3 PGDip
Surgery	1 MMed 1 PGDip	1 MMed 1 PGDip	1 MMed 2 PGDip	1 MMed 2 PGDip	1 MMed 2 PGDip
O&G	1 PGDip + "know-how"	1 MMed 1 PGDip	1 MMed 2 PGDip	1 MMed 2 PGDip	1 MMed 2 PGDip
Paediatrics	1 PGDip	1 PGDip	1 PGDip	1 MMed 2 PGDip	1 MMed 2 PGDip
Special Topics					
Anaesthesia	2 PGDip + "know-how"	2 PGDip + "know-how"	2 PGDip + "know-how"	2 PGDip + "know-how"	1 MMed 2 PGDip
Ophthalmology	3 CNS	3 CNS	1 MMed 3 CNS	1 MMed 3 CNS	1 MMed 3 CNS
Public Health	4 MPH	5 MPH	5 MPH	5 MPH	5 MPH

Abbreviations: MMed = Master of Medicine; MPH = Master of Public Health; PGDip = Postgraduate Diploma; CNS = Clinical Nurse Specialist; O&G = Obstetrics and gynaecology

Colour code: ■ = Inadequate ■ = Borderline (≥1 PGDip) ■ = Adequate (≥1 MMed, or 2 PGDip)

Source: MHMS, WHO and FNU (Kiribati Internship Program Design and Feasibility Document, 2013)

Figure 9: Projected numbers entering Kiribati Internship Program, by year and location of undergraduate training for entrants from Kiribati, Tuvalu and Nauru, 2013-17



Location of undergraduate training: C = Cuba, F = Fiji, T = Taiwan

38) **In view of a shortage of clinical specialists, many specialised clinical services are currently provided by visiting teams or are accessed through offshore referrals** (see paragraph 32)**. In 2010, there were a total of 14 visiting specialised clinical teams** (11 to TCH and 3 to Kiritimati Island) from Australia (Royal Australasian College of Surgeons [RACS]), Taiwan, Japan (the Osakawa Eye Team), and New Zealand (obstetrics and gynaecology specialists engaged through the Medical Treatment Scheme [MTS]). More recently, USA-based specialists engaged through the Pacific Island Medical Aid program (an NGO established by former Peace Corps volunteers) have begun visiting Kiritimati Island via the air link from Honolulu.

4.5. Health information

39) **The national health information unit (HIU) has recently spent two years converting the TCH medical records to electronic format.** There are limitations to the timeliness and accuracy of disease surveillance and data on health services provided, but this is improving.

40) **The HIU produced a MHMS *Annual Report* for 2011** – the first such publication for many years; the format and data analysis will continue to be developed in subsequent annual publications.

4.6. Medicines and therapeutics

41) **The Pharmacy Department at TCH is responsible for management and distribution of all medicines and consumables for disease programs for the whole country. The estimated pharmaceutical budget for 2009 was US$ 1.8 million.** There is a national Essential Drug List but medicines legislation remains in draft form. National standard treatment guidelines exist for: 1) emergencies; 2) cardiovascular, neurological, psychiatric and diabetes; 3) gastrointestinal and respiratory; and 4) obstetrics, gynaecology and paediatrics. There are no private retail pharmacies in Kiribati.

5. Current development partner assistance for health

42) **Current Australian assistance for health is generally directed through mechanisms that align with other bilateral priorities (e.g. workforce development, infrastructure support) or are delivered through regional organisations or initiatives.** A new maternity ward at the Betio Community Hospital is due to open in February 2014, and detailed design work has been completed for refurbishment of KSON (ready for and cost quotation and construction). The Kiribati-Australia Nursing Initiative (KANI) was not primarily designed to improve domestic health outcomes but to contribute to international labour market mobility for I-Kiribati; the Australian Government response to a recent review suggests that no further KANI intakes will be sent to train in Australia due to a lack of demonstrable effectiveness or value-for-money. Other social sector support includes prevention and management of disabilities, the elimination of SGBV and the provision of tools and equipment, seedlings and agricultural techniques for domestic vegetable gardening through the Kiribati Climate Action Network (KiriCAN). Australia also has a major investment in the water/sanitation sector through the South Tarawa Sanitation Improvement Program ($A 13.95 million to 2018). Regional programs have been addressing HIV prevention, immunisation, NCDs, specialised clinical services (through RACS) and accelerated TB control (through SPC). Non-health sector support includes sanitation installation works on Betio.

43) **Current New Zealand assistance for health addresses social determinants of health through non-health sectors: water supply and sanitation, and housing design quality.** New Zealand has collaborated with Australia to assist with rainwater harvesting at the Betio Community Hospital and at TCH. Detailed design work has been undertaken

on housing quality and standards. FPNZ is engaged to provide technical support and strengthen the capacity of KiFHA to provide reproductive health and SGBV-related services; parallel bilateral technical and funding support is provided to the Domestic Violence and Sexual Offences unit of Kiribati Police through New Zealand's Pacific Prevention of Domestic Violence Program. New Zealand also supports the primary care clinic at the MTC, including a medical officer position and diagnostic infrastructure. The regional MTS continues to give Kiribati access to some offshore medical and surgical treatment in New Zealand. New Zealand is assisting the Kiribati Police to develop and implement traffic and speed management strategies on South Tarawa.

44) **Other DPs working in the health sector include UN agencies, the Cuban and Taiwanese technical missions and some local and international NGOs.** Taiwan's annual program of assistance for health is valued at A$ 500,000; it is largely used to fund visiting clinical specialists, scholarships to Taiwanese institutions and small scale local health informatics support. Cuba is willing to continue to provide undergraduate medical training but does not currently have bilateral funding available; this would require direct GOK funding or third party ('trilateral') donor arrangements. There is a WHO Country Liaison Office, and a UN Joint Presence (UNICEF and UN Women). UNFPA and UNDP have no in-country presence (support is coordinated from regional offices in Suva, and they are represented in-country by UNICEF). SPC has no in-country presence; its support is based on outreach from regional offices in Suva and Noumea and, for specific activities, Honiara. NGOs include KiFHA (which is affiliated with IPPF) and the Kiribati Red Cross. A *Safe Net* committee has been formed to guide the response to elimination of SGBV; however, its role and mandate are not yet clear and meetings generally reflect its current status as 'a good idea'.

6. Proposed Australian and New Zealand assistance in health

45) **Based on the 'problem analysis' presented above** (paragraphs 7-41)**, it is recommended that Australian and New Zealand support for health in Kiribati could focus on up to four priority areas and two supportive areas. The priority areas are: 1) population and reproductive health; 2) health workforce; 3) maternal, neonatal and child health and 4) NCDs. The supportive areas are 5) health system analytical support and; 6) social determinants and other factors outside the health sector that have a bearing on health outcomes**. The alignment of this support with NHSP priorities (and therefore also the KDP) is summarised in Figure 10. Australia and New Zealand are well placed to be able to provide support to the Kiribati health sector. Australia has existing experience in reproductive and child health programs in other parts of the world, and the health of women and children is a key priority in the aid program's core policy document.[16] Australia is also already very familiar with KSON and workforce issues, having funded detailed design work already for the KSON refurbishment (paragraph 42) and provided support for the establishment of the medical internship program (paragraph 36). New Zealand has existing engagement with Kiribati on population and reproductive health, including through partnerships with KiFHA and FPNZ. Both Australia and New Zealand have some of the region's leading thinkers and policy experts on chronic diseases and NCDs, and highly relevant experience in managing the more mature NCD 'epidemic' in indigenous and Pacific Island populations.

46) **Future Australian and New Zealand support should primarily align with: the KDP; the NHSP 2012-15; the national 10-year Health Work Force Plan (to be completed in 2014); and the respective bilateral development agreements (including – especially – where they address SDHs like gender, water, sanitation, housing and economic prospects)**. Australia and New Zealand should commit to a predictable, medium- to long-

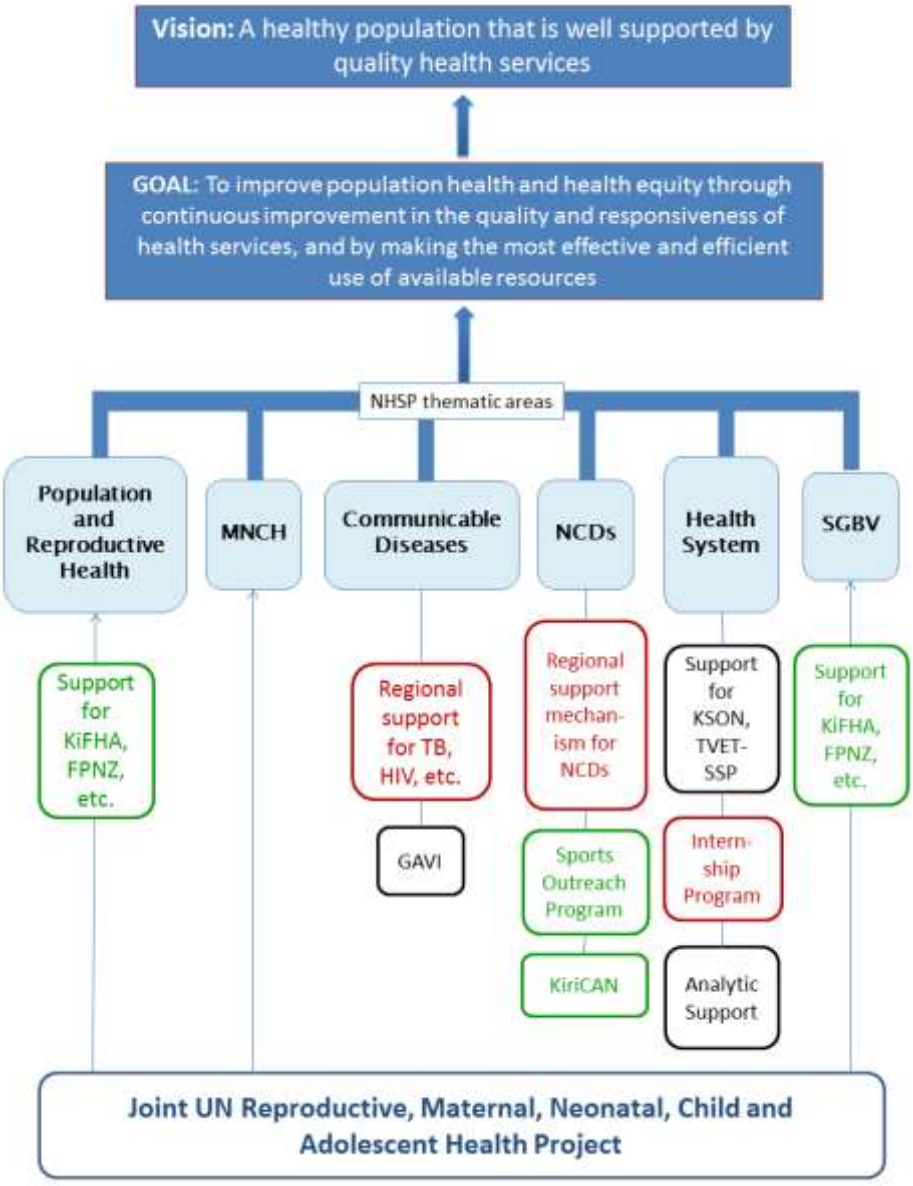
[16] *An Effective Aid Program for Australia: Making a real difference - Delivering real results.*

term program of support for NHSP and KDP priorities; their attention should not be diverted by a quest to find 'quick wins' or 'low-hanging fruit' – development priorities in Kiribati are long-term, and require solid, long-term solutions.

6.1. Population and reproductive health

47) **Population and reproductive health would potentially be addressed through partnerships with UN agencies (e.g. though the proposed Joint UN Program on Reproductive, Maternal, Neonatal, Child and Adolescent Health) and civil society organisations (CSO; e.g. KiFHA, FPNZ)**. This approach will depend largely on the quality of the UN proposal, which has undergone initial technical appraisal and is now subject to follow-up discussions.

Figure 10: Alignment of proposed support with NHSP vision, goal and thematic areas, and possible modes of delivery



Legend and colour scheme: modality for proposed areas of Australia/New Zealand support to Kiribati health sector:

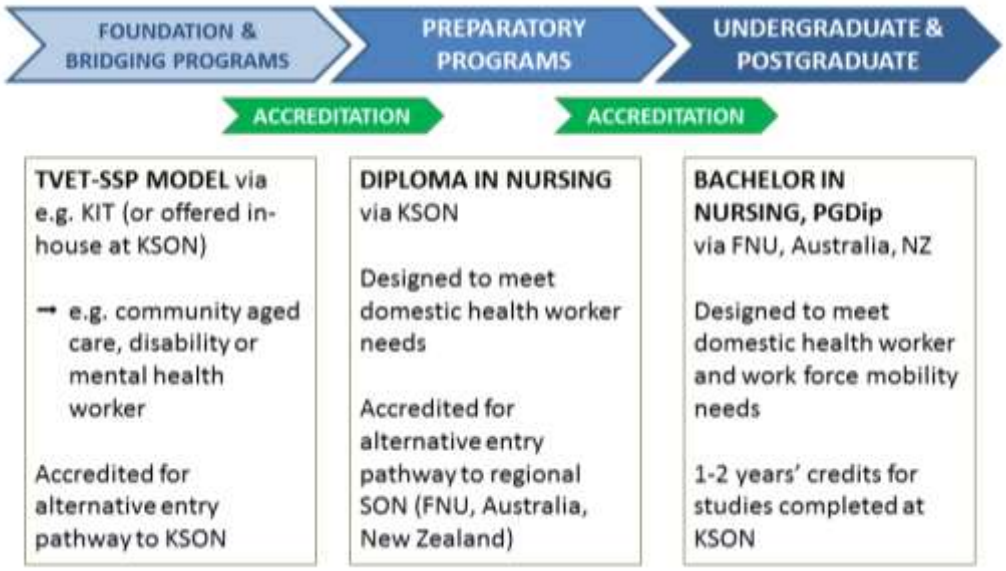
48) **It is noted that UNFPA (the lead UN agency nominated for Kiribati under a Joint UN Program) does not have a representative office in Kiribati**. In the Kiribati operating environment, this would severely constrain Program governance, monitoring and effectiveness and must be addressed in the final implementation arrangements. Australia and New Zealand are involved in quality assurance for the Joint UN Program during the present design stage, and their bilateral missions in Kiribati must remain involved in quality monitoring during subsequent implementation.

6.2. Health workforce

49) **Support for the health workforce would be directed at improving the capacity, quality and throughput at KSON and maintaining the quality of the Kiribati Internship Program**. This would include completing the refurbishment and extension of KSON so that it can take its place alongside such institutions as the MTC, the Fisheries Training Centre and the Kiribati Institute of Technology (KIT) in providing a standard of training that prepares students to enter the international workforce. A refurbished KSON would also provide useful facilities for the teaching and learning program for the medical Internship Program. The focus on health workforce would address a parallel agenda in strengthening the quality of health service delivery.

50) **In parallel, Australia and New Zealand could support the further development of the capacity and standards of KSON teaching staff and continuous quality improvement in the nursing curriculum**. This might require a technical partnership with nursing faculties at any (or all) of AUT, James Cook University and Fiji School of Nursing at FNU. Additional pre-service and community cadres of health worker might be developed using a labour market model with multiple exit points (Figure 11). Foundation and bridging programs might be developed – either in-house at KSON or in conjunction with KIT – leading to a stand-alone community care worker qualification that would also be accredited for direct entry to the Diploma of Nursing program. The ultimate objective would be a KSON Diploma in Nursing that meets local HRH plans and service delivery needs, but is also pre-accredited with a regional academic institution for graduate and postgraduate training (e.g. at FNU or Australian or New Zealand universities).

Figure 11: Suggested labour market model for nursing training (incorporating multiple, sequential exit points)



Abbreviations: TVET-SSP = Technical and Vocational Education and Training Sector Support Scheme; SON= schools of nursing

51) **The Kiribati Internship Program will potentially need donor support for up to four years**, but is currently only funded for the first two years of operation. Maintaining support for the Internship Program will neatly complement anticipated continued Cuban interest in undergraduate medical training and assistance from both Cuba and Taiwan in backstopping key medical specialist positions pending the return of I-Kiribati graduates from specialty training programs in Fiji.

6.3. Maternal, neonatal and child health

52) **Maternal, neonatal and child health would also potentially be addressed through the Joint UN Program and existing NGO relationships (e.g. FPNZ and KiFHA)**, subject to appropriate quality assurance on the design and proposal and Australia and New Zealand's capacity to monitor the quality of delivery, governance and continuing alignment with MHMS priorities. The Joint UN Program should address not only advocacy for improved adolescent reproductive health and access to reproductive health commodities, but also the important challenges associated with e.g. poor neonatal outcomes (an area where WHO has technical expertise and a good track record) and immunisation strengthening (with joint UNICEF and WHO inputs). UNFPA must work closely with MHMS to develop a protocol and standard operating procedures for the investigation of and response to maternal deaths: no mother should die in childbirth but, if there are inevitable reasons that she does, her death should not be in vain.

53) **Australia, UNICEF and WHO should use their established links to the board of the GAVI Alliance to encourage review of eligibility criteria for new vaccines** against conditions that contribute disproportionately to under-5 mortality in Kiribati (e.g. rotavirus and pneumococcal conjugate vaccines). The draft joint UN work plan contains very little detail on strengthening immunisation services, but it is expected that this will be rectified following technical feedback on the proposal. The opportunity also exists to undertake cost-effectiveness analysis in relation to possible introduction of human papillomavirus (HPV) vaccine for adolescents.

6.4. Non-communicable diseases

54) **The mechanism of support for NCDs is, as yet, uncertain and may depend on Australian and New Zealand decisions for the future of regional technical assistance funded through WHO and SPC.** The approach should focus on primary and secondary prevention of NCDs: a) primary prevention through behaviour change and promotion of healthy lifestyle choices (linked closely with the Australian-funded community Sports Outreach Program) and small-scale home vegetable gardening (linked with KiriCAN); and b) secondary prevention through continued implementation of the Package of Essential NCD (PEN) interventions being promoted by WHO. In-country capacity to manage an additional funds injection through core budget support (to either MHMS or WHO) is limited.

6.5. Health system analytic support

55) **Technical support for broader health system functions would primarily focus on health finance and policy analysis to guide efficient use of resources and equitable access to services, and potentially to monitor the impact of workforce investments on increasing demand for and utilisation of those services**. Several institutions in Australia (e.g. the former Health Policy Health Financing 'knowledge hub' at the Nossal Institute for Global Health) and New Zealand (e.g. the University of Otago) have relevant expertise, as does the World Bank. Continued mobilisation of the HSCG would be used to ensure that Australian, New Zealand and other DPs inputs into health in Kiribati remain aligned with the NHSP and sub-sectoral strategies through a well-coordinated partnership. Technical assistance for other health system functions like logistics and commodities management and health information (e.g. through the former Health Information Systems 'knowledge hub' at the University of Queensland) could be included in the program of support.

56) **Additional technical assistance could be provided to undertake an initial assessment of the TCH's current operations, costs and related performance and what steps might be taken over the short and medium term to improve the provision of services.** If funds were available, this might include some refurbishment of physical infrastructure and an assessment and budget for replacement of some instruments and equipment.

6.6. Social determinants and other factors outside the health sector

57) **Noting that health outcomes are strongly linked to performance and services in other sectors, the MHMS and health DPs should collaborate strongly with the water/sanitation, housing, education and transport (road safety) sectors**. This may involve joint inputs on policy formulation, or developing joint approaches to health promotion and behaviour change. The HSCG meeting provides a potential forum for dialogue with other sectors on the NHSP and health sector priorities. Similarly, the MHMS and health DPs should avail themselves of opportunities to participate in planning activities in other, health-related sectors.

58) **The strong association between poor quality water and sanitation infrastructure, diarrhoeal disease and childhood malnutrition suggests that the funding agencies should maintain direct funding support for the water/sanitation sector**. The multi-year Australian-funded South Tarawa Sanitation Improvement Program is expected to provide 80% of South Tarawa communities in Betio, Bairiki and Bikenibeu with access to better sanitation and a consequent reduction in the incidence of diarrhoeal disease among children 0-5 years of age.

59) **The option should also be retained to address the elimination of SGBV and the needs of people living with disabilities through mechanisms outside the health sector.** For example, SGBV could be addressed through partnership with the law and

justice sector and in conjunction with the newly inaugurated Ministry of Women and Social Affairs – possibly as a component of the Joint UN Program on reproductive health and MNCH.

7. Implementation and program management

7.1. Modalities of support

60) **Modalities of support will need to be determined following careful consideration and frank discussion between funding agencies, GOK and potential implementing partners.** A Public Expenditure and Financial Accountability assessment conducted by the Asian Development Bank in 2010 paints a mixed picture of the performance of public financial management systems in Kiribati. Nevertheless, capacity and compliance with donor accountability requirements continues to improve; SPC, as principal recipient for the Global Fund, directs resources through a national project management unit in the MHMS, and Australian-funded support for the TB Program is expected to follow this route after the next Program review. In most cases, it is expected that Australian and New Zealand funding for health would be directly allocated to an implementing partner or agency (which might include the MHMS itself, e.g. through core funding for the national NCD strategy). Financial oversight and management would be determined by the funding modality selected for each element of the program of support.

7.2. Budget and financial management

61) **If partners agree to the proposed activities suggested in this concept note, it is thought that around A$ 10 million will be required over an initial three year period.** A more detailed estimate would be subject to further dialogue between partners, discussions within the individual agencies and costing of a more refined proposal. It is re-emphasised that this would be an initial phase of a longer term program of coordinated Australian and New Zealand support for the Kiribati health sector and other sectors influencing health outcomes.

62) **DFAT and MFAT country and Pacific regional offices may retain management responsibility for a smaller proportion of funds to enable a more responsive approach to requests for assistance**; this would especially apply to the implementation of health policy, financing, information management and other health system support.

7.3. Program management and monitoring

63) **Primary responsibility for oversight and monitoring of implementation should rest with the MHMS and the HSCG.** The proposed program of support is aligned with current NHSP priorities, and these are expected to remain priorities beyond the life of the current NHSP. Donors may need to provide additional monitoring support to meet their own agency accountability requirements. Further discussion will be required once the proposals in this *Concept Note* have been discussed among partner agencies.

7.4. Technical assistance

64) **Some additional technical assistance may be necessary, and should be budgeted.** Kiribati is a challenging operating environment and turnover of staff within partner agencies and even Government is high.

8. Next steps

65) Key messages from this final draft of the *Concept Note* have been incorporated into the briefing paper that will be used to guide Australia's **partnership talks with the GOK in**

Tarawa later in February 2014. Additional adjustments may be made following further discussion with the New Zealand Aid Programme.

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Annex 1: Terms of reference for field visit to Fiji and Kiribati (3-11 December 2013)

Developing a Concept Note to inform

Australian assistance to the Kiribati Health Sector 2014-2016

1. Background

Kiribati faces a great number of development challenges which are being exacerbated by the impacts of a fragile environment, faltering economic growth and a fast growing population. Key health challenges include maternal and child mortality, the highest incidence of tuberculosis in the Pacific, frequent outbreaks of other communicable diseases (predominantly related to poor environmental sanitation and hygiene; e.g. diarrhoeal disease, acute respiratory infection), and a steadily rising prevalence of non-communicable diseases.

DFAT through its Tarawa Post (& Canberra desk) provides financial resources to support to the Ministry of Health & Medical Services (MHMS) in Kiribati on a range of clinical and public health activities. Australia's development cooperation country strategy and programs are currently defined by the Australia–Kiribati Partnership for Development (2009), in which health is not currently a Partnership priority outcome area (but remains an agenda item in annual Partnership Talks). Australia also provides development assistance in other sectors, including Water and Sanitation, Gender (focus on sexual and reproductive health services), Disability (focus on improving access to basic services including health services) which have the potential to have a positive impact on health; through a variety of regional programs, Kiribati also receives assistance from Australia for tuberculosis control, strengthening specialised clinical services and assisting the integration of Cuban- and other foreign-trained medical graduates into the Kiribati health system.

In 2011 a Concept Note was developed to inform both Australia and MHMS on how to better tackle prevailing health concerns through existing partnership priority areas: education and workforce skills development. Key developments since the Concept Note was completed include:

i) MHMS Strategic Plan 2012-2015 was launched in early August 2013 (see section 7 for other relevant health publications);
ii) Continued Australian funding for tuberculosis control and elimination, administered by the Secretariat of the Pacific Community but with responsibility for management gradually transferring to the MHMS;
iii) Launching of a report: 'Pacific Youth, their Rights our Future' which outlines the results of an open hearing on sex and reproductive health in the Pacific
iv) An outbreak of diarrhoeal disease in July this year which resulted in the deaths of six children under five, pointing to underlying weaknesses in the surveillance system and the quality of health services;
v) An updated Integrated Management of Childhood Illness protocol.

The Government of Kiribati has requested additional support in the health sector and Australia and New Zealand are both at the early stages of exploring the possibility of developing a new health program in the medium term. In addition, the UN health agencies (UNFPA, UNICEF and WHO) are scaling up their support to health in Kiribati through a new joint program focussed on maternal and child health. Australia-Kiribati Partnership talks are scheduled for February 2014 and a Country Situation analysis and new budget process will begin soon afterwards – which may pave the way for new investments in health from 2015-onwards.

In view of these developments, Adviser assistance is required to: provide advice on how existing investments might be improved; consider the feasibility and need of a new health program; and scope out the broad areas of focus for that program. This work would form the basis on an updated Concept Note; a summary paper based on this concept note would feed into the partnership talks in February.

2. Purpose/objective of assignment

DFAT is commissioning the services of an Adviser to develop a Concept Note to inform Australian assistance to the Kiribati Health Sector over the three year period from 1 January 2014 to 31 December 2016. The Concept Note will build on previous work, and be informed by, and align with, *Effective Aid*,[17] the Kiribati Development Plan 2012-2015, the MHMS Strategic Plan 2012-2015, and will address recent and current public health concerns. Specifically, the new concept note will:

1. Make recommendations on how the Australia's existing health investments, and health-related investments could be better linked and, with small additional investments contribute to better health results (e.g., would health promotion activities linked to WASH investments be a 'quick win' for health);
2. Review the feasibility and need for a new program of development assistance in the health sector, beginning 2015, based on discussion with the Government of Kiribati (GOK), DFAT post and the New Zealand;
3. Scope out possible areas of investment/focus for any new health program, taking into consideration planned investments of other development partners (e.g., Cuba, Taiwan).

3. Methodology

The methodology will include desk-based review of documents and analysis, stakeholder consultations (including with New Zealand), and an in-country mission.

3.1 Document review & analysis (and in-Australia consultations)

A review of relevant documents (see section 7) will underpin the development of the updated concept note and inform planning for the in-country mission. This will be done through consultations with:

(a) members of the Pacific Health team (Canberra) to discuss emerging regional programming and its implications for Kiribati;
(b) Kiribati Desk (Desk Officer, Director and Post);
(c) regional offices of relevant development partners active in Kiribati (e.g. UNFPA, WHO, IPPF).

DFAT will assist with setting up these meetings, which will be held in Suva on 3-4 December.

The health adviser from NZ aid programme, Wellington, and the NZ representative in Tarawa will be invited to join these preliminary discussions.

Based on these discussions, a brief work plan for the in-country visit will be developed.

[17] An Effective Aid Program for Australia: Making a Real Difference Delivering Real Results (Updated June 2012).

3.2 In-country mission (and consultations)

The adviser will carry out a scoping mission to Kiribati from 5-12 December 2013. A schedule of consultations will be agreed with Kiribati desk and post prior to the mission, and Post will provide logistical support to organise meetings. The purpose of the in-country mission is to:

(a) consult with key stakeholders (see below);
(b) test ideas for future programming; and
(c) get a better sense of the operational context, enabling ideas for any new program to be well 'grounded'.

At the start of the mission the Adviser will meet with DFAT staff for an initial briefing (health, safety, security and an overview of Australia's aid programming in Kiribati). Meetings with other program staff (working on gender, WASH, infrastructure, climate change and disability) should take place during the course of the mission in Tarawa.

The Adviser will also meet key domestic health sector stakeholders and GOK officials and visit the main service delivery centres (hospital, public health clinics, Kiribati School of Nursing, Ministry of Health and Medical Services). In addition, the Adviser will meet staff of UN health agencies, other donor partners and civil society organizations (Red Cross, Kiribati Family Health Association). At the end of the in-country mission, it is anticipated that a meeting will take place with DFAT and MHMS officials to discuss early conclusions and the broad direction of the Aide Memoire (and presentation on the same if possible).

4. Outputs/deliverables (Including reporting channels)

The Adviser will report directly to DFAT Kiribati Post's Health Program Manager (copying the Senior Program Manager and Development Program Specialist), and submit the following outputs in the manner, and at the time, indicated.

4.1 Work plan for in-country mission (see above).

A schedule of visits will be prepared by DFAT Tarawa, which the Advisor will review prior to the in-country mission.

4.2 Aide Memoire

An Aide Memoire (of 5-7 pages) is to be prepared and presented to key stakeholders at the end of the in-country mission. The intended audience of the Aide Memoire is comprised of DFAT Post representatives and officials from the MHMS, and development partners. While DFAT has no particular preference for format in this regard, the Aide Memoire should cover the key areas of the concept note. A suggested structure (which the Adviser may wish to adapt) is as follows:

- a brief statement of background,
- a brief summary of the outcomes of the in-country mission
- summary recommendations on DFAT's existing health and health-related investments
- the 'business case' for why Australia should invest in health in Kiribati (pitched at a non-health audience)
- an indicative outline of the parameters and focus of, and delivery mechanisms for, potential future Australian support to the health sector in Kiribati;
- any other observations and recommendations (including key constraints and risks);
- a statement of 'next steps'; and
- acknowledgements and a full list of people and organisations consulted.

4.3 Concept Note

The main output of the consultancy will be an updated Concept Note, titled *Australian Assistance to the Kiribati Health Sector 2014-2016*, of up to 20 pages plus annexes.[18] It will build on the previous Concept Note, providing updates where required, and meet the three objectives set out in section 2, above. It should include the 'business case' for why Australia should invest in health in Kiribati, e.g., by comparing health needs in Kiribati to needs in other Pacific Island Countries and discussing Australia's comparative advantage.

4.4 Briefing Papers

The Adviser will also prepare three short briefing papers which summarise key areas of the Concept Note. These will be stand-alone documents of 1-2 pages, focussed on:

1. Recommendations on how the Australia's existing health investments and health-related investments could be better linked and potentially contribute to better health results;
2. The 'business case' for a new health program beginning 2015; this paper will be used as a briefing for the partnership talks scheduled for late February 2014.
3. Recommendations of key areas of investment/focus for any new bilateral health program, including if relevant strategic partnerships with UN agencies in-country.

4.5 Timeline

Draft Concept Note: *Australian Assistance to the Kiribati Health Sector 2014-2016* is to be submitted to DFAT by 6 January 2014.

Based on feedback on the draft provided by DFAT (by 3 February 2014), a final Concept Note, *Australian assistance to the Kiribati Health Sector 2014-2016*, is to be submitted to DFAT by 10 February 2014.

The three briefing papers, based on the concept note, will be provided by 10 February 2014.

5. Skills and experiences of the Adviser

The following attributes are considered important:

- Qualifications in public health or similar;
- Extensive successful experience working in the health sector, preferably in policy development, strategic planning and/or program design;
- Successful experience working in a developing country context, preferably including in the Pacific (experience in, or familiarity with Kiribati highly-regarded),
- Effective conceptual, analytical and interpersonal skills (especially communication and facilitation); and
- Excellent writing skills.

6. Duration

The Consultancy will have a duration of up to 20 days, starting 2/12/ 2013.

7. Key Documents

An Effective Aid Program for Australia Making a Real Difference Delivering Real Results (Updated June 2012)

[18] In consultation with DFAT and New Zealand MFAT, it was decided that the Concept Note would be re-titled to include New Zealand, and that the notional timeframe would be from 2015 onwards (to align with both countries' bilateral discussions).

Australian assistance to Kiribati health sector 2011

Kiribati Development Plan 2012-2015

Kir-MHMS Strategic Plan 2012-2015

Kir-MHMS Annual report 2011

WHO-Kiribati Rotavirus Outbreak report 2013; and other relevant publications/reports (covering NCD, CD, maternal & child health)

Draft Kiribati Program Poverty Assessment (2013)

Cholera Contingency Plan – Mission TORs (2014)

Disability - Design Mission TORs (2014)

ADB South Tarawa Sanitation Improvement Program – relevant WASH documents

Pacific Women Shaping Pacific Development - Kiribati Country Plan (2013)

GoK Shared Implementation Plan to Eliminate Sexual and Gender-Based Violence in Kiribati (2013)

UN Joint Programme for Eliminating Sexual and Gender-Based Violence – Concept Note (2013)

ESGBV (Elimination Sexual and Gender Based Violence)

Organisation Capacity Assessment (2013)

Kiribati Internship Pgm Feasibility and

Design Document 2013, WHO Towards TB Elimination in Kiribati design document (MHMS-SPC) … plus report of recent TB TAG

Annex 2: Suva and Tarawa visit program and list of persons met, 3-12 December 2013

Date	Time	Program	Persons met	Facilitator	Venue & comments
Monday 2 December	9:15pm 10:00pm	Arrive Nausori International Airport Check-in at Novotel Lami	—	RC/HRF	Novotel Suva, Lami Bay
Tuesday 3 December	9:00am – 11:00am	Meet with WHO South Pacific Health Systems and HRH/POLHN focal points and SRH focal point	Dr Ezekiel Nukuro, Dr Rodel Nodora, Dr Mads Salva	RC	WHO-SP office, Ellery St
	11:00am – 12:00am	Meeting with IPPF Regional Office	Ms Suman Chandra, Mr William Fuata	RC	Dominion House, Thomson St
	12:15am – 1:45pm	Meeting with Fiji School of Medicine	Dr Berlin Kafoa	RC	FSMed, Hoodless House, Brown St
	1:45pm – 2:30pm	Follow up meeting with SSCSiP program	Ms Mabel Taoi	RC	FSMed, SSCSiP Office, Brown St
Wednesday 4 December	9:30am – 11:00am	Meet with UNFPA Pacific focal points for Kiribati and UN Joint Program	Dr Adriu Naduva, Ms Virisila Raitamata	RC	UNFPA office, Kadavu House, Victoria Parade
	11:30am – 1:30pm	Follow-up meeting with WHO-SP	Dr Ezekiel Nukuro	RC	WHO-SP office, Ellery St and over lunch
	1:45pm – 4:30pm	Desk work	—	RC	Novotel Suva, Lami Bay
	6:30pm – 8:00pm	Travel Nausori – Nadi Check-in at Raffles Gateway	—	RC/HRF	Raffles Gateway Hotel, Queen's Rd, Nadi

Thursday 5 December	8:00am	Arrive Bonriki International Airport Check-in at Utirerei Guest House; collect car	—	RC/KE	Utirerei Guest House, Ambo Village
	11:00am – 12:30pm	Entry briefing with AAP (First Secretary, Counsellor and Health Team)	Mr Michael Hunt, Dr Iobi Batio, Ms Erimeta Barako, Ms Kakiateiti Erikate	MH/KE/RC	AAPO, Bairiki
	2:15pm – 3:15pm	Meeting with Minister of Health	Dr Kautu Tenua	RC/IB	AAPO, Bairiki
	3:15pm – 4:30pm	Planning, background reading	—	RC/IB	AAPO, Bairiki
Friday 6 December	**HUMAN RIGHTS DAY (Public Holiday in Kiribati)**				
	9:00am – 9:45am	Meeting with Australian Head of Mission, Counsellor Development	Hon George Fraser	MH/RC/IB	AHC, Bairiki
	10:00am – 11:15am	Meeting with Senior Program Manager, Education and Training	Mr Mark Sayers	RC	AAPO, Bairiki
	11:30am – 12:30pm	Meeting with NZ MFAT Deputy High Commissioner / Human Development focal point	Mr Peter Kemp	MH/RC/IB	AAPO, Bairiki
	1:30pm – 4:00pm	Visit to the Mental Health Unit Drop by Fisheries Training School	Dr Miireta Batio	RC/EB	Bikenibeu
Saturday 7 December	9:00am – 10:30am, 2:00pm – 5:00pm	Background reading and research	—	RC	Utirerei Guest House, Ambo Village
	11:00am – 1:30pm	Meet with WHO review team	Dr Pieter van Maaren, Professor Sunia Foliaki	RC	Chatterbox Café, Bikenibeu
	7:00pm – 9:30pm	Meeting over dinner with New Zealand Family Planning	Ms Jessica Ducey, Ms Eliza Raymond	RC	Utirerei Guest House, Ambo Village
Sunday 8 December	8:00am – 10:30am	Meeting with Australian Sports Outreach Program	Mr Warwick Povey	RC/MS	Utirerei Guest House, Ambo Village

	10:30am – 4:30pm	Background reading and research; commence preparation for de-brief and Health Sector Coordination Group meeting	—	RC/HRF	Utirerei Guest House
Monday 9 December	8:00am – 9:00am	Attend Grand Rounds at TCH	All available medical staff	RC/IB	TCH Board Room, Nawerewere
	9:15am – 11:30am	Meeting with Director of Public Health and Director of Clinical Services	Dr Teatao Tiira, Dr Bwabwa Oten	RC/IB	TCH Board Room
	11:45am – 1:15pm	Meeting with Principal KSON; walk-around KSON, POLHN labs and Library	Ms Tareti Ioane	RC/IB	TCH Board Room
	2:30pm – 3:30pm	Meet with Kiribati Family Health Association	Ms Norma Yeeting, Ms Abi, Ms Helena Palmqvist	RC/EB	Teaoraereke
	3:45pm – 5:00pm	Meet with Cuban Ambassador	Sen Esteban Lobaina Romero	RC/EB	An-te-Non
Tuesday 10 December	8:30am – 9:45am	Visit Eita Health Centre	Medical Assistant Tanguru, RN Timemwe	RC/IB	Taborio / Eita
	10:00am – 11:30am	Meet with Head of UN Joint Presence, UNICEF EPI focal point	Ms Nuzhat Shahzadi, Ms Tinai Iuta	RC/EB	Nawerewere
	11:30am – 11:45am	Courtesy call to Leprosy Mission house	—	RC/EB	Nawerewere
	12:00 noon – 12:45pm	Visit Outpatients Clinic; meet with Leprosy Program outpatient nurse, IMCI nurse	RN Falelasi Hopi, RN Tebere Abere	RC/IB	Nawerewere
	1:40pm – 2:40pm	Meet with Domestic Violence and Sexual Offences Unit, Kiribati Police Service	Inspector Eribwebwe Takirua	RC/EB	Betio Police HQ
	2:50pm – 4:00pm	Visit to the Betio Maternity Ward Drop-by Betio Community Hospital; meeting with Cuban Trained Medical Graduate and 2nd in-Charge Nurse	Dr Fatima Mwemwenikeaki, RN Namorua Tebaubau	RC/EB	Betio
	4:30pm – 5:30pm	Meet with Taiwan Medical Mission focal point	Ms Maya Huang	RC	Taiwan ROC Embassy

Wednesday 11 December	8:30am – 9:50am	Presentation: Australian Aid Program Staff Development Meeting (before general staff meeting)	—	RC/MH	AAPO
	10:15am – 11:15pm	Meet with Kiribati Red Cross	Ms Meaua Tooki, Ms Mareta	RC/EB	Betio
	12:00 noon – 2:30pm	Attend Health Sector Coordination Group Meeting	Attended by Minister, Secretary, Directors of Clinical and Public Health Services, Australia, New Zealand, Taiwan, UNICEF	RC/KE/IB	Utirerei Guest House Conference Centre, Ambo Village
	3:15pm – 4:30pm	Meeting with Cuban Trained Medical Graduates over coffee	Dr Richard, Dr Elena	RC/IB	Chatterbox Café, Tobaroi Travel, Bikenibeu
	5:00pm – 5:30pm	Wrap-up, next steps, exchange of documents	—	RC/EB	AAPO
	6:30pm – 8:30pm	Consolidation of reports; dinner with visiting disability consultant	—	RC	Utirerei Guest House, Ambo Village
Thursday 12 December	9:00am	Depart Tarawa for Fiji and Australia Discussion with Australian Federal Police adviser re road safety, SGBV en route	Inspector David Jones	RC/HRF	Bonriki

Legend:

MH	Michael Hunt
EB	Erimeta Barako
IB	Iobi Batio
KE	Kakiateiti Erikate
RC	Rob Condon
MS	Mark Sayers
AAP	Australian Aid Program
AAPO	Australian Aid Project Office
HRF	Health Resource Facility for Australia's aid program

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