Note: This is a Concept Paper only and does not commit AusAID funds in anyway.

Concept Paper

Australian Assistance for Health in Kiribati, 2010-11 to 2013-14

Key Points

- Despite progress against some key indicators, Kiribati is not yet on track to achieve its health-related Millennium Development Goal (MDG) targets: improvement in infant and under-five mortality rates has recently stalled, maternal outcomes are variable, prevalence of non-communicable diseases (NCDs) is increasing, and incidence of tuberculosis and sexually transmissible infections is among the highest in the Pacific.
- Progress towards the health MDGs is hampered by systemic factors including a shortage of skilled health care workers, the age and condition of health infrastructure and teaching facilities, and difficulty meeting the recurrent costs of service delivery.
- AusAID's country strategy and programs are defined by Australia–Kiribati Partnership for Development; health is not currently a PPD priority outcome area, but will remain an agenda item in annual Partnership Talks.
- Since 2006, AusAID has supported Component 1 of the Kiribati–Australia Nursing Initiative (KANI) – a pilot program to help candidates to obtain an Australian nursing degree and access the global nursing market. Its outcomes now need to be monitored and, where necessary, the engagement of graduates in the international labour market supported. We agree with the decision not to enrol a fourth KANI cohort for off-shore training at this time.
- A package of Australian assistance for improving maternal (MDG 5) and neonatal (MDG 4) health outcomes is proposed, focusing first on urgently needed work force planning and development (through KANI Component 2) and some critical supporting infrastructure.
- This would be underpinned by an increasing level of ongoing policy engagement and dialogue, with are particular focus on: a) participating in and supporting the development of the MHMS Strategic Plan for 2012 and beyond, and b) strengthening health sector coordination in support of Government of Kiribati priorities and improved health outcomes
- Subsequently – and subject to the development of a robust MHMS Strategic Plan – assistance could expand to focus on improving early childhood health outcomes (i.e. further contributing to MDG 4), focusing especially on identified needs in childhood nutrition, immunisation and the integrated management of childhood illness.
- A budget of AUD$3.9 million over four years is available for this program of assistance.
- This could be the first phase of a longer-term coordinated commitment to strengthening the performance of the health sector and health outcomes in Kiribati
- In the meantime, health should remain a standing agenda item in the annual Partnership Talks. This will provide a formal venue to monitor health sector progress and to consider if health should be included as a new PPD priority outcome area.

Introduction

Background to the Present Proposal

1. Recent discussions between AusAID and the Kiribati Ministry of Health and Medical Services (MHMS) have identified a range of shorter- and longer-term funding needs to support health service delivery and outcomes in Kiribati, mainly addressing:

   a) health work force training and development;

   b) a range of health infrastructure and equipment; and

   c) other activities to support progress towards the Millennium Development Goals (MDGs) – in particular, MDGs 4 and 5 on maternal and child health.

2. In November 2010, Australia's Parliamentary Secretary for Pacific Island Affairs, the Hon Richard Marles MP, visited Kiribati and announced that Australia will support the redevelopment of the Kiribati School of Nursing (KSON), with a specific view to enhancing its capacity to increase the number of midwives trained.

Consultations with Partner Government and Other Stakeholders

3. From 6 to 13 January 2011, Rob Condon (Health Adviser) and Anna Gilchrist (Health Policy Manager) from AusAID's Human Development Section visited Kiribati to:

   a) undertake further analysis;

   b) consider options on how to progress components 2 and 3 of the Kiribati–Australia Nursing Initiative (KANI); and

   c) develop a coherent, efficient approach to delivering an increased level of development assistance in the health sector through a well-coordinated partnership with government, other donors and regional institutions.

   Full Terms of Reference (TORs) are included at Annex I.

4. Activities in Tarawa included:

   a) consultation with Government of Kiribati (GOK) – MHMS, Ministry of Public Works and Utilities (MPWU) and Public Service Office (PSO);

   b) consultation with UN and other development partners in-country (WHO, UNICEF, UNIFEM, New Zealand High Commission, Cuban Medical Mission) and by teleconference (UNFPA and the WHO-managed Pacific Human Resources for Health Alliance [PHRHA] and Pacific Open Learning Health Network [POLHN] in Suva);

   c) consultation with one NGO (Kiribati Family Health Association); and

   d) visits to health facilities and consultations with health workers (Nawerewere Hospital and Kiribati School of Nursing, Betio Hospital, and Bairiki and Bikenibeu Health Centres).

5. Time and weather conditions were not conducive to visiting any sub-national hospital or outer island health centre or community during the visit. It would be instructive to include this in the schedule for any subsequent visit.

6. Follow-up teleconferences were held with PHRHA nursing consultants based at the Auckland University of Technology (AUT) in New Zealand, and with the New Zealand Aid Programme (Pacific regional health).

Analysis

Country and Sector Context

Note: A more detailed country and health sector analysis is included at Annex II.

Kiribati Development Plan and National Health Strategy

7. Kiribati has a low per capita gross domestic product and increasing poverty. Development is constrained by rapid population growth, rapid urbanisation on Tarawa, poor water supply and sanitation infrastructure, youth unemployment, and high vulnerability to climate change and external financial influences.

8. The Kiribati Development Plan (KDP) 2008–2011 is strongly aligned with the MDGs, and includes health as one of its 6 priority areas. The health-related strategies of the KDP focus appropriately on MDGs 4 and 5 and disease-specific aspects of MDG 6.

9. The MHMS Strategic Plan 2008-11 attempts to draw together the intended KDP health outcomes, the work plans of UN and other development partners (each of which has a different format and time frame but has been adapted to fit into the MHMS Strategic Plan), and a range of MHMS initiatives designed to strengthen the health system.

10. In practice, most of the funded elements of the Strategic Plan reflect the work plans of development partners. Those elements of the Strategic Plan for which the MHMS has sole implementation responsibility are identified for funding through the recurrent budget.

11. A new Health Strategic Plan is due to be developed this year. It would be most strategic for this process to be completed before parliamentary elections take place in October.

Health Status and Outcomes

12. Despite progress against some key indicators, overall health status and outcomes remain poorer than in most other Pacific Island countries (PICs), and Kiribati is not yet on track to achieve its health Millennium Development Goal (MDG) targets.

13. On average, I-Kiribati have shorter life spans than those most other Pacific Island populations. In 2005, life expectancy at birth was estimated at 59 for males and 63 for females. Infant and under-five mortality rates are declining, but progress has recently stalled. Principal causes are neonatal conditions, respiratory infections, diarrhoea and malnutrition.

14. Over the last five years maternal mortality increased from an average of 1-2 per year to 4-5 per year before declining to just one reported death in 2010. This apparent recent improvement remains vulnerable to access to health services, quality of service delivery, efficiency of referral pathways, high fertility rates and low contraception use.

15. Kiribati has the highest incidence of tuberculosis in the Pacific, high rates of sexually transmissible infections (resulting in significant vulnerability to HIV) and an increasing prevalence of non-communicable diseases (NCDs).

16. As in many PICs, delivery of health services and progress towards the health MDGs is hampered by systemic factors that include a shortage of skilled health care workers (HCWs), difficulty meeting the recurrent costs of service delivery, and the age and condition of health infrastructure.

Human Resources for Health

Overview

17. Annex II includes details of the current health work force in Kiribati.

Policies and Strategies

18. At the national level, the PSO has a National HR Development Strategy in place for 2011-13, which is now guiding pre- and in-service training during that period.

19. A detailed long-term (e.g. 10-year) HRH Plan and projections are not yet available.

20. There is no national Nursing Services Plan to define geographic placement, roles, career defining qualifications and structures, and training needs projections for nurses (or other categories of health worker).

School of Health Sciences (Kiribati School of Nursing)

21. Nurses provide the backbone of the health work force, comprising about 70 per cent of all health sector employees.

22. The Kiribati School of Nursing (KSON) is located on the Nawerewere Hospital campus. It caters predominantly for I-Kiribati candidates, but may accept up to 5 trainees per year from Nauru.

23. The projected through-put of trainees at KSON and intended number of nursing scholarships sought for overseas training for the duration of the current National HR Development Strategy are summarised in Tables 1 and 2.[1] Depending on staff capacity, the number of midwifery trainees may be increased from 9 to 11 per year and the number of Medical Assistant trainees increased from 9 to 12 per year during the course of this three-year plan.

24. KSON has significant institutional capacity limitations. Its buildings are either in disrepair or condemned, teaching facilities are cramped and lack teaching aids, the library is under-stocked and not secure enough for a computer laboratory, and dormitory space is insufficient to accommodate an increased number of pre-service or in-service trainees from the outer islands.

[1] Note: The announcement by the Parliamentary Secretary referenced at paragraph 2 suggested that KSON currently trains 20 midwives per year. As noted in Table 1, the current cohort is 9 per year, although this may be increased to 11 per year in 2011-13. The School does not currently have the capacity to train 20 midwives per year (let alone 60).

Table 1: Estimated through-put of training courses at KSON each year, 2011-13

Year	Course	Number
Each year, 2011-13	Midwifery Training	9
	Public Health Training	6
	Medical Assistant (MA) Training	9
	Refresher training for Nurses and MAs through workshops and attachments	According to capacity (space, funding)
Total (minimum number of trainees)		24

Table 2. Overseas training attachments being sought for nurses, 2011-13

Year	Course	Number
2011	Bachelor of Nursing	5
	Master's program	1
2012	Bachelor of Nursing	5
2013	Bachelor of Nursing	1
	Short Courses / Attachments	According to capacity (space, funding)
	Total (minimum number of trainees)	12

25. The KSON staff establishment is 11, with two currently undertaking postgraduate studies in Nursing Education overseas. Teaching staff are relatively unfamiliar with the approaches needed to deliver a modern curriculum, which is being developed with technical assistance from the Faculty of Nursing at the AUT (engaged through the WHO-based PHRHA, and funded through the New Zealand Aid Programme).

Development Assistance in the Health Sector

26. In 2008, the Kiribati health budget was $24,188,356, equivalent to 15 per cent of total Government expenditure; 7.44 per cent of this was contributed by AusAID.

Australian Development Assistance

27. The AusAID country strategy and programs are defined by Australia–Kiribati Partnership for Development (PPD; signed January 2009). The three agreed partnership priority outcomes are:

    a) improved basic education;

    b) work force skills development; and

    c) improved growth and economic management.

28. Health is identified as one of five further priority areas that are reviewed in annual Partnership Talks and which may receive future Australian support.

29. Recent Australian support has included just over AU$2 million for the development of a centre for tuberculosis diagnosis, prevention, treatment and control on the Nawerewere Hospital campus. Other current AusAID assistance for health in Kiribati includes:

a) Several regional programs (e.g. HIV, immunisation, NCDs, specialised clinical services)

b) Small grant support to KSON (e.g. textbooks)

30. AusAID has also supported the Kiribati–Australia Nursing Initiative (KANI) since 2006:

a) Component 1 = a pilot scholarship program for three intakes of 30 pre-service students to undertake a nursing degree (mostly Bachelor or Diploma of Nursing) in Australia.

b) Components 2 and 3 include scholarships program for in-service nurses, and upgrading of KSON respectively; these two components have not yet been designed or implemented.

The structure of the KANI design is summarised in the following Box.

Component	Description
Component 1	**Scholarship program to obtain an Australian Nursing qualification up to a Bachelor of Nursing level in Australia**
	Output 1.1 Student Selection
	Output 1.2 Academic Preparation Program
	Output 1.3 Nursing Diploma Preparation Program
	Output 1.4 Certificate Level 3 and Diploma of Nursing (or equivalent)
	Output 1.5 Bachelor of Nursing (Registered Nurse qualification)
	Output 1.6 Student Management
	Output 1.7 Nurse Registration
Component 2	**Scholarship program to obtain a Nursing qualification at Australian standards in Kiribati and/or overseas**
	Output 2.1 Preparatory planning (including GOK HRH Plan, curriculum)
	Output 2.2 Scholarship program and course delivery
Component 3	**KSON upgraded to provide a higher standard of basic nurse education**
	Output 3.1 Education in Australia for KSON Nurse Educators
	Output 3.2 Scoping mission for Component 3

Note: i) KANI was not primarily designed to improve health outcomes (i.e. MDG 4, 5 or 6), but rather to contribute to the Government of Kiribati's efforts to reduce youth unemployment and to diversify the country's remittance base through emigration of skilled people accessing the global nursing market (i.e. more aligned with MDG 1).

ii) If implemented fully, KANI can have a positive impact on health in Kiribati by increasing the number of nurses trained (who may then choose to work in Kiribati) and the quality of training provided to nurses in Kiribati through KSON.

Other Development Partner Support for Health

31. UN Agencies:

a) WHO has a Country Liaison Office in Tarawa (physically located behind the MHMS on the grounds of the main hospital) which works under the oversight and support of the WHO Representative Office for the South Pacific in Suva. WHO provides regular technical assistance (TA), usually in the form of fly-in fly-out visits by WHO Suva

technical staff but occasionally tapping into WHO's wider regional and global networks. PHRHA consultants have undertaken a preliminary analysis of HR planning for Kiribati.

b) UNICEF has a field office with 11 staff members based at a 'UN joint presence' office but a large amount of management of the program occurs out of Suva. Its health program is primarily focused on child survival, nutrition and safe motherhood.

c) UNIFEM has a field office with two staff members based at the 'UN joint presence' office.

d) UNFPA and UNDP have no in-country presence – their programs in Kiribati are coordinated from regional offices in Suva.

32. Inter-governmental: SPC has no in-country presence - support is based on outreach from regional offices in Suva and Noumea and, for specific activities, Honiara.

33. Bilateral: no bilateral donor is providing broad-based health support to Kiribati. Support tends to be for one-off items or focused on a particular area.

a) Cuban support is through the provision of doctors and medical scholarships to Cuba

b) Taiwan and Japan have provided some limited support (e.g. funding the purchase of incinerators for the main hospital.

c) The European Union funded a major project (the Kir-EU project) to build health clinics on the outer islands; this has now been completed.

d) New Zealand is supporting redevelopment of the curriculum of the Kiribati School of Nursing in partnerships with AUT and WHO.

34. Non-Government: Some small NGOs are active in the health sector (e.g. Kiribati Family Health Association, Kiribati Red Cross).

Health Sector Coordination

35. Opportunities for meaningful, pro-active coordination and policy dialogue have been limited; this may contribute to the apparently fragmented approach under the MHMS Strategic Plan whereby agency plans tend to reflect agency priorities (or those of their donors). There are currently no mechanisms for more comprehensive health coordination (e.g. regular development partner [DP] meetings to improve harmonisation, or regular meetings between key DPs and the MHMS).

36. During the present visit, there was general agreement by DPs and the MHMS that such a mechanism(s) would be beneficial for the health sector in Kiribati. Improvement in the area of donor coordination could have a particularly important role to play in the development of the new MHMS Strategic Plan for 2012 and beyond. WHO could potentially play an important role in supporting the Government in this regard.

Underlying Principles for Proposed Australian Assistance

37. Any new Australian assistance for health in Kiribati should align with Government priorities as outlined in the following strategic documents:

a) the Kiribati Development Plan 2008–2011;

b) the current MHMS Strategic Plan 2008–2011 and its successor; and

c) the Australia-Kiribati Partnership for Development.

38. It is particularly important that any medium- and longer-term assistance should provide a predictable program of support for the new MHMS Strategic Plan, which is being developed this year for 2012 and beyond.

39. In keeping with the development effectiveness principles articulated in the Paris Declaration, Accra Agenda for Action and Cairns Compact, donor harmonisation is an important underlying aspect of the proposed Australian support. Australia should at all times work closely with DPs active in supporting health in Kiribati to help to implement the MHMS Strategic Plan through a well-coordinated partnership. Australia should encourage and support WHO to take a strong sector coordination role and supporting GOK.

40. Proposed Australian assistance in Kiribati should also be considered within the broader context of AusAID's approach to health across the Pacific. The draft *Pacific Health Guidance Note* provides the principles and strategic framework that will shape Australia's support for health in the Pacific as the aid program increases in size over the period to 2015; key messages from this document are summarised in Annex III. The *Guidance Note* identifies that, in order to achieve improved health outcomes in the Pacific, the quality of health service delivery needs to improve and access to health services needs to expand. Achieving this requires the following shifts:

    a) a more horizontal health systems strengthening approach, as opposed to vertical, single disease- or single issue-specific approaches, which can distort health priorities and divert resources;

    b) HRH needs to be prioritised by countries and partners;

    c) performance assessment and risk management must focus on outcomes and how best to achieve them – reliable baselines, milestones and data sources need to be identified and tracked; and

    d) regional mechanisms should be used to support regional solutions where these are more appropriate than national level actions or support – they should rarely be used to deliver specific country level support or as an expedient means of financing or dealing with issues better addressed at the country level.

Intended Purpose and Principal Outcomes

Strategic Intent (Purpose)

41. To accelerate progress towards achievement of the health MDGs in Kiribati, in particular MDG 4 (child health) and MDG 5 (maternal mortality), through targeted bilateral Australian support that is well coordinated with the work of other development partners.

Outcomes

42. The principal Outcomes of the proposed Australian assistance would be:

    a) harmonised, coordinated donor support for GOK priorities in the health sector;

    b) increased number and skills of nurses in Kiribati, including strengthened capacity for nurse training within Kiribati; and

    c) provision of critical infrastructure at the Kiribati School of Nursing and Betio hospital.

Description of Proposed Assistance

Overview

43. An initial package of assistance aimed at improving maternal (i.e. MDG 5) and neonatal (i.e. MDG 4) outcomes is proposed. This would focus initially on:

    a) urgently needed work force planning and development (in line with PPD Outcome Area 2 and KANI Components 2 and 3), and

    b) some essential elements of infrastructure to facilitate the better application of those skills.

44. Subsequently – and subject to the development of a robust MHMS Strategic Plan for 2012 and beyond – assistance could expand to focus on improving early childhood health outcomes (i.e. further contributing to MDG 4), focusing especially on identified needs in:

    a) the prevention and management of malnutrition, and

    b) the prevention (e.g. through vaccination) and management (e.g. through support for integrated management of childhood illness; IMCI) of common, serious childhood infections like diarrhoea and acute respiratory infection.

45. The logical contribution of these activities to the PPD, KDP and achievement of MDG goals and targets is summarised in the diagram in Annex IV.

46. This should be underpinned by an increasing level of ongoing policy engagement and dialogue with are particular focus on:

    a) participating in and supporting the development of the next MHMS Strategic Plan, and

    b) strengthening development partner coordination in support of GOK priorities and improved health outcomes.

Monitoring KANI Component 1

47. The first three cohorts of scholarship holders under KANI Component 1 (see Box, page 6) constitute a pilot program to explore the effectiveness and impact of this approach to establish I-Kiribati nurses within the international work force.

48. Adequate time must be allowed to monitor and, where necessary, support the engagement of current trainees in the international labour market for nurses – possibly for as long as 4–6 years. ***We therefore note (and support) the recent decision not to enrol a fourth KANI cohort for off-shore training at this time***. Kiribati has immediate health needs that are distinct from the country's wider labour market priorities and which can be supported through KANI Components 2 and 3.

Activating KANI Component 2

49. There is an immediate need to activate the preparatory stages of KANI Component 2 (Box, page 6; i.e. development of a detailed 10-year HRH Plan).

50. Noting that nurses comprise the single largest cohort of health workers and their increasing average age, the priorities include:

a) development of national HRH and Nursing Services Plans (which would define geographic placement, roles, career defining qualifications and structures, and training needs projections for all categories of health worker), and

b) completion of KSON curriculum realignment and development that has been commenced by nurse consultants from AUT (through WHO).

51. The MHMS and KSON have identified a need for targeted technical assistance in developing the HRH and Nursing Services Plans. This can build upon preliminary work undertaken by PHRHA for GOK identifying health workforce needs in Kiribati.

52. Subsequent elements of KANI Component 2 (i.e. developing nurse education to Australian standards for nurses who train and are registered in Kiribati) potentially represent a more cost-effective model than Component 1 but cannot be activated until completion of Component 3.

Activating KANI Component 3

53. We believe the time is also appropriate to activate all of KANI Component 3. This will involve upgrading and, where necessary, redeveloping KSON to provide a higher standard of basic nurse education and increase the number of trainees each year.

54. An immediate priority is the urgently needed upgrading (refurbishment and extension) of student dormitory accommodation to allow for increased student numbers from outside Tarawa.

55. Concurrently, a formal design process will also be needed, to address a full functional review of KSON (aligned with the HRH and Nursing Services Plans that will be addressed as a priority under Component 2). This design process will also need to include consideration of priority infrastructure, library and teaching aid needs to support expanded teaching capacity (i.e. extended office and teaching space, installation of POLHN computers in the library and demolition and replacement of the condemned office building located in the courtyard).

56. A small proportion of KANI Component 1 trainees have already signalled their intention to return to Kiribati from Australia on graduation and not pursue a career in the international labour market. The Independent Progress Review of KANI in 2010 noted that the skills of this cohort are more suited to Australia and other industrialised Pacific Rim countries than to the expanded primary care roles of nurses in Kiribati. KANI Component 3 will therefore also need to address the bridging training needs of KANI trainees returning from Australia to seek a place in Kiribati's domestic health work force.

Upgraded Infrastructure for Improved Delivery of Obstetric Care

57. The national referral hospital, Nawerewere Hospital, also serves as the obstetric facility for greater Tarawa (including Betio) and records about 2,500 births each year. At least 25-50 per cent of these mothers are resident on Betio or in adjacent communities across the causeway in South Tarawa.

58. To relieve congestion at Nawerewere, the design, construction and equipping of a new maternity ward at Betio Hospital could receive early support (subject to some further

consideration of construction capacity and building plans, i.e. patient capacity and flow, refinement of design appropriate to specialised function, etc).

Support for Child Survival and Improved Early Childhood Health Outcomes

59. AusAID engagement on both maternal and child health should focus on scaling-up known cost effective interventions and getting more from working with others in partnership (e.g. GAVI Alliance, Global Fund, UN Agencies, World Bank, etc).[2]

60. The principal avenue for early inputs contributing to improved child health will be through the absorption of evidence-based interventions into the KSON curricula for basic trainees and Medical Assistants (autonomous nurse practitioners) and refresher training for existing nurses.

61. Through their existing GAVI Alliance links, AusAID, UNICEF and WHO are well placed to facilitate and support applications for the introduction of new vaccines against conditions that contribute disproportionately to under-5 mortality (e.g. rotavirus and pneumococcal conjugate vaccines). The Government of Kiribati intends to apply for GAVI Alliance funding for pneumococcal vaccine in the first half of 2011 with technical assistance from UNICEF.

62. Depending on priorities of the new MHMS Strategic Plan, resources could be made available to Nawerewere Hospital for:

    a) assistance with relocation of the postnatal ward and neonatal special care unit to another ward building that will become available soon; and

    b) extension or replication of the currently very over-crowded paediatric ward.

    Both options would require an assessment and budget for replacement of some instruments and equipment.

Resourcing and Sequencing

Funding Envelope

63. Estimated AusAID funding availability to support KANI components 2 and 3 and other health-related activities (as agreed) is summarised in the following table:

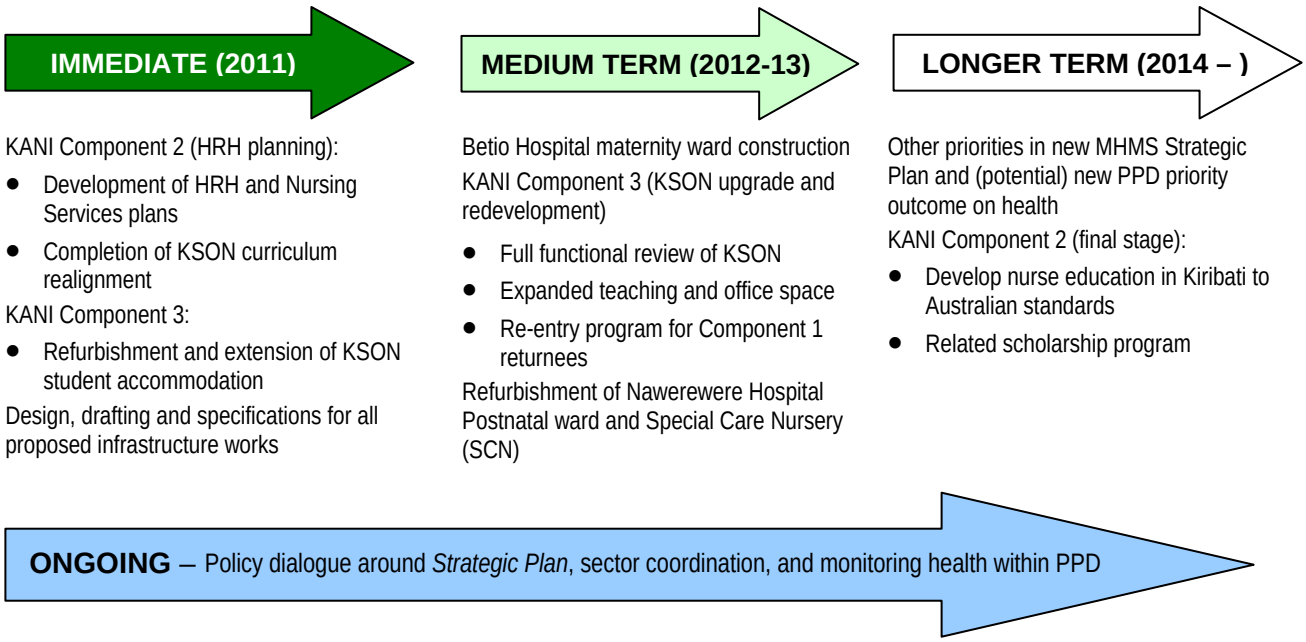
Financial year	2010-11	2011-12	2012-13	2013-14	TOTAL
AU$ million	0.135	0.80	1.00	2.00	**3.90**

64. The availability and allocation of medium- to longer-term funding and the expansion or extension of Australian support will be strongly influenced by the priorities within the new MHMS Strategic Plan and the evolution of the PPD.

[2] AusAID internal issues paper *Maternal and Neonatal Health: Key Issues and Priorities for AusAID* (May 2010)

Timing and Sequencing of Assistance

65. The suggested phasing for Australian support is summarised in the following diagram.



Future Evolution

66. It is recommended that Australian financial assistance is aligned with the Kiribati planning and budget cycle, i.e. by calendar year.

67. The availability and allocation of medium- to longer-term funding and the expansion or extension of Australian support will be strongly influenced by the priorities within the new MHMS Strategic Plan and the evolution of the PPD.

    a) We strongly recommend that health remains an agenda item in annual Partnership Talks between the Governments of Kiribati and Australia. This will provide a formal venue to monitor progress in the health sector and consider whether a new PPD priority outcome on health is needed for long term, comprehensive, coordinated support for the new MHMS Strategic Plan.

Design Considerations and Implementation Arrangements

Suggested Delivery Options

68. Based on discussions in Tarawa, concurrent delivery options are favoured:

    a) For immediate infrastructure work on the KSON and later at Betio Hospital, options for further consideration that were identified during the Tarawa visit included:

        i) accountable cash grants through the Ministry of Finance (these funds would remain under the oversight of the MHMS, with MPWU contributing design and specification expertise);

        ii) using existing managing contractors engaged by AusAID for infrastructure work in Kiribati or using managing contractors on AusAID period offer.

Technical assistance for review of the hospital building plans can be sourced through the AusAID Health Resource Facility.

b) For HRH development and strengthening the capacity of KSON to deliver the type of technical expertise envisaged under KANI Component 3, Australian funding could leverage the existing relationships already established by AUT through a service agreement with WHO South Pacific (PHRHA).

   i) WHO (PHRHA) has developed and submitted a project proposal titled *Curriculum Development and Infrastructure Support for the Kiribati School of Nursing*. The project is intended to provide funding assistance and support for KSON beyond the current New Zealand funded WHO-AUT project. The project is costed at $1,841,579 over three years (2012-14). Although it is intended to be implemented by WHO, FSMed and AUT alongside KANI Components 3 and 2, many of its approaches are consistent with those proposed in the present document. It potentially forms a basis for the design of a collaboratively funded intervention (managed by WHO South Pacific) for addressing non-infrastructure aspects of the proposed Australian assistance.

   ii) As a first step, discussion with PHRHA should be undertaken as to how this proposal could be modified to more closely both meet our objectives under KANI Components 2 and 3 and address other aspects of HRH strengthening identified in this concept note and in discussion with GOK (e.g. technical assistance for the development of a long term HRH strategy).

Sector Coordination Mechanism

69. Based on consultations to date with DPs, it is envisaged that a multi-partner sector coordination mechanism be established with a view to building harmonisation and synergy of inputs between agencies and close alignment of those inputs with the evolving MHMS Strategic Plan.

    The coordination mechanism could potentially be chaired by MHMS and include representation from:

    a) Donor agencies (i.e. AusAID, NZAID)

    b) UN (WHO, UNICEF, UNFPA, UNIFEM) and other regional development agencies (e.g. SPC)

    c) Regional medical education institutions (e.g. the Fiji Schools of Medicine [FSMed] and Nursing [FSN])

70. GOK would also be invited to attend (noting, however, that the initial purpose of the mechanism would be harmonisation and coordination).

71. The coordination mechanism would ideally meet once every month or two, with non-Tarawa-based agencies joining by teleconference.

72. There is an opportunity to use the next Kiribati-Australia Partnership talks in June 2011 to initiate the coordination mechanism and dialogue with UN agencies and other DPs.

Opportunities for Wider Participation and Partnerships

73. The TORs for the sector coordination mechanism should include options for new or emerging DPs to participate, the principles that would guide their joining, and the

responsibilities of additional joining members.

74. It is not envisaged that any NGOs would be founding members of the coordination mechanism.

Terms of Reference and Secretariat

75. Partners would also need to agree on Secretariat functions and arrangements for chairing meetings. These processes should be kept as simple as possible. TORs or functions for the Chair and Secretariat would be developed as part of initial consultations between MHMS and DPs.

76. TORs for the coordination mechanism could be developed as part of the design process, following consultation with all partners during initial meetings.

Initial Observations around Cross-Cutting Themes

Gender

77. The proposed program of assistance will support the further development of health services for women and contribute to the achievement of MDG 5.

Environment

78. Following completion of the maternity ward at Betio Hospital, it is envisaged that ambulance referrals to Nawerewere Hospital will be much less common than at present, reducing vehicular carbon emissions and wear and tear on the main road through Tarawa.

79. Some planning will be needed to address disposal of the increase in medical waste that would be generated by an obstetric facility in Betio.

80. As Kiribati has a limited manufacturing base for building materials (and none at all for hospital fittings and instruments), importation of some materials and fittings will inevitably generate a carbon footprint.

HIV Infection

81. Improved curricula for nurses and midwives will strengthen infection control practices in health facilities and contribute to improved standards of care for people living with HIV.

Disability-Inclusive Approach

82. Improved obstetric, post-natal and child care will reduce the likelihood of disabilities related to poor neonatal outcomes.

Partnership

83. The approach represents a strengthening of partnerships among donors, and between donors and GOK.

Critical Risks

Governance and Corruption

84. A 2010 Public Expenditure and Financial Accountability (PEFA) assessment by the Asian Development Bank (ADB) has highlighted concerns about the quality, transparency and completeness of financial reporting, and found systemic weaknesses in controlling expenditure. The PEFA found that GOK's strategic allocation of resources is weakened by lack of medium-term fiscal forecasts and poor links between capital investments and recurrent cost implications. For procurement, there is no systematic mechanism for collecting data on the use of open competition, no public disclosure of contracts awarded and a lack of procurement regulations. Recent improvements in the timeliness of GOK's audits means that the accounting and use of funds is subject to more detailed scrutiny, which can help to improve the effectiveness of service delivery.

85. The PEFA found that GOK has improved its management of public finances in some areas (e.g. more up-to-date audit of central government financial statements; strengthening its tax and customs administration) and other reforms are ongoing or planned (e.g. introduction of medium-term budgeting and the reform of the state owned enterprise sector). GOK has developed a draft Public Financial Management (PFM) plan which is being assessed. Once adopted this will support GOK to better manage future revenues effectively to achieve overall policy objectives.

Institutional Capacity

86. To compensate for any lack of technical experience in the MPWU design team, AusAID may consider mobilising some technical assistance for quality assurance of the design and specification work (potentially through the AusAID Health Resource Facility) before the tendering and commencement of any construction work (see also paragraph 68).

87. Implementation arrangements should note the current capacity of the AusAID country office to manage a number of cash grants to GOK at the same time as an in-country work force development program.

Next Steps

Follow-up Consultations

88. It would be useful to undertake a follow-up visit to both Fiji and Kiribati in April. This would focus on additional consultations with Suva- based DPs and determining the technical assistance needs of GOK in relation to development of the new Strategic Plan.

89. The next Partnership talks, due to be held on 29 June 2011, represent a good opportunity to confirm GOK and DP commitment to the health programming new partnership arrangements.

Recommendations

Findings of the Concept Paper Peer Review

90. This concept paper underwent internal AusAID peer review on 11 February 2011. The review group included Tarawa Post (Joanne Craigie; Michelle Rojas; Kakiateiti Erikate), Kiribati Desk (Nic Notarpietro; Christine Bouchard); the Health and HIV Thematic Group (Beth Slatyer), the Pacific Economics Adviser (Rob Harden), the Pacific Health Adviser (Rob Condon) and Human Development Section (Anna Gilchrist).

91. The review group agreed that short- and medium-term work should progress in line with the concept note. Whether or not the longer-term options identified are progressed depends on factors such as the development of a new MHMS Strategic Plan and consideration of health programming under the Australia-Kiribati Partnership for Development.

92. The review group noted that AusAID staff resources to achieve successful engagement in the health sector in Kiribati are limited and expectations as to what can be delivered without additional resources must be kept realistic. Implementation will need to leverage other partners as much as possible (e.g. WHO leading on DP coordination in Kiribati; potentially supporting the WHO/PHRHA health workforce proposal). It was noted that regular input from the Pacific Health Adviser will be needed for the foreseeable future.

93. The review group identified three options for supporting the short-term infrastructure work included in this concept note (i.e. dormitories and facilities at KSON, maternity ward at Betio hospital) that will be explored further for feasibility.[3] These are: (i) accountable cash grants to the Ministry of Labour; (ii) funding through the WHO/PRHRA proposal - this includes a small infrastructure component which could potentially be built upon; (iii) using an existing managing contractor engaged by AusAID for education infrastructure.

94. It was recommended that a follow-up trip should be undertaken by Rob Condon in April 2011, including:

    a) a visit to Suva meetings to meet (i) WHO/PHRHA to discuss their proposal; (ii) UNFPA as their Kiribati programming is managed from Suva; (iii) Fiji Schools of Nursing and Medicine to discuss their relationship with KSON;

    b) a visit to Kiribati to progress the infrastructure issues and meet with government and development partners, particularly in relation to the development of the new MHMS strategic health plan.

[3] The outcomes of peer review were reviewed by the AusAID Minister Counsellor for the Pacific, who further recommended that infrastructure be supported in a step-wise fashion; in this way, lessons learned about design and construction in the Kiribati context could be applied incrementally. Under this recommendation, KSON redevelopment would be the first to be initiated, followed by (and subject to prioritisation in the new Strategic Plan) the Obstetric Ward at Betio and other ward space at Nawerewere Hospital,

Annex I –
TORs for the first Kiribati trip (6-12 January 2011)

Background

More support for health services and systems is required to improve Kiribati's progress towards the health MDGs [4] (4 – child mortality; 5 – maternal health; 6 – HIV, malaria and other diseases). Of particular concern is that Kiribati has recorded a worsening in maternal mortality rates in recent years.

In recognition of this, the new AusAID budget measure *Investing in Health* has an indicative allocation for Kiribati of $4.6 million over four years (2010-11 to 2013-14) that can be used for bilateral health support. Budget measure funding from *Investing in Health* to the Pacific is intended to support all the health MDGs but with a particular focus on achieving maternal and child health outcomes (MDGs 4 and 5). In keeping with the Paris Declaration, Accra Agenda and Cairns Compact, AusAID wishes to maximise the use of this funding by developing a well-coordinated partnership with the Government of Kiribati (GoK), other donors and regional institutions involved in the health sector.

On 30 November 2010, Australia's Parliamentary Secretary for Pacific Island Affairs, the Hon Richard Marles MP, announced that the Australian Government will support the redevelopment of the Kiribati School of Nursing so it can deliver internationally recognised courses in basic nursing. Specifically, Mr Marles announced that Australia will assist with the expansion of the GoK midwife training program, boosting the number of midwives trained from 20 to 60 per year by 2015.

Current AusAID support for health in Kiribati

AusAID supports health in Kiribati through several regional programs (e.g. HIV, immunisation, NCDs, specialised clinical services) via other partners such as the Secretariat of the Pacific Community, UNICEF and the Royal Australasian College of Surgeons. Previous AusAID funding support for health in Kiribati has included small grant support to the Kiribati School of Nursing and support for tuberculosis prevention and treatment.[5]

AusAID has also provided support for the Kiribati Australia Nursing Initiative (KANI) since 2006, which includes a pilot scholarship program for three intakes of approximately 30 pre-service students to undertake a nursing degree in Australia (Component 1). Components 2 and 3 of KANI include a scholarships program for in-service nurses, and upgrading of the Kiribati School of Nursing (KSON) respectively. These two components have not yet been designed and it was recently agreed that future support of the KANI should focus on delivering support through the design of components 2 and 3 and therefore should be considered in this situational analysis.

Potential areas for increased AusAID support and analysis required

Priorities that have been identified by the Kiribati Ministry of Health include:

1. capacity building of health staff – human resources plan;

[4] Source: 2010 *Pacific Regional MDG Tracking Report*
www.forumsec.org.fj/resources/uploads/.../PIFS_MDG_TR_**2010**1.pdf

[5] Health is not identified as one of the priorities under the Partnership for Development between the Australian and Kiribati governments.

2. refurbishment of KSON (e.g. building, computers, library);
3. creating a new maternity unit at Betio Hospital; and
4. increasing to 60 midwifes trained annually.

These priorities fit within Outcome 2 of the *Australia-Kiribati Partnership for Development* which is focused on workforce skills development.

In order to implement KANI components 2 and 3, several pieces of work need to be done in the first half of 2011, including:

- support to the MoH for nurse workforce planning, and foundation work to ensure positive integration of KANI nurses into the Kiribati health workforce;
- increased engagement with key stakeholders including Ministries (Health and Labour), KSON, Fiji School of Nursing, WHO, New Zealand Aid Programme, the Public Service Office to identify who will lead on the various projects and to ensure work is coordinated;
- investigate regional options for scholarships (e.g. to the Fiji School of Nursing);
- build on the work completed by New Zealand Nurse consultants and WHO to institutionally strengthen the Kiribati School of Nursing to deliver regionally-recognised nursing courses; and
- assist the Ministry of Labour to form the necessary relationships with nurse employers in Australia to promote the capabilities of KANI-trained nurses.

Purpose

To provide an analysis of how best to improve health workforce development and of additional options for improving maternal and child health outcomes in Kiribati, particularly in relation to existing commitments made by AusAID.

To initiate a conversation with GoK and other development partners about how to ensure the various health support to Kiribati is strategically directed and well coordinated, and who is best placed to lead work to ensure this and the roles of other donors.

The work covered by these ToRs can begin to develop a programming structure around the above. The visit will be the first in a series of sequenced stages to bring development partners and the GoK together to agree a coordinated approach.

Objectives

a) To provide an analysis of how to progress KANI components 2 and 3.
b) To consider options for further Australian support for the health sector in Kiribati (through a well-coordinated partnership with government, other donors and regional institutions), with a focus on improving maternal and child health outcomes.

Scope

The visit and subsequent report will need to include the following:

- analyse the needs and capacity of the Kiribati health sector in terms of workforce development and child and maternal health and how AusAID can align with GoK health priorities and priorities agreed through the *Australia-Kiribati Partnership for Development*;
- identify options for progressing commitments under Components 2 and 3 of KANI program;

- consider priorities identified by the Kiribati Ministry of Health identified in the ‘Background’ paragraph of this terms of reference;
- consider how AusAID can work with donor partners based in Kiribati to implement the GoK’s national health plan, in a coordinated, collective way to avoid fragmentation in the health sector; and
- consider how AusAID’s engagement in the health sector should be monitored and evaluated.

Reporting

Development of a Mission Report (up to 15 pages). This should cover the issues outlined under ‘Scope’ above.

Annex II –
More Detailed Country and Sector Context

Political Economy and Development Context

Kiribati is one of the most remote and geographically scattered countries in the world, comprising 33 islands spread over 3.5 million square kilometres in the central Pacific. The population of around 97,200 people live on 20 inhabited coral atolls and a single volcanic island. The total land area is less than 800 square kilometres.

Kiribati has been a democracy with a 46-seat parliament since achieving independence from Britain in 1979. The next election is due in October 2011.

The Kiribati economy is volatile and extremely vulnerable to external financial influences. It is highly dependent on: earnings from the Revenue Equalisation Reserve Fund (the trust fund established in the 1950s to invest royalties from the now-defunct phosphate industry); official development assistance (about 25 per cent of GDP); the sale of fishing licenses to foreign fleets (about 20 per cent of GDP); and remittances (mainly from I-Kiribati nationals working in the international maritime industry; 10-20 per cent of GDP). Export earnings (mainly from copra) are equivalent to just 3 per cent of GDP. Many staples – including food, water and fuel – need to be imported.

With most of the country just a few metres above sea level, Kiribati is highly vulnerable to natural disasters (e.g. tsunami) and faces long term susceptibility to climate change and rises in mean sea level. The President has been a vocal advocate on the world stage for vulnerable small island states and, in June 2008, publicly declared that Kiribati citizens would eventually need to resettle in larger Pacific island country metropolitan centres or in developed countries of the Pacific Rim. He also spoke at the 2010 Copenhagen conference on climate change.

The Kiribati Development Plan 2008–2011 is strongly aligned with the Millennium Development Goals (MDGs) and the principles of the *Mauritius Declaration* on small island states and the *Pacific Plan*. The KDP prioritises 6 policy areas: (i) human resource development (including education quality, standards and retention), (ii) economic growth and poverty reduction, (iii) health, (iv) environment, (v) governance, and (vi) infrastructure.

The focus of the Government of Kiribati on climate change issues on the international stage may have diverted attention from its provision of basic services in the infrastructure (including clean water, sanitation and housing), education and health sectors.

Social Determinants of Health [6]

Kiribati is one of the poorest countries in the Pacific, with a *per capita* income around AU$2,000. Low *per capita* income is closely associated with childhood malnutrition. Absolute poverty is rare as cultural factors and a historically egalitarian society mean that disadvantaged members of the family or community are generally provided with basic food and shelter.

The islands comprising South Tarawa have become the most densely populated in the Pacific, with about 45,000 people living on a total land area of 16 km^2; the island of Betio at the

[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. The social determinants of health are mostly responsible for health inequities seen within and between countries. (Source: http://www.who.int/social_determinants/en/)

western end of the atoll has more than 10,000 people living on a land area of just over 1 km^2. Standards of housing are variable but generally poor. Over-crowding and poor ventilation contribute to the ready transmission of communicable diseases like tuberculosis (TB), other acute respiratory infections, diarrhoea, skin diseases and conjunctivitis.

Water supply and sanitation facilities are rudimentary on the outer islands and are particularly problematic in the crowded urban areas of South Tarawa. The thin underground fresh water lenses are fragile and vulnerable to faecal contamination and increasing salinity. On Tarawa, about two-thirds of the population use either the lagoon of the ocean beaches for basic sanitation and only one-third has access to any improved type of sanitation. Outbreaks of cholera and typhoid have been documented on Tarawa since the 1980s and outbreaks of diarrhoeal illness and sporadic cases of typhoid continue to occur. Capacity for solid waste management and recycling is limited, and there is just one Government veterinarian providing services mainly for domestic animals.

Education participation is strong, with 97 per cent of children aged 6–14 years enrolled in school, however quality is an issue. In 2007, only half of year 6 students were found to have satisfactory or above literacy (in Kiribati) and only 18 per cent had satisfactory or above numeracy. The Government provides free primary education, and churches also play a role in the education system. Post-primary education outcomes are poor; the University of the South Pacific (USP) campus on Tarawa focuses mainly on providing bridging courses to bring high school graduates up to the level required by the region's tertiary institutions.

UNICEF and WHO have supported the development of a national Child Survival Strategy, modelled on the framework of their Regional Child Survival Strategy. No early childhood development policy was identified during the mission.

Although Kiribati has signed the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), gender outcomes are mixed; a recent SPC study [7] highlighted high rates of domestic violence against women and children. Women's economic empowerment is limited by the fact that they work mainly in the informal economy.

Arable land is limited, and increasing soil salinity is further reducing the amount of land available for cultivation. Although we found no studies documenting the nutritional quality of local agricultural produce, the environmental context suggests that micro-nutrient deficiency is likely and would contribute to childhood malnutrition.

The public sector includes 24 state owned enterprises and provides two thirds of formal employment; staff numbers have been frozen for several years and pay increases limited. The private sector consists mainly of small businesses – only two are large enough to employ more than 200 people. There are limited opportunities for school-leavers, and therefore high levels of youth unemployment.

Health Status and Outcomes

Despite progress against some key indicators, overall health status and outcomes in Kiribati remain poorer than in most other Pacific Island countries. Kiribati is subject to a double burden of disease from both communicable and non-communicable diseases.[8] Indicators suggest that the health status of people living in South Tarawa is now worse than that of people living in the Outer Islands.

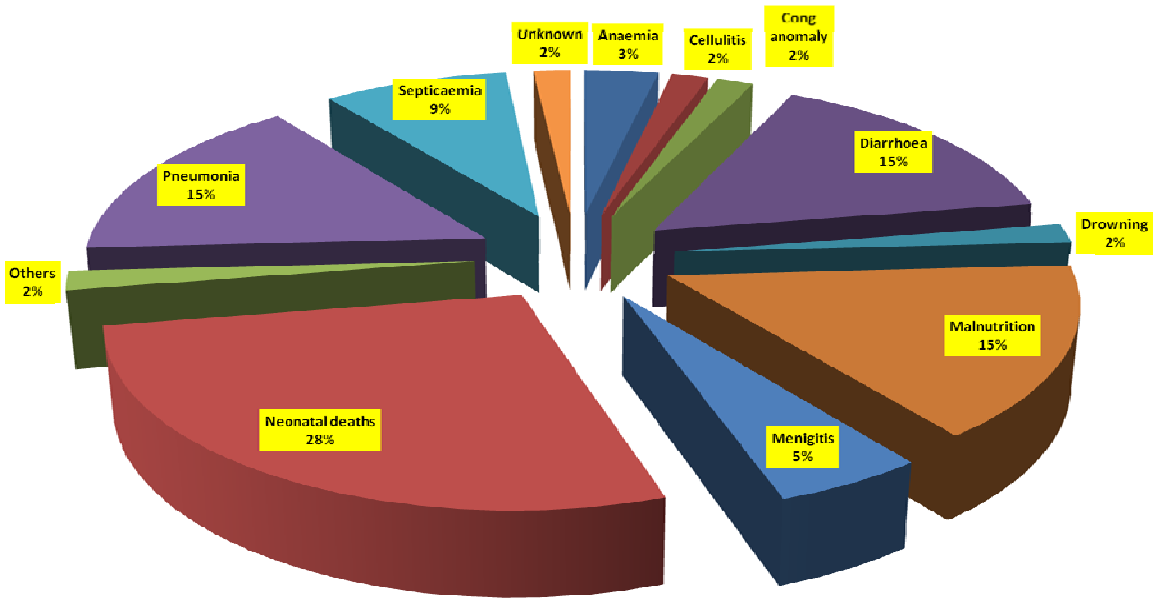
---

[7] Kiribati Family Health and Support Study: A study on violence against women and children (2010) http://www.spc.int/hdp/index.php?option=com_docman&task=cat_view&gid=89&Itemid=44

[8] 2010 Pacific Regional MDG Tracking Report - http://www.forumsec.org.fj/resources/uploads/attachments/documents/PIFS_MDG_TR_20101.pdf

MDG 4 (child health): There has been significant reduction in the under-five mortality rate (U5MR), from 88 per 1,000 live births in 1990 (the MDG 4 baseline year) to 66 per 1,000 in 2004 and 48 per 1,000 in 2009 – a rate that is still amongst the highest in the Pacific. There is also evidence that progress may have stalled recently as U5MR increased slightly in 2010, to 50 per 1,000.[9] Conservative estimates indicate that under five mortality still represents about 13 per cent of all deaths in Kiribati between 2000 and 2005 and, of all these under five deaths for the period, about 75 per cent died within the first week of life.[10] The principal causes of under five mortality (Figure) include neonatal conditions (approximately 28 per cent), pneumonia, respiratory diseases and malnutrition (approximately 15 per cent each, with malnutrition also contributing to other morbidities). Coverage of routine vaccines for one year olds has increased to greater that 70 per cent;[11] however progress is heavily dependent on donor funding.

Figure – Principal causes of Under-5 Mortality, Kiribati, 2005-08



Source: Ministry of Health and Medical Services, 2010

MDG 5 (maternal mortality): Kiribati's small population and therefore small absolute number of maternal deaths means that rates are often unreliable and may not accurately reflect trends in maternal mortality. Over the last five years, attendance by skilled attendants at births has increased. Over the same period, maternal mortality increased from 1-2 per year to 4-5 per year before declining to just one reported death in 2010. This apparent recent improvement is vulnerable to access to health services, quality of service delivery, efficiency of referral pathways, high fertility rates and low contraception use.

[9] UNICEF regards a country as on track to meet its MDG 4 target if the U5MR is currently < 40 per 1,000 and/or the average annual rate of reduction (AARR) in U5MR is at least 4 per cent. In Kiribati, the AARR is about 1.6 per cent. To meet the MDG 4 target (U5MR < 2/3 of the 1990 baseline), Kiribati would aim to reduce its U5MR to below 30 per 1,000 live births by 2015.

[10] MHMS 2009: Kiribati Child Survival Strategy 2008-2012

[11] http://www.unicef.org/infobycountry/kiribati_statistics.html

MDG 6 (HIV, malaria and other diseases): Incidence and prevalence rates of tuberculosis in Kiribati are the highest in the Pacific, a problem exacerbated by domestic overcrowding, especially in South Tarawa. Kiribati has high rates of STIs and therefore high vulnerability to HIV. While progress is being made on prevention and treatment of tuberculosis and HIV, the programs supporting this are highly dependent on external funding by development partners[i].

In addition to a significant burden from communicable diseases, the prevalence of non-communicable diseases is increasing due to factors such as a very high smoking rate (e.g. 70 per cent of males between the ages of 30 and 54 are regular smokers), over-nutrition and decreased physical activity. It is estimated that 20 per cent of the adult population has diabetes and diseases of the circulatory system are now the second leading cause of mortality.[12]

Health Systems Development Context

The health system in Kiribati is publicly funded and managed, and services (including medications and other consumables and) are provided free of charge.

In 2008, the Kiribati health budget was just over AU$24 million – about 12.7 per cent of GDP. Of this, GOK contributed 54 per cent (representing just over 13 per cent of total Government expenditure), while AusAID contributed around 7.4 per cent.

The MHMS has a comprehensive framework of policies, plans and legislation. Some of this has been developed outside the Ministry through donor-assisted programs and, although the level of ownership is good, capacity to implement and monitor is variable.

Primary care, prevention and health systems development remain the cornerstones of national health plans and regional assistance to health sector development in the Pacific. In Kiribati, this is reflected in the structure of the current MHMS Strategic Plan and the priorities of bilateral and regional development partners.

Clinical services (including treatment and rehabilitation costs for chronic diseases) and clinical work force development are important (and prominent) components of the health system. They have attracted support from the Governments of Australia (through a long-standing visiting specialist program managed by the Royal Australasian College of Surgeons [RACS]), Cuba (through a program providing resident doctors in Kiribati and medical student scholarships in Cuba; see below) and Taiwan (through a visiting specialist scheme similar to that managed by RACS) and occasional international NGOs.

There is a risk that a proliferation of activities provided by medical staff from more affluent health systems in support of secondary and tertiary care will: 1) divert attention from primary and preventive care and health systems, and 2) start to draw more recurrent budget and donor resources into expensive 'shopping lists' for monitors and instruments developed by resident and visiting specialists.[13] [14]

---

[12] WPRO Country Profile – Kiribati. http://www.wpro.who.int/countries/2010/kir/

[13] In the absence of a fully costed, integrated annual operational plan for the health sector, it has not been possible to calculate the proportions of GOK and donor resources that are allocated to secondary and tertiary health care compared with primary and preventive care.

[14] A new Australian-funded Strengthening Specialised Clinical Services in the Pacific (SSCSiP) program will be based at the Fiji School of Medicine (FSMed) and will take over the organisational and planning aspects of the current RACS program (but not the service delivery aspects). The coordination team will include a health planner who will be available to assist the MHMS in planning, projecting and costing secondary and tertiary services within an overall budget envelope.

In parallel with the Government system, a traditional health system exists under which traditional healers and traditional birth attendants (TBA) provide local medicines, massage and antenatal, delivery and postnatal care. Most people use both systems, but there is no formal coordination or collaboration between the two systems. Health workers reported that the majority of recent maternal deaths and an unquantified (but probably significant) proportion of neonatal deaths followed delivery either supervised by a TBA or took place at home with only a family member in attendance.

As in many PICs, delivery of health services and progress towards the health MDGs is hampered by systemic factors including a shortage of skilled health care workers (HCWs), difficulty meeting the recurrent costs of service delivery, and the age and condition of health infrastructure

Human resources for health (HRH), governance and development partner coordination are discussed below. There was not time during the recent mission to explore procurement and supply management or the health information system (HIS); however, development partners and MHMS informants alike cautioned us on the quality of available data.

Human Resources for Health

The HCW-to-population ratio varies considerably around the country but, at one nurse per 300 people and one doctor per 2,500 people, the overall ratio of 3.76 per 1,000 is slightly above the WHO-recommended minimum of 2.5 per 1,000.

Nurses provide the backbone of the health work force, comprising about 70 per cent of all health sector employees. There are 386 approved nursing positions for 2011 (but a shortfall of 59 nurses to fill them, often filled by retirees). There is no national Nursing Services Plan to define geographic placement, roles, career defining qualifications and structures, and training needs projections for nurses (or other categories of health worker).

There are currently 39 doctors in-country (including 9 specialists and 5 community physicians from Cuba). The GOK pays all in-country costs (accommodation and salary) for the Cuban doctors, while the Government of Cuba funds air fares. The Cuban medical mission is keen to expand to 32 doctors but is constrained by available funding for air fares.

A reciprocal program sees I-Kiribati high school graduates awarded scholarships to study in Cuba. So far, 32 medical students have travelled to Cuba; of these, 18 are in their third of six years of study, 12 are in first year and two have become pregnant and returned to Kiribati. The Cuban medical mission is considering allowing the I-Kiribati medical students to undertake the final year of their course at the national referral hospital in Tarawa (Nawerewere Hospital) under the supervision of locally-placed Cuban specialists.

The Human Resources for Health (HRH) Knowledge Hub at the University of Sydney estimated that, in 2009, there were 134 health workers from other categories and 32 MHMS administrative staff.[15] Other categories of health worker include:

- dentists and technicians (18);
- pharmacists and technicians (22);
- environmental and public health workers (13); and
- laboratory technicians (27)

[15] University of New South Wales School of Public Health and Community Medicine. *Mapping Human Resources for Health Profiles from 15 Pacific Island Countries*. Report to the Pacific Human Resources for Health Alliance from the Human Resources for Health Knowledge Hub, June 2009.

Training for allied health workers and technicians is mainly on-the-job and/or by distance and flexible learning via POLHN (with laboratory staff showing a strong up-take of the on-line POLHN diploma courses).

Factors contributing to the shortage of health professionals include:[16]

a) emigration of skilled health personnel;

b) a lack of effective HRH policies and planning;

c) relatively inadequate numbers of students completing professional training;

d) pregnancy, obtaining an overseas scholarship, a relatively early retirement age of 50 years and death during the period of employment; and

e) low salaries, poor working conditions and limited opportunities for professional development compared with higher income Pacific Rim countries.

[16] Pak S, Tukuitonga C. *Towards Brain Circulation: Building the Health Workforce Capacity in the Pacific Region* (NZAID, November 2006)

Annex III –
'Key Messages' from the Draft Pacific Health Guidance Note

The situation

- Non-communicable diseases and their complications are now responsible for more than three of every four deaths across the Pacific islands region. Their prevalence is growing and they will continue to influence health outcomes over at least the next two generations – yet the bulk of donor funding for health in many countries continues to be oriented towards infectious diseases.
- There is overwhelming evidence that investing in the health of women and girls means investing in future generations as well as in the health of society today – yet women in the Pacific continue to die of preventable and treatable complications in pregnancy and childbirth, often because of delays in receiving required care.
- In many Pacific island countries, child mortality rates have not improved since 2000 and in some countries they have deteriorated – yet the most common causes of child mortality (diarrhoeal disease and pneumonia) are preventable and treatable.
- Most Pacific island governments spend more per person on health services than other countries with similar levels of income – yet poor planning and inappropriate targeting (e.g., focusing on curative rather than preventive and primary services) means needed services often fail to reach the poor.

What needs to change?

Basic health services need to be available to all communities at all times to achieve improved health outcomes (notably the Millennium Development Goals and Pacific Partnership for Development targets). In the Pacific, the quality of health service delivery needs to improve and access to health services needs to expand. This requires a strong, service oriented health system that is staffed by quality health workers, resourced with drugs, blood, equipment and communication tools, and informed by information systems that feed back relevant data to ensure service improvements over time. In the Pacific, achieving this requires the following shifts.

A more horizontal health systems approach is needed – an approach that supports health system *functions* (such as long-term care for chronic diseases). Vertical or silo approaches to particular *diseases* or issues can distort health priorities and divert resources, and achievements often regress once dedicated funding ceases. Health systems must also be viewed as a whole, as weaknesses in one area can constrain progress in others. A whole-of-government perspective is needed and cross-sector linkages need to be understood.

Human resources for health need to be given priority by countries and by donor partners – without effective workforce planning and management, health outcomes are unlikely to improve.

Performance assessment and risk management must focus on outcomes and how best to achieve them. Reliable baselines, milestones and data sources need to be identified and tracked.

Regional mechanisms can only be effective if used to support regional solutions that are more appropriate than national responses. They should not be used to deliver country level support or as an expedient means of financing or dealing with issues better addressed at the country level. In the interests of better health outcomes and improved aid effectiveness,

the regional architecture and regional processes for health in the Pacific are in urgent need of streamlining and coherence.

How Australia can help

Australia must focus on helping countries to bring all health sector resources together, ideally under one plan, within a single budget and with a single performance assessment framework, equipping them to function better within their constraints. AusAID must focus on:

- Helping improve the capacity of governments to plan and manage their entire resource envelope – by engaging in effective, inclusive dialogue; undertaking effective analysis of context to improve the evidence base for decision-making and understanding of institutional challenges, incentives etc; and aligning or integrating its external support within national systems.
- Considering issues of policy first (within and beyond the health sector), and then supporting technical and managerial needs within that context.
- Maximising the impact on service delivery – this is best done by working bilaterally in support of national health systems.
- Engaging with regional and global organisations based on analysis of their strengths, mandate and track record, and ensuring they are not drawn into unfamiliar roles to suit donor interests.
- Helping countries meet the recurrent costs of operating their health sector – supporting them to use their available resources wisely and providing financing into their system to meet vital but genuinely unaffordable costs.
- Using broader delivery mechanisms (such as program-based and sector-wide approaches, recurrent cost financing, direct budget support, pooled funds) – to achieve better continuity and outcomes by ensuring aid funding is predictable, of appropriate duration, and appropriately integrated with other available resources in a single budget.
- Identifying innovative alternatives to providing services that are not cost-effective to provide locally, and supporting them over the long term (e.g., long-term access to referral to Pacific Rim centres for certain services, visiting specialists, telemedicine and organisational links between countries).
- Monitoring and assessing outcomes rather than inputs and outputs – through measurement of a small number of relevant indicators, preferably those that national systems themselves use.

Annex IV –
Logic (Cause-and-Effect) Diagram of Proposed Assistance