THE PRIMARY HEALTH CARE SYSTEM OF THE REPUBLIC OF KIRIBATI

A PRIMARY HEALTH CARE PERFORMANCE INITIATIVE ASSESSMENT

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WORLD BANK GROUP
Health, Nutrition & Population

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Report prepared by the World Bank in consultation with the
Ministry of Health and Medical Services, Government of Kiribati

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ACKNOWLEDGMENTS

This report presents the key findings of the Primary Health Care Performance Initiative assessment in the Republic of Kiribati, which was completed by a World Bank team led by Manuela Villar-Uribe and Wayne Jeremy Irava in collaboration with the Ministry of Health and Human Services of the Republic of the Marshall Islands. Qualitative data collection and analysis was led by Valeria Cruz-Villalba with support from Iobi Batio. Quantitative data analysis and curation were led by Marwa Ramadan. Cameron Feil, Awa Diallo, and Latifat Okara provided analytic input and writing support to this report. Diego Hernan Vapore provided design support. Lucy Hartshorn, Caitlin Noonan, and Baldeep Dhaliwal also provided critical input at different phases of the assessment.

The team is grateful for the outstanding leadership, support, and guidance provided by the Ministry of Health and Medical Services, Kiribati – Dr. Tekeua Uriam (Director Hospital Services), Ms. Ereti Timeon (Director Public Health), Ms. Helen Murdoch (Director Nursing Services), Dr. Tanebu Tong (Deputy Director Public Health), Dr. Alfred Tonganibeia (Deputy Director Hospital Services), and Ms. Toata Titaake (Deputy Director Nursing Services). They provided valuable input and mobilized support for the assessment's success. The team also thanks the key informants interviewed for their time and contributions, without which this assessment would be incomplete.

ABBREVIATIONS

ANC	Antenatal care
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CSO	Civil society organization
DPT3	Diphtheria-pertussis-tetanus, third dose
EHR	Electronic health record
GBV	Gender-based violence
GDP	Gross domestic product
HIES	Household income and expenditure survey
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
MHMS	Ministry of Health and Medical Services
MICS	Multiple Indicators Cluster Survey
MWYSSA	Ministry of Women, Youth, Sport, and Social Affairs
NCD	Noncommunicable disease
NGO	Non-governmental organization
PHC	Primary health care
PHCPI	Primary Health Care Performance Initiative
RMNCH	Reproductive, maternal, newborn, and child health
SARA	Service Availability and Readiness Assessment
SRH	Sexual and reproductive health
TB	Tuberculosis
UHC	Universal health coverage
UNICEF	United Nations Children's Fund
VSP	Vital Signs Profile
WHO	World Health Organization

EXECUTIVE SUMMARY

The assessment of Kiribati's primary health care (PHC) system, carried out by the World Bank in collaboration with the Government of Kiribati under the Primary Health Care Performance Initiative (PHCPI), marks a unique opportunity to identify the system's strengths and gaps and to catalyze further improvements. The PHCPI tools, including the Vital Signs Profile (VSP) methodology, provide important insights into the country's PHC system and generate actionable policy recommendations for improvements.

METHODOLOGY

Built on the belief that PHC is the cornerstone of sustainable development, the PHCPI has supported Kiribati and other countries in efforts to improve their PHC systems through measurement. PHCPI teams work closely with governments and development partners that are looking to strengthen PHC; they help governments analyze data and provide the information and support they need to drive evidence-based improvements.

As part of the PHCPI, a VSP was developed for Kiribati using the latest available quantitative data and information gathered from comprehensive document reviews, as well as in-depth interviews with multiple health sector actors. The process synthesized qualitative data (based on interviews with diverse stakeholders representing the Ministry of Health, allied health sector agencies, civil society organizations, and local governments) with quantitative data from national administrative databases, health and economic country surveys, and global databases of the World Bank and World Health Organization. Drawing on these diverse data sources, the VSP provides important insights across multiple levels in Kiribati's PHC system. The VSP illustrates the strengths and weaknesses of Kiribati's PHC system and provides the foundation for actionable policy recommendations for improvement. The VSP results are mapped to key

PHC domains and sub-domains: financing, capacity (including governance, inputs, and population health management), performance (including access, coverage, and quality), and equity. Each is measured through best-practice indicators derived from qualitative and quantitative data sources.

VITAL SIGNS PROFILE

Financing: While health system-level indicators demonstrate a continued commitment to health, data on the financing of the PHC system is unavailable. It is important that future efforts are made to routinely collect and disaggregate information on PHC financing. This is especially important for understanding how to fund and allocate resources for PHC effectively through indicators such as the level of overall PHC spending and funding allocation across levels of care and individuals.

Capacity: In the absence of strong quantitative and globally comparable data sources for measuring core PHC capacities, analysis of the capacity domain used a mixed-methods assessment approach that scored 33 measures of specific PHC systems, inputs, or service delivery elements from low to high.

Regarding **Governance,** the VSP assessment identified a strong policy foundation for PHC through the development of strategic policies such as the National Strategic Plan (2013–23) and upcoming Health Sector Plan. However, Kiribati does not have a single focal point or unit dedicated to PHC within the Ministry of Health and Medical Services (MHMS), thus limiting coordination and integration. There are also several opportunities to advance the quality management infrastructure by advancing on ongoing initiatives and engaging patients, families, and communities.

For **Inputs,** this analysis found that the density and distribution of PHC facilities is well understood, which translated into a strong understanding of the population's health needs. However, there are significant challenges with supply chain management for drugs and supplies, as the current

management system is not operational, and staff are not trained on supply chain management. There are also challenges in ensuring that health visits are made systematically, as there are separate processes for outpatient visits and vertical health programs. Facilities also lack autonomy over their budgets, which results in significant delays when requesting supplies, drugs, and maintenance.

Although not systematic, community groups are often solicited for their inputs in health planning; however, coordination and communication can be limited, resulting in fragmented efforts for **population health management.** Regarding **facility management,** staff used to receive regular management training, but this has been discontinued. There are also bi-annual supervision assessments, which score staff and supervisors on leadership, budgeting, and planning.

Performance: The performance domain relates to the ability of a PHC system to provide high-quality services to populations in need without financial or geographic barriers.

There are limited barriers to **accessing** care, as 75 percent of households were able to seek care when needed and 79 percent travel less than 30 minutes to the nearest health facilities; however, longer travel times were slightly more likely to be reported by those living on the main island (24 percent of households) compared to the outer islands (21 percent of households).

The **coverage** of essential PHC services is a strength of the PHC system, although further efforts are required to adapt to new challenges. Specifically, there are high levels of reproductive, maternal, newborn, and child health (RMNCH) coverage, including care-seeking for pneumonia (87 percent) and diphtheria-pertussis-tetanus coverage (92 percent). However, recent data indicates that 15 percent of patients with noncommunicable diseases (NCDs) are treated.

Concerning **quality,** specifically comprehensiveness, this analysis found large variation in the availability of NCD (93 percent), RMNCH (71 percent) and infectious disease (47 percent) services. Moreover, data for four sub-domains of quality, competence, availability, and provider competence were unavailable at the time of this assessment.

To overcome the challenges identified in the VSP, the following steps are recommended for Kiribati:

1. **Strengthen governance to support comprehensive, integrated PHC services that meet population needs.** This includes supporting the implementation of the Health Strategic Plan by establishing a clear definition and scope of PHC services; developing a PHC unit or focal point within the MHMS to improve care coordination, integration, and the effective delivery of health services; involving civil society in policy development and implementation; and establishing clear roles and responsibilities for government agencies to address multi-sector challenges such as NCDs.

2. **Strengthen information systems to better manage resources and improve performance monitoring.** This includes establishing an auditing process to ensure that essential inputs are consistently available; enhancing coordination between the MHMS, PHC facilities, and outer islands to promote coordination; and routinely collecting facility-level data through a unified health management information system and centralized data aggregation at the national level.

3. **Invest in the quality of care to effectively enhance PHC services.** This includes enhancing the capacity of PHC facilities to deliver essential RMNCH, infectious disease, and NCD services, leveraging the role delineation policy as an opportunity to consolidate various programs and clinical guidelines and strengthening the competencies of health assistants and nurse aids to improve care quality and address the growing burden of NCDs.

4. **Optimize facility management for efficient PHC services.** This includes transitioning to performance-based budgeting to enhance efficient resource allocation; enabling PHC facilities to utilize diagnostic-related groups to effectively manage patients with chronic conditions; establishing and actively employing formal mechanisms to integrate community perspectives into facility planning and organization; and investing in the skills of managers to ensure facilities are effectively operated.

INTRODUCTION

COUNTRY CONTEXT

Remarkably one of the smallest and most remote countries in the world, Kiribati is a lower-middle-income country with an estimated population of 119,940. The country consists of 32 atolls and 1 solitary island scattered over all 4 hemispheres in the South Pacific and is geographically divided into 3 archipelagoes or groups of islands—Gilbert, Phoenix, and Line Islands. Only 21 of the 32 atolls and islands are inhabited. About 8 out of 10 people living in Kiribati work in the public sector, with 20 percent of the country's population formally employed in the cash economy. Food security relies largely on fisheries and subsistence agriculture. Its economic base is largely dominated by (a) the sale of fishing licenses; (b) remittances; and (c) aid flow, among others. The total land area is only 811 square kilometers, but its exclusive economic zone covers approximately 3.5 million square kilometers. With its low-lying coral reef rising barely 3 meters above sea level, Kiribati is one of the most vulnerable countries to climate change. The sea has infiltrated drinking water wells, inundated local crops and food sources, and forced families to rebuild houses further inland. Around 50 percent of the population live in villages across the islands, and the rest live on the main island of South Tarawa where the capital Tarawa is located, which is one of the most densely populated areas in the Pacific. Fishing license fees have seen a steady rise over the years, although this level of income may not continue due to changing climate and tuna migration patterns.

ECONOMIC CONTEXT

Annual health expenditure in Kiribati increased by 7 percent between 2008 and 2018, growing from US$21.6 million to US$23.1 million. However, per capita spending has declined, and the impact of COVID-19 may pose a risk to some of the health gains made in recent years. From 2008–2018

the Kiribati population rose by 17.3 percent, growing from an estimated 98,761 to 115,847. As a result, per capita spending on health declined from US$219 to US$200. Overall health spending as a share of gross domestic product (GDP) also fell from 15 percent to 12.3 percent. Apart from some minor out-of-pocket charges, health services in Kiribati are provided free at the point of care. Due to COVID- 19 border restrictions and the inability to refer patients to overseas medical providers, government expenditures on health fell in 2020 and may decline further despite increased budget allocation in 2021 (national data reports recent nominal expenditure of about US$26.6 million in 2019, about US$20.7 million in 2020, and a budget of US$38 million in 2021). Overseas referral expenditure fell from 15.7 percent of domestic health expenditure in 2019 to 7 percent in 2020. The current decline in overseas referrals is expected to be temporary as there is likely to be pent-up demand when travel resumes. However, vaccination rates remain low, and the borders remain closed in response to the recent outbreak.

GENDER LANDSCAPE

Kiribati experiences critical gender gaps in economic opportunity, health, and decision-making. Even though women have higher rates of secondary completion in school than men, estimates from the 2019 Household Income and Expenditure Survey (HIES) show that female labor force participation is low (28.7 percent) and significantly lower than the rate for men (43.1 percent). The 2019 HIES estimates further indicate that women represent slightly more than one-third (38 percent) of paid employees in the country and are more likely to be in vulnerable employment than men. Strong patriarchal norms, which are especially prominent in rural areas, have been identified as a main deterrent to women's participation in paid employment and decision-making. As of 2020, there are only 3 women (6.7 percent) in Kiribati's 45-member Parliament; only 4.2 percent of representatives in local island councils and about 5 percent of police officers are female.

The policy and legal landscape for preventing and responding to gender-based violence (GBV) is a high priority for the Pacific region. At the international level, Kiribati is party to the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child, and the Convention on the Rights of Persons with Disabilities. These distinct factors all impact policies and legislation related to sexual and reproductive health (SRH) and GBV in Kiribati. The right to health is generally viewed as an economic, social and cultural right, contained within the International Covenant on Economic, Social and Cultural Rights (Article 12). However, Kiribati does have health-related obligations under CEDAW, including the obligation to take all appropriate measures to "eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning" and to "ensure to women appropriate services in connection with pregnancy, confinement and the postnatal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation" (Article 12).

ABOUT PRIMARY HEALTH CARE PERFORMANCE INITIATIVES

The Primary Health Care Performance Initiative (PHCPI) is dedicated to transforming the global state of primary health care (PHC). Founded in 2015 by the Bill & Melinda Gates Foundation, the World Health Organization, the World Bank and United Nations Children's Fund (UNICEF), in collaboration with Ariadne Labs and Results for Development, PHCPI has supported countries to improve their PHC systems through measurement. PHCPI was built on the belief that PHC is the cornerstone of sustainable development, and that improving PHC begins with better measurement. PHCPI teams work closely with governments and development partners who are looking

to strengthen PHC, helping them analyze data and providing them with the information and support they need to drive evidence-based improvements.

PHCPI uses technical tools to support countries in improving the performance of their PHC systems. PHCPI's conceptual framework was developed to describe the critical components of a strong health care system. The conceptual framework defines five core domains of a PHC system and serves as the foundation of the initiative's activities. The framework is operationalized into the Vital Signs Profile (VSP), which provides a snapshot of PHC systems in individual countries and/or states, shining a light on where systems are strong and where they have challenges. It is designed to help countries and/or states and development partners identify priority areas for improvement and to track and trend improvements over time.

METHODOLOGY

The assessment of the PHC system of Kiribati presented in this report uses PHCPI's conceptual framework and methodologies. The PHCPI framework was developed to describe the critical components of a strong PHC system and results in the VSP, which is a measurement tool that health system stakeholders can use to identify and track priority areas for an improved PHC in Kiribati. The PHC assessment, using the VSP, answers some of the most critical questions about PHC systems across four core domains: financing, capacity, performance, and equity. The results include information based on a collection of quantitative and qualitative indicators for a comprehensive analysis as presented in Figure 1. To facilitate the understanding of the PHC assessment results, this report explains the assessment's methodology, describes the main findings, and proposes recommendations that can improve the PHC system in Kiribati.

The PHC assessment that results in a VSP is designed to collate data from several national surveys, global databases, and additional data collected in Kiribati while reviewing regulations, strategic plans, and key informants' interviews. When available, globally comparable data sources were preferred to promote international comparability. However, in some cases, such data does not exist. The PHCPI team worked with the Ministry of Health and Medical Services (MHMS) and other partners to find alternative data sources that are consistent with the PHCPI framework and methodology. The VSP sub-domains (coverage, access, quality, and equity) are measured using quantitative data from available secondary sources, including surveys, such as the Multiple Indicators Cluster Survey (MICS), and global data sources from the World Health Organization (WHO), UNICEF, and the World Bank, among others in the last five years. Additionally, the Capacity domain of the VSP was assessed using the PHC Progression Model, a mixed-methods assessment tool developed to systematically assess the governance capacities, availability, and distribution of inputs as well as PHC facility management and population outreach strategies. The progression model methodology brings together expert stakeholders with

varying and complementary knowledge of PHC from across the country to yield an objective and comparable assessment of PHC capacity.

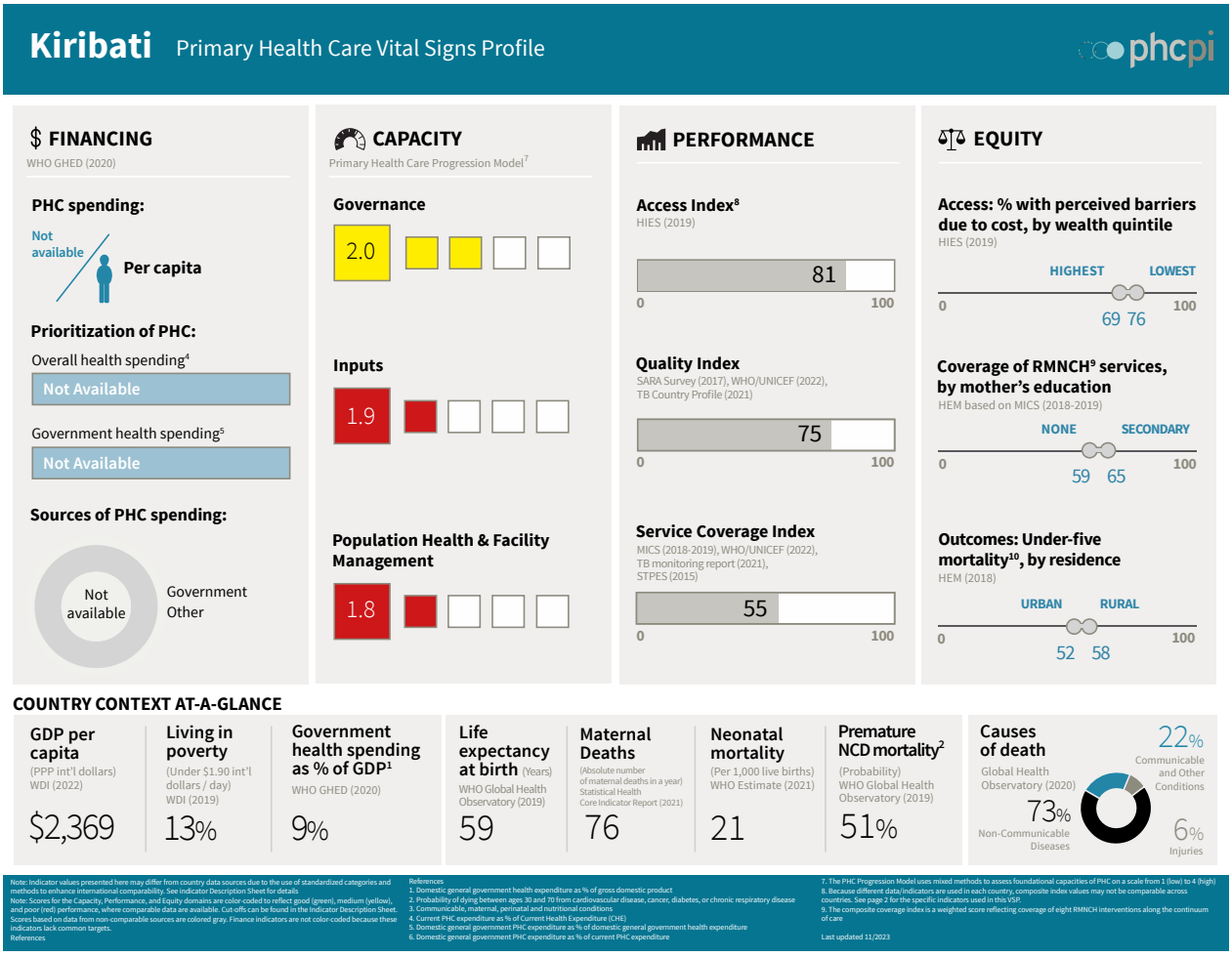
The initial data compilation process was implemented by a national consultant who performed a document review of policies, plans, strategies, reports, and surveys. The consultant conducted 15 interviews with the government and non-governmental organizations (NGOs). The information collected was used to propose an initial score for the 33 Progression Model measures. These scores were validated in a national workshop in October 2023. Consolidation and validation were performed in collaboration with the MHMS to address discrepancies between the internal and external scores. The VSP findings have been outlined to answer the following questions:

- Capacity: Have the necessary policies and governance structures, the necessary physical and human inputs, and a system for facility management and population outreach been implemented in the country?
- Performance: Does the PHC system ensure access to high-quality services and effective coverage of the population's health needs?
- Equity: Does the PHC system effectively serve the most marginalized and disadvantaged groups in society?

Additionally, and in support of goals to target NCDs and strengthen a gender-informed PHC approach, Kiribati supplemented the standard PHCPI VSP with targeted deep-dives into NCD and gender across conceptual domains. The gender deep-dive conducts a detailed investigation into the barriers experienced by diverse populations. This includes assessing (i) how well national policies cater to the specific needs of the population and (ii) the accessibility of high-quality services at PHC facilities. The NCD deep-dive aims to assess the capacity of the PHC systems to detect, diagnosis, treat, and manage NCDs. Specifically, this assessment aimed to understand the policy and planning capacities required of

effective NCD management. Five questions were answered through a desk-based review and key informant interviews, including: (i) Does the national Health Strategic Plan include components on NCDs and/or risk factors for NCDs? (ii) Are there clear roles and responsibilities for PHC related to NCDs? (iii) Are data and evidence used to develop best practices for management of key risk factors? (iv) Do policies include specific funding mechanisms for NCDs in PHC? and (v) Do policies and/or strategies include monitoring and evaluation frameworks for NCDs?

KEY FINDINGS FROM THE VSP



RESULTS

PERFORMANCE

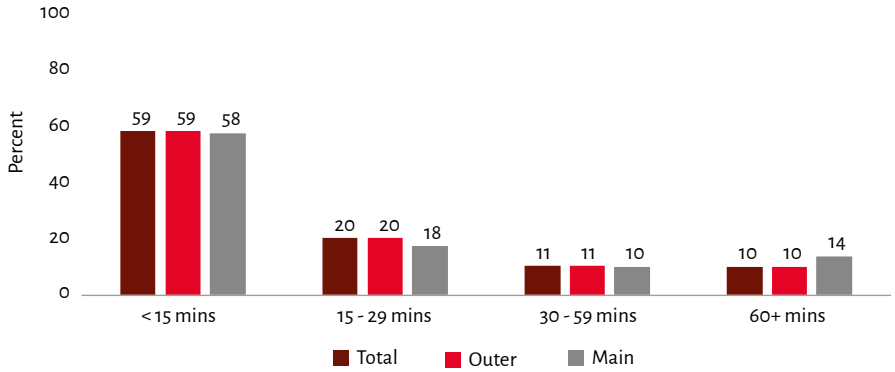
ACCESS

The Access domain in this assessment captures whether services are accessible when needed and without undue barriers. Access to care is an important dimension of PHC performance, as it uncovers how well health systems address the systemic barriers that patients face when accessing care for equitable access to a high-quality and high-performing PHC system. Specifically, Kiribati's VSP results on access include measurements of geographic barriers to care (reported travel time to the nearest health facility) using data from the 2019 HIES survey.

The majority of households seek care when needed and travel less than 30 minutes to reach the nearest health facility. Data from the 2019 HIES survey shows that 75 percent of households were able to seek care when needed, and 79 percent travel less than 30 minutes to the nearest health facilities. Longer travel times were slightly more likely to be reported by those living on the main island (24 percent of households) compared to the outer islands (21 percent of households).

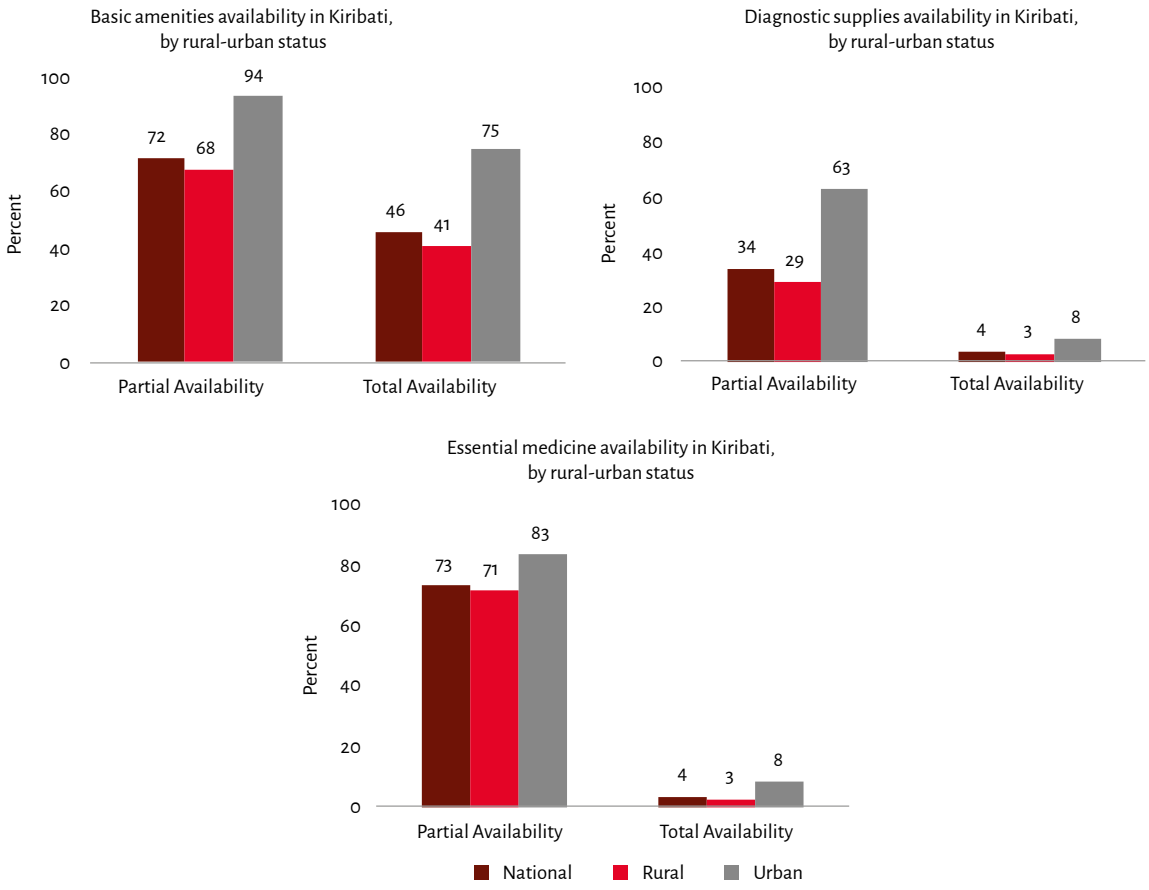
However, access to facilities does not guarantee receiving services; not all the facilities have the capacity to provide services, especially those located on the outer islands. Facility assessment through the Service Availability and Readiness Assessment (SARA) survey in 2017 showed that on average, only two-thirds of the facilities had a stable electricity source, while only one-third (34 percent) had diagnostic supplies. Furthermore, only 4 percent of the facilities had all the necessary essential medicines. These limitations in capacity were more likely to be observed in the outer islands than in urban Tarawa.

Figure 1. Travel time to the nearest health facility in the main and outer islands of Kiribati, 2019



Source: Original calculations for this publication using [HIES 2019]

Figure 2. Availability of basic amenities, diagnostic supplies, and essential medicine in Kiribati, by urban-rural status, 2019



Source: Original calculations for this publication using [SARA 2017]

COVERAGE

The Coverage domain encompasses measurement of the effectiveness of service delivery for reproductive, maternal, newborn, and child health (RMNCH), NCDs, and infectious diseases. VSP coverage indicators were selected through extensive literature reviews and consultations with international experts intended to measure countries' coverage of PHC services. Table 1 below presents a summary of the coverage of services for RMNCH, infectious diseases, and NCDs using data from the most recent household surveys (MICS 2019) and monitoring reports in Kiribati.

Table 1. Coverage of services for RMNCH, infectious diseases, and NCDs using data from the most recent household surveys and monitoring reports in Kiribati.

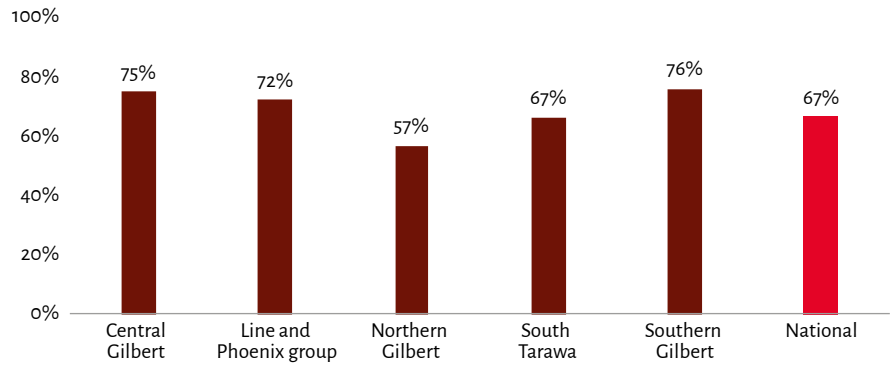
Indicator	2015		2019–21		Percentage Point Change
	Estimate (%)	Source	Estimate (%)	Source	
RMNCH					
Care-seeking for suspected child pneumonia	81	UHC 2017	87	MICS 2019–21	↑6
Coverage of DPT3 vaccination	78	UHC 2017	92	WHO/UNICEF 2021	↑14
Demand for family planning satisfied with modern methods	43	UHC 2017	54	MICS 2019–21	↑11
Antenatal care coverage (4+ visits)	71	UHC 2017	67	MICS 2019–21	↓4
Noncommunicable diseases					
Hypertension treatment coverage	34%	STEPS 2015	15%	UHC 2023	See note
Infectious disease					
Tuberculosis cases detected and successfully treated	70	UHC 2017	60	UHC 2023	↓10
People living with HIV receiving anti-retroviral treatment	42	UHC 2017	55	UHC 2023	↑13
Children under five years of age with diarrhea receiving oral rehydration solutions	-	-	61	MICS 2019–21	-

**Estimates* may not be comparable due to differences in standardization, modeling, and age groups. STEPS estimate is calculated in the population ages 18–69 whereas UHC estimates are based on modeling among the population ages 30–79.

Coverage of child health services has relatively improved in Kiribati between 2015 and 2021. However, opportunities for improvement still exist. Coverage of child health services is assessed using two standard universal health coverage (UHC) indicators: 1) care-seeking for pneumonia and 2) diphtheria-pertussis-tetanus (DPT3) immunization coverage. Kiribati has achieved an increase in the percentage of children that seek care when suffering from pneumonia-like symptoms. According to the MICS 2019–21, 87 percent of children under the age of five with pneumonia sought care from a health facility or a provider compared to 81 percent in 2015 (UHC 2017). However, there is still an opportunity for further improvement in pneumonia care-seeking, especially in rural settings where a relatively lower number of children with pneumonia (84 percent) seek care, compared with 89 percent in urban Tarawa. Meanwhile, a notable improvement has been made in DPT3 immunization coverage in the Republic of the Marshall Islands; data from WHO/UNICEF joint reporting on immunization shows that the percentage of children receiving three DPT3 doses by the age of one year has increased from 78 percent in 2015 to 92 percent in 2021.

The latest coverage estimates for Kiribati's maternal health services demonstrate substantial bottlenecks that warrant further investigation. Family planning coverage with modern methods improved from 43 percent in 2015 (UHC 2017) to 54 percent in 2021 (MICS 2019–21); however, coverage estimates remain low. Despite the relative improvement in family planning coverage, the coverage levels for antenatal care (ANC) over the same period dropped by four percentage points from 71 percent in 2015 (UHC 2017) to 67 percent in 2021 (MICS 2019–21). ANC coverage also varied by subnational region and ranged from a low of 57 percent in Northern Gilbert to a high of 75 percent in Central Gilbert (MICS 2019–21)

Figure 3. Coverage of antenatal care (attendance of four or more antenatal care visits) by subnational area in Kiribati



Source: Original calculations for this publication using [MICS 2019–21]

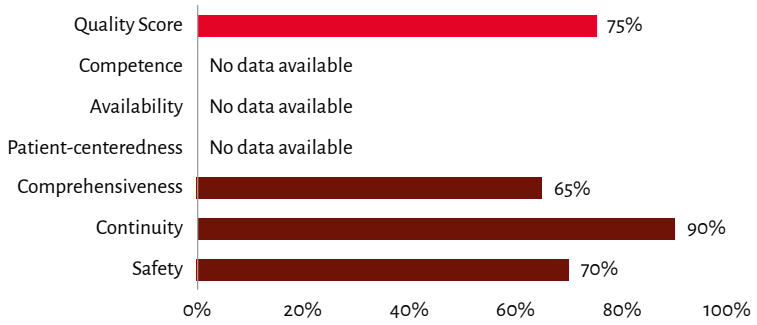
The prevalence of hypertension continues to increase in Kiribati with challenges in treatment coverage. According to the WHO Global Health Observatory data, the prevalence of high blood pressure among the population ages 30–70 increased in Kiribati from 39 percent in 2015 to 42 percent in 2019. Furthermore, in 2015 the STEPS survey indicated that only 34 percent of adults ages 18–69 with hypertension were being treated, while the latest UHC modeling estimates indicate that only 15 percent of adults (30–70 years old) with hypertension receive treatment – an issue that warrants improved and greater service provision to patients with cardiovascular illnesses in PHC.

Coupled with a growing burden of NCDs, the coverage of infectious diseases is significantly lagging in the country. Despite the improvements in human immunodeficiency virus (HIV) treatment coverage, coverage of other infectious diseases still poses challenges for Kiribati's PHC system. Based on the UHC 2023 report, 55 percent of persons with HIV received anti-retroviral treatment compared to 42 percent in 2015 (2017 UHC report). In addition, more than one-third (40 percent) of tuberculosis (TB) patients were not successfully treated in 2021, with a 10 percentage-point increase compared to 2015 estimates (WHO TB country profiles). Moreover, more than one-third (39 percent) of children with diarrhea never received oral rehydration solutions according to MICS 2019–21

QUALITY

In Kiribati, analysis of PHC quality indicates room for improvement across all three quality sub-domains for which data are available. Using the PHCPI methodology, PHC quality is measured across components of clinical quality and core principles of service provision, such as comprehensiveness, continuity of infectious disease services, provider competence, person-centeredness, availability, and safety. Figure 4 provides a summary of results on PHC quality and indicates that there are substantial gaps in the comprehensiveness of services offered at PHC facilities and in communities, continuity of TB treatment, and safety at PHC facilities, presenting additional challenges to strengthening the quality of care. No data was found in Kiribati to measure person-centeredness, competence, or availability of PHC providers.

Figure 4. Summary scores for quality domain and sub-domains in Kiribati

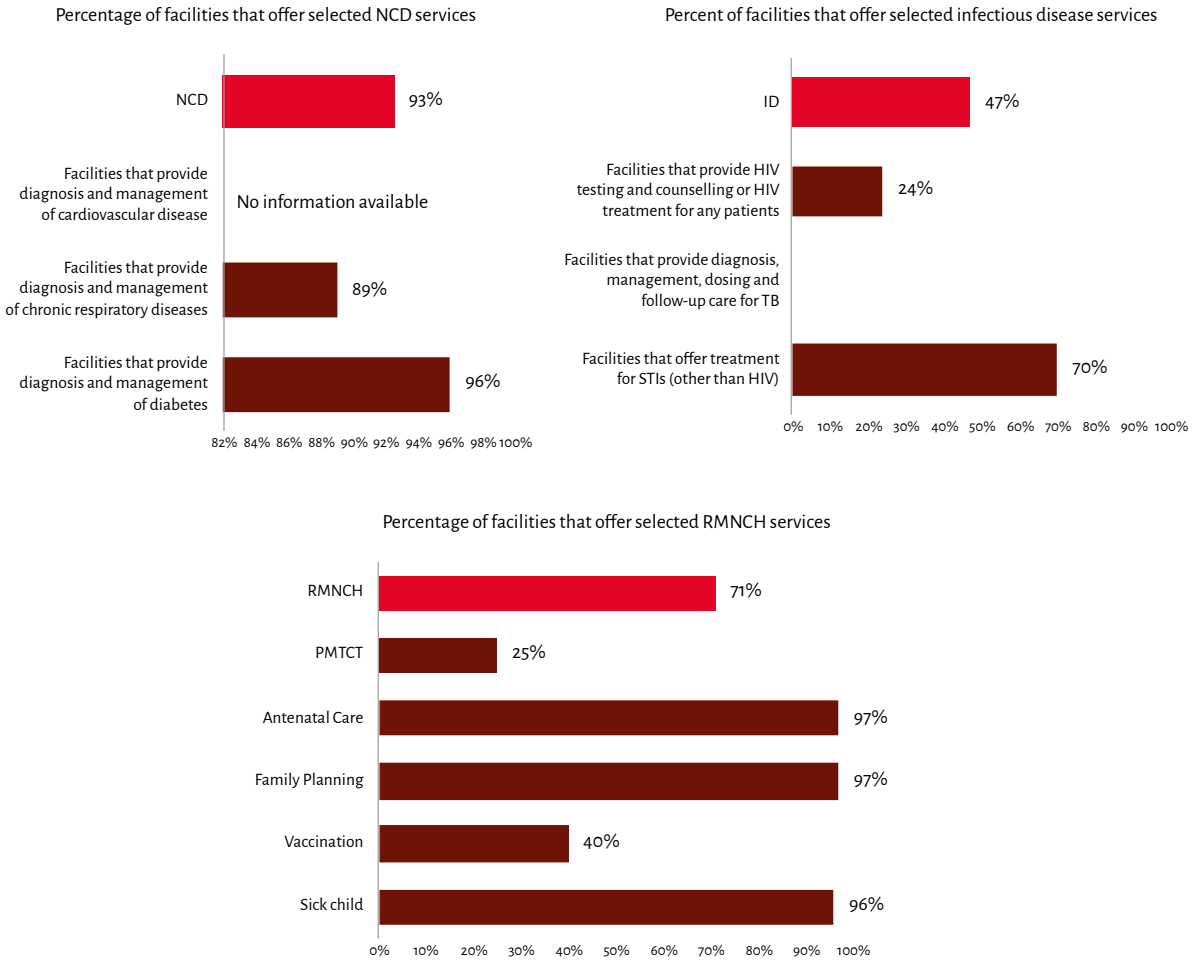


Source: Original calculations for this publication using [SARA 2018, TB country profile 2021, UNICEF 2021]

In Kiribati, there are substantial gaps in the comprehensiveness of infectious disease services, with an opportunity for improvement in the availability of RMNCH and NCD services. A comprehensive PHC system refers to the integration of basic and appropriate care services across and within one facility addressing a spectrum of health problems and treatment modalities for various population groups. A closer look at available indicators shows that more than 70 percent of facilities offer diagnosis and management of diabetes, chronic respiratory diseases, and maternal

and child health services. However, as indicated earlier, most facilities do not have the operational capacity to provide these services with sufficient quality due to limited availability of medicines, diagnostic supplies, and equipment. In addition, there was a limited number of facilities (24 percent) that could offer HIV testing or treatment services and not enough information was available to access the capacity of facilities to deliver TB diagnosis and treatment services. Further, more than half of facilities (60 percent) were not able to deliver full child immunization services on daily basis and only one-quarter (25 percent) offered prevention of mother to child transmissions services.

Figure 5. Summary scores for comprehensiveness sub-domain in Kiribati

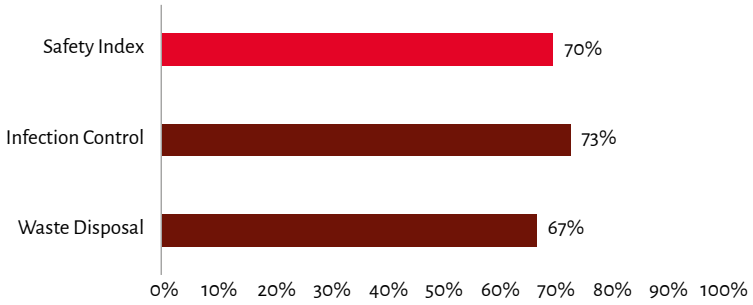


Source: Original calculations for publication using [SARA, 2017]

There are persisting challenges to ensuring the continuity of care for infectious disease services in Kiribati. Between 2015 and 2021, notable improvements have been made in DPT coverage, as demonstrated through the increase in the percentage of children who received at least one dose of the DPT vaccine from 81 to 99 percent. However, 7 percent of children who received their first DPT vaccination did not receive a third dose. In addition, one-fifth (19 percent) of TB patients did not complete their treatment. Incomplete vaccination or lack of TB treatment adherence reduces the effectiveness of the prevention and worsens the course of diseases such as TB.

The most recent facility survey (SARA 2017) indicates room for improvement in patient safety practices. In this assessment, adequate infection prevention and control and adequate waste disposal measures are used to determine patient safety at health facilities. Both measures refer to the availability of infection control tracer items (for example, soap and running water or storage for sharps waste) and adherence to standards for disposing medical and hazardous waste and sharps as well as the availability of guidelines for waste disposal at the facility. In Kiribati, more than one-quarter of facilities (29 percent) lack adequate infection control measures. Similarly, adequate waste management remains a challenge in the country, and one-third of PHC facilities (33 percent) lacked adequate waste disposal practices in 2017 [SARA survey] (Figure 6).

Figure 6. Summary scores for safety sub-domain in Kiribati



Source: Original calculations for this publication using [SARA,2017]

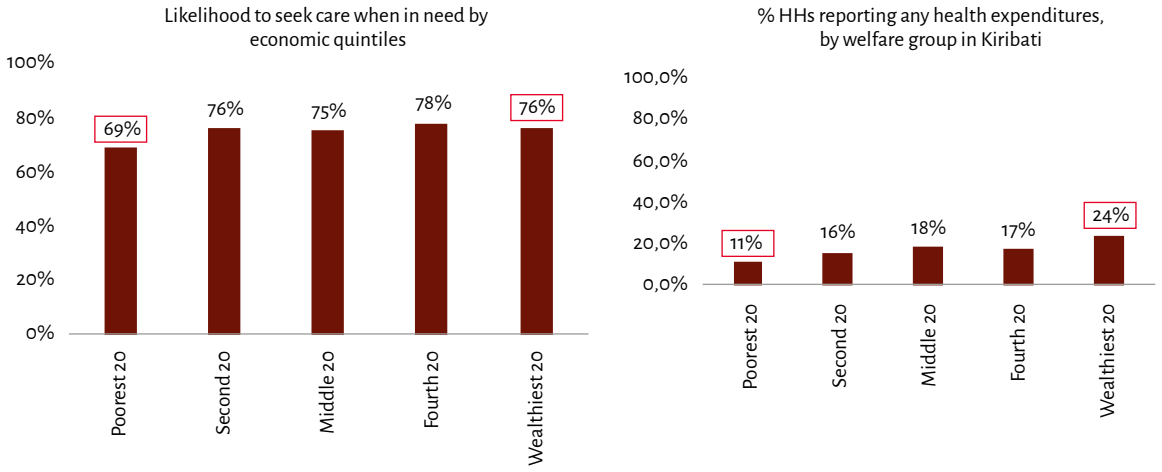
EQUITY

The Equity domain in the PHCPI VSP measures equity across access, coverage, and outcomes to understand if the PHC system serves vulnerable populations equally compared to non-vulnerable populations. The PHCPI VSP assesses equity using indicators disaggregated by socioeconomic status, including wealth, mother's education, and place of residence. It looks at the difference in perceived financial barriers to care, coverage of maternal and child health care services based on a mother's level of education, and mortality of children residing in urban and rural areas.

In Kiribati, there is a notable disparity in access and coverage of PHC services between the upper and the lower wealth quintiles. The latest available data (HIES 2019) shows that 69 percent of households in the lowest wealth quintile [poorest] seek care when needed compared to 76 percent of households in the fifth economic quintiles [wealthiest], who were also more likely to spend on health care (see Figure 7). These wealth disparities in access are reflected in the coverage of some essential RMNCH services across wealth quantiles. For example, 64 percent of women in the poorest quintile received four or more ANC visits, compared with 72 percent of women in the wealthiest quintile; and 50 percent of children with diarrhea whose caregivers were in the poorest wealth quintiles received

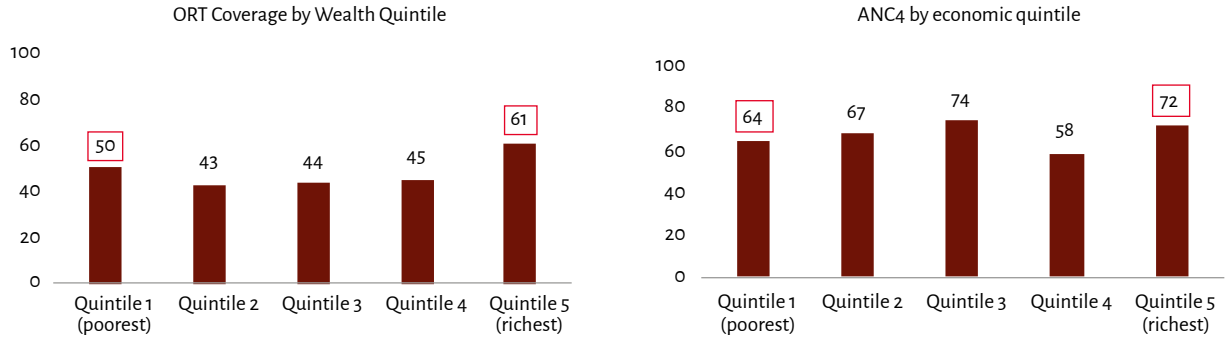
oral rehydrating therapy versus 61 percent of children whose caregivers were in the richest quintile.

Figure 7. Likelihood to seek care and health care spending by wealth quintile in Kiribati 2019



Source: Original calculations for this publication using [HIES 2019]

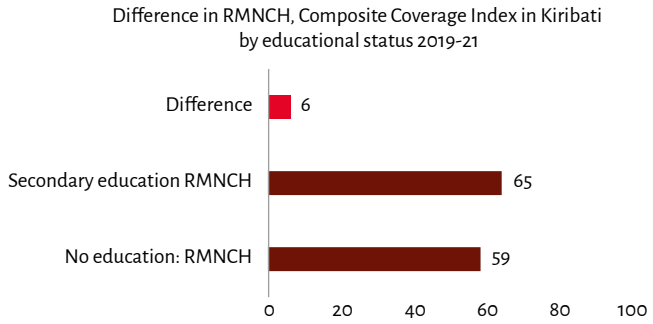
Figure 8. Coverage of RMNCH services by wealth quintile in Kiribati 2019–21



Source: Original calculations for this publication using [MICS 2019–21]

Moderate educational disparities, in line with wealth disparities, were also found in the coverage of RMNCH services. In households where the mother completed secondary or more education, about 65 percent of mothers and children receive a complete basic package of RMNCH services whereas 59 percent of mothers and children in families where the mother had not completed primary education received such care (Figure 8).

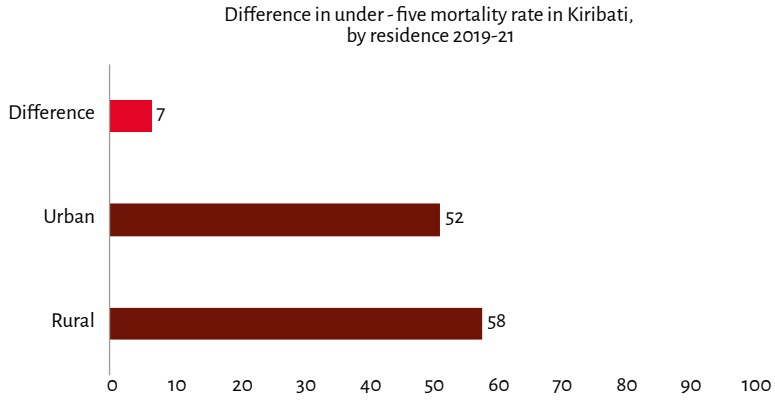
Figure 9. Composite Coverage Index for RMNCH services in Kiribati in 2019–21 by educational status



Source: Health Equity Monitor [based on MICS 2019–21]

Moderate disparities by residence in the mortality of children under five were also reported in Kiribati. According to data from the Health Equity Monitor in 2021 [based on MICS 2019–21], there is a seven percentage-point difference in under five mortality rates between urban and rural areas in Kiribati (Figure 9). Specifically, the mortality rate among children under five years of age in rural areas is 58 deaths per 1,000 live births versus 52 deaths per 1,000 live births in urban areas. These disparities highlight the difficulties confronting the PHC system in both urban and rural areas, where the challenge of reducing child mortality remains substantial.

Figure 10. Mortality among children under five years of age in Kiribati in 2019–21, by residence



Source: Health Equity Monitor [based on MICS 2019–21]

CAPACITY

GOVERNANCE

Kiribati has a national development plan (2020–23) that expires this year and has some components of health and specifically PHC. The National Strategic Plan for health is under development now and has outlined six areas which are all relevant to PHC. Moreover, each program has its own strategic plan, which all generally aim to align with the National Strategic Plan. Additionally, Kiribati is currently developing a role delineation policy which is helping to define the roles and responsibilities of clinics and health centers in rural and urban areas for PHC delivery. These plans will be key to setting Kiribati's path for a strong PHC such that goals, activities, responsibilities, and measurement indicators are defined to coordinate across programs and ensure a focus on a comprehensive and resolutive PHC system. Kiribati benefits from a participatory process with different sectors to formulate health policies; however, the evidence base must be strengthened for these exercises. Moreover, the legal framework on which PHC sits must be updated to provide legal accountability to patients. As regards PHC fundamentals, Kiribati now has a service package and a monitoring and evaluation framework defined by the new Role Delineation Policy, but financing must be strengthened so that it can be fully implemented.

Box 1. Overview of NCD policies and strategies

NCD is recognized as a key priority in health and development through a combination of strategic plans and components, including the Ministry Strategic Plan (2016–19) and Kiribati Development Plan (2020–23). The Ministry Strategic Plan (2016–19) emphasizes an inter- and multi-sectoral approach for addressing NCDs and NCD risk factors, while outlining specific actions for addressing NCDs through outreach, coverage, and awareness of

risk factors and improving screening, detection, and treatment. The actions are linked to six strategic objectives focused on strengthening NCD services and reducing exposure to key risk factors. Each of these objectives are linked to specific indicators, which also outline sub-action, lead organizations, timeframes, and budgets. Additionally, the Kiribati Development Plan (2020–23), which outlines all the country's development objectives, also recognizes NCD as a major challenge to development. The plan includes an indicator focused on reducing the burden of NCD cases across the country and also recognizes the importance of formally evaluating the NCD programs.

Kiribati does not have one person or role that is in charge of PHC, and ensuring that responsibility is defined with clear roles will be key to ensuring the implementation of the new plan and delineation policy. As of now, PHC oversight is divided between the Director of Nursing, who oversees the clinical health services provided by nurses, and the Director of Public Health, who is in charge of the programs; this division has precluded accountability between both. Moreover, medical assistants have minimal ability to request budget, equipment, or support, thus diminishing their possibilities of reaching the community health goals effectively.

Quality of care has not been a focus in Kiribati, and engagement with other sectors only arises on an ad hoc basis. As of now, there is no document or person responsible for quality of care in Kiribati, although the mission and the vision of the MHMS is based on quality. There are isolated efforts and actions, such as the Ministry of Infrastructure's licensing facilities, the World Bank's assessing facilities, and nurses being ranked by a star system; however, there is no set national direction as regards quality of services. There are protocols for infection prevention and control as well as adverse events reporting and some clinical support tools. However, there are no clear interventions to foster the engagement of patients, families, and communities on care services nor systems to collect, publish, and share data on quality. National stakeholders agreed that having a clear

set of goals and standards for quality will help ensure the implementation of the plans and the delineation policy. Other sectors' involvement, besides government actors, in health care planning, policy formation, and monitoring and evaluation is only moderate. Although partners are usually involved in planning, NGOs and civil society are only called to coordination committees when relevant.

Kiribati has had participation of civil society in its policy making processes, but this does not seem to be systematic. There has been previous participation of the Traditional Healers Committee and the Red Cross, MSF, and the Kiribati Family Health Association which have participated in the health sector coordination committees. Other ministries do participate through steering committees of program-specific activities (the participants tend to be the same across many programs), and there are instances where memoranda of understanding have been defined between ministries. However, when other partners or stakeholders participate in policy discussions, they are given the opportunity to comment but do not have an equal voice in the decision-making process. Policies are not disclosed on the website because it is unclear who manages the website and how to ensure the documents are uploaded for the Ministry.

Box 2. Overview of NCD governance and implementation

The NCD Unit is responsible for operationalization through the NCD program; however, the lack of a defined benefit package and responsibility for service delivery limits the effectiveness. The actions specified in the Ministry Strategic Plan (2016–19) and Kiribati Development Plan (2020–23 are delivered through a well-established program for NCDs, led by the NCD Unit at the MHMS headquarters. The NCD Unit, which is financed through the MHMS (staffing and facilities) and Ministry of Foreign Affairs and Trade (outreach activities), is responsible for delivering the activities specified in the NCD program and also receives support from other development partners, including the WHO, and civil society organizations. While the Ministry Strategic Plan includes priority areas, actions, and strategies for addressing

NCDs in Kiribati, it does not specific what the essential package of NCD services is or the role of PHC providers in the delivery of NCD services. This was identified as a significant barrier in the delivery of NCD services across Kiribati.

Box 3: Deep-dive into governance and gender

Gender-informed PHC governance ensures that the PHC system is responsive to the needs of all individuals, regardless of gender. It recognizes that gender influences health outcomes and that health systems must be designed to address these differences. Gender-informed governance can help to ensure that health care services are accessible, affordable, and of high quality for all individuals through policy formulation and effective implementation strategies of specific and targeted health interventions.

There are policies such as the Kiribati National Policy on Gender Equality and Women's Development 2019–22 that are designed to address gender mainstreaming and consider gender-responsive elements. Kiribati has implemented these policies by prioritizing both the elimination of GBV and reproductive health services. These policies emphasize improving access to high-quality health care services for GBV victims and addressing the specific needs of youths (Ministry of Women, Youth, Sport, and Social Affairs (MWYSSA) 2019 and MIA 2010). Various other policies and plans, including the Health Strategic Plan 2016–19, use the same approaches and aim to enhance access to high-quality health care services, particularly for women and girls with disabilities, by focusing on GBV service delivery points and GBV task force activities (MHMS 2015). Additionally, the Policy and Strategic Action Plan 2011–21 and the 2014 Shared Implementation Plan to Eliminate Sexual and Gender-Based Violence in Kiribati provide a framework for an integrated multi-sector response through SafeNet. However, it is unclear whether the policies have been effectively implemented to ensure high-quality and appropriate health care services delivery, particularly across multiples services such as

adolescent health services and family planning services for both men and women (MIA 2010).

Multiple coordinating authorities exist in Kiribati to manage gender issues, primarily focusing on the wellbeing of women and girls, but questions remain regarding budget sufficiency and the authority's capacity to fulfill its activities. SafeNet and the Ministry for Women, Youth, Sport, and Social Affairs (MWYSA) are the main players in assisting with the implementation of GBV service delivery, such as providing counseling services. SafeNet supports the delivery and case management of GBV services nationwide while the MWYSA places a strong emphasis on human resource development, youth and sports, and the protection of women and children (MWYSSA, United Nations Population Fund, and UniMelb 2022). Specific initiatives include the Women and Children Support Centre, which provides free confidential counseling for women and children, GBV case management, community awareness programs, and other related services. There are also shelters and crisis centers such as the Our Lady of the Sacred Heart Crisis Centre, which are part of the coordinated services for Kiribati women and girls (KPS and MCO 2019 and MWYSSA, MOJ, and KNHRT 2020). In terms of budget allocation, MWYSA had a recurrent budget program of US$7,640,255 in 2018, which, while considerably lower than other ministries, covered administration and policy, development, social welfare, youth development, women's services, and NGO coordination (NEPO and MFED, 2017).

Regarding gender data availability and use for promoting policies relevant to gender-responsive PHC systems, challenges remain. A few gender-disaggregated indicators such as women's share of government ministerial positions or managerial positions from administrative data records and the percentage of female police officers from the Population & Housing Census are used for decision-making, but not for PHC services (MWYSSA 2019 and Anon 2017). However, there are plans to collect disaggregated data, particularly for priority climate change, health care, and disease-related sectors such as the Water and Coastal

Zone Management and Resilience Enhancement for Adaptation project. Further investigation is needed to verify the strategies' effectiveness and implementation outcomes.

INPUTS

The medicine supply chain in all PHC facilities depends on the stocks at the central pharmacy at Tungaru Central Hospital. Health centers usually have more stocks than health clinics, as the clinics depend on the centers to restock. MSupply is not operational at the moment; accordingly, there is a lack of supply chain tracking that makes stock-outs more probable as the central pharmacy lacks a real-time snapshot of the stock in PHC facilities, even in mainland Tarawa. The facilities send requests to the central pharmacy for replenishing stocks. With regards to equipment, there is no system in place to assess the functionality of the equipment in health facilities, which could be done during supportive supervision visits. It has been suggested to make biomed or pharmacy units responsible for the oversight of the equipment, rather than the vertical programs. Most PHC facilities lack diagnostic tests, and they diagnose using only clinical tools (clinical history and physical examination). Facilities that do have diagnostic kits might not have functional kits. There is, however, ongoing support from the World Bank and United Nations to improve the availability of diagnostic tests through the Health Systems Strengthening project. PHC facilities located in mainland Tarawa may have better availability of diagnostic kits due to its proximity to the main hospital; however, outer islands health facilities do not usually have these kits.

There have been assessments of PHC density and distribution, and medical assistants and nurses have good knowledge of their catchment areas and the population they care for. The MHMS Standard Operating Procedure has an expected target per facility at PHC level, where one clinic

must service a population of between 300–600. Staff working in the outer islands receive monthly top-ups on their mobile phone to be able to contact mainland Tarawa and discuss referrals and perform reporting.

In regards to amenities, most PHC facilities lack running water systems and a stable electricity supply. If PHC facilities have generators, these generally belong to the medical assistants or nurses, who take them with them when they are transferred to another facility. Overall, 20–50 percent of PHC facilities in Tarawa need repairs, while this increases to 20–70 percent in the outer islands. In the outer islands, the World Bank Kiribati Health Systems Strengthening Project will support facility rehabilitation works. On the other hand, personal protective equipment for clinical care and proper waste disposal is not readily available for PHC facilities, and proper guides to infection prevention control are absent. Mainland Tarawa has better systems to collect waste and guide safety processes.

A child protection officer from MWYSSA works directly with the MHMS to register newly born infants in the system. On Tarawa, another child officer from MWYSSA sits at the labor ward to provide birth certificates to newborn babies from Monday to Friday. However, coordination between MWYSSA and MHMS must be strengthened at the outer island level, as parents directly report newborn babies to the Island Councils. As regards death registration, in Tarawa, TCH provides death notifications for death certificates that need to be signed by physicians. However, as neither medical assistants nor nurses can sign death certificates, in the outer islands relatives need to take the note from the medical assistants to the Island Councils for them to facilitate the issue of the death certificate in mainland Tarawa.

As regards the health management information system (HMIS) in facilities, a fully resourced vertical program does have recording systems in place, but general outpatients are entered into the OPD register, which informs the MS1 reports. In some PHC facilities in the outer islands, there are no OPD or referral registers, so the medical assistants or nurses make

their own registers in notebooks. Reporting mechanisms are paper-based, but work is underway to make it electronic. The MS1 form is reported monthly from health facilities to the MHMS Health Information Unit, either by email, by sending it out with pilots on flights returning from the outer islands, or by phone, but this last option is expensive. Personal care records in the outer islands are documented in the OPD register for general outpatients, and vertical health programs have their own patient cards. Personal care records include problem lists, care history and notes, and medication and allergies lists, but lack ID (except for some specific health programs), referrals and results of referrals (they can be found in health centers, but not in health clinics), and laboratory, radiology, and other test results.

Box 4. Overview of NCD-related information systems and feedback mechanisms

There are opportunities to advance information systems and improve documentation of NCD service delivery and programs. PHC facilities were identified to use a standard system for filing paper-based records of outpatient services and NCD registries at PHC facilities. However, because these systems are not digitalized, they do not track patients longitudinally, and aggregating NCD utilization across PHC facilities is challenging. Furthermore, interviewees noted that the registries are often used by the clinic administrator to identify high-risk patients. The limited use of information systems is also reflected in the system's ability to document and monitor the effectiveness of the NCD program. Specifically, adapting this system to a basic digital program would reduce the risk of oversight, as clinics could develop systems to identify patients who are overdue for a visit or were lost to follow-up. It was also identified that formal documentation on NCD services and NCD policies is scarce. While there have been robust efforts to generate strategies and policies around NCDs; it is important that these efforts be formally evaluated to ensure that these programs are appropriately scaled up and effective.

According to the health bulletin, Kiribati has about 45 health workers per 10,000 population, of which most are nurses. The distribution of the workforce per capita seems to be higher in the outer islands that have smaller populations, as compared to Tarawa where approximately 5,000 people are served by two to three nurses and one medical assistant. For nurses and doctors to practice in Kiribati, the nursing and medical council needs to approve and issue certificates; however, this happens only once for the initial hiring and no recertification or accreditation happens again. The councils have information on certified nurses and doctors, but this information is not available to the Ministry for its planning or monitoring purposes. Principal nursing offers ask health workers on a yearly basis, using a checklist, if they are able to undertake certain tasks such as CPR, but there is no system to assess the actual capacities of health care workers to undertake such tasks with quality. Different programs have protocols that mention the specific competencies of the workforce required to undertake program tasks but some, like TB, have not been updated. The guidelines that have been updated are not available or used by the school of nursing for training, which constitutes a missed opportunity to ensure a trained workforce as per updated guidelines. The role delineation policy implementation will need to review and revise the guidelines to ensure they can be implemented as per each level of care and each health worker cadre. Kiribati has three types of outreach/non-staff health workers in the system to support service delivery: the nurse aids who are hired by the Islands Council, the TB directly observed therapy community workers, and the contact tracing workers. These last two receive specific training but the nurse aids would benefit from more formalized training and terms of reference for their work. These three types of health workers are supervised on a regular basis. The nurse aids work within the clinic system and are integrated into the care team while the directly observed therapy and contact tracing workers are not working in coordination with the facilities; they work directly with the program, making the management of those cases at the clinic level very difficult.

Facilities do not manage their own budgets, as they are provided with equipment and supplies, rather than money. The facilities' budget is managed at central level and, thus, when there is a need for maintenance, the back-and-forth reporting process may delay it. The Health Ministry reviews the budget annually, deciding how much will be allocated to clinics and centers. During the review, the Ministry takes into account how much was requested in top-ups (extra budget on a specific area if the money ran out before the year ended) during the last year. Then, the Ministry of Health submits its budget to the Ministry of Finance, which usually cuts some expenses off; as of now, that is why communication support has not been funded. Each island receives the money that corresponds to it based on the number of clinics and centers it has; this money is transferred to the Island Councils. The budget is earmarked to be used in kerosene, petrol, rations, referrals, or transportation of staff, but there is no set allocation for maintenance. Medical assistants conduct financial reporting for all facilities on the entire island they work for, in conjunction with the Islands Council accountant. Staff remuneration is received fortnightly, and it is generally reliable (stable, timely, and predictable) for the whole of the country.

Box 5: Deep-dive into inputs and gender

Gender responsiveness of the PHC workforce can help ensure that health care providers are trained to provide gender-sensitive care and that quality assurance mechanisms are designed to identify and address gender-based disparities in health care access and outcomes. Gender is an important consideration in inputs such as quality assurance mechanisms and data quality.

There are no quality standards and guidelines in Kiribati that effectively translate gender-related policy objectives into PHC service delivery practice. While the country has implemented training programs addressing gender-based violence and adolescent health and has integrated GBV and sexual violence prevention into health outreach strategies, there is no evidence of

specific quality mechanisms that ensure gender sensitivity in service delivery (MHMS 2015 and UN Women 2017). Key informants mentioned that although the SRH curriculum and individual training packages aim to establish standardized service delivery practices, the extent to which PHC workers exhibit gender sensitivity, including understanding barriers to health services and gender inequality implications on health, remains unclear. Additionally, current training activities are focused on specific areas but do not demonstrate comprehensive gender-sensitive quality assurance mechanisms for PHC service delivery.

POPULATION HEALTH MANAGEMENT

Even when facilities have limited capacity to translate national policies into local priorities, the involvement of communities and local leaders play a pivotal role in deciding what is important to deliver in the community. Nurses in the outer islands try to involve the communities, working with the Islands Council and with community welfare groups. However, these processes are highly dependent on individuals' capacities and willingness, rather than being built-in systematically. Local plans appear to be created only in outbreak emergency situations. In urban settings, local councils may have their own plans which lack a clear connection with the national plans. At facility level, communities share their input primarily in environmental health issues only, focusing on improving the living conditions of the communities; thus, the communities' impact in how PHC services are structured and delivered is practically nil. Clinics have a very strong empanelment system, where each of them conducts a census at the beginning of each year to have full knowledge of the community she attends to and its needs. Patients are strongly encouraged to go to the clinic that cares for their catchment area, and in cases of referrals they need a letter from it. However, in emergencies, they can attend another one.

All facilities do outreach activities, which are scheduled either by place (schools, churches, etc.) or by program.

In the outer islands, island teams are put together by the medical assistants, and they meet fortnightly. There is a clear division of roles and responsibilities within the teams. Mowever, most of the responsibility falls on medical assistants, as they supervise, manage referrals, etc., on top of caring for their own catchment area. In the past, staff used to undergo management training, but not anymore. However, a problem-solving training by the WHO is now being organized for some medical assistants, as it is intended to upskill them in management training and leave clinical work for nurses. There are annual assessments twice per year, where both staff and supervisors score staff; skills in leadership, budgeting, planning, and other areas are included in this assessment. In clinics, nurses have paper-based documents and registers to store information, which are then consolidated onto the MS1 form that is reported monthly to the MHMS monthly. Overall, 30 percent of clinics send it to the medical assistant first, whereas the other 70 percent send it to the Health Information Unit directly, but with more missing data. As regards reporting for conducting quality improvement activities, different programs report individually, and the central level only oversees who is under or overperforming, sending back information on what needs to be improved. On supportive supervision, visits by the district principal nursing officers to health facilities in the outer islands are supposed to be made at least once a year; however, it is only when vertical programs have enough budget can most of these be done. Medical assistants make frequent supervision visits to the clinics on the island they manage (generally every three months). UNICEF and United Nations Population Fund will provide support to increase the frequency of supportive supervision visits.

Box 6: Deep-dive into population health and facility management and gender

PHC gender responsiveness is an important consideration in population health and facility management, especially in community engagement and team-based care approach. Gender-based differences in health outcomes and access to health services must be identified and addressed to ensure equitable health outcomes for all. Women are often the primary caregivers in families and communities, and their participation in health care decision-making is crucial. Engaging women in health care decision-making can lead to better health outcomes for women and their families. In addition, it is important to ensure that health care teams are diverse and inclusive and are trained to provide patient-centered care that is sensitive to the needs of all patients, regardless of their gender. For example, both men and women may feel more comfortable discussing certain health issues with providers of the same gender identity. Gender diversity can help ensure that the team is better equipped to meet the needs of all patients and understand and address the unique health needs of male and female patients.

Feedback mechanisms in place for assessing the quality of services, service satisfaction, and patient/provider respect and trust in health facilities is unclear in Kiribati. Experts interviewed indicated that there is no information available regarding the accessibility and utilization of such mechanisms by women and girls, as well as the frequency of PHC facilities receiving and addressing complaints, especially from women and girls.

Despite a workforce primarily consisting of female health professionals, particularly nurses (86 percent female versus 14 percent male), there is no reference to the presence of women's perspectives in decision-making related to health services, particularly women's services at facility level (WHO 2014). According to experts, in terms of tasks distribution, it is unclear whether women and men in health care teams perform similar roles based on their job descriptions or if a non-discriminatory environment based on gender is effectively established within health facilities in Kiribati.

FINANCING

The Financing domain assesses a country's commitment to primary health care by evaluating the allocation of funds to PHC and sources of expenditure. The assessment uses five indicators to evaluate the total spending on and prioritization of PHC. The first indicator—current PHC expenditure per capita—examines the financial commitment to PHC by capturing the absolute amount of PHC spending per person. The subsequent two indicators focus on the spending prioritization on PHC. The first is the current PHC expenditure as a percentage of current health expenditure, which captures PHC spending in relation to total health spending. The second is the domestic general government PHC expenditure as a percentage of the current health expenditure, which compares PHC spending to total government health spending. The last set of primary health care financing indicators examines the sources of PHC spending, including government spending as a percentage of total PHC spending and other spending (domestic private and external) as a percentage of total PHC expenditure. At the time of this assessment, data on PHC financing was not available for Kiribati. It is important that Kiribati develop the methodologies and tools, such as adhering to the System of Health Accounts that is widely adopted across both high and low-income countries, for routinely capturing PHC financing.

RECOMMENDATIONS

1. **Strengthen governance to support comprehensive, integrated PHC services that meet population needs**

1.1. Support Health Strategic Plan implementation to ensure a more integrated and comprehensive health system. Kiribati would benefit from providing additional support to ensure that the upcoming implementation of the Health Strategic Plan is effectively integrated. This process would include clearly defining the scope of PHC in Kiribati within the National Strategic Plan. Additional support could include the establishment of feedback mechanisms between PHC facilities and the MHMS, which would enable more rapid adjustments to policies and plans and make it possible to contextualize them to the facility's needs. It is also critical that an integrated monitoring framework that establishes formal indicators and targets for PHC is developed and adhered to. Each of these actions would benefit from regular evaluations to assess the impact of these policies and further refine the meaning of PHC in Kiribati. Both a monitoring framework and regular evaluations would enable Kiribati to adjust policies to better meet population needs and promote accountability among PHC actors.

1.2. Establish a PHC unit and/or focal point within the MHMS to improve coordination, integration, and the effective delivery of health services. To enhance coordination and oversight for PHC policies, plans, and strategies, Kiribati would benefit from establishing a dedicated PHC unit and/or focal point within the Ministry of Health. The establishment of a PHC unit and/or focal point would consolidate key decision-making power and authority while improving coordination and accountability. In combination with implementation of the Health Strategic Plan, these actions would help to define PHC. For example, a dedicated PHC unit would help advocate for and ensure that PHC is considered across the health system, promoting a more integrated health system. A specific

starting point could be coordinating with a national TB program and TB outreach workers to better communicate with clinics to help identify and manage patients with diabetes in the households who have also been diagnosed with TB.

1.3. Formally involve civil society in policy development and implementation to ensure policies reflect population health needs. Kiribati would benefit from proactively and systematically involving civil society in PHC policy development. Establishing a formal mechanism for incorporating CSO feedback into policy could include establishing a national steering committee with appointed representatives from the Ministry of Health and CSOs who regularly convene to share insights and better adapt PHC policies. The steering committee could also provide a formal mechanism for soliciting CSO feedback during the policy development and implementation process. In Mumbai, India, the presence of CSOs and NGOs working with hard-to-reach populations in informal settlements was found to improve PHC policy by being trusted local resources in communities and therefore possessing a strong knowledge of community needs and having a strong understanding of the health systems capabilities, enabling them to identify actionable solutions to address challenges.[1]

1.4. Establish clear roles and responsibilities for government agencies to address multi-faceted challenges such as NCDs. Kiribati would benefit from clearly defining and allocating clear roles and responsibilities among different government sectors for the effective implementation, monitoring, and evaluation of multi-sectoral policies. This would equitably distribute the responsibility of implementation of multi-sectoral policies across various government sectors, promoting accountability among actors. This type of

1 Jayaraman, A., & Fernandez, A. (2023). Role of civil society in health care: Mechanisms for realizing universal health coverage in vulnerable communities of India. Frontiers in Public Health, 11, 1091533.

delegation would also benefit from the development of a results framework, which clearly outlined the role, responsibility, and funding sources of multi-sectoral policies and links actions to specified targets and indicators. This is especially crucial for addressing the challenges posed by NCDs. The WHO has launched an initiative to develop multi-sectoral action plans (MSAPs) globally, with several countries demonstrating good progress. An evaluation of MSAP development in four countries (Lebanon, Morocco, Sudan, and Yemen) shows that the process fosters collaboration between sectors and helps to establish a common perception of health issues, competing priorities, responsibilities, and the meaning of success.[2]

2. Strengthen information systems to better manage resources and improve performance monitoring

2.1. Establish an auditing process to ensure that essential inputs are consistently available. Kiribati would benefit from establishing an auditing mechanism to guarantee the consistent availability of essential resources and inputs. A regular auditing process would manually collect data on the availability of essential inputs in PHC facilities, providing longitudinal data to be used to target facilities with frequent stock-outs. This system would manually collect information on the availability of essential inputs at health facilities at regular time intervals. This information could be aggregated to higher levels of authority to identify patterns in stock-outs, enabling high-risk facilities to be targeted. An audit system would be most effective if complemented with training for health care providers related to input management. In Uganda for example, health care workers were trained on medical management capacity, with specific modules focused on dispensing quality, prescribing quality, stock

2 Wickramasinghe, K., Wilkins, E., Foster, C., Fadhil, I., Hammerich, A., Slama, S., & Townsend, N. (2018). The development of national multisectoral action plans for the prevention and control of noncommunicable diseases: experiences of national-level stakeholders in four countries. Global Health Action, 11(1), 1532632.

management, storage management, and ordering and reporting. Health care workers were trained through supervisor visits to health facilities who conducted training and performance assessments. Significant improvements were reported across all five of the module areas over a three-year period.[3] Additionally, in the long term, a audit system can be used to develop a digital information system. As the digital system is developed, the audits could transition to monitoring the information system used and be trained to provide technical support to facilities.

2.2. Enhance coordination between MHMS, PHC facilities, and outer islands facilities to ensure seamless and coordinated PHC service delivery. There is an opportunity to build on the coordination between the MWYSSA and the MHMS, with a specific focus on the outer islands. This entails establishing clear protocols and pathways to communication from outreach, PHC facilities, and the MHMS. These mechanisms can include using basic messaging channels (for example, WhatsApp or other messaging platforms) or video conferencing (for example, Zoom or other video platforms) to communicate at scheduled frequencies. Regardless of the mechanism, it is essential that it is designed in a way that promotes open, constructive, and frequent communication between PHC stakeholders. For example, Belize leveraged previous communication channels during the COVID-19 pandemic to enhance coordination among national and community-level PHC stakeholders. These channels were especially useful during the pandemic, as increased communication and coordination was required to adjust services. In addition to enhancing communication between national and local

3 Trap, B., Ladwar, D. O., Oteba, M. O., Embrey, M., Khalid, M., & Wagner, A. K. (2016). Article 1: Supervision, Performance Assessment, and Recognition Strategy (SPARS)-a multi-pronged intervention strategy for strengthening medicines management in Uganda: method presentation and facility performance at baseline. Journal of pharmaceutical policy and practice, 9, 1-15.

stakeholders, the channels fostered greater levels of facility-to-facility communication.[4]

2.3. Routinely collect facility-level data through a unified HMIS and centralize data aggregation at the national level to facilitate ongoing performance monitoring. Maximize the use of the HMIS to consolidate various vertical programs into an integrated PHC system. This involves aggregating data collection under a unified HMIS and making data available at the national level for evaluation and decision-making. It is important that a unified HMIS is integrated with community-level facilities and providers to ensure patient information is continuously collected, especially for the hard-to-reach population. Facing similar challenges, including highly fragmented information systems, Nepal developed the Nepal Electronic Health Record (EHR). The EHR system combines three easy-to-use, low-cost information systems including: Bahmni, an open-source facility-based information system and electronic health system; Commcare, a community-based data collection platform with off-line functionality and integrating with facility records; and DHIS2, a web-based open-source management and information system with additional decision-making tools. The EHR system collects and aggregates patient and facility data in the community and at the facility, and information is displayed on dashboards which facilitate decision-making.[5]

3. Invest in quality of care to enhance the effectiveness of PHC services

3.1. Enhance the capacity of PHC facilities to deliver essential RMNCH, infectious disease, and NCD services. Take immediate action

4 The Role of Belize's Primary Health Care System in Pandemic Preparedness and Response: A Qualitative Study. 2023: Retrieved: https://openknowledge.worldbank.org/entities/publication/73d804c3-eaf6-47a0-bc96-4cfb6d279338.

5 PHCPI Improvement Strategies, Nepal. Retrieved from https://www.improvingphc.org/nepal-information-technology.

to improve the comprehensiveness of services related to RMNCH, infectious disease, and NCDs to better address community needs. Beyond ensuring that RMNCH, infectious disease, and NCD services are consistently available in facilities, it is critical that PHC facilities promptly gain access to diagnostic tests and actively train health care providers in their usage and interpretation. Specifically, there is an opportunity to build on the Medical Council's program for medical accreditation to continuously monitor health care providers' skills and competencies by conducting evaluations of provider competencies. Continuously assessing the skills of health care providers is critical for ensuring the quality of care and that the resources available to them are used effectively. Establishing an auditing system will also enable a responsive system to identify and support low-performing providers and facilities through additional training and improvement opportunities.

3.2. Leverage the Role Delineation Policy as a direct opportunity to consolidate various vertical programs and clinical guidelines/ protocols. The implementation of the Role Delineation Policy is a critical opportunity to ensure that health care services are consistently delivered across Kiribati. Specifically, the Role Delineation Policy has the potential to help consolidate clinical guidelines and protocols, shifting PHC away from a collection of vertical programs. Identifying opportunities to consolidate and integrate PHC through the Role Delineation Policy is critical for implementing clear guidelines and referral protocols, especially for NCD management. In the Solomon Islands, the development of the Role Delineation Policy has been instrumental in defining the range of services and where these services are to be delivered. The Role Delineation Policy is integrated with the Service Delivery Package and is also embedded within the National Development Plan and National Health Strategic Plan. Furthermore, the Solomon Islands Role Delineation Policy has been continuously adapted to organizational reforms. These adjustments

include changes to the service delivery package and organizational structures of the health system. Regardless, the Role Delineation Policy has been instrumental in helping Solomon Islands to ensure national, regional, and local stakeholders guide resource allocation, understand what services to deliver, and who is expected to provide them.[6]

3.3. Strengthen the competencies of health assistants and nurse aids to improve care quality and address the growing burden of NCDs. Expanding the capacity of health assistants and nursing aids has the potential to greatly enhance the quality of PHC services. This can include formally integrating nursing aids into the health system. In addition, the training for nurse aids and health assistants can be enhanced to equip them with the skills to address population health challenges, including standardizing pre-service training for both cadres. It is especially important that treatment guidelines be updated, and these updates be reflected in training curriculum. Health worker competencies can be further supported through supportive supervision, which can also be used to continuously evaluate and assess provider skills and competencies, and by providing health care workers with additional training. Kenya provides an example of leveraging a task-shifting and supportive supervision to improve NCD service delivery. In addition to adopting a team-based approach that shifted service delivery from clinical offers to teams consisting of physicians, nurses, counselors, social workers, health promoters, and laboratory staff, Kenya provided nurses with additional supportive supervision to enhance their clinical skills related to NCD diagnosis and management. Results demonstrated significant improvements

6 PHCPI Improvement Strategies, Solomon Islands. Retrieved from https://www.improving-phc.org/solomon-islands-organisation-..services#:~:text=The%20Role%20Delineation%20Policy%20defines,at%20different%20levels%20of%20care.

to clinical protocols related to screening and laboratory monitoring, along with higher levels of patient satisfaction.[7]

4. **Optimize facility management for efficient PHC services**

4.1. Transition to performance-based budgeting to enhance efficient resource allocation. Kiribati would benefit from the establishment of performance-based budgeting, which would provide PHC facilities with greater autonomy and flexibility. Performance-based budgeting is focused on achieving predefined outcomes while proactively considering the required resources. This approach to budgeting ensures that health care facilities be responsible for delivering tangible results, such as effectively preventing, diagnosing, and treating patient conditions, rather than solely tracking resource expenditure. Output-based budgeting offers a transparent depiction of the expected outcomes associated with the allocated funds, as opposed to solely verifying that funds were spent according to the initial plan. Furthermore, adopting this approach enhances budget flexibility to address evolving local health demands. Argentina provides an example of changing budgeting approaches to improve resource allocation. Specifically, 60 percent of funding was provided to facilities based on the number of individuals empaneled. The remaining 40 percent of funds were allocated based on a set of tracer conditions. Setting up budgets in this manner provides incentives to increase population coverage, while also more efficiently transferring funds to front-line providers. It also reimbursed providers for the service provider through fee-for-service, further incentivizing providers to increase the provision of priority services.[8]

7 PHCPI Improvement Strategies, Brazil, Cuba, Ghana, Kenya, and Nepal. Retrieved from: https://www.improvingphc.org/brazil-cuba-ghana-kenya-nepal-serviceavailability-readiness.

8 PHCPI Improvement Strategies, Argentina. Retrieved from: https://www.improvingphc.org/argentina-purchasing-payment-systems.

4.2. Enable PHC facilities to utilize diagnostic-related groups (DRG) to effectively manage patients with chronic conditions. DRGs are a provider-payment mechanism that provides prepaid funds to facilities for treating patients with a common condition. DRGs group patients with similar clinical conditions and resource utilization patterns together for the purpose of budgeting, resource allocation, and reimbursement. This system helps health care facilities and providers in lower-middle-income countries to streamline their financial and medical management by assigning a fixed payment rate for a specific group of patients with similar health conditions. Establishing DRGs for patients with chronic conditions would help to support PHC facilities in the efficient management of patients with chronic conditions by ensuring facilities have the funds available to properly treat and manage patients when needed. In Thailand, DRGs were introduced to provide an additional payment on top of the capitation rate for more severe patients. This system provides health care providers with additional funding to manage complex and chronic conditions, helping to ensure funds are immediately available to serve these populations, thus improving care coordination and responsiveness.[9]

4.3. Establish and actively employ formal mechanisms for integrating community perspectives into facility planning and organization. Formally establishing a mechanism to facilitate patient and community feedback, such as a basic redressal mechanism, will help PHC facilities adapt services to population health needs. Specifically, there is a need to embed patient and community feedback into facility planning beyond environmental and public health issues to focus on holistic PHC service development. Peru provides an example of embedding communities' perspective into

9 Bredenkamp, C., Bales, S., & Kahur, K. (eds.). (2019). Transition to Diagnosis-Related Group (DRG) payments for health: lessons from case studies. World Bank Publications.

policy making and decision process. This includes the establishment of Local Committees for Health Administration (CLAS), which consist of a physician, three community members selected by the physician, and three members of the community selected by the community. These groups assist in local needs assessments, operational decisions, and financial management. They are also involved in developing key definitions of national health strategies and local development plans. Outcomes associated with the introduction of CLASs include improved patient satisfaction and greater access to services among poor populations.[10, 11]

4.4. Invest in the skills of managers to ensure facilities are effectively operated. Kiribati would benefit from conducting a formal evaluation of facility managers' skills, including their ability to operate the facility, deploy human resources in multidisciplinary teams, routinely collect and use information for decision-making, and oversee initiatives. Upon identifying strengths and gaps in providers' skills, the MHMS can develop or provide funding to providers to undertake in-service training programs to address their skill gaps. Ethiopia provides an example of implementing facility management reform. Specifically, the government partnered with administrators from the United States to complete short courses on facility management within the Master of Public Health program. Participants who completed the course demonstrated improved key indicators within their facilities, leading to greater efficiency and more effective service delivery.[12]

10 PHCPI Improvement Strategies, Ethiopia. Retrieved from https://www.improvingphc.org/ethiopia-management-services-0.

11 PHCPI Improvement Strategies, Kenya, Peru, Uganda, and Zimbabwe. Retrieved from https://www.improvingphc.org/kenya-peru-uganda-zimbabwe-management-services.

12 Iwami, M., & Petchey, R. (2002). A CLAS act? Community-based organizations, health service decentralization and primary care development in Peru. Journal of Public Health, 24(4), 246-251.

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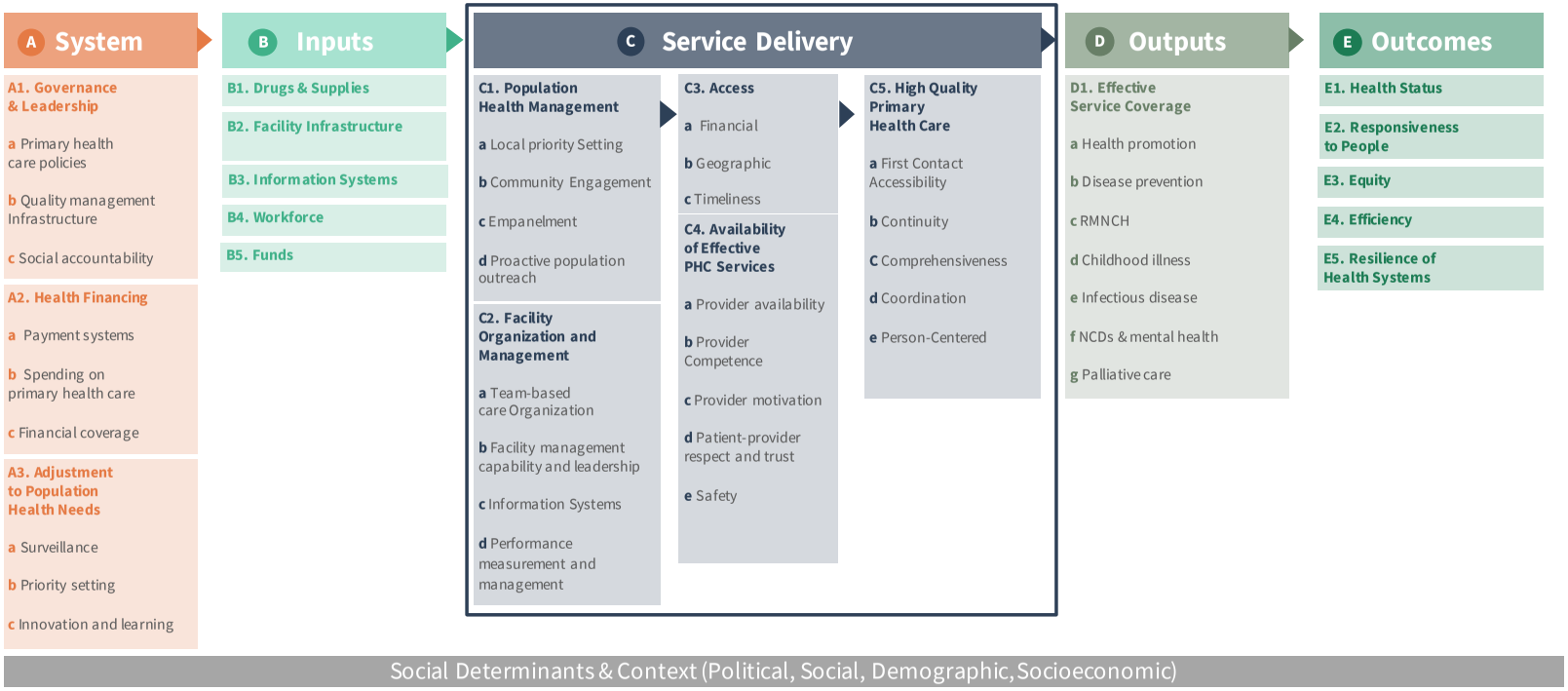
ANNEXES

ANNEX 1. PRIMARY HEALTH CARE PERFORMANCE INITIATIVE FRAMEWORK



Source: Veillard et al. 2017.

ANNEX 2. PERFORMANCE DOMAIN

phcpi

PERFORMANCE DOMAIN: DETAILED VITAL SIGNS PROFILE INDICATORS

Kiribati	SCORE	PERCENTAGE	SOURCE	YEAR
ACCESS	81			
Financial				
Perceived access barriers due to treatment costs*		17%	*HIES*	*2019*
Geographic				
Perceived access barriers due to distance*		21%	*HIES*	*2019*
QUALITY	75			
Comprehensiveness				
Avg. availability of 5 tracer RMNCH services		71%	*SARA Survey*	*2017*
Avg. availability of services for 3 tracer communicable diseases		42%	*SARA Survey*	*2017*
Avg. availability of diagnosis & management for 3 tracer NCDs		92%	*SARA Survey*	*2017*
Continuity				
DTP3 dropout rate*		93%	*WHO/UNICEF*	*2022*
Treatment success rate for new TB cases		83%	*TB country Profile*	*2021*
Person-Centeredness				
% of caregivers who were told sick child's diagnosis		No data available		
Provider availability				
% of family planning, ANC, and sick child visits over 10 minutes		No data available		
Provider absence rate*		No data available		
Safety				
Adequate waste disposal		67%	*SARA Survey*	*2017*
Adequate infection control		73%	*SARA Survey*	*2017*
SERVICE COVERAGE	55			
Reproductive, Maternal, Newborn and Child Health				
Demand for family planning satisfied with modern methods		54%	*MICS*	*2018-2019*
Antenatal care coverage (4+ visits)		67%	*MICS*	*2018-2019*
Coverage of DTP3 immunization		92%	*WHO/Unicef*	*2022*
Care-seeking for suspected child pneumonia		87%	*MICS*	*2018-2019*
Infectious diseases				
Tuberculosis cases detected and treated with success		50%	*TB monitoring report*	*2021*
People living with HIV receiving anti-retroviral treatment		55%	*UHC Global Monitoring Report*	*2021*
Use of insecticide-treated nets (ITN) for malaria prevention				
Children under 5 with diarrhea receiving ORS		61%	*MICS*	*2018-2019*
Non-Communicable Diseases (NCDs)				
% of treatment among adults with hypertension***		34%	*STEPS*	*2015*

*Indicators where lower values are preferable were transformed before inclusion in the index. The modified indicator was defined as 100-X, where X is the original percentage shown in this table. **Country-specific (proxy) indicator, used in absence of globally comparable survey data. ***Prevelance of treatment among adult population(18-69) with hypertension. For more details see Tracking UHC: 2023 Global Monitoring Report. Note: Summary scores for the domains of Access, Quality, and Coverage are calculated by taking the average of indicator values within each subdomain, and then taking the average across subdomain scores.

ANNEX 3. CAPACITY DOMAIN

PERFORMANCE DOMAIN: DETAILED VITAL SIGNS PROFILE INDICATORS

Kiribati	SCORE
GOVERNANCE	2.0
Governance and Leadership	2.4
Measure 1: Primary health care policies (1/2)	
Measure 2: Primary health care policies (2/2)	
Measure 3: Quality management infrastructure	
Measure 4: Social accountability (1/2)	
Measure 5: Social accountability (2/2)	
Adjustment to Population Health Needs	1.7
Measure 6: Surveillance	
Measure 7: Priority setting	
Measure 8: Innovation and learning	
INPUTS	1.9
Drugs and Supplies	1.3
Measure 9: Stock-out of essential medicines	
Measure 10: Basic equipment availability	
Measure 11: Diagnostic supplies	
Facility Infrastructure	1.7
Measure 12: Facility distribution	
Measure 13: Facility amenities	
Measure 14: Standard safety precautions and equipment	
Information Systems	2.0
Measure 15: Civil Registration and Vital Statistics	
Measure 16: Health Management Information Systems	
Measure 17: Personal care records	
Workforce	2.0
Measure 18: Workforce density and distribution	
Measure 19: Quality assurance of primary health care workforce	
Measure 20: Primary health care workforce competencies	
Measure 21: Community health workers	
Funds	2.7
Measure 22: Facility budgets	
Measure 23: Financial Management Information System	
Measure 24: Salary payment	
POPULATION HEALTH AND FACILITY MANAGEMENT	1.8
Population Health Management	2.3
Measure 25: Local priority setting	
Measure 26: Community engagement	
Measure 27: Empanelment	
Measure 28: Proactive population outreach	
Facility Organization and Management	1.4
Measure 29: Team-based care organization	
Measure 30: Facility management capability and leadership	
Measure 31: Information system use	
Measure 32: Performance measurement and management (1/2)	
Measure 33: Performance measurement and management (2/2)	

ANNEX 4. RECOMMENDATIONS FOR IMPACT, FEASIBILITY, AND TIMELINESS

Recommendation	Resources required, from low (+) to high (+++)	Difficulty of execution, from low (+) to high (+++)	Potential impact, from low (+) to high (+++)	Time horizon from impact, (short, medium, or long)	Main PHC dimensions affected
1. Strengthen governance to support comprehensive, integrated PHC services that meet population needs					
1.1. Support Health Strategic Plan implementation to ensure a more integrated and comprehensive health system	+	+	+++	Medium	Capacity Performance
1.2. Establish a PHC unit and/or focal point within the MHMS to improve coordination, integration, and the effective delivery of health services	+++	+	+++	Medium	Capacity Performance
1.3. Formally involve civil society in policy development and implementation to ensure policies reflect population health needs	+	++	++	Medium	Capacity Performance
1.4. Establish clear roles and responsibilities for government agencies to address multi-faceted challenges such as NCDs	++	+++	+++	Long	Capacity Performance
2. Strengthen information systems to better manage resources and improve performance monitoring					
2.1. Establish an auditing process to ensure that essential inputs are consistently available	++	+++	+++	Long	Performance Capacity
2.2. Enhance coordination between MHMS, PHC facilities, and outer island facilities to ensure seamless and coordinated PHC service delivery	+	++	++	Medium	Capacity Performance Equity
2.3. Routinely collect facility-level data through a unified HMIS and centralize data aggregation at the national level to facilitate ongoing performance monitoring	+++	+++	+++	Long	Capacity Performance
3. Invest in quality of care to enhance the effectiveness of PHC services					
3.1. Enhance the capacity of PHC facilities to deliver essential RMNCH, infectious disease, and NCD services	+++	++	+++	Short	Performance Equity Capacity
3.2. Leverage the Role Delineation Policy as a direct opportunity to consolidate various vertical programs and clinical guidelines/protocols	+	++	++	Medium	Capacity Quality
3.3. Strengthen the competencies of health assistants and nurse aids to improve care quality and address the growing burden of NCDs	+++	++	++	Medium	Capacity Performance Equity

Recommendation	Resources required, from low (+) to high (+++)	Difficulty of execution, from low (+) to high (+++)	Potential impact, from low (+) to high (+++)	Time horizon from impact, (short, medium, or long)	Main PHC dimensions affected
4. optimize facility management for efficient PHC services					
4.1. Transition to performance-based budgeting to enhance efficient resource allocation	++	+++	++	Long	Capacity Financing
4.2. Enable PHC facilities to utilize diagnostic-related groups (DRG) to effectively manage patients with chronic conditions	++	+++	++	Long	Capacity Financing
4.3. Establish and actively employ formal mechanisms for integrating community perspectives into facility planning and organization	+	++	+	Short	Capacity
4.4. Invest in the skills of managers to ensure facilities are effectively operated	+++	++	++	Medium	Capacity

Note: PHC = primary health care.

ANNEX 5. STAKEHOLDER INVOLVEMENT IN IMPLEMENTATION OF RECOMMENDATIONS

Recommendation	National government	Local government	Academia	Patients and citizens
1. Strengthen governance to support comprehensive, integrated PHC services that meet population needs				
1.1. Support Health Strategic Plan implementation to ensure a more integrated and comprehensive health system	F, E, M, P	P, I, D	D	I
1.2. Establish a PHC unit and/or focal point within the MHMS to improve coordination, integration, and the effective delivery of health services	F,E,M, P	D,I	D,I	I
1.3. Formally involve civil society in policy development and implementation to ensure policies reflect population health needs	F,E,M	P,I	P,I,D	P,I,D
1.4. Establish clear roles and responsibilities for government agencies to address multi-faceted challenges such as NCDs	F,E,M,P	P,I,D	P,I,D	I
2. Strengthen information systems to better manage resources and improve performance monitoring				
2.1. Establish an auditing process to ensure that essential inputs are consistently available	F,E,M,P	P,I,D	I,D	I
2.2. Enhance coordination between MHMS, PHC facilities, and outer island facilities to ensure seamless and coordinated PHC service delivery	F,E,M,P	P,I,D	I,D	I
2.3. Routinely collect facility-level data through a unified HMIS and centralize data aggregation at the national level to facilitate ongoing performance monitoring	F,E,M,P	P,I,D	I,D	I
3. Invest in quality of care to enhance the effectiveness of PHC services				
3.1. Enhance the capacity of PHC facilities to deliver essential RMNCH, infectious disease, and NCD services	F,E,M	P,I,D	P	P
3.2. Leverage the Role Delineation Policy as a direct opportunity to consolidate various vertical programs and clinical guidelines/ protocols	F,E,M	P,I,D	P,I,D	I
3.3. Strengthen the competencies of health assistants and nurse aids to improve care quality and address the growing burden of NCDs	F,E,M	P,I,D	P,I,D	I

Recommendation	National government	Local government	Academia	Patients and citizens
4. Optimize facility management for efficient PHC services				
4.1. Transition to performance-based Budgeting to enhance efficient resource allocation	F,E,M, P	P,I,D	P,I,D	I
4.2. Enable PHC facilities to utilize diagnostic-related groups (DRG) to effectively manage patients with chronic conditions	F,E,M, P	P,I,D	I,D	I
4.3. Establish and actively employ formal mechanisms for integrating community perspectives into facility planning and organization	F,E,M, P	P,I,D	P,I,D	P, I, D
4.4. Invest in the skills of managers to ensure facilities are effectively operated	F,E,	M,P	E,I,D	I

Note: F = provide financing or financial incentives; E = establish strategic direction; M = manage the program; P = participate in the implementation of the program or support it; I = stay informed on the program activities; D = make informed or strategic decision; PHC: primary health care.

ANNEX 6. PROGRESSION MODEL PARTICIPANTS

PROGRESSION MODEL KEY INFORMANTS

Interviewee	Title
Dr. Revite Kirition	Director General, MHMS
Pauline Beiatau	Legal Adviser for Kiribati Medical Council
Tamoa Moannata	Program Lead, KFHA
Antje Reiher	NCD Program Coordinator
Teanibuaka Tabunga	NCD Consultant
Bereti Bureimoa	MFAT Health Focal Point
Tiareti Mareko	District Principal Nurse Officer
Katarina Ruteiko	District Principal Nurse Officer
Manrenga Itibwerere	District Principal Nurse Officer
Helen Murdoch	Director Nursing
Tinia Raj	SAS
Kantaake Corbett	Health Information Unit
Neya Harry	Senior Account Officer, MHMS
Moannara Benete	Chief Pharmacist, MHMS
Tebe Harding	PMU, MHMS; M&E Officer, KHSSP

WORKSHOP PARTICIPANT LIST (OCT. 17-18/2023)

	Name	Department/Unit/Organization
1	Dr Tekeua Uriam	DHS MHMS, TLT
2	Ms Ereti Timeon	DPH MHMS, TLT
3	Ms Helen Murdoch	DNS MHMS, TLT
4	Dr Tanebu Tong	DDPH MHMS, TLT
5	Ms Toata Titaake	DDNS MHMS, TLT
6	Ms Tiroia Teikake	RMNCAH MHMS
7	Ms Nikarawa Nanimatang	E-Health MHMS

	Name	Department/Unit/Organization
8	Ms Mweritonga Temareti	H-Promotion, MHMS
9	Ms Antje Reiher	NCD specialist MHMS
10	Dr Marou Tikataak	CD specialist MHMS
11	Ms Raebwebwe Taoaba	Trachoma Program Manager
12	Tiareti Mareko	DPNO MHMS
13	Manrenga Itibwere	DPNO MHMS
14	Teoraiti Tetoa	PNO MHMS
15	Atata Tekeniman	PNO MHMS
16	Terry Eromanga	PNO MHMS
17	Ms Kantaake Corbett	HIU MHMS
18	MA Bereluta Ereman	PHC Clinic Betio
19	MA Tirite Irooti	PHC Clinic TUC
20	Dr. Tabutoa Eria	EM/OPD Representative MHMS
21	Tareti Ioane	KIT SONH Representative
22	Ms Odylia Teaero	Kiribati Medical Council Representative
23	Mohamed Abdalla	UNICEF Representative
24	Aren Teannaki	UNFPA Representative
25	Manuela Villar Uribe	World Bank Representative
26	Valeria Cruz Villalba	World Bank Representative
27	Iobi Batio	World Bank Representative
28	Misato Assahil	MSF PMR
29	Sue Bocknell	MSF Field Coordinator
30	Gabrielle Appleford	UNICEF Representative
31	Bwakoua Merang	WHO Representative
32	Enoka Arabua	HP
33	Tennanera Teromon	
34	Monica Tarabo	SONH
35	Riitz Rajinda	SONH
36	Koorio Tetaboa	WHO

ANNEX 7. PROGRESSION MODEL DOCUMENTS REVIEWED

Kiribati Development Plan 2016-19
Kiribati Development Plan 2020-2023
Mid-term Review of the National Health Strategic Plan
Kiribati–WHO Country Cooperation Strategy 2018–2022
Kiribati–WHO Country Cooperation Strategy at a Glance
Kiribati Climate Change Policy
Kiribati 20-year Vision 2016-2036
Regional Framework on the Future of PHC in the Western Pacific
Public Health Act (Cap 111)
Kiribati Joint Implementation Plan for Climate Change and Disaster Risk Management (KJiP) 2019-2028
Primary Health and the National Women's Federation in Kiribati – Primary Health Care in Kiribati
Ministry Strategic Plan 2016-2019
Ministry Strategic Plan 2020-2025
Strategic Roadmap for Emergency Management – Kiribati 2020 – 2024
Tracking Universal Health Coverage: 2017 Global Monitoring
National Quality Policy of Kiribati 2017-2023
MICTTD Strategic Plan 2021-2024
Kiribati Country Planning Framework
Kiribati NCD Risk Factors STEPS Report
Role Delineation Policy
National Health Strategic Plan 2020-2023
Kiribati Annual Health Bulletin 2015
Universal Health Coverage and the Pacific Islands: An Overview of Senior Leaders' Discussions, Challenges, Priorities and Solutions, 2015-2020
Priority Setting Workshop for Pacific Subregion, 23rd to 26th February 2021. Lima Adaptation Knowledge Initiative
Kiribati Family Health Association. Strategic Plan 2023-2028
Establishment Register 2023

Supportive Supervision Assessment Tool. PHC. Rural Health Centres
Supportive Supervision Assessment Tool. PHC. Rural Clinics
Public Health Infectious Disease Regulation
Kiribati Essential Medicines List
Medical Services Act 1996
Medicines Act 2018
Quarantine Ordinance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