Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 27-Feb-2022 | Report No: PIDA32906

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Kiribati	P176306	Kiribati Health Systems Strengthening Project	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
EAST ASIA AND PACIFIC	18-Feb-2022	15-Mar-2022	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Republic of Kiribati	Ministry of Health and Medical Services	

Proposed Development Objective(s)

To improve equitable access and quality of health services in targeted areas and in the case of an eligible crisis or emergency, respond promptly and effectively to it.

Components

Component 1: Improving equitable access and quality of health services on the outer islands
Component 2: Strengthening the quality and range of services provided through hospitals
Component 3: Project management and health information system enhancement
Component 4: Contingent emergency response component (CERC)

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	14.00
Total Financing	14.00
of which IBRD/IDA	14.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	14.00

IDA Grant	14.00

Environmental and Social Risk Classification

Substantial

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **One of the smallest and most remote countries in the world,[1] Kiribati is a lower middle-income country with an estimated population of 119,940.[2]** Kiribati 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 atolls and islands are inhabited. Around 20 percent of the country's population is formally employed in the cash economy, with 80 percent of the jobs provided by the public sector; food security relies largely on fisheries and subsistence agriculture. It has a limited economic base, dominated by (a) investment income from its sovereign wealth fund, the Revenue Equalization Reserve Fund; (b) the sale of fishing license fees; (c) remittances; and (d) aid flow. The total land area is only 811 square kilometers, but its exclusive economic zone covers approximately 3.5 million square kilometers.[3] With its low-lying atolls on average rising barely 3 meters above sea level, Kiribati is one of the most vulnerable countries to climate change. Around 50 percent of the population live in villages across the islands, 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. The 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.[4]

2. **Kiribati faces critical gender gaps in economic opportunity, decision-making and health.** Despite no gaps in primary enrolments, and women's higher rates of secondary completion in school, estimates from the 2019 Household Income and Expenditure Survey (HIES show that, at 28.7 percent, female labor force participation is low, and significantly lower than the one for men (43.1 percent). The 2019 HIES estimates further reveal that women represent slightly more than a 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.

[1] It is more than 4,000 kilometers (km) from the nearest major economies (Australia and New Zealand).
[2] Kiribati 2020 Census (Provisional).

[3] Kiribati Household Income and Expenditure Survey (HIES) for 2019-20.
[4] World Bank Regional Partnership Framework FY2017-2021.

3. **Community transmission of COVID-19 was confirmed in January 2022 with 2,487 cumulative cases and 11 deaths reported as of February 22, 2022.**[5] Prior to this only 2 imported COVID-19 infections had been reported, both on-board an offshore fishing vessel. In response to the recent outbreak, which has been classified as a large-scale community transmission, the Government of Kiribati (GOK) raised the national alert level to Alert Level 3. A national lockdown was imposed, movement was restricted to essential goods and services, and mask mandates, social distancing and quarantine requirements for positive cases and close contacts were introduced. As of February 22, 2022, 61 percent of its total population (74,579) have received the first dose of COVID-19 vaccines and 38 percent (46,015) of the total population have been fully vaccinated. Bilateral and non-government development partners including the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), Pacific Community (SPC), and Governments of Australia (DFAT), China, India, New Zealand (MFAT) are providing support to GOK through in-kind assistance such as personal protective equipment (PPE) and medical supplies, including oxygen concentrators and masks, GeneXpert cartridges, rapid test kits and technical assistance on surveillance, clinical management, infection prevention and control, risk communications, logistics, and laboratory.

4. **Annual health expenditure in Kiribati increased by 7 percent between 2008-2018, growing from US$21.6 million to US$23.1 million,[6] 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 increased by 17.3 percent, growing from an estimated 98,761 to 115, 847.[7] As a result, per capita spending on health declined from US$219 to US$200. Overall health spending as 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.[8] 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 an 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,[9] and a budget of US$38 million[10] 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.

5. **The Kiribati Ministry of Health and Medical Services (MHMS) is responsible for overseeing health policy and delivering health care services, managing health workforce training and development, as well as implementing statutory and regulatory functions.** The MHMS is also responsible for health sector contributions to national cross-cutting agendas, such as climate change, disability and aged care services, and gender-based violence (GBV). The draft *National Health Strategic Plan* (NHSP, 2020-2023) aims to operationalize both the Government's health objectives as outlined in *Kiribati Vision20* (KV20, 2016-2036)[11] and the *Kiribati Development Plan* (KDP, 2016-2019), as well as its commitments to regional and global initiatives.[12]

[5] Pacific COVID-19 Daily Epidemiological Update, WHO February 22, 2022.
[6] Constant 2018 US$
[7] WHO Global Health Expenditure Database accessed 23 August 2021.

[8] For example, private ward accommodation, employment related medical check-ups for visas/passports, and dentures.
[9] 2020 is an anomaly given the national elections in early 2020 – expenditures for January and some of February that year has not been recorded against MHMS and is not available from the Annual Accounts for 2020.
[10] This includes substantial increases in *off system* development partner funding i.e., through their own systems (World Bank US$3.3 million, WHO US$2.5 million, MFAT-US$2.8 million) as well as an increase in the recurrent budget of US$1.6 million.
[11] *KV20* recognizes that a healthy population is a productive population and good health is a pre-requisite to economic growth and poverty reduction.
[12] The draft NHSP 2020-2023 includes a mention of the Sustainable Development Goals; although there is no explicit reference to universal health coverage (UHC) in the NHSP, the 6 key priority areas are consistent with international efforts to improve UHC.

6. **The MHMS has developed a draft Role Delineation Policy (RDP) which sets out what services are expected to be provided at each level of the health system to improve the range and quality of services available closer to where people live and to reduce unnecessary local referrals.** The RDP includes plans to strengthen supportive supervision of health workers across facilities, particularly for those working in more remote and isolated locations. The kinds of activities under supportive supervision, include (a) better patient monitoring and care closer to home, with telehealth support to local health workers for more effective case management; (b) more supportive supervision of health workers as a result of ongoing learning and professional development; (c) more timely monitoring of health service data; and (d) more efficient stock management of pharmaceuticals and medical supplies. As part of the World Bank financed *Kiribati COVID-19 Emergency Response Project* (ERP, P174219)[13] and informed by the RDP preparation process, the MHMS has completed a user requirement analysis on information communication technology (ICT) for health facilities to improve connectivity. This is being carried out in close collaboration with the Ministry of Information, Communication, Transport and Tourism Development (MICTTD) who leads GOK's efforts to improve telecommunication services in a more integrated way across the country.

Key health sector challenges

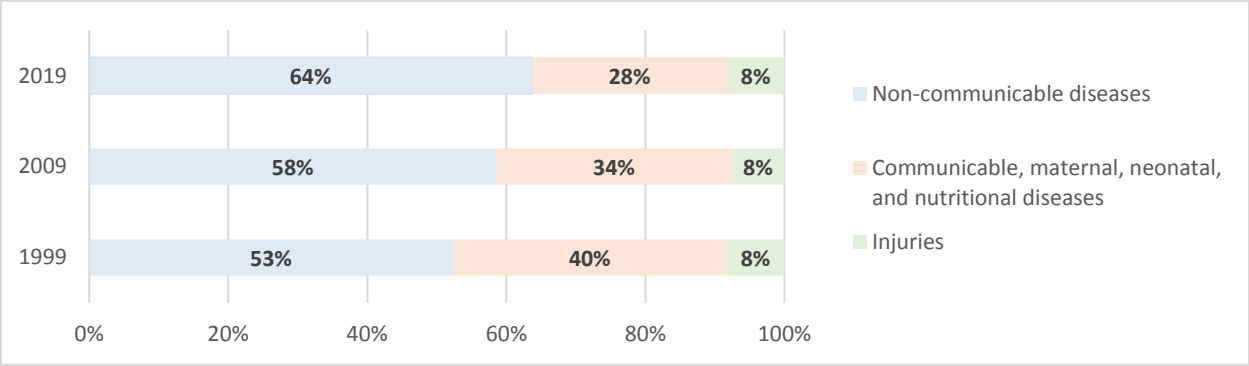
7. **International datasets generally report positive progress for most maternal and child health indicators in Kiribati although there is a growing concern with NCDs; such indicators, however, are only available at the national level.** MHMS has advised of substantial gaps in reporting from facilities; as a result currently available routinely collected national data may not be reliably used to demonstrate differences in performance between those health facilities in the main urban center of South Tarawa and the other islands. That said, the *Kiribati Social Development Indicator Survey 2018-19* (KSDIS) does provide some indication, reporting differences in child mortality rates across the islands, with neonatal deaths in South Tarawa at 15 per 1,000 live births compared with 18 on the outer islands, and infant deaths at 35 in South Tarawa compared with 48 on the outer islands. Deaths in children under 5 years of age in South Tawara was reported as 57 compared with 66 on the outer islands. The adolescent birth rate was also higher on the outer islands: 58 per 1,000 women in that age group. NCD risk factors measured in the survey showed use of tobacco within the last month at 49 percent in South Tarawa compared with 56 percent on the outer islands. Conversely, use of alcohol within the last month was higher in South Tarawa (27 percent) compared with 18 percent in the outer islands, although excessive kava consumption is widespread. Anecdotally, MHMS' experienced staff confirmed that they have observed generally poorer health outcomes on the outer islands linked to delayed care caused by the absence of required pharmaceuticals and medical supplies, and/or staff without the knowledge to provide the necessary care, and/or reluctance of citizens to seek care close to home given the poor state of local facilities and lack of confidence in the service provided.

8. **In 2019, NCDs accounted for 64 percent of the burden of diseases, up from 53 percent in 1999 (see Figure 1), and females have a slightly higher burden of disease than males.** Kiribati had the world's second highest age-adjusted comparative diabetes prevalence in adults in 2019 (22.5 percent) and this is projected to increase to 23.6 percent and 23.9 percent in 2030 and 2045, respectively. The major NCDs causing the most death and disability combined in Kiribati are ischemic heart diseases, stroke and diabetes. The draft NHSP reports that, based on 2019 data, NCDs are estimated to account for 54 deaths per 10,000 population aged 30 to 69 years in Kiribati, and the probability of dying from any cardiovascular, cancer, diabetes, and chronic respiratory diseases between the ages of 30 and 70 is 28.4 percent. The major risk factors in the adult population are tobacco use, unhealthy eating, alcohol and kava consumption and physical inactivity. Additionally, mental illness, suicides, domestic violence and injuries are growing

[13]World Bank. 2020. Kiribati - COVID-19 Emergency Response Project. Washington, D.C.: World Bank Group. https://imagebank2.worldbank.org/search/32292856

health concerns that need to be addressed. The leading communicable diseases reported in Kiribati include tuberculosis (TB), leprosy, trachoma, diarrhea, dysentery, and sexually transmitted infections; notwithstanding a steady decline over the years, the incidence of TB remains one of the highest in the region.[14]

Figure 1: Disease Burden by Case in Kiribati, 2009-2019



Source: Institute for Health Metrics Evaluation, Global Burden of Disease Study 2019 Results

9. **Infection prevention and control (IPC) and health care waste management (HCWM) also remain a key challenge in Kiribati.** An IPC baseline survey[15] conducted in 2019-20 reported that Kiribati has an average of 4 Methicillin Resistant Staphylococcus Aureus (MRSA) infections per month. Standardizing HCWM procedures across health facilities is identified as one of the key priority areas for health; the MHMS is finalizing its IPC Guideline. This Guideline is aimed at addressing IPC specific responses targeting the reduction of hospital acquired infections (which are partly caused by overcrowding/overflow of wards, beds in close proximity causing cross transmission more easily, lack of alcohol-based hand rubs, and a single water basin in wards at the front of the ward- inconvenient for health workers in terms of access); improving HCWM; ensuring health worker safety; and guiding preparedness and response to communicable disease outbreaks including emerging infections e.g., COVID-19 and other infectious diseases such as TB and measles. The combined 2019-2020 KSDIS and Multiple Indicator Cluster Survey, however, reported that both measles containing vaccine (MCV) and the full three dose course of diphtheria, tetanus and pertussis (DTP3) coverage was 52 percent, which may explain the recent measles and diphtheria outbreaks since 2019. The more densely populated South Tarawa has a lower immunization coverage (because of the large size of the population and limited community outreach programs by health workers), 51 percent for DTP3 and 48 percent for MCV3, in comparison to the outer islands, average of 59 percent for DTP3 and 58 percent for MCV3.

10. **Access to antenatal care in Kiribati is among the lowest in the Pacific, with about 67 percent of women accessing the recommended 4 or more antenatal visits during their most recent pregnancy in both South Tarawa and the outer islands.** Equitable access to services is also an issue between the urban center and outer islands. Although there are no gaps in frequency of visits between urban and rural women, the diagnostic services available to outer-island women during these visits are limited. Based on the KSDIS, during their antenatal visits close to 80 percent of urban women had access to at least 3 of the diagnostic services recommended by the WHO (blood pressure, urine sample tests and blood sample testing), while only 58 percent of rural women did. The lack of such diagnostic services could leave conditions such as anemia and infections undetected and could contribute to adverse pregnancy outcomes.

[14] In 2019, 419 case notifications per 100,000 population, United Nations Development Program/Global Fund Multi-Country Western Pacific Integrated HIV/TB Program.
[15] Source: MHMS Infection Prevention and Control (IPC) Monthly Reporting 2019-20.

Challenges in service delivery

11. **The MHMS indicated that there are significant gaps in available health information and data, which are subsequently unreliable for supporting resource allocation and other health service management decisions.** This is in part linked to the predominantly paper-based recording systems and the delays in collating information. MHMS has advised that the current Kiribati hospital information system is not working to meet the needs of clinicians and hospital management. Patient information is fragmented and not well maintained with some using digital records while some are paper based. However, building on the pre-pandemic rollout of the mSupply[16] mobile application which included the provision of tablets/notebooks to selected health facilities, MHMS began piloting the digitization of its MS1[17] health facility data form in 2019, using the same tablets provided to selected facilities in South Tarawa using mSupply mobile. MHMS has started the implementation of Tamanu, a patient-level electronic medical record platform designed specifically for the Pacific context, to boost the capacity of local health systems, supporting COVID-19 testing and active case management.

12. **Hospitals play a central role in the Kiribati health system, providing acute surgical and chronic care for all citizens as well as delivering substantial primary health services for people living nearby.** Tungaru Central Hospital (TCH) currently provides most of the acute and chronic care in Kiribati. TCH, Betio Hospital, and Southern Kiribati Hospital (SKH) provide services to the population groups based in the Gilbert and Phoenix Islands. The MHMS is seeking to strengthen the capacity of the provincial hospitals so they provide expanded services where appropriate, as well as taking on a more substantial local referral and telehealth center support function that helps improve the range and quality of primary services in health centers/clinics closest to them (an overview of the service capacity at each hospital is provided in Figure 2). As part of these plans, MFAT is supporting the construction of a new district hospital in Betio[18] to replace the existing facility currently servicing this major urban center. To provide more effective support for the remaining population that live in the Line Islands, the MHMS has requested World Bank assistance to rebuild the London Kiritimati Hospital (LKH-see Figure 2 below, picture from June 2018).[19]

[16] MHMS has been using mSupply since 2008 and started the rollout of the mSupply mobile app in 2019. mSupply is also being used for COVID vaccination rollout and reporting. mSupply (and mSupply mobile) is a logistics management software used for drugs and medical supply chain.

[17] The Monthly Consolidated Statistical Report. This report is used to collect health information from clinics and health centers for input to the central MS-1 database maintained by the Health Information Unit. Health information collected includes Clinical Services, Home Visits, Inpatient Services, Immunizations, Family Planning, Referrals, Deaths, Malnutrition, Births, Maternal Deaths, Chronic Diseases, Outbreak Reporting, Morbidity Reporting and Gender Based Violence Cases.

[18] Betio has high population density (equal to Hong Kong SAR, China). Kiribati's main seaport is at Betio.

[19] The existing hospital was built in August 1989 by the 844th Engineer Battalion of the United States Army.

Figure 2: London Kiritimati Hospital, June 2018

13. **Health services are provided through a network of 118 health facilities spread across the country**.[20] This includes TCH (about 140 beds) which serves as the national referral hospital based in Tarawa, 3 district hospitals serving other main population hubs (Betio Hospital about 33 beds, SKH about 20 beds, and LKH about 17 beds), 37 health centers, and 77 health clinics (including 3 which are run by non-governmental organizations). A recent health facility cost analysis and benchmarking completed by the World Bank in 2018-19[21] provided an overview of how MHMS was using its resources to achieve their service outputs (see Figure 4 below).[22] Similar to many countries, hospitals in Kiribati consume over half of all health resources, and staff costs are the largest budget item for every facility.[23] A review of more recent data suggests broadly similar expenditure patterns have continued, except for the decline in overseas medical referrals in 2020-2021 due to COVID-19 travel restrictions, and an across the board 30 percent increase for public servant salaries from January 2018. As of 2019, there were 62 doctors and 409 nurses on the establishment register, which equates to 0.5 physicians, and 3.5 nurses per 1,000 population. Most of the country's doctors are based at TCH. Although up from 39 in 2015, Kiribati's universal health coverage (UHC) index score of 41 is below the average for lower-middle income countries (54.8).[24]

14. **There is considerable variation in the number of LLF as well as level of staffing and workload across island groups across Kiribati.** The level of facility concentration in an area has an impact on the equity of service provision across communities, and the distribution of workloads amongst nurses; key analytical information on LLFs – grouped by island, and island group – across the country is provided. Overall, the national average is 1 LLF per 1,039 people, but there is considerable variation in the number of people served by a facility across the country. As expected, South Tarawa, with its higher density population, has 1 LLF per 4,028 people compared with the average of 1 facility per 578 people in the outer islands. Under Component 1 the proposed project will support refurbishment of selected lower-level health centers and clinics on the outer islands.

[20] This is the total number of health facilities reported in the draft NHSP (version as of 12 April 2021). By way of comparators, Tonga with its similar population but more limited geographic spread, has a total of ~ 31 health facilities, Vanuatu has a total ~115 health facilities serving a population almost twice that of Kiribati, and Fiji has a total of ~ 208 health facilities serving an estimated population of 864,000.
[21] Kiribati Facility Focus: Health Facility Cost Analysis and Benchmarking, conducted by MHMS and World Bank in 2018-2019 using 2017 dataset.
[22] In 2017 there were 110 health facilities: 4 hospitals and 106 lower-level health facilities.
[23] Payroll costs shown in Figure 4 do **not** include the 30% salary increase provided to public servants from January 2018.
[24] Latest data available (2017).

15. **While medical referrals, both internal and overseas, are necessary and important components of a small country's service delivery mechanisms, Kiribati has been reviewing ways to manage referrals more effectively.** The health facility cost analysis and benchmarking completed in 2018-19 reinforced that, compared with 2 other small Pacific countries, Kiribati spends much more on both internal[25] and overseas referrals (see Figure 3). There are clear reasons for some of these differences, but more can be done to achieve better health outcomes and overall value from these investments. There are clear reasons for some of these differences, but more can be done to achieve better health outcomes and overall value from these investments.

Figure 3: Estimated Expenditure on Patient Referrals in Kiribati and Two Pacific Country Comparators – Tonga and Vanuatu (2017, in AUD)

	Kiribati		Pacific Comparator 1 - Tonga		Pacific Comparator 2 - Vanuatu	
National Expenditure	*AUD*	*Per Capita*	*AUD*	*Per Capita*	*AUD*	*Per Capita*
Patient Referral (domestic)	1,071,308	9.7	57,514	0.6	297,918	1.1
Overseas Medical Treatment	3,685,451	33.5	1,431,109	14.2	427,183	1.5

16. **Before COVID-19 related international border closures were introduced in Kiribati in early 2020, expenditure on overseas medical referrals (OMR) had been increasing rapidly; in 2019, OMR expenditure represented over 15 percent of total Government expenditure on health (~AUD 4.8 million, or $US3.4 million).** This provided medical treatment to 132 patients (0.11 percent of the population[26]). Over the 5 years to 2019, the average cost per patient referred overseas increased by 100 percent, from AUD 18,307 (~US$ 13,773) to AUD 36,630 (~US$ 25,471). In comparison, total GOK expenditure for its citizens per capita on health in 2019 was US$ 263 (about AUD 370). MHMS is drawing on the World Bank Health Program of Advisory Services and Analytics (PASA) to improve its reporting and analysis of referrals while Subcomponent 1.2 of this project focuses on improving domestic patient referral system and access to telehealth.

17. **While some form of a health facility[27] is usually accessible, the physical quality of facilities and the quality of services delivered varies.** Restricted communication and related support systems add to the many challenges faced by service providers and the people they serve. Perhaps reflecting the relatively high number of facilities to population ratio,[28] Kiribati generally reports considerably higher health seeking behavior compared with most other lower-middle income Pacific countries, with outpatient consultations between 2015-2020 reported at 4.7 per person per year.[29] Nationally this dropped to 3.75 per person per year in 2020, with most reductions seen in the populated urban centers of South Tarawa (including Betio) which was reportedly down to 3.4 consultations, while the outer islands (including

[25] Using the 2017 referral data, current travel costs on normal flights (i.e., fares), assuming the patient and a caregiver travelled to the same destinations and were repatriated, the estimated cost was just over AUD 507,000. The combined cost estimate of referrals using passenger and charter flights is AUD 592,237 (AUD 507,000 + AUD 84,740), this is approximately half of the actual expenditure of AUD 1.1 million in 2017.

[26] Kiribati 2020 Census (provisional)

[27] Either health clinic, center, district hospital or the national referral hospital.

[28] Kiribati most recently reports a total of 115 health facilities that are Government run. Tonga with its similar population but more limited geographic spread has a total of ~ 31 health facilities, Vanuatu has ~115 health facilities with double the population of Kiribati.

[29] As a comparison both Solomon Islands and Vanuatu average less than 2 outpatient visits per person per year, while Tonga in 2017 reported 3.7.

North Tarawa) reported an average of 4.1 consultations per capita. This most likely reflects COVID-19 movement restrictions and related changes to health seeking behavior, particularly in the more populated urban areas.

18. **There are fewer alternatives in the outer islands**. In March 2020, a *Health Facility Readiness and Service Availability Assessment* was published, setting out the findings of a survey conducted in Kiribati in July-August 2019.[30] The survey covered 112 public health facilities and one private family planning center and included 65 criteria for the availability of reproductive, maternal and neonatal care services. While negative responses (service not available at that facility) were broadly similar across South Tarawa and the outer islands (47 versus 45 services unavailable per facility) on the outer islands there is much less opportunity to access an alternative facility. On South Tarawa, the urban clinics are in close proximity to each other and the two hospitals there. However, on the outer islands, the rural clinics and health centers are usually quite significant distances apart. Transport options are also usually limited. In addition, availability of updated stock records shows a major variation between outer islands and South Tarawa – on average 0.5 and 3.9 respectively out of a total of 8 criteria used in the survey, which may also speak to a broader challenge of data quality and completeness. To improve timely access to health services for the communities served by these facilities, it is critical that the outer islands have a much higher level of service availability than on South Tarawa. For these reasons Kiribati and MHMS have requested World Bank financing to help address service quality differences across islands so that citizens receive the essential services they need safely and sustainably closer to home.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

To improve equitable access and quality of health services in targeted areas and in the case of an eligible crisis or emergency, respond promptly and effectively to it.

Key Results

PDO Level Indicators

19. The proposed project's contribution to the country's overall health systems strengthening goals will be monitored primarily through project development objective (PDO) and intermediate indicators that focus on integrated health services to the outer islands, in-service training to health care workers, the upgrade and expansion of selected hospitals[31] and lower-level health facilities, IPC and HCWM, and developing an integrated health information system.

20. PDO Indicators:

- Percentage of outer island facilities offering at least 70 percent of the full range of services as set out in the draft Role Delineation Policy.
- Percentage of women aged 15 to 49 years with a live birth who received antenatal care four times or more, disaggregated by outer islands and South Tarawa.

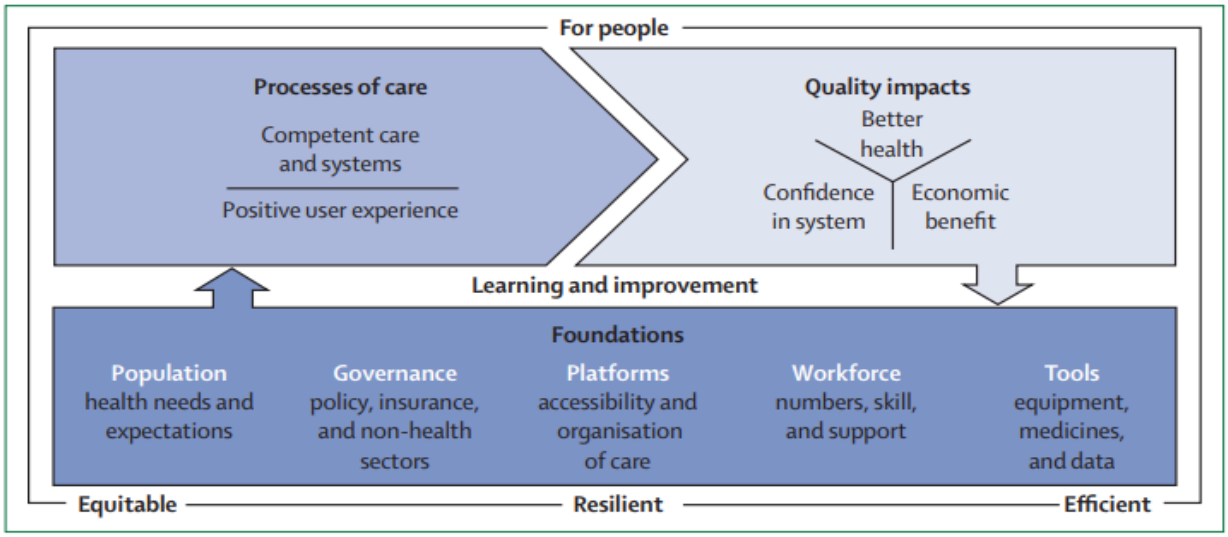
[30] https://pacific.unfpa.org/sites/default/files/pub-pdf/hfrsa_assessment_kiribati_8april_preview.pdf
[31] Hospitals are an important part of the primary health services network in Kiribati, but until recently have received limited assistance for strengthening their role in essential health service delivery.

- Reduction of rate of Methicillin Resistant Staphylococcus Aureus (MRSA, Multi-Resistant Organisms) [32] across the two main hospitals (Tungaru Central Hospital and London Kiritimati Hospital)

21. Operational definitions of the key PDO elements:

a. *Equitable access*: The project is focused on strengthening the health system to provide access to health services that does not vary in quality because of geographic location. This includes between islands as well as between those living in main urban centers such as South Tarawa compared with those on the outer islands. Health service outputs and outcomes will also be monitored wherever possible by other personal characteristics such as sex and age.

b. *Quality*: Kiribati MHMS is at an early stage in its efforts to improve quality of the health system and health services. The project will predominantly focus on the foundations domain (including investment in rolling out health policies and strategies, medical equipment and supplies, health workers' skills, availability of data for decision making and program management, and so on) as set out in the conceptual framework of the *Lancet Global Health Commission on High Quality Health Systems in the SDG Era* (presented in Figure 6 below).[33]



B. Project Components

22. **The proposed project will improve equitable access and quality of health services in Kiribati, based on identified gaps and targeted areas that support MHMS to implement the NHSP.** The project comprises four components: (a) improving equitable access and quality of health services on the outer islands; (b) strengthening quality and range of services provided through hospitals; (c) project management and health information system enhancement; and (d) a contingent emergency response component (CERC). Project activities and the financing of goods and services will take

[32] Methicillin resistant staphylococcus aureus (MRSA) is a significant infection control threat, with some reported community spread in Kiribati. An increase in this organism may require the consideration of further preventive actions by the hospitals to prevent nosocomial spread. Having a laboratory-based indicator to monitor as part of the results framework helps to reflect the substantial investments that have been made in strengthening laboratory capacity in Kiribati over recent years as part of MHMS' broader quality of care improvements and more integrated approaches to health information and management systems.
[33] SDG: Sustainable Development Goals; https://www.thelancet.com/action/showPdf?pii=S2214-109X%2818%2930386-3

into consideration existing and planned investments by other development partners. All health infrastructure development, including waste management and procurement of vehicles, equipment and supplies, will be carried out in accordance with the World Bank Environmental and Social Framework as well as climate-resilient and sustainable standards. Training and supportive supervision activities will include gender as well as climate disaster response elements. The training of staff will also include aspects related to COVID-19 transmission and prevention. The project, by investing to enhance critical care capacity on the main island and LKH as well as strengthening primary care across the outer islands, will help Kiribati prepare for a state of managed endemicity of COVID-19. In addition, during project implementation options to expand support for managed endemicity of COVID-19 will be considered. Citizen engagement will be carried out through collection of information at facility level relating to patient and staff satisfaction with services received and provided, respectively. The feedback collected will be utilized to adjust implementation arrangements and design accordingly.

23. **Component 1: Improving equity and quality of health services on the outer islands (US$4.8 million).** This component will support interventions to improve capacity and quality of health services in the outer islands by financing health infrastructure upgrading, medical equipment and supplies, training of health workers, telehealth and integrated outreach programs, and supportive supervision in outer islands as described in the following two subcomponents. Access to integrated outreach on the outer islands will be monitored and the number of islands visited will be collected at the completion of each outreach trip.

24. ***Subcomponent 1.1: Improving capacity and quality of health services on the outer islands (US$2.3 million)*** **comprises two sets of activities designed to address the capacity and quality aspects, the first one relates to health infrastructure and equipment**. It is understood that existing health infrastructure and equipment in many instances across outer island health centers and clinics is inadequate to support basic medical services, and staff housing is insufficient to attract staff. Under this subcomponent, targeted outer island health centers and health clinics will be refurbished and provided with essential equipment and supplies based on a survey that assesses their current gaps and needs,[34] including staff housing needs, to improve foundational quality of care, including essential equipment and supplies related to improving antenatal care outcomes in the outer islands. In addition, selected health centers staffed by medical assistants (MAs) will be upgraded to support a broader range of essential services.[35] The refurbishment of facilities will include gender considerations with a view of ensuring availability of an appropriate examination room, waiting area, toilets, and wash areas for women. All infrastructure and equipment investments will be carried out in line with climate resilient and sustainable standards.

25. **The second aspect focuses on training of health workers[36] and supportive supervision.** The training of nurses and MAs, as well as increased number of MAs to the current workforce in the outer islands is in line with the overall theme of improving access to high-quality health-care services in the outer islands. In accordance with the draft RDP, it is recommended that all 22 outer island health centers and selected clinics on the more remote islands be staffed by an MA as well as a skilled nurse; the MAs take on the role of a doctor, with the assistance of several skilled nurses stationed

[34] The survey is/will be based on the draft RDP which provides recommendations for clinic and health center level equipment/tools needed for them to provide a higher standard of care. This survey is expected to be conducted at the start of project implementation and financed by the project. The assessment will consider planned and ongoing infrastructure renovation and refurbishment investments e.g., MFAT support for 20 clinics on outer islands and South Tarawa; Least Developed Country Fund GOK support for 10 clinics on outer islands; UNICEF/MFAT support for water, sanitation and hygiene facilities.

[35] Asset management for stock control (including registration, stock control and funding arrangements for maintenance and eventual replacement that considers climate risks at the end of useful life) will be supported under Component 3.2 - Enhancing the health information system.

[36] The development of the training modules and its rollout will consider and build on existing efforts, including those through reproductive, maternal, newborn, child and adolescent health supported by UNICEF, UNFPA and WHO; NCD supported by MFAT and WHO; communicable diseases supported by DFAT, UNDP and WHO.

across clinics on the outer island's outskirts. Under this subcomponent, support will be provided to improve outer island health providers' skills through in-service training, particularly for the MAs, nurses and midwives, in a range of maternal, neonatal and child health and NCD high priority issues. This support will allow MAs and nurses to be up to date with current approaches in a range of maternal, neonatal and child health, communicable diseases and NCD medical conditions. Financing will also be provided for integrating supportive supervision into the capacity building efforts with the monitoring aspect of these efforts covered under Component 3. The in-service training will include sessions on GBV utilizing the Standard Operation Procedures[37] prepared by MHMS, as well as support for essential supplies (e.g., first aid kit, emergency contraceptives, post exposure prophylaxis starter kit, etc.) as part of the standard package for survivors of GBV.

26. ***Subcomponent 1.2: Improving domestic patient referral system and access to telehealth (US$2.5 million).*** This subcomponent supports improvement of the domestic patient referral system through investments in policy development, vehicles, equipment and digital infrastructure**.** The aim is to (a) bridge the gap of a lack of specialized care in the outer islands, and to improve transfer and referral of cases requiring higher level care to the main island as well as for overseas referral where necessary; (b) provide transportation for urgent referrals (including return home), as well as distribution of critical medical supplies to the outer islands; and (c) facilitate the reach of preventive and public health services, including services related to GBV and antenatal care. Financing under this subcomponent includes updating the existing referral policy (the 2012 Domestic Patient Referral Policy) and guidelines/protocols for implementation rollout; procurement of sea ambulances for the outer islands (which will serve two-way – to bring services from main islands for outreach and other times to transport patients back to Tarawa on an emergency basis), and regular ambulances (for select hospitals as part of the support to the referral system) with appropriate critical medical and communications equipment, and their operating costs on a decreasing basis over the life of the project. The subcomponent also supports purchasing of equipment (hardware), software, and requisite telecommunication upgrading, along with the provision of training in order to use evolving ICT technologies to strengthen telehealth consultation options between facilities and enhance resilience of communities to help ensure service continuity when weather events occur which can disrupt physical access to facilities.

27. **Component 2: Strengthening the quality and range of services provided through hospitals (US$7.3 million).** The MHMS recognizes the need for well-functioning hospitals and allied health services in the provision of quality health services for all of Kiribati through its four hospitals – TCH, Betio, Tabiteuea, and LKH. With the rebuilding of Betio Hospital underway with assistance from MFAT and ADB, and substantial refurbishment of priority work areas in TCH will be supported by ADB, the MHMS identified the following core hospital needs for support under the proposed project.

28. ***Subcomponent 2.1: Rebuilding and equipping the district hospital in Kiritimati and equipping Tarawa central medical stores (US$4.5 million***). This subcomponent will finance the rebuilding of the district hospital in Kiritimati on a new site[38] which will include an adequate storage facility for pharmaceuticals and medical supplies to provide buffer stocks for the LKH and other health facilities in the Line Islands Group. These investments will focus on ensuring climate-resilient and sustainable infrastructure. This subcomponent will also finance the procurement of essential warehouse equipment, including forklifts, trucks and other equipment as required for the central medical warehouse in Tarawa. The design for the hospital will include gender considerations, particularly for ensuring availability of an examination room, waiting area, toilets, and wash areas for GBV survivor referred services.

[37] *Standard Operations Procedures for Response, Mitigation and Prevention of Sexual and Gender Based Violence including Clinical Management of Rape*, prepared by the MHMS and issued by the Minister of Health and Medical Services in January 2020.
[38] The fact that there is no land acquisition issue has been confirmed and captured in the E&S instruments.

29. ***Subcomponent 2.2: Strengthening health workers' capacity, infection prevention control, and health care waste management in hospitals (US$2.8 million)***. The subcomponent will support in-service training for health workers across the four hospitals in selected skill areas as well as support MHMS to implement the IPC strategy, which includes supporting improved and well-equipped management of hazardous waste at hospitals and preparation of a rolling annual work plan and budget. Further, in-service training on GBV will be included to improve capacity of hospital-based health workers. This includes procuring the necessary equipment and supplies for sustainable waste management practices in line with the IPC guidelines, and for ongoing refresher training of the health workforce.

30. **Component 3: Project management and health information system enhancement (US$1.9 million).** This component will provide technical, administrative and operational assistance for project management, support for enhancing the health information system to address data gap issues, as well as supporting citizen engagement and beneficiary monitoring.

31. ***Subcomponent 3.1: Project management enhancement (US$0.7 million).*** This subcomponent will finance project implementation, monitoring and evaluation (M&E), financial management (FM), procurement, and E&S support and risk mitigation activities. The fiduciary, as well as E&S support, will be provided through the Kiribati Fiduciary Services Unit (KFSU), located in the Ministry of Finance and Economic Development, which supports the World Bank-financed projects in Kiribati and their services are paid from another source. The project management unit (PMU) established for the Kiribati ERP, which currently only has a Project Manager (PM), with support from KFSU and addition of two staff (M&E and general E&S/community engagement officers) will be responsible for the overall administration of the project and day-to-day operation of the project, including the preparation of annual work plans and budgets and preparation of the project operations manual (POM). As the COVID-19 project in Kiribati has a closing date before the HSSP, funding provision to extend the service of the Project Manager for the remainder of the project life is considered.

32. ***Subcomponent 3.2: Enhancing health information system (US$1.2 million)***. Support under this subcomponent aims at enhancement of the health information system (i.e., collection, storage and connectivity), building on MHMS' ongoing efforts to consolidate health data for management oversight and use, including for management of the health workforce; and development of real time core health indicator dashboard to monitor NHSP implementation progress as well for use by health program managers; and enhance interoperability of the various information systems through appropriate interfaces and data interchange protocols, alongside the necessary asset management of hardware[39] and software noted earlier. Activities under this subcomponent will be closely coordinated with development partners and the World Bank financed Kiribati Digital Government project which is currently under preparation[40] in terms of support for digital health and taking into considerations data privacy requirements. For climate mitigation purposes hardware to be procured will be required to comply with Energy Star certification will be procured by using whole of lifecycle assessment as part of the evaluation criteria.

33. **Component 4: Contingent emergency response component (CERC, US$0 million). The objective of the contingent emergency response component (CERC), with a provisional zero allocation, is to allow for the reallocation**

[39] The COVID Emergency Project is supporting procurement of a broad range of ICT equipment and supplies to improve connectivity across the country – this is being coordinated with MICTTD, MHMS as well as the various partners funding ICT related equipment and supplies.

[40] https://documents.worldbank.org/en/publication/documents-reports/documentdetail/164781631299073813/concept-project-information-document-pid-kiribati-digital-government-project-p176108.

of financing to provide an immediate response to an eligible crisis or emergency[41] as needed. The GOK can request the World Bank to urgently activate CERC and reallocate any uncommitted balance to support the implementation of the GOK's emergency response plan.

Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Assessment of Environmental and Social Risks and Impacts

34. **Whilst the project aims to deliver significant environmental benefits through the financing of HCWM infrastructure and capacity building, the Environmental risk rating is considered substantial due to the complexity of managing risks and impacts such as health care waste in remote atoll island environments with limited natural resources, infrastructure, and capacity.** Potential environmental risks and impacts include: (a) the consumption of finite natural resources (construction materials, aggregates, water and energy) during both construction and operational phases, particularly for the LKH; (b) the generation of health care waste such as liquid contaminated waste (e.g., blood, other body fluids and contaminated fluid), infected materials (water used, laboratory solutions and reagents, syringes, bed sheets, etc.) and expired vaccines and other drugs; (c) increased dust and noise, sedimentation, minor hydrocarbon spills and waste disposal (potentially including hazardous materials such as asbestos and e-waste) from construction activities; and (d) other operational risks such as the ongoing storage and disposal of laboratory chemical, e-waste and sewage. Construction works are expected to be completed on brownfield sites minimizing any impacts to biodiversity. Potential occupational health and safety risks and impacts relate to the completion of construction activities, IPC, use of project financed equipment including the two sea ambulances (and more generally travel to outer islands) and the handling of medical or other hazardous waste, such as asbestos or laboratory chemicals.

35. **Social risks for the project are considered substantial given risks and impacts are of moderate significance but manageable.** Most physical works are located within existing brownfield sites and therefore are not considered to be sensitive areas. Project activities are of medium complexity and impacts are expected to be site specific and primarily temporary and/or reversible. Activities have a generally low potential for harming people or the environment, with any anticipated risks expected to be temporary, predictable, and readily managed through project design features and mitigation measures. Key social risks and potential impacts for LKH construction and road upgrade include land access, potential land acquisition, community health and safety risks due to interactions with construction workers and equipment, social disruption due to labor influx, risks to vulnerable groups and GBV as a result of construction activities and the movement of people, sexual exploitation and abuse (SEA) and sexual harassment (SH) risks which are associated with construction; increased traffic

[41] An eligible crisis or emergency may include (a) cyclone, (b) earthquake, (c) storm, (d) storm surge and strong waves, (e) tornado, (f) tsunami, (g) volcanic eruption, (h) flood, (i) landslides, (j) forest fires, (k) drought, (l) severe weather, (m) extreme temperature, (n) high winds, (o) dam break, and (p) any natural disaster or man-made crisis.

incidents and reduction in road safety due to road construction activities or improved road conditions which encourage faster travel times; and social inclusion risks such as unequal distribution of benefits to vulnerable groups.

36. SEA/SH risks have been assessed as low, the project will involve moderate scale civil works, with a low to moderate influx workforce which are not expected to significantly increase the risk of GBV and SEA/SH risk within the community, mitigation measures will be included in the workers code of conduct. There are some (low) risks SEA/SH of health workers operating in remote areas. The E&S risks have been assessed for similar projects in Kiribati and are therefore generally well understood.

37. **Project risks and impacts will be managed through the inclusion of E&S risk management activities and instruments.** Following a World Bank appraisal mission on February 18, 2022 the following instruments have been finalized: (a) environmental and social commitment plan (ESCP); (b) labor management procedures (LMP); (c) stakeholder engagement plan (SEP); (d) resettlement framework (RF); (e) environmental and social management framework (ESMF); and (f) a preliminary environmental and social impact assessment (P-ESIA) for Kiritimati Hospital. The mission reviewed the ESCP conditions and confirmed that MHMS would raise any questions that they might have prior to its final agreement during negotiations. MHMS and KFSU agreed that the KFSU E&S team will provide support and input into the development of the project's annual work plan.[42]

[42] Other priority next steps were discussed and include: (a) update of the P-ESIA for the Kiritimati Hospital to final once designs have been reviewed and updated to ensure climate resilience; (b) E&S screening of sub projects in accordance with the ESMF; and (c) subsequent instrument development and approval.

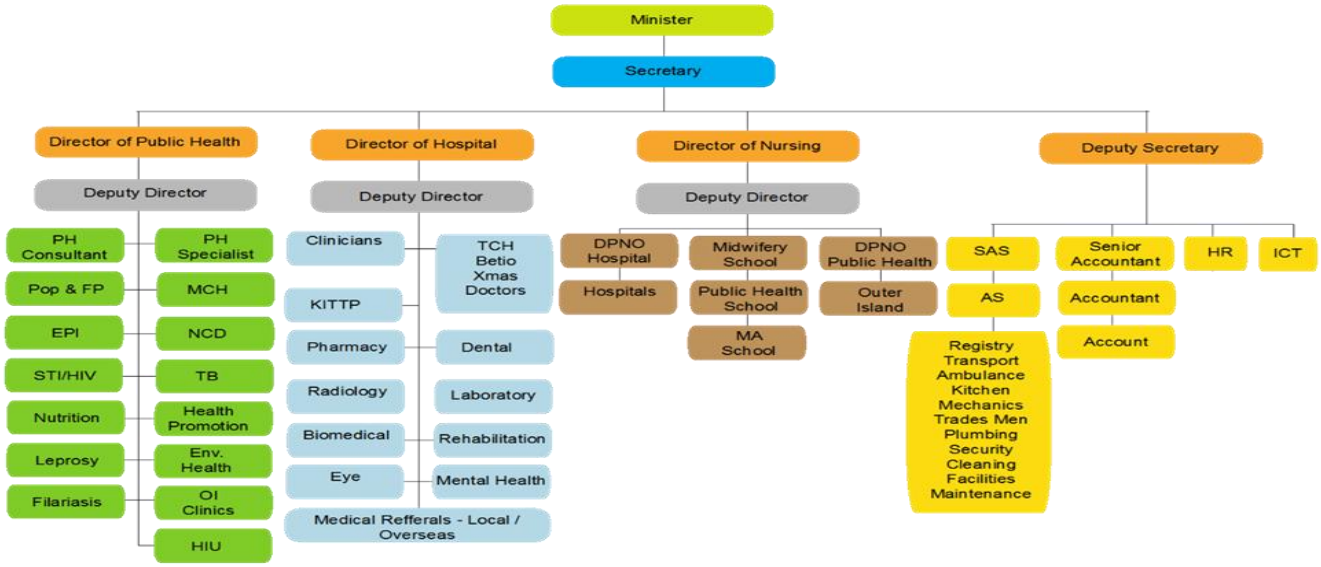
E. Implementation

Institutional and Implementation Arrangements

38. **MHMS has primary responsibility for national health care in Kiribati and its organizational structure includes hospital services, public health services, and nursing services.** The Government is the sole provider of health services as there is no private health care sector outside of three NGO clinics, and services are provided free at the point of access in hospitals, health centers and clinics (including the NGO clinics). The MHMS responsibilities are framed by statutory functions, policies, plans and responsibilities. These extend to the national cross-cutting agendas of climate change, GBV, support for vulnerable populations such as the disabled and elderly, and community empowerment and development.

39. **The Minister and Secretary of Health are supported by substantive Directorates in Public Health, Hospitals, and Nursing** (see Figure 8 for the organizational structure). A Deputy Secretary Directorate is responsible for general administrative and management tasks such as accounting, human resources, with roughly 40 sub-units in the Directorates and approximately 600 health workers at all levels. There are various subject councils and committees, including an HSCC and an Executive Management Committee which monitors progress and performance results of the NHSP based on health sector reports from multiple data sources. However, the frequency and influence of such committees have varied considerably, for example, the HSCC has not met in almost 2 years (since mid-2019).

Figure 8: Organizational Structure of the Ministry of Health and Medical Services



40. **The project will be implemented by the MHMS.** Overall implementation responsibility rests with Secretary of Health with support from technical departments. The responsible MHMS technical departments include (a) Hospital Services with the following allied services (i) Laboratory; (ii) Pharmacy; (iii) Radiology; and (iv) Biomedical; (b) Public Health; and (c) Nursing. The PMU, established for the Kiribati ERP, which currently

only has a Project Manager, with support from KFSU and the addition of two staff, will be responsible for the (a) overall administration of the project, and day-to-day operation of the project, including the preparation of AWPB and preparation of the POM; (b) the overall implementation of project activities and achievement of project results with support from the MHMS technical departments; (c) coordination with other Government ministries and stakeholders on all aspects of project implementation as required; (d) the overall administration of FM, procurement, E&S risks management, and communication on all project activities; and (e) the overall M&E and reporting on project activities. Additional staff, including an M&E Officer and E&S expert, will be recruited to the PMU to provide M&E and E&S support to the project.

41. **The KFSU will provide implementation support to the MHMS on fiduciary aspects.** The KFSU, which provides fiduciary support to all World Bank financed projects in Kiribati, is based within the Ministry of Finance and Economic Development. As such, and as indicated above, the Project Manager will be working closely with KFSU on the overall administration of FM, procurement, and E&S risks management.

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