RECORD OF MISSION

KIRIBATI HEALTH SECTOR: JOINT AUSTRALIAN, NEW ZEALAND AND WORLD BANK HEALTH TEAM VISIT TO TARAWA, 28 JULY – 4 AUGUST 2014

1. A joint Australian, New Zealand and World Bank health team visited Kiribati from 28 July to 4 August 2014.[1] The principal objectives of the mission were: i) to undertake follow-up discussion with the Government of Kiribati (GOK), other development partners and civil society organisations (CSO) on continuing and potential future areas of support for the Kiribati health sector, including action on the Non-Communicable Diseases (NCDs) *Roadmap* that was endorsed by a joint meeting of Pacific Islands Forum Economic and Health Ministers in Honiara on 11 July 2014; and (ii) to participate in the Health Sector Coordinating Committee (HSCC) meeting, convened by the Ministry of Health and Medical Services (MHMS) on 30 July.

2. The mission builds on a joint Australian / New Zealand Health Concept Note (*Options for Australian and New Zealand Development Assistance in Health – Kiribati*) that was developed by one of the team members (RC) in early 2014 following an initial scoping visit in December 2013. The Concept Note prioritised four core areas and two enabling areas for possible future support.

3. Following consultations during the mission, the team has realigned the core areas to include: 1) Population and reproductive health; 2) Maternal, neonatal and child health (MNCH); 3) Non-communicable diseases; 4) Communicable diseases; and 5) Health workforce. The team has also expanded the enabling areas to include: 1) continuing support to strengthen the HSCC as a forum for strategic dialogue between GOK and development partners; 2) Health sector analytic work (including health policy and financing and models of health service delivery); and 3) Continuing support through other sectors contributing to social determinants of health (SDH).

4. On the visit, the team was also asked to: 1) explore options for moving towards strategic, programmatic support in the health sector (including potentially aligning regional and country level support from Australia and New Zealand); 2) provide guidance on how to integrate the DFAT-supported project, Towards Tuberculosis Elimination in Kiribati (TTBEK), into general health services; and 3) undertake a rapid review of progress in establishing the Kiribati Internship Training Program (KITP) for medical graduates following training in Cuba and Fiji.

5. The Governments of Australia and New Zealand, and the World Bank, thank the GOK – especially the MHMS and the Ministry of Finance and Economic Development (MFED) – and other development partners for the opportunity to undertake extremely productive discussions and arranging facility visits. A list of activities and people met is attached at Annex 1.

[1] Team members from the Australian Department of Foreign Affairs and Trade (DFAT) included: Rebecca Dodd (RD; Senior Health Advisor), Jacqueline Herbert (JH; Pacific Regional Health Program, Canberra), Robert Condon (RC; Consultant Public Health Physician) and Iobi Batio (IB; Senior Program Manager, Health, Kiribati). Alex Cameron (AC; Development Manager, Health) represented the New Zealand Ministry of Foreign Affairs and Trade (MFAT). Susan Ivatts (SI; Senior Health Specialist) represented the World Bank. RD and SI departed Kiribati on 31 July, while AC, JH and RC remained in-country until 4 August.

KEY FINDINGS AND RECOMMENDATIONS

Population and reproductive health

6. **Current New Zealand support for population and reproductive health in Kiribati is directed through the non-government organisation Kiribati Family Health Association (KiFHA, via Family Planning New Zealand) and the United Nations Population Fund (UNFPA).** KiFHA has been supported since 2012 and a further three-year phase of funding for the KiFHA "Healthy Families" project is currently under consideration to improve in-country knowledge and skills for sexual and reproductive health services in Kiribati. Additional New Zealand support from the regional level will be available through the Pacific Regional Sexual and Reproductive Health initiative, directed through UNFPA, which will focus on: improved provision of clinical services, education and health promotion, and the enabling environment.

7. **Negotiations are continuing between DFAT and the UN agencies to initiate a Joint Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) program in Kiribati, Solomon Islands and Vanuatu.** The Kiribati arm of the program will be managed by UNFPA, which has engaged a Program Officer for Health (the former MHMS Director of Public Health) to establish a country office and prepare for commencement of the joint program. Regional support for population and reproductive health, through the International Planned Parenthood Foundation, is also being considered by DFAT.

8. **The National RMNCAH committee has been reactivated** and will provide oversight and coordination of activities. The UNFPA Program Officer is aware of the role of the committee in ensuring alignment of donor-funded initiatives with GOK health priorities, maximising efficiency, and minimising the risk of duplication and excessive reporting burden on CSO partners.

Maternal, neonatal and child health

9. **Construction of the Australian-funded Betio Maternity Ward is complete**; the facility is fully equipped and staffed, and began providing maternity services for Betio and adjacent South Tarawa communities in late May. At present, approximately one baby per day is born there, and the number of referrals to Tungaru Central Hospital (TCH) is decreasing; the Director of Nursing is monitoring trends in obstetric and neonatal referrals and admissions. The team notes the issue of sea water entering the delivery room during storm surges, and recommends that the Ministry of Public Works and Utilities (MPWU) is engaged to raise the height of the adjacent sea wall.

10. **Other Australian support for MNCH, to be channelled through UN agencies, is pending final review in Suva and Canberra.** As noted above (paragraph 7), this joint proposal covers Kiribati as well as the Solomon Islands and Vanuatu. The Kiribati chapter has been completed and is ready to proceed on commencement of the joint program.

11. **The child health component of the Australian funded joint program will address strengthening of the expanded programme on immunisation** (EPI; see below) **and support for improved childhood nutrition.**

12. **Additional New Zealand support for MNCH is available through the regionally funded UNICEF Pacific Maternal Newborn and Child Health Initiative**, which includes a focus on EPI, improved nutrition and newborn health, and improvement of health systems to address maternal newborn and child health in the region.

Non-Communicable Diseases

13. **The *NCD Road Map*[2] proposes that countries implement four "best buy" interventions through their updated national NCD strategies**,[3] and presents a range of further options for consideration. The team recommends that Kiribati reviews its national NCD strategy and, where relevant and appropriate, adopts the recommended strategic adjustments from the *NCD Road Map*. In consultation with WHO, partners are able to contribute to reviewing and revising the strategy and identify suitable areas for support, aligned with GOK priorities.

14. **As a first step, legislation and regulations for increasing the tobacco excise in Kiribati from the current 30% up to 70% should be introduced.**[4] Kiribati is already a signatory to the World Health Organization (WHO) Framework Convention on Tobacco Control, and relevant legislation has been passed by Parliament (excluding the increased tobacco excise). After consideration by Cabinet, a paper recommending a step-wise annual increase in tobacco excise has been referred to a task force for review. This task force is yet to meet. WHO and the World Bank have the expertise to provide technical assistance for drafting the legislation on excise and related tobacco control measures (such as advertising), as well as regulations and protocols for monitoring and enforcement. It was agreed that these may be areas to include as policy actions under the World Bank and other development partner budget support operations over coming years.

15. **A pilot Health Outreach Program for Equity (HOPE) has commenced, focusing on door-to-door screening for and management of personal risk factors for diabetes (including obesity) and other NCDs in adolescents and adults.** The National Tuberculosis Program (NTP) is already using a similar approach during enhanced active case finding in several South Tarawa communities. The team recommends that MHMS and partners explore opportunities for operational convergence between the NTP, HOPE and potentially other public health and physical activity programs at the community level, making more efficient use of available financial resources and engaging fully with community based health staff (e.g. Public Health Nurses, Directly Observed TB Treatment [DOT] Workers, etc.).[5]

16. **Additional New Zealand support may be available through regional assistance channelled through WHO's Pacific Non-Communicable Diseases Initiative** which focuses on reduction of adult tobacco consumption and reduction in adult cardio-vascular disease risk by 2018.

[2] The *NCD Roadmap* was developed at the request of Forum Economic Ministers in 2013, who tasked the Secretariat of the Pacific Community to work with its Pacific quintilateral health group partners (Australia, New Zealand, World Bank and WHO) to prepare the *Roadmap*; this work was led by the World Bank. It outlines proven, affordable, cost-effective interventions for the NCD-related health crisis in the Pacific, including the specific role and contribution of Ministers.

[3] The "best buys" include: 1) strengthened tobacco control (Ministers agreed to raising the excise duty to a target 70% of the retail price of tobacco), and an increase in taxation of alcohol products as a way of reducing harmful alcohol consumption; 2) policies on food and drink products directly linked to obesity, heart disease and diabetes; 3) improved efficiency and impact from existing health budgets by reallocating resources to primary and secondary prevention of cardiovascular disease and diabetes; and 4) strengthening the evidence base for better investment planning and program effectiveness.

[4] The *Road Map* suggests that the tobacco excise in Kiribati is 41.7%. During the mission, the MFED informed the team that the tobacco excise is actually 30%.

[5] Physical activity programs include the Kiribati Community Clubs (KCC), which was initiated by the Australian Sports Outreach Program through the Australian Sports Commission. KCC is in the process of amalgamating with the Sports Department of the Ministry of Women, Youth and Social Affairs.

17. **A proposal for a follow-up to the 2005-06 cross-sectional survey of personal NCD risk factors using the WHO STEP-wise approach has been developed, and is expected to commence later in 2014.** The sample size for the STEPs survey is 3,589 people aged 18 to 69 years, and includes South Tarawa and 7 outer islands. The survey has been costed at USD 255,000 and is currently 50%-funded (10% by MHMS, 40% by WHO). The team recommends that partners consider options for funding the remaining 50% of the survey cost as it will provide overdue, important information on the progression of the NCD epidemic in Kiribati to contribute to an updated NCD strategy (see paragraph 13). The team also identifies the opportunity to conduct HOPE activities concurrently with community visits by the STEPs team.

18. **The MHMS estimates that approximately two-thirds of off-shore referrals are related to NCDs** (see also paragraph 33)**.** Cardiac patients comprise about one-third of referrals, and most of these are for further assessment and surgical treatment for **rheumatic heart disease** (RHD). A program of technical support through the Menzies School of Health Research, Charles Darwin University (CDU) has recently ended. To maintain the quality of care for patients with RHD, the team recommends that the GOK undertakes an annual review of RHD cases in Kiribati and continues to seek technical advice from relevant experts, in particular to guide the strategic management of RHD in Kiribati.[6] Each year, 6-8 patients with invasive or metastatic **gynaecological malignancy** are being selected for referral to India for chemotherapy and radiotherapy, but about 50% of such cases are found to be too advanced for anything other than palliative care and die within two months of return. The team recommends that a further review of referrals, protocols, and outcomes be completed (see paragraph 33).

Communicable Diseases

19. **Tuberculosis remains a major public health challenge in Kiribati, fuelled by domestic over-crowding, high levels of tobacco use and significant TB-diabetes co-morbidity.** TB prevalence rates remain stubbornly high at around 300 cases per 100,000, but with good case detection and treatment completion rates and no drug-resistant cases (all signs of program effectiveness). SPC, as manager of the TTBEK project, mobilised a Technical Advisory Group (TAG) in late 2013 to review the progress of the project and the overall performance of the NTP. The TAG made numerous recommendations to strengthen diagnostic infrastructure and NTP capacity for active case finding, treatment and community mobilisation. The NTP and SPC are currently awaiting the outcome of a multi-country funding application to the Global Fund to determine the feasibility of implementing some of the TAG's more costly recommendations. The team recommends that MHMS, SPC and DFAT carefully consider the budget implications of these recommendations, some of which lie beyond current TTBEK and MHMS funding envelopes.

20. **The design of the TTBEK project specified progressive alignment with the NTP and GOK systems.** The TAG noted this aspect of the design, but did not make any recommendations on how to proceed. The team initiated discussion on this with the MHMS TB-HIV-Leprosy Program Manager and the TTBEK-funded NTP Adviser. The team recommends early consultation with SPC to further review the performance of the project and the NTP prior to the scheduled mid-term review (MTR) of TTBEK, due by the end of 2014. In turn, the MTR should carefully assess:

[6] Rheumatic fever is typically acquired during childhood; RHD develops subsequently, and requires lifelong antibiotic prophylaxis and, in more severe cases, valvular surgery. Ongoing technical assistance could be provided through the existing New Zealand Medical Treatment Scheme, or through Menzies-CDU or the Capital and Coast District Health Board in Wellington (which have significant expertise in managing RHD at the population health level).

the capacity of the NTP to manage aspects of the current project; the possible shift of some operational areas of the project towards NTP management, linked with HOPE at the community level; and the likely risks and challenges associated with this transition.[7]

21. **The introduction of childhood pneumococcal conjugate (PCC) and rotavirus (RV) vaccines would have a significant impact on childhood mortality in Kiribati, with the potential to reduce the under-five mortality rate (U5MR) by at least 25%.**[8] Kiribati has already introduced 13-valent PCC vaccine after securing Global Alliance for Vaccines and Immunization (GAVI) start-up funding; programmatic costs comprise an estimated 50% of the current annual EPI budget (approximately AUD 60,000-80,000), but the ability of GOK to provide continuation funding is extremely uncertain. Eligibility for GAVI funding was withdrawn before an RV vaccine application could be lodged. The Australian Head of Mission (HOM) in Kiribati has written to GAVI to advise of the inappropriateness of withdrawal of eligibility. Following the mission to Kiribati, RC travelled to Suva to consult with the Fiji Ministry of Health EPI Manager and the Australian-funded Fiji Health Sector Support Project on the funding sustainability strategy for the recent introduction of PCC, RV and HPV vaccines in that country. In consultation with UNICEF, GOK and partners will need to undertake further analysis of the pricing and availability of these new vaccines for Kiribati.

22. **A trial of human papillomavirus (HPV) vaccine commenced in 2011, with full funding and technical assistance provided through the Australian Cervical Cancer Foundation.** The trial delivered 9,600 doses of HPV vaccine through a three-dose schedule targeting year 3-5 schoolgirls in South Tarawa and 6 outer island communities with the highest rates of abnormal cervical smears. The EPI Manager estimates that the cost of the vaccine used in the trial was AUD 1.2 million. The trial concluded in 2013 and HPV vaccination is no longer available in Kiribati. Review of available data on the prevalence of abnormal cervical smears in Kiribati is pending at the time of writing.

23. **The team notes that Kiribati draws support for its EPI through the regional revolving fund (Vaccine Independence Initiative [VII]), and achieves generally adequate coverage (range to 90% and above, nationally) but with sometimes variable coverage on the outer islands.** New Zealand's support to the regional Pacific MNCH Initiative and Australia's support for the joint UN RMNCH program will provide ongoing programmatic support for ensuring high levels of EPI coverage, reporting and cold chain maintenance. New Zealand has communicated with UNICEF's Executive Board on the need to retain the VII for the Pacific.

Health Workforce

24. **The Kiribati Internship Training Program (KITP) commenced on 31 March 2014, with 15 new graduates from Cuba and three from the Fiji School of Medicine (FSMed) at Fiji National University (FNU).** Six I-Kiribati FSMed graduates since 2010 have also been unable to complete an internship and are currently completing requirements for the internship at a more senior (registrar) level. Australia is funding FSMed to implement a support project to help the MHMS

[7] The incoming SPC TB Adviser in Noumea, Mr Jojo Merilles, plans to visit Kiribati in September (pending MHMS approval). This visit provides an excellent opportunity to begin the proposed discussions.
[8] The U5MR in 2011 was 47 per 1,000 live births. Diarrhoeal disease (confirmed as mainly due to RV) and pneumonia (presumed to be mainly due to PC infection) each contributed 15% of under-5 deaths.

initiate the KITP during 2014-15; FSMed provides three in-country supervisors [9] and independent assessment of candidates' progress, delivers short bridging courses in priority topics, and coordinates the participation of visiting specialist teams in the teaching and learning program. The supervisors believe that the majority of interns are on track to complete the program as expected; however, three of the 18 candidates in the first cohort have been required to extend their initial block by 6 weeks and three have been required to repeat it in full.

25. **The KITP design and feasibility study anticipated that the progressive return of I-Kiribati postgraduate medical trainees would allow the MHMS to achieve sustainable domestic management of the KITP by 2017.** In addition to teaching and supervision, the FNU support project currently provides significant back-stopping for the specialist medical workforce at TCH. Progress to date suggests that the KITP will not reach critical supervisory capacity until at least one year following conclusion of the current two-year support project at the end of 2015. The team recommends that the KITP Governance and Coordination Committee (GCC) urgently consider the need for an additional year or more of support (albeit at a reduced level of inputs compared with the present time) and how that might be resourced. This recommendation and development of a transition plan for the support project is being explored further with FSMed.[10]

26. **The need remains for further curriculum development and significant infrastructure works at Kiribati School of Nursing (KSON).** Improvements in these areas would enable increased numbers of graduates from KSON to address shortages in the health workforce at hospital and community level, potentially increasing the size of nursing cohorts from 30 to around 40 per year and midwifery cohorts from 10 to 20-30 per year; the revised curriculum would facilitate accreditation of KSON qualifications against evolving regional standards. Detailed construction drawings, costed at approximately AUD 4 million, have been completed by MPWU and quality assured by an Australian architectural firm. The team recommends that the MHMS reviews the costed plans and consults with GOK and New Zealand about potential funding.

27. **The World Health Organization is currently developing a revised Health Workforce Strategy for Kiribati.** The mission agreed that future work on human resources for health (HRH) would be guided by this policy, and agreed to review HRH needs (including nursing and midwifery) once the policy has been finalised.

28. **Australia's Biomedical Engineering and Maintenance Initiative (BEMI) provided a biomedical engineer for Kiribati and Samoa until June 2014.** The MHMS has requested Australian support for a biomedical engineer to assist the TCH for a period of one year. DFAT will consider its current capacity to provide further support, which may be shared with Nauru and Tuvalu.

Strengthening the HSCC

29. The team recognises the value of the HSCC as the key forum for high level policy dialogue on the health sector. The HSCC held on 30 July 2014 included noteworthy presentations from MHMS, providing a high-level analysis of the health sector, including some discussion on health expenditure and burden of disease**.** The team considers such analysis important to inform

[9] FNU provides Australian-funded supervisors in anaesthesia, internal medicine and paediatrics. Additional funding for a fourth supervisor in general surgery is provided by Taiwan, through the FNU project account.
[10] RC's visit to Suva included further consultation with FNU on KITP progress and the second-year work plan. Options for financial and human resources sustainability were discussed at the KITP-GCC meeting in Tarawa on 15 August and will be incorporated into a rapid review of the establishment phase of the KITP, which RC is preparing for DFAT.

future policy dialogue at the HSCC, and encourages a continued focus on this at future meetings. It was agreed that DFAT would support MHMS to further strengthen the organisation of the HSCC including finalising the terms of reference, developing standing agenda items and aligning the timing of the HSCC with GOK planning and budgeting cycles (including the new annual sector performance review; see Health Sector Analytical Support, paragraph 32 below).

Health Sector Analytical Support

30. **The MFED has established systems for the deposit and disbursement of donor project funds (through Account #4), and for monitoring and evaluating the conduct of such projects.** The team considers that these systems provide adequate visibility and safeguards to enable donor funded health sector projects to include at least an element of funds management through Government systems, according to priorities on the National Health Strategic Plan (NHSP).

31. **GOK (both MHMS and MFED) indicated interest in completing a public expenditure review** (PER) **for the health sector to provide more detailed analysis of expenditure against priority areas; a PER would also help inform the next NHSP (to be developed in 2015), and would help to determine suitable timing for establishing a sector support mechanism in health.** The team recommends that a public financial management expert, working in conjunction with a public health specialist, undertakes a health sector expenditure review and a more detailed analysis of Government systems.[11] The World Bank has relevant expertise and is able to mobilise the necessary technical inputs to work with MHMS, MFED and development partners. The World Bank will follow up with GOK and development partners to progress this work.

32. **A joint annual sector performance review would be an important element of a sector program.** The team and Government counterparts recognised the value of an annual review and supported further planning for this through the HSCC. Discussion between GOK and the team suggested that March/April 2015 would be a suitable time for the first joint health sector review as this would then inform the preparation of the following year's budget submission.

33. **The cost of off-shore referral for tertiary care has become a major driver of health expenditure**: referrals increased from 58 in 2012 to 96 in 2013, and are expected to cost AUD 1.3 million in 2014 (i.e. almost 10% of the health budget). Some referrals appear not to be appropriately screened and selected (as noted in paragraph 18). The team recommends that an independent analysis of off-shore and outer island referrals, protocols and outcomes is undertaken as soon as possible with a view to tightening selection and referral criteria (including through closer alignment with New Zealand Medical Treatment Scheme [MTS] criteria).[12]

34. **Importation of antimicrobial-resistant bacterial infections from Asia following referral of I-Kiribati patients for invasive or operative treatment represents an imminent, extreme threat to the Kiribati hospital system and budget.** The Strengthening Specialised Clinical Services in the Pacific (SSCSiP) program has undertaken a short literature review on the risk of importation of resistant organisms to Pacific Island countries. The team strongly recommends that pre-return screening protocols for patients referred from Kiribati are developed and implemented as a matter of urgency.

[11] This would also address the third recommendation of the *NCD Road Map*.

[12] This type of analysis falls within the role and mandate of the Australian-funded Strengthening Specialised Clinical Services in the Pacific team at FNU. An evaluation of the current phase of the New Zealand MTS is planned for late August-September, and will potentially also inform the review of referrals from Kiribati.

35. **As HOPE matures and begins to roll out, it may be useful to undertake facility surveys to determine their preparedness to implement the package of clinical "best buys" for NCDs**, including through a modified version of the WHO Service Availability and Readiness Assessment (SARA) tool.

36. **Physical facilities at Tungaru Central Hospital are not yet at the standard expected of a teaching hospital.** A facility survey of TCH would provide guidance on how best to align its standards at teaching hospital level, and should also be considered (in conjunction with MHMS facility development and maintenance plans).

37. **KiFHA is an important CSO partner to MHMS, and also implements a number of donor-funded reproductive health initiatives and investments.** The team notes that KiFHA's management systems are able to cope well with current administrative and service requirements, and is keen to avoid any risk that multiple funding and reporting streams may impose. During planning for the next phase of the "Healthy Families" project, the team recommends a follow-up examination of KiFHA's organisational capacity; the team also recommends that the RMNCAH committee maintains effective oversight of the strategic cohesion of the various funds and other resources being directed towards KiFHA.

Social Determinants of Health

38. **MHMS managers are highly aware of the contribution of SDHs to the burden of disease and patterns of morbidity and mortality in Kiribati, as noted in the National Health Strategic Plan.** New Zealand MFAT continues to support these areas through its work on housing and urban design, water and sanitation, and waste management. The team recommends that the MHMS continues to engage other relevant ministries on health issues, and that the health sector is involved in significant decisions about development activities in Kiribati (especially large scale infrastructure projects, e.g. the health and safety implications of the new road in South Tarawa).

NEXT STEPS

39. The following represent the key recommendations of this *Record of Mission* report that require early attention by Government and partners:

    a) The World Bank will work with GOK and development partners on plans for a health expenditure review, analysis of off-shore referrals and other proposed analytic support.

    b) Development partners will work with GOK to further strengthen the HSCC as a forum for policy dialogue, with the eventual aim of moving towards a sector program.

    c) The GOK will provide feedback on the response to the Cabinet Submission on tobacco excise legislation and regulations. Subject to a favourable response, the World Bank and WHO will provide any necessary technical support that may then inform options for policy actions as part of ongoing development partner budget support operations.

    d) All partners will continue to contribute to discussions around the adoption of other relevant elements of *NCD Road Map* into the national NCD strategy and HOPE.

    e) Australia and SPC will initiate discussions about the MTR of the TTBEK project and the recommendations of the TAG report, and will review NTP and project performance, current year work plans, expenditure and HRH support to determine the feasibility of directing some operational funding through GOK systems.

f) Australia, New Zealand and other donors will consider either individual or joint funding for the balance of the budget for the forthcoming STEPs survey.

g) MHMS and New Zealand will review the costed plans and asset management planning for KSON refurbishment and resumption of curricular support.

40. Partners involved in the joint health mission look forward to the opportunity to discuss progress with GOK and other health sector development partners at the next HSCC meeting, which is currently scheduled for October 2014.

ANNEX 1 – RECORD OF MEETINGS, ACTIVITIES, AND PEOPLE AND ORGANISATIONS CONSULTED

Date	Activity / Organisation	Persons met
28 July 2014	Briefing with DFAT team	Dr Iobi Batio (Senior Program Manager, Health) Ms Kakiateiti Erikati (Program Manager, Health)
	Meeting with MFED	Mr Jason Reynolds (PacTAM Adviser) Ms Kurinati Robuti (Director, Planning)
	Meeting with Australian HOM	Mr George Fraser (High Commissioner) Mr Michael Hunt (Counsellor, Development)
	Meeting with NZ MAT	Mr Peter Kemp (Deputy High Commissioner) Ms Bereti Awira (Development Officer)
29 July 2014	Meeting with Minister and Secretary of Health	Dr Kautu Tenaua (Minister of Health) Mr Terieta Mwemwenikeaki (Acting Secretary of Health)
	Meeting with MHMS Directors	Dr Burentau Teboriki (Acting Director of Clinical Services) Ms Helen Murdoch (Acting Director of Nursing) Ms Eretii Timeon (Nutritionist; Acting Deputy Director of Public Health)
	Tour of Tungaru Central Hospital and TB Centre	Dr Burentau Teboriki (Acting Director of Clinical Services) Ms Helen Murdoch (Acting Director of Nursing)
	Visit to Bairiki Health Centre	Nursing staff, Community Health Workers
	Visit to Betio Maternity Ward and Community Hospital	Nursing staff and Midwives
30 July 2014	Australian Aid Program staff development meeting	Mr Michael Hunt and team
	Preparation for HSCC Meeting	Internal team activity (RD, SI, AC, IB, JH, RC)
	HSCC Meeting	Chaired by Acting Secretary for Health; attended by Directors, UN agencies and bilateral donors and CSOs active in health
	Interim de-brief on HSCC meeting	Internal team activity (RD, SI, AC, JH, RC; prior to departure of RD and SI the next morning)
	HSCC – informal follow-up discussion over dinner	Dinner at Parliament House, hosted by Acting Secretary for Health

JOINT HEALTH MISSION TO KIRIBATI, 28 JULY TO 4 AUGUST 2014

Date	Activity	Persons met
31 July 2014	Meeting with UNFPA	Dr Teatao Tiira (Program Officer, Health)
	Meeting with National TB Program	Dr Alfred Tonganibeia (Program Manager, TB-Leprosy-HIV) Dr Takeieta Kienene (NTP Adviser) Ms Bereka Reiher (NTP Coordinator)
	Meeting with KITP Supervisors	Dr Alani Tangitau (Anaesthetist; Lead Supervisor) Dr Peter Asuo (Paediatrician) Dr Ran Israel (General Physician) Dr Ako Millan (General Surgeon)
	Informal discussion with interns over lunch	Dr Thomas Russell (FNU graduate) Dr Kaanong Tekoreaua (Cuban graduate)
	Meeting with members of Parliamentary Population Committee	Sir Ieremia Tienang Tabai (Chairman; MP for Nonouti, Gilbert Islands) Mr Rutiano Benetito (MP for Marakei, Gilbert Islands) Ms Rereao Tetaake Eria (MP for Teraina, Line Islands) Mr Aretaake Ientaake (Deputy Clerk, Parliament of the Republic of Kiribati)
	Meeting with KiFHA	Ms Norma Yeeting (Director) Mr Amota Tebao (Male Nurse) Ms Andrew Okoro (Sexual and Gender-Based Violence Coordinator) Ms Tamoa Moanata (Program Manager)
1 August 2014	Verbal de-brief with Directors, including discussion of points to be included in aide memoire	Dr Burentau Teboriki (Acting Director of Clinical Services) Ms Helen Murdoch (Acting Director of Nursing) Dr Patrick Timeon (Acting Director of Public Health)
	Team discussion of points to be included in *aide memoire*; preparation for afternoon de-brief with DFAT and MFAT	Internal team activity (IB, RC, AC, JH)
	Verbal presentation of *aide memoire* (principal findings and recommendations)	Mr Michael Hunt, Dr Iobi Batio, Ms Kakiateiti Erikate (DFAT) Mr Peter Kemp, Ms Bereti Awira (MFAT)

Date	Activity	Persons met
2 August 2014	Meeting with EPI Manager	Ms Tikua Tofinga Tekitanga (EPI Manager)
3 August 2014	Team meeting to finalise *aide memoire* and draft Record of Mission	Internal team activity (RC, JH, AC)
	Meeting with Kiribati Community Clubs	Mr Kautu Temakei (Manager, KCC)