Health for all proves its worth in Kiribati

Kiribati has achieved a considerable measure of success in health and family planning during the past five years, thanks to an integrated nationwide approach based on primary care and appropriate technologies. Self-help has been encouraged, the capabilities of health workers have been increased, and the people have a growing confidence that they can win good health through community effort.

Kiribati is a group of low-lying atolls scattered over 5 million square kilometres of the Central Pacific. The population of about 62 000 inhabits 22 islands where subsistence fishing and small-scale farming are the main livelihoods.

In 1978 the health status of the people was reported as one of the worst in the Pacific with a comparatively high infant mortality rate and a low life expectancy at birth. The inappropriate vertical delivery of health care, a legacy of the colonial system, was the principal cause. Limited resources and a shortage of experienced staff were additional factors.

A development project for primary care

Since 1981, a nationwide primary health care development project has been set in motion with the collaboration of the World Health Organization. A planning group carried out the following tasks:

- preparation of terms of reference;
- analysis of population;
- analysis of health status;
- analysis of ecological factors;
- analysis of health resources;
- identification of problems, solutions and areas of change;
- formulation of national health objectives;
- programme planning;
- design of health services;
- identification of projects;
- preparation of budget estimates;
- approval of the plan;
- implementation of the plan;
- evaluation.

A working group identified 28 major factors that had been responsible for failure to improve the situation; among them were the...
underutilization of health facilities, their inadequacy, the geographical isolation of communities, a scarcity of resources, a low level of community awareness and participation in respect of health matters, and poor management of services.

Some of the features of the project have been:

— adoption of the health-for-all strategy and primary health care;
— institution-building for project development;
— developmental management to prepare staff for the change to the primary health care approach;
— countrywide programme planning for activity direction and built-in monitoring;
— evaluation and research for programme improvement;
— health education for community involvement and participation;
— integration of programmes for intra- and intersectoral cooperation;
— a health manpower development programme with a series of orientation courses.

A mechanism for programme improvement in the form of regular monitoring, evaluation, research and review exercises has inspired confidence in both health workers in the field and support sectors.

**Surveys**

In 1983, orientation courses were held for all health staff and during the following year courses were given for long-term primary care workers. Surveys of the health situation in the communities were conducted. As part of the orientation courses for health staff, groups of at least three village communities were surveyed by different groups of staff. The surveys were done on household units using a random sampling technique and simple questionnaires. The health and social problems that were identified were studied and discussed by the communities themselves.
while health workers gave explanations and advice.

Community action

The communities decided how they would tackle the identified problems and appointed working committees that have now become village welfare groups. In prioritizing their health and social needs most village communities embarked on the improvement of wells for drinking-water, the construction of water-seal latrines, general hygiene measures, and gardening for better nutrition. Some village welfare groups have proceeded to build health clinics, while others have imposed corporal penalties for the abuse of alcohol.

The communities are implementing the project on a voluntary basis. Facilities are

tours have increased owing to the rise in demand for services.

There have been reductions in morbidity associated with many of the most common diseases, in hospital utilization, and in hospitalization costs, and family planning coverage has increased sharply, as shown in the figure.

Numbers of people attending outpatient departments, Kiribati, 1982–85

<table>
<thead>
<tr>
<th>Year</th>
<th>Outer islands</th>
<th>Tungaru Central Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>1982</td>
<td>74,275</td>
<td>17,123</td>
</tr>
<tr>
<td>1983</td>
<td>78,289</td>
<td>23,378</td>
</tr>
<tr>
<td>1984</td>
<td>76,786</td>
<td>11,880</td>
</tr>
<tr>
<td>1985</td>
<td>61,713</td>
<td>5,318</td>
</tr>
</tbody>
</table>

Source: Ministry of Health and Family Planning, Kiribati.

A mechanism for programme improvement in the form of regular monitoring, evaluation, research and review exercises has been developed.

provided by governmental and nongovernmental agencies only if unobtainable locally.

Voluntary efforts have led to the building of 22 new health clinics/dispensaries, giving a total of 56 units and increasing coverage from about 70% to about 99%. Supervisory

Difficulties arose because some members of the planning team and some senior staff in the Ministry of Health and Family Planning took a rather long time to grasp the concept of planning for primary health care and the principles of the health-for-all strategy. Another problem was caused where local institutions undertook health-related programmes in isolation, thus hampering the activities of village welfare groups. Some foreign institutions wished to force preconceived ideas on the Ministry, and certain nongovernmental organizations introduced health programmes with high material incentives. These external pressures have gradually diminished. Thus, Kiribati has achieved a considerable measure of success in health and family planning.