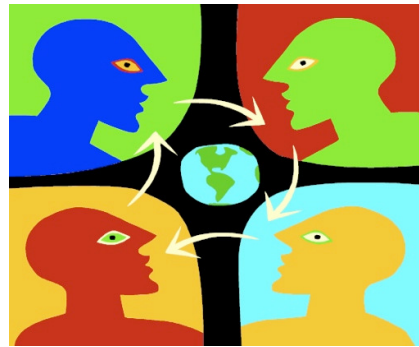


WHO MIND

Mental Health in Development



WHO proMIND:
Profiles on
Mental Health in
Development



Republic of
Kiribati

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Republic of Kiribati



“To provide the highest quality of care to our most vulnerable, and to help to prevent mental illness where possible. People need to have respect, love and care and their human rights supported.”

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The WHO Pacific Islands Mental Health Network (PIMHnet)



The idea to establish the Pacific Islands Mental Health Network (WHO PIMHnet) came about at a meeting of Ministers of Health for the Pacific Island Countries (Samoa, 2005) during which the idea of a Pacific network as a means of overcoming geographical and resource constraints in the field of mental health was discussed.

There was unanimous support among countries of the Pacific Region to establish the network, and with the support of New Zealand's Ministry of Health, the World Health Organization initiated the process to establish PIMHnet. The network was officially launched during the Pacific Island Meeting of Health Ministers in Vanuatu in 2007.

- ▶ PIMHnet currently counts 19 member countries, each with an officially appointed focal point: **American Samoa, Australia, Commonwealth of the Northern Mariana Islands, Cook Islands, Federated States of Micronesia, Fiji, Guam, Kiribati, Marshall Islands, Nauru, New Zealand, Niue, Palau, Papua New Guinea, Samoa, Solomon Islands, Tokelau, Tonga and Vanuatu.**

The key aim of the Pacific Island Mental Health Network is to enable Island countries to work together and draw on their collective experience, knowledge and resources in order to establish mental health systems that can provide effective treatment and care.

In consultation with countries, PIMHnet has identified a number of priority areas of work, including advocacy; human resources and training; mental health policy, planning, legislation and service development; and access to psychotropic drugs; and research and information. Network countries meet on an annual basis to develop work plans outlining major areas for action to address these priorities, to be officially endorsed by their Ministers of Health.

PIMHnet has also been successful in forging strategic partnerships with NGOs and other agencies working in the Pacific Region in order to reduce the existing fragmentation of mental health activities and to build more coordinated and effective strategies to address the treatment gap, to improve mental health care and put an end to stigma, discrimination and human rights violations against people with mental disorders.

PIMHnet is funded by the New Zealand Ministry of Foreign Affairs and Trade through the New Zealand Aid Programme.



THE PROJECT

“To provide the highest quality of care to our most vulnerable, and to help to prevent mental illness where possible. People need to have respect, love and care and their human rights supported.”

KEY ACHIEVEMENTS FOR MENTAL HEALTH IN KIRIBATI

- Completion of a detailed situational analysis of mental health in Kiribati
- Development of a strategic plan by the Ministry of Health and Medical Services that provides a framework for actions to improve the health system that will positively impact mental health care
- Development of a human resource and training plan for mental health in Kiribati
- Development of a mental health basic training programme for nursing assistants
- Involvement of WHO consultants in the reform of the undergraduate School of Nursing curriculum and training of staff in the mental health unit
- Improvements in the culture of the mental health unit including regular activities organised by churches
- A weekly mental health outpatient clinic in Nowerewere hospital has been created

NEXT STEPS FOR KIRIBATI

- Review the current Mental Health Act 1977
- Complete the mental health policy and plan
- Implement mental health and human resources plan
- Improve the conditions at the mental health facility, which is known as the "Mental Health Wing" to ensure that all have a safe and comfortable place to sleep and privacy, as well as putting in place safeguards for female patients
- Regular input into the training programmes for medical assistants
- Adding mental health training into the update course for medical assistants to be held at the end of 2012
- Continue with the development of an mental health outpatient clinic at the dispensary of the Mental Health Wings a first step towards developing community-based services
- Develop links with NGOs as well as families and carers
- Develop job descriptions, procedures, protocols and other documents to run the mental health unit effectively

OVERVIEW

Mental illness in the Republic of Kiribati is a major concern. However, the lack of available information about the prevalence of mental illness presents problems for mental health services planning and delivery. Collecting data needs to be a priority to set the foundation for improved mental health services. Mental health problems are thought to be common, and frequently result from unfavorable social and economic conditions, including unplanned urbanization and overcrowding. Although it is difficult to calculate treatment rates for people with mental health, the treatment gap is likely to be large given the very limited service development. The workforce is small with minimal mental health training available, and there is minimal leadership and insufficient capacity for expanding services.

There is no separate budget allocation for mental health within government health spending, which has resulted in inadequate funding for mental health services and an absence of a development plan for the workforce and services. Limited inpatient mental health services are delivered through a mental health unit within the national referral hospital. Over 50 percent of the population lives in rural areas with access only to basic primary health care facilities that currently have minimal ability to care for those with mental illness.

HISTORY AND MILESTONES

2000

September: US Peace Corps and WHO held a week long workshop for educating Medical Assistants from the outer islands about awareness and care of people with mental health conditions. Working with staff at the Tungaru Mental Health Wing, strategies were developed to decrease the high rate of relapse among patients. The training provided the country's first opportunity to discuss mental illness. The focus was on stigma, culturally appropriate counseling, psychological classifications and integration of western diagnosis and treatment techniques. The training led to the development of a comprehensive manual that is a country specific reference for mental health diagnosis and treatment.

2004

The Ministry of Finance and Economic Development published the National Development Strategies (2004-07) which outlines six key policy areas, of which one is public sector performance (which included the Ministry of Health).

2005

Situational Analysis on Mental Health Needs and Resources in Pacific Island Countries was completed by the World Health Organization and the Auckland University as part of a Pacific wide review of mental health care and services.

2007

January: *The Kiribati 2005 Census Volume 2: Analytical Report* was produced, the aim of which was to provide an analysis of the 2005 Kiribati census data with an emphasis on demographic trends, patterns and levels. The profile was prepared by SPC's Statistics and Demography Programme.

March: Kiribati joins the Pacific Island Mental Health Network (PIMHnet) and attends the launch meeting.

June: Kiribati participates in the inaugural PIMHnet meeting in Apia, Samoa, and the mental health policy workshop.

October: The Republic of Kiribati Ministry of Health and Medical Services Strategic Plan 2008-2011 was finalized. The plan includes an overarching goal, strategic objectives and priority actions based on a situational analysis of the health situation in Kiribati.

2008

Improvement of Health Services on the Outer Gilbert Islands is a European Union funded project that aims to enhance access to health and medical services in the outer islands and achieve the Millennium Development Goals by: refurbishing Outer Island health facilities; providing in-country training courses from the Fiji School of Medicine; and developing primary health care capacity in the Outer Islands.

January: A stakeholders workshop was held to establish the vision and strategies of the mental health policy and plan with the assistance of the PIMHnet facilitator. Key stakeholders were involved in this process during the facilitator's visit. A draft mental health policy was developed for further in-country consultation.

September: Kiribati national focal contact participates in the PIMHnet workshop held in Fiji on policy planning and human resource development for mental health.

2009

April: A Human Resources and Training Plan for Kiribati is produced with the support of WHO PIMHnet. The human resource plan for mental health services identifies gaps, key strategies, and activities to build service capacity and clinical infrastructure.

2010

September: Review of School of Nursing curriculum by a WHO consultant and a process is initiated to incorporate mental health components into the undergraduate curriculum.

2011

April to July: A volunteer psychiatrist from the Royal College of Psychiatrists, UK, spends three months in Kiribati as a WHO consultant. During this time, she is involved in the introduction of the mhGAP implementation guide through the training of a recently graduated doctor, and other staff and doctors at the Tungaru Central Hospital and Mental Health Wing, as well as nurses based on the outer islands. The WHO consultant also initiated Community Education Days, which were facilitated by locally trained staff. One of these, focusing on psychosis, was held in July 2011.

2012

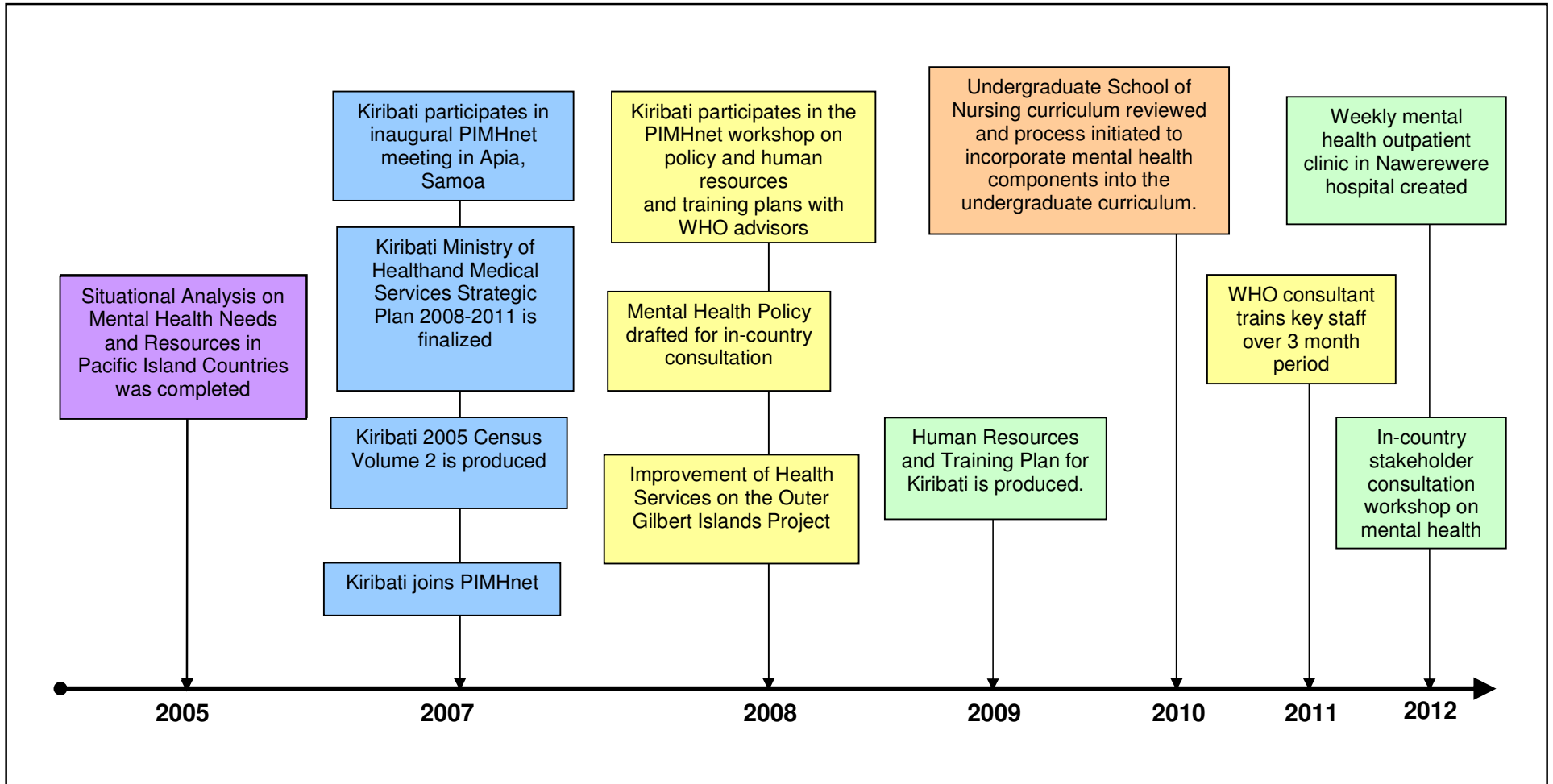
September: An in-country stakeholder consultation workshop on mental health care was conducted and an international consultant provided recommendations for actions to improve mental health care and outcomes.

Weekly mental health outpatient clinic in Nowerewere Hospital was created.

A local doctor and nurse accepted to undergo the post graduate diploma on mental health at the Fiji National University in 2013.

A plan to create a vegetable garden at the mental health ward to assist recovery was finalized during February 2013.

Figure 1. Timeline



OFFICIAL DOCUMENTS

DEVELOPMENT AND POVERTY REDUCTION POLICIES, STRATEGIES AND PROGRAMMES

- Republic of Kiribati, Ministry of Health and Medical Services. National Development Plan 2008-2011

HEALTH AND MENTAL HEALTH POLICIES, PLANS AND PROGRAMMES

- Republic of Kiribati, Ministry of Health and Medical Services. Corporate Strategic Plan for the Health Sector 2008-2011
- Republic of Kiribati, Ministry of Health and Medical Services. Monitoring and Evaluation Framework, 2008-2011.

LEGISLATION

- Laws of the Gilbert Islands - Revised Edition 1977. Chapter 56, Mental Treatment.

SITUATIONAL ANALYSES

- Situational analysis of mental health needs and resources in Pacific Island countries, 2005, WHO and the Centre for Mental Health Research, Policy and Service Development, University of Auckland.

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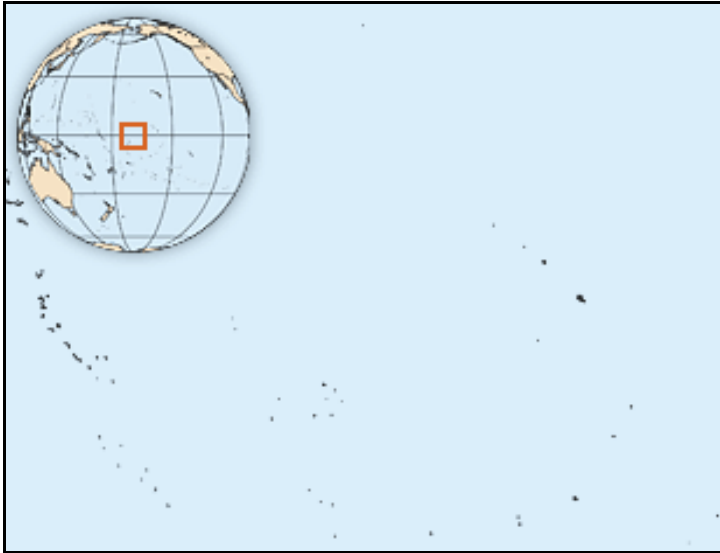


THE CONTEXT

1. COUNTRY DEMOGRAPHIC AND SOCIOECONOMIC PROFILE

Figure 2

Location of Kiribati



This map is an approximation of actual country borders.

Source: reference (1)

The Republic of Kiribati, located in the Pacific Islands between the central and western Pacific, consists of 33 low lying atolls dispersed over 3.5 million square kilometers of ocean (2). Combined, the islands have only a surface area of 811 km². Kiribati has a population of 100,000 (3) which is spread over 21 inhabited islands. There are three main island groups: the Gilbert, Phoenix, and Line Islands.

Geography and climate

Kiribati is extremely vulnerable to external environmental events, and is one of the countries expected to suffer greatly from climate change, with the worst case scenario being the disappearance of the country (4). The atolls in Kiribati create harsh environmental conditions for residents of Kiribati. Flat ribbons of sands, scarce fresh water, limited vegetation, and substantial geographic fragmentation means that transportation and communication systems experience difficulties. Furthermore, environmental conditions are deteriorating, particularly in the urban centre of South Tarawa (4).

Migration

There is a substantial amount of migration from the outer islands to South Tarawa, as indicated by the urban population growth rate of 1.7% annually (2). Overcrowding in South Tarawa places stress on both the environment and infrastructure (2). New urban settlements in North Tarawa and Kirimati Island have shifted urban growth rates as well (2), in addition to increasing overall population density.

Culture

The official language of Kiribati is English, but outside of Tarawa, English is not used often and Pidgin English mixed with "Gilbertese" is more common (5). Ethnically, 98.8% of the population of

Kiribati is Micronesian, with a small number of Tuvaluans, Nauruans and Europeans (6). The majority of the Islands have three or more villages, which are typically separated by religion and traditional village rivalries (6). The largest religious groups are Roman Catholic and Protestant, with the Northern Islands of the main Gilberts group being predominantly Catholic, whereas the Southern Islands are predominantly Protestant (6).

Demography and Population

Kiribati has a growing population with a substantial portion consisting of youth under the age of 15. The youth population consists of one-third of Kiribati's population. The annual population growth rate is 1.22% (7), (see Figure 2 and 3, below); by 2050, Kiribati's population is projected to expand, particularly in older cohorts. This can be attributed to increasing life expectancy and ameliorated health outcomes. Additional demographic indicators can be seen in Table 1.

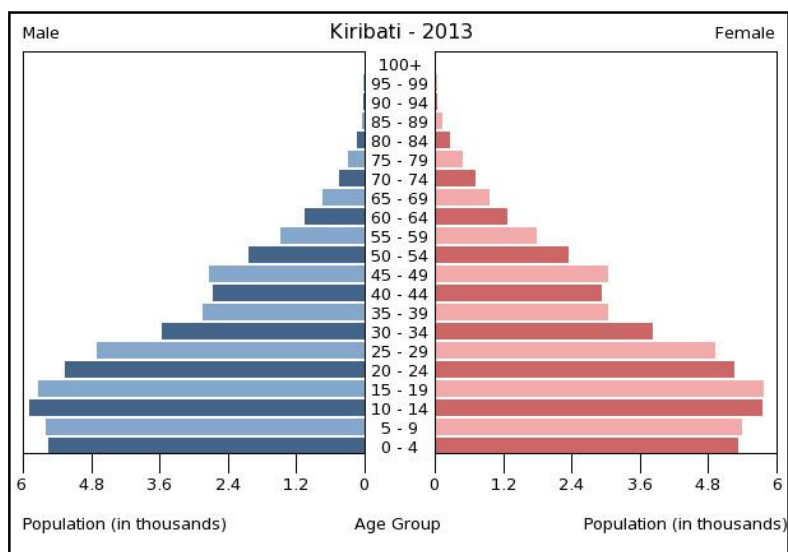


Figure 3
Age structure diagram
Illustrating the 2013
population in Kiribati

Source: reference (7)

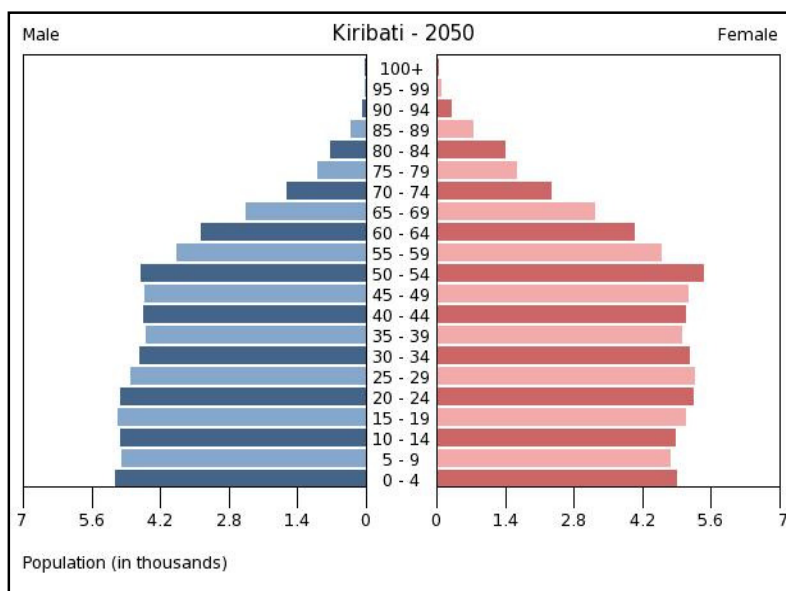


Figure 4
Age structure diagram
showing Kiribati's
population by 2050

Source: reference (7)

Economy

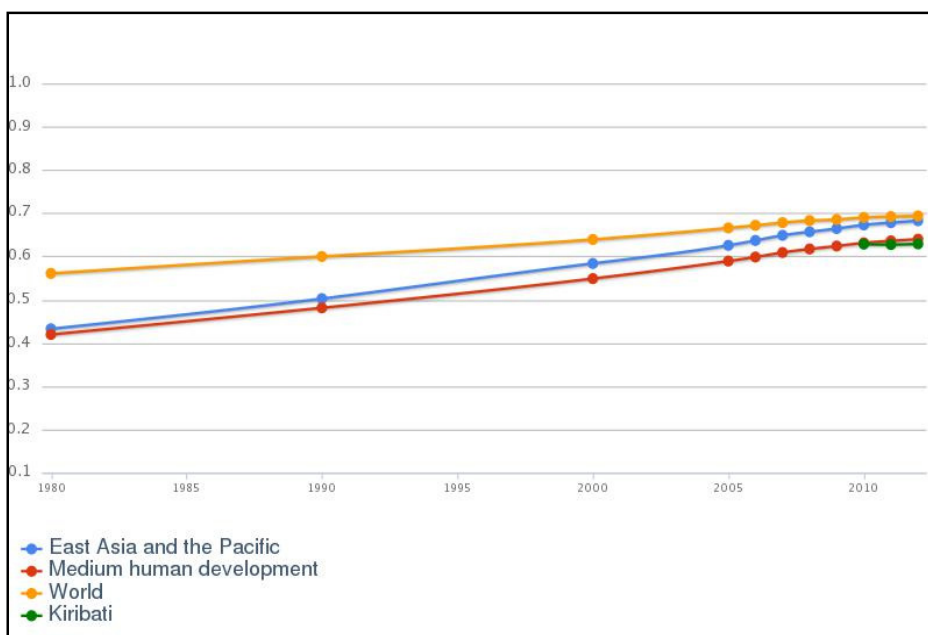
Kiribati is a lower-middle income country (8), with economic development hindered by a lack of resources and dependency on: prices received for copra and fish; overseas investments, remittances from Kiribati people working abroad; license fees for foreign-owned ships; and, foreign aid (4). The primary sector of employment is public administration (9), with 53% employed in public administration and the remainder mainly working as subsistence farmers, seafarers, or fishermen(10). Copra plantations are also a source of revenue for the people of Kiribati. The economic trends in Kiribati are shifting from a more agricultural-based economy to a more services-oriented economy, illustrated by the figures showing 86.4% of GDP came from services, versus 7.1 % from agriculture, 6.6% from industry and 0.9% from manufacturing (8).

Development indicators

Kiribati's Human Development Index (HDI) is one of the lowest in the region at 0.629 (11), and has not improved much over time. Between 1980 and 2013, Kiribati's HDI value increased only slightly from 0.432 to 0.683(11). On the Human Poverty Index (for the Pacific Region), Kiribati ranked poorly as well, falling behind the majority of Pacific Island countries (11). It is ranked as a least developed country (see Table 1). Figure 5 plots Kiribati's HDI index trend from 2010 to 2013. Kiribati ranks 121th out of 187 countries. Additional development indicators for Kiribati are shown in Table 1.

Kiribati's progression towards achieving the Millennium Development Goals remains mixed. While Kiribati is doing well in increasing primary education enrolment, promoting gender equity in education, and on some health indicators (e.g. tuberculosis treatment rates and reducing the spread of HIV) (12). The country is having less success in addressing 5 out of the 8 MDGs.

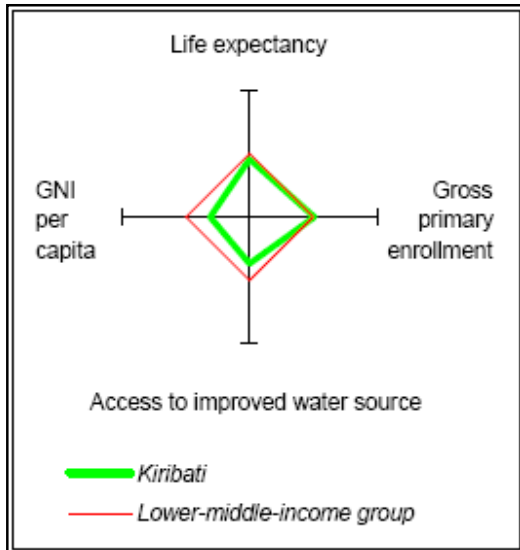
Figure 5
HDI for Kiribati compared with global and regional HDI trend



Source: reference (11)

The Human Development Diamond (Figure 6) depicts four key socioeconomic indicators comparing Kiribati with the lower-middle income country group average. Kiribati was similar to other lower-middle income countries on gross primary enrolment and life expectancy, however gross national income per capita and access to improved water source are significantly poorer than other low-middle income group countries.

Figure 6
Human Development Diamond for Kiribati



Source: reference (8)

Table 1
Individual indicators of human development for Kiribati

National Indicators		
1. Demography & Population	Indicator	Source: reference
Population (number)	100 000	(3)
Population Under Age 15 (%)	35.9	(2)
Urban Population (%)	44	(3)
Population Growth Rate (%)	1.22	(7)
Infant Mortality Rate (rate per 1,000)	38	(13)
Under-five Mortality rate (rate per 1,000)	47 [34 -70]	(13)
Maternal Mortality Ratio (rate per 100,000)	No information	(14)
Life Expectancy at birth – Males (years)	65	(13)
Life Expectancy at birth – Females (years)	71	(13)
2. Income & the economy	Indicator	Source: reference
GDP (US\$)	166.7 mil	(15)
Country Income Classification	lower middle income	(8)
Proportion of population living below national poverty line	51%	(16)
Government Allocation to Health as % of GDP	10.7%	(13)

2. CONTEXTUAL FACTORS INFLUENCING MENTAL HEALTH NEEDS AND SERVICES

URBANIZATION AND HEALTH OUTCOMES

Over 44% of Kiribati people live in urban areas, with the average population density at 121 people per km² (3). A substantial proportion of the population has migrated to the urban centre of South Tarawa. The population density is very heterogeneous in Kiribati, varying greatly between regions. For example, in 2005, the population density was estimated at 130/ km² in Kiritimati Island but over 2500 / km² in South Tarawa (6).

The overcrowding in South Tarawa has led to higher levels of unemployment, poor housing conditions, and poorer health outcomes. This has created a deteriorating social environment and increased challenges for health (6). The overcrowding has also resulted in reduced access to sanitation and clean drinking water, compounded by issues of lack of personal hygiene, and inadequate food handling and storage. This has facilitated the spread of infectious diseases in Kiribati, particularly diarrheal, skin, eye, and respiratory diseases (2).

Furthermore, a noticeable variability exists on health indicators between those living in urban South Tarawa versus those living on the Outer Islands. For example, infant mortality rate has been reported as worse in South Tarawa than those living in the Outer Islands (2).

SUBSTANCE USE

Prevalence data on actual substance and alcohol use is limited; however, alcohol consumption in particular is perceived as a common social problem, especially among youth(2). In some Kiribati communities alcohol use begins around the age of eleven and continues into adulthood (17). Consequences of excessive alcohol consumption in Kiribati include road traffic accidents and domestic violence, with domestic violence becoming an increasing problem. Police reports show that alcohol abuse is a factor for many people presenting to mental health facilities. Alcohol use and abuse in Kiribati is often misdiagnosed as schizophrenia because of acute behavioral changes and, in alcohol withdrawal, the occurrence of visual hallucinations.

POVERTY

A UNDP report indicates that 1 in 5 households and nearly 25% (or 1 in 4) of Kiribati people are living below the national minimum cost of living or basic needs poverty line (6). An additional 5.6 % of the population is vulnerable to falling into poverty (6). Poverty rates are the highest in South Tarawa (24.2% living below poverty line and 7.4% at risk for falling into poverty) compared with all other regions of Kiribati (6). Poverty is due to limited economic opportunities to earn income, poor delivery of basic services, rising prices of basic commodities, poor home environment caused by overcrowding, loss of traditional values and skills particularly among young people, and use of alcohol.

INFECTIOUS DISEASES

There is a high prevalence of sexually transmitted diseases (STIS) in Kiribati. A surveillance study in 2004 revealed that nearly 15% of pregnant women had STI's. Kiribati also has one of the highest rates of HIV/AIDS in the Pacific. A spike in incidence rates occurred between 1994 and 2001, where more than 35 cases were confirmed. By the end of 2006, a cumulative total of 50 HIV/AIDS cases, of which 24 are known to have died, were reported. Furthermore, 70% of reported cases of tuberculosis in 2005 were found in the urban settlement of Betio in South Tarawa. The facilitated transmission of infectious disease via poor living conditions in urban settlements as well as the impact of having an infectious disease can have substantial consequences on mental health (2).

UNEMPLOYMENT

The 2005 Census found that 64% of people above the age of 15 were "economically" active, however only 23% had regular paid employment (10). This unemployment rate is expected to rise due to the growing population and large youth population who will soon be seeking employment. The lack of employment opportunities in Kiribati has been associated with an increase in youth violence and alcohol misuse. Unemployment rates across the country were reported to be around 38% (6).



MENTAL HEALTH PROBLEMS AND TREATMENT IN KIRIBATI

3. BURDEN OF DISEASE AND TREATMENT GAP

PREVALENCE AND BURDEN OF DISEASE IN COUNTRY

There is very limited data available on prevalence and incidence of mental disorders in Kiribati. As a result, any prevalence data available is based on estimates or from small surveys. For example, a national survey on disability identified 3840 people with 4358 disabilities throughout the country, of which 17% (or 653 people) had an intellectual disability, epilepsy or psychiatric illness (10). According to the 2004 World Mental Health Survey (18), it can be estimated that 13% of a country's adults population will experience a mental illness over their lifetime, of which 10% will experience a mild to moderate form of a mental illness, and 3% will experience a severe mental illness. If we apply these prevalence estimates to Kiribati's adult population (over the age of 15), we can estimate that 8333 adults have a mental illness, and 1923 people have a severe mental illness.

Depression is particularly underreported and untreated in Kiribati, and rates are likely to be widespread. High suicide rates and alcohol consumption have been reported to be a factor for many service users presenting to mental health services (19).

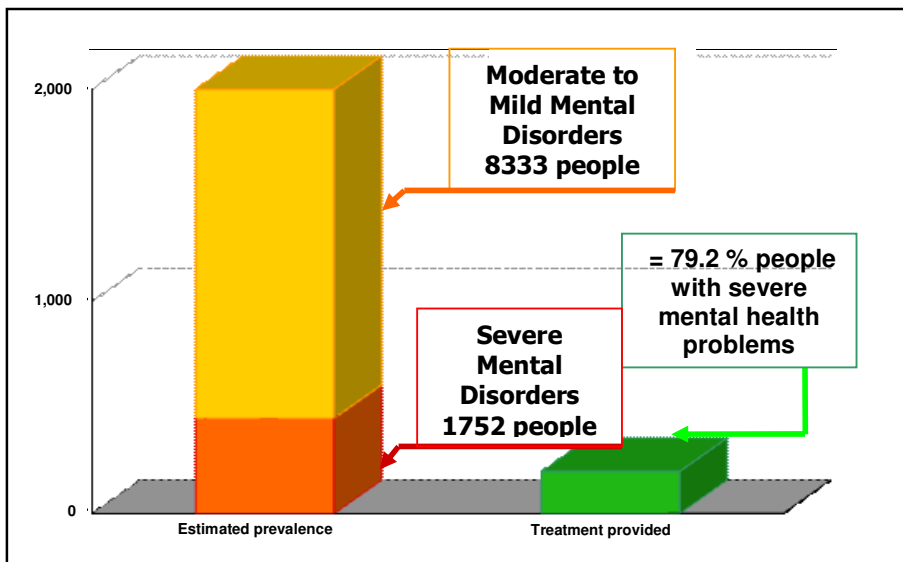
TREATMENT AND SERVICE UTILIZATION DATA

Within a one-year period, 208 people used the mental health inpatient service and 156 people used the mental health outpatient service provided.

TREATMENT GAP

Given that there is limited data on the prevalence of mental disorders in Kiribati, the treatment gap has been estimated based on the global prevalence rates of 10% for mild to moderate and 3% for severe mental illness, respectively (18). Based on these figures, 8333 of adults (persons 15 years of age and older) in Kiribati (13% of the total adult population) are estimated to have experienced some form of mental disorder, and approximately 1923 people (3% of the total adult population Kiribati) can be estimated to have had a severe mental disorder. Recent service utilization data estimates that approximately 364 people received treatment in 2011. If we assume that most of the people in Kiribati who were treated had a severe mental disorder, then the treatment gap would be 79.2%. If we consider the treatment rates for all severities of mental disorders, then the estimated treatment gap would be 95.2%. The treatment gap is illustrated in Figure 7, below.

Figure 7
Estimated treatment gap for mental disorders in Kiribati





MENTAL HEALTH WITHIN THE GENERAL HEALTH SYSTEM

4. MENTAL HEALTH WITHIN THE GENERAL HEALTH SYSTEM

Kiribati's health care system is organized through a network of referral hospitals, district hospitals, health centres, and dispensaries. In addition to the formal health care system, traditional health care provided by traditional healers is also prominent in Kiribati. There is a strong primary health care network throughout Kiribati, which was adopted in 1981 (20).

In Kiribati, people with health problems often go to the community health worker first (a health aide or traditional birth attendant, for example) who treats or refers upwards to a public health nurse who works in the village dispensary. The public health nurse is responsible for further management of the patient or can refer upwards to the health care centre, staffed by a medical assistant. Patients from here can be hospitalized at the district or national level hospitals if necessary. The medical assistant can also receive advice via a radio community network of tertiary-level specialists (20).

In terms of health facilities, there is one tertiary-level national referral hospital in the country, Tungaru Central Hospital, located in South Tarawa. Linked to the Tungaru Central Hospital, there is a dedicated stand-alone inpatient mental health unit, however, it is not situated at the main hospital building.

At the secondary level, there are three district hospitals in Kiribati; one on Kiritimati Island providing basic surgical, medical and maternity services, one hospital in North Tabiteuea to serve the Southern islands or district of the Gilbert Islands, and one small hospital providing basic medical services in Betio, South Tarawa.

At the primary care and community level, there are 34 health centres in the country, and 66 dispensaries, both of which provide primary health care services throughout Kiribati (2). The primary care system in Kiribati has a support role in the health care system. The primary care network provides diagnosis and treatment for common diseases and health problems; as well as basic surgical interventions, family planning, and laboratory and medical examinations.

The Marine Training Medical Center at Betio is engaged in providing private medical services.

Figure 8. Ministry of Health Organogram

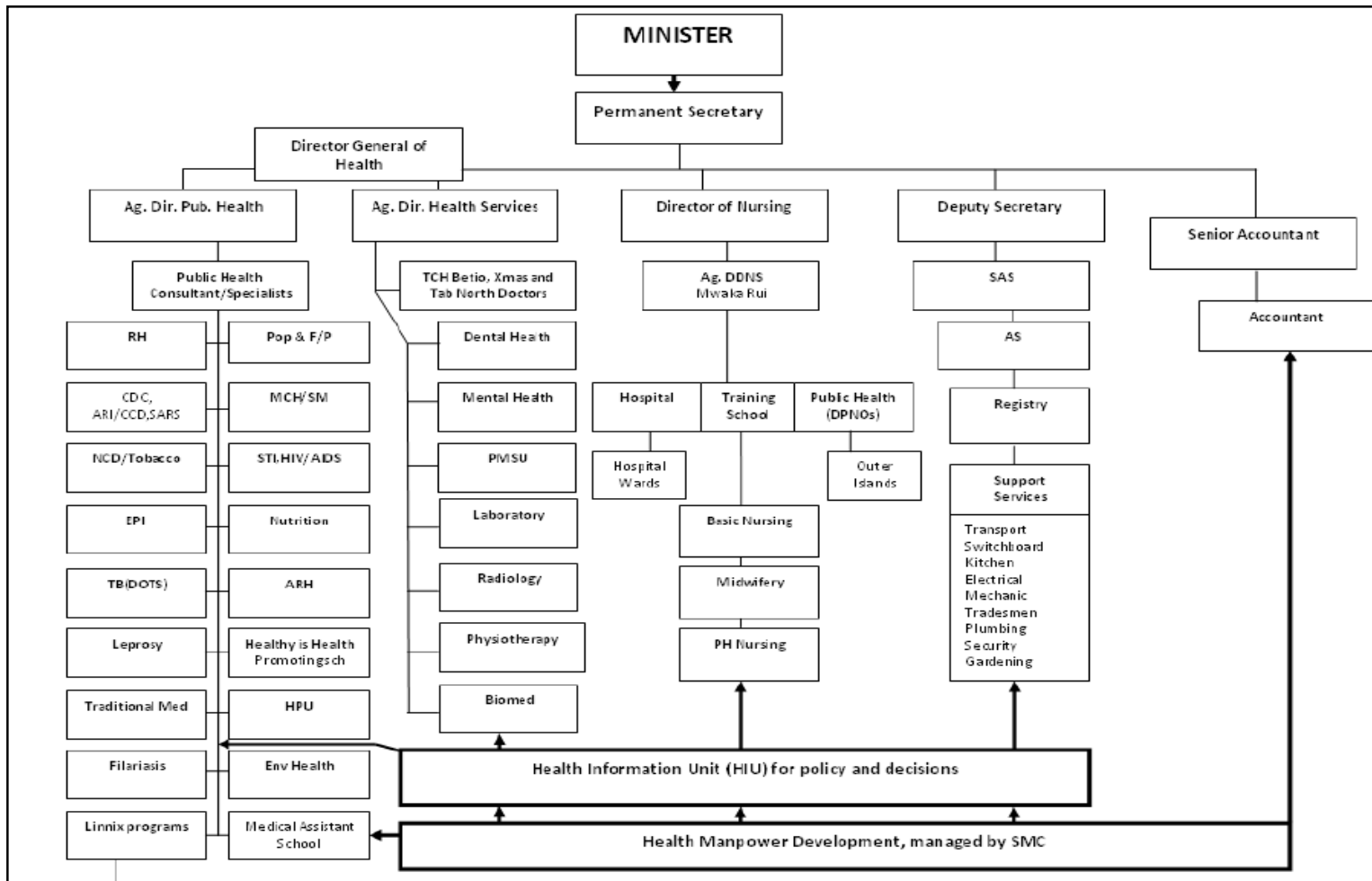
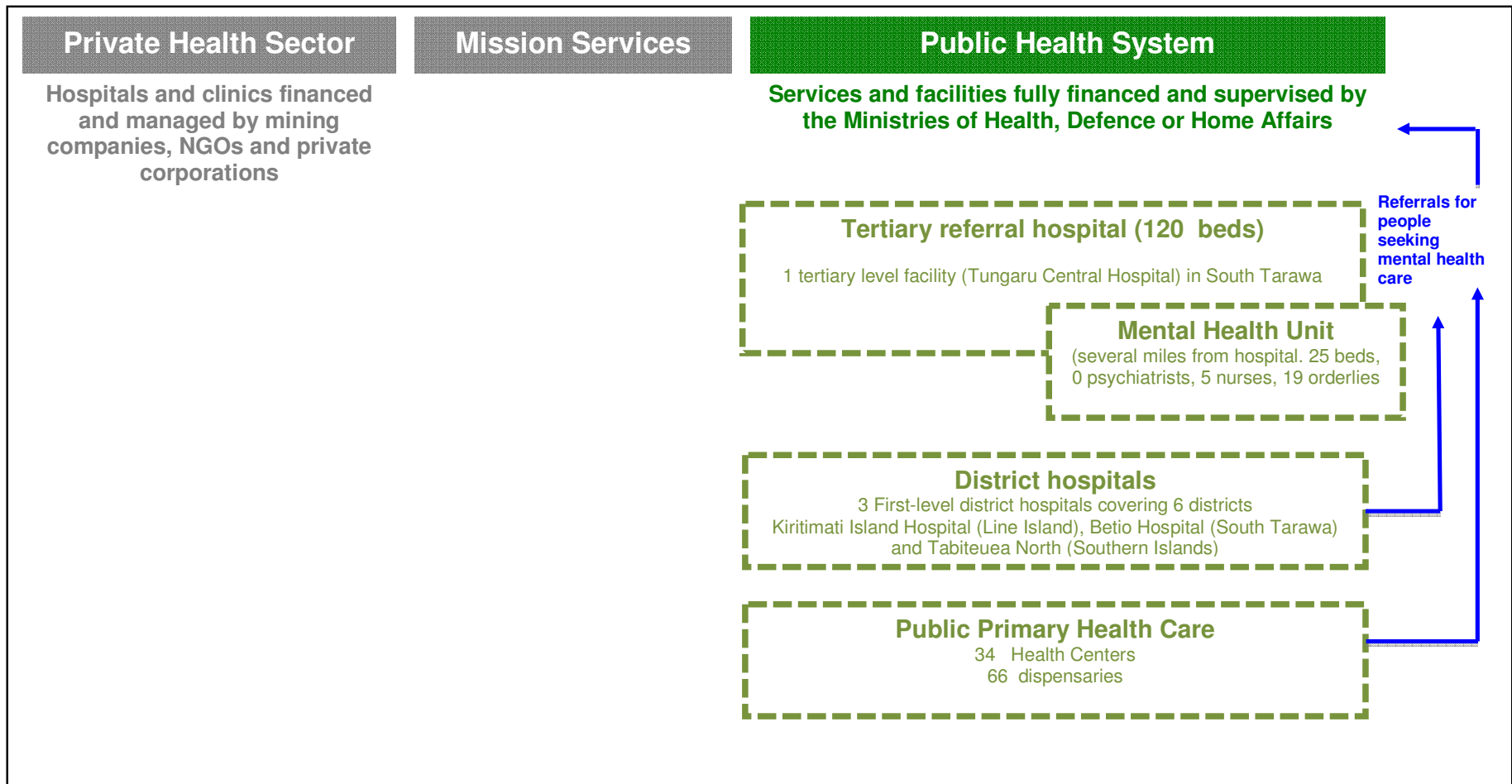


Figure 9. Mental health services mapped against the general health system



COORDINATION

For general health services, Kiribati's primary and secondary health care services work together, with principal nurses and doctors leading the health services (e.g. health centres and district hospitals). The Ministry of Health and Medical Services provides leadership however their recent strategic plan acknowledges some shortfalls in management and reporting lines, quality control and communication.

For mental health services, there is a Mental Health Division under the Hospital Services Division. Six Principal Nursing Officers based in Tarawa are responsible for the support and oversight of health services in each district and one of these officers is a trained mental health nurse. There are unclear management reporting lines and poor communication between health centers and hospitals, and within the mental health care system. There is also a lack of quality control and patient focus.

LEGAL FRAMEWORK AND POLICIES

Kiribati's mental health legislation, the Mental Health Act 1977, is outdated and does not reflect the Convention on the Rights of Persons with Disabilities. For example, the mental health legislation does not provide for community treatment and needs to be updated to include more clear definitions and standards aligned with human rights.

MENTAL HEALTH POLICY AND PLAN

Kiribati is currently in the process of developing a mental health policy with the assistance of a PIMHnet facilitator. Initial consultations with stakeholders took place in January 2008.

The draft Mental Health Policy aims to provide the highest quality care to help prevent mental illness and to support the human rights of persons with mental disorders.

The objectives of the policy are to:

- Improve the knowledge, skills and attitudes of staff in the mental health unit, through access to mental health nursing education programmes, mentoring and on the job training.
- Improve support to, and education of, the School of Nursing lecturers who teach mental health nursing.
- Increase the ability of medical assistants within the outer islands to provide early interventions, assessments, treatment and follow up for those with mental illness.
- Improve the physical environment and the culture of the mental health unit such that it meets the needs of patients and reflects the community in which they live.
- Ensure that the mental health service protects patient's rights and addresses concerns and complaints.
- Involve the community in the day to day programmes of the patients within the mental health unit at the national referral hospital.
- Be focused on rehabilitation and assisting people to reintegrate into the community for programmes with mental health.
- Increase community support across the islands with a focus on access to medications timely assessment and follow up.
- Promote greater community awareness through health education and promotion in relation to mental health.
- Provide opportunities for community members to receive training about mental health so they have a greater role in supporting families and people with mental illness.

Kiribati's Strategic Health Plan (2008-2011) outlines six key objectives, one of which is to improve mental health service delivery. The specific actions to attain this objective include addressing the needs of high risk groups including patients with a mental illness (Strategic Objective 1.4) and improve mental health services (Strategic objective 2.6) through preparation of a funding proposal for the revision of the mental health policy and plan; implementation of the mental health plan; and the development of partnerships with neighbouring countries via PIMHnet (19).

Human rights and equity

In 1999, Kiribati signed the Proclamation of the Full Participation and Equality of People with Disabilities in the Asian and Pacific Region (21). This Proclamation was commissioned by the Economic and Social Commission for Asia and the Pacific Special Body on Pacific Island Developing countries. The main features of this Proclamation are to promote the participation of people with disabilities via: national coordination; public awareness; accessibility and communication; training and employment; prevention; regional coordination and self-help organizations (22).

Kiribati does not have disability or social benefits for people with mental illness (5).

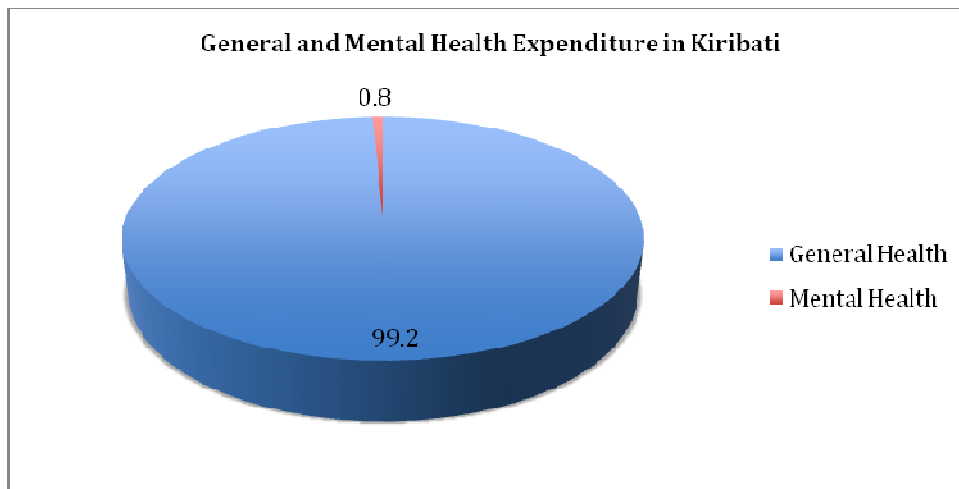
5. RESOURCES FOR MENTAL HEALTH

Financing

Kiribati's health system is primarily publicly funded. Government expenditure on health as a percentage of total government expenditure was 10% in 2010 (13). Of the total health expenditure in Kiribati, 84.7% of the budget comes from government funds, and 15.3% comes from private funds (23). Individual out-of-pocket payments, as a percentage of private expenditure of health, are low at 0.6% in 2009 (23). The majority of government expenditure is allocated towards curative care (as opposed to preventive care), pharmaceuticals and staff.

There is a specific budget allocation for mental health services under the Director of hospital services, however, the data is not disaggregated and therefore it is not possible to identify the exact funding level allocated or spent on mental health. It is likely that the country spends less than 1% of the overall health budget on mental health (Figure 10) (5).

Figure 10
General and mental health expenditure in Kiribati



Human Resources

Kiribati has an ageing health workforce and relies on retired health staff employed on contract to fill some nursing and medical positions. The current intake of health workforce trainees is unlikely to meet future employment requirements. In 2004, a total of 238 locally trained nurses and midwives made up 80% of the health workforce, with doctors making up the next largest group of health workers. There are only 18 doctors: 1 at Betio, 3 at Christmas island, 1 at Tab North and 13 at Tungaru Central Hospital, providing clinical services in the four hospitals. Four of these are retired and on contracts. Several doctors from Cuba had been working in Kiribati since 2006.

The Ministry of Health and Medical Services state that the high number of untrained or unskilled staff is a major problem for the health system; both in general and in mental health care (19). In particular, there is a shortage of paramedical and support staff (e.g. pharmacists). The retirement of a pharmacist in 2006 left only one qualified pharmacist in the country.

For mental health, there is no psychiatrist working in Kiribati. There are two nurses in Kiribati who have received specialist mental health/psychiatric training – the Principal Nursing Officer (PNO) and the charge nurse of the mental health unit in Tungaru Central Hospital. One obtained diploma in psychiatry nursing through a one-year course in New Zealand, and the other obtained a bachelor in nursing through one year course in Fiji.

Table 2. Human resources across facilities

Facility/Level	General Health							Mental Health				
	Medical Doctor	Registered Nurse	Medical Assistants	Midwife	Nurse Aide	Pharmacist	Social Worker	Psychiatrist	Orderlies	Clinical Psychologist	Psychiatric Social Worker	Registered Psychiatric Nurse
PROVINCE 1												
TERTIARY LEVEL CARE												
Tungaru Central Hospital												
Total	15 ¹	383	48 ²	78	0	4	0	0	0	0	0	2
Tungaru Mental Health Unit (Within the hospital)												
Total	0	5	0	0	0	0	0	0	19	0	0	1
SECONDARY LEVEL CARE: 3 district hospitals												
Kiritimati District Hospital	3	21	0	4	0	0	0	0	2	0	0	0
Southern Kiribati District Hospital	1	21	0	3	0	0	0	0	2	0	0	0
Betio Hospital	1	19	0	1	0	0	0	0	2	0	0	0
Total	5	61	0	8	0	0	0	0	6	0	0	0
PRIMARY LEVEL CARE												
Health Centre (34)												
Total	0	0	34	0	0	0	0	0	0	0	0	0
Typical Average*	0	0	0	0	0	0	0	0	0	0	0	0
Dispensaries (66)												
Total	0	66	0	0	Not Available ³	0	0	0	0	0	0	0
Typical Small*	0	Not Available ⁴	0	0	Not Available	0	0	0	0	0	0	0
Typical Large*	0	Not Available	0	0	1	0	0	0	0	0	0	0
Typical Average*	0	Not Available	0	0	Not Available	0	0	0	0	0	0	0

¹ Of the 16 Doctors in Tungaru central hospital, 9 are established, 4 are interns and 3 are retired contracted doctors

² Of the 48 Medical Assistants in the Tungaru Central Hospital, 34 are in the Health Centers throughout Kiribati and 14 are doing other programmes in the hospital or are in charge of disease-specific programmes.

³ Dispensaries are staffed by nurses and nurse aids. However, the exact numbers are not known.

⁴ Dispensaries are staffed by nurses and nurse aids. However, the exact numbers are not known.

TRAINING

Training for nurses is provided in-country through a three-year, hospital-based training programme, with approximately 25 nurses enrolled in the programme annually (2). Locally recruited medical students are usually trained at the Fiji School of Medicine and more recently, in Cuba. Once they graduate, doctors in Kiribati continue professional development through short courses and workshops, provided mainly through regional health programmes (2).

In 2009, the Fiji School of Medicine and the University of the South Pacific provided training to nurses in Kiribati in priority areas. These areas included primary trauma care, health service management, post-graduate certification in midwifery, public health nursing, health service management, and postgraduate diplomas in public health.

With regard to mental health, Kiribati has identified the need to train staff working in the community in mental health prevention and promotion. The health workers would come from a wide array of services in Kiribati, including community groups, churches, and police and would include a police educator and trainers from the Police Training School in Kiribati. Kiribati hopes to train 20 people through in-country workshops in order for them to become key community educators.

From April to July 2011, mental health training, organized by WHO as a part of PIMHnet was provided by a psychiatrist through the volunteer scheme offered by the Royal College of Psychiatrists in the UK in collaboration with WHO Geneva. The aim of this training was to develop competencies in mental health for health care staff in the country. Training activities centered on the on-the-job training of a graduate doctor in order to develop her capacity to provide mental health services in Kiribati. The consultant also conducted weekly sessions with the ward staff and doctors at Tungaru Central Hospital and carried out two intensive training courses using the mhGAP intervention guide as the core text for training. The first training was delivered to 9 experienced nurses from the Outer Islands who are training to become Medical Assistants (MAs), and the second training to 12 MA trainees from Kiritimati Island.

More intensive clinical training was also given to five health workers, including the Senior Nursing Officer and three of the nursing officers on the Mental Health Unit. Intensive training was also provided to the trainer from the School of Nursing who will use the training to improve the development of the undergraduate nursing curriculum.

Finally, a Community Education Day took place on 4 July 2011 using the trained staff to manage the day's events. The focus was on psychosis and the training was conducted in the local language by the former trainees. It was intended to be the first of many such events to encourage community involvement in mental health and was supported by a range of organisations such as Alcoholics Anonymous and Family Recovery, the Kiribati Protestant Church (and Youth Group) and the Social Support Service.

Since her departure, the consultant has maintained contact with the graduate doctor who is working in mental health in order to provide her with support and supervision at a distance.

Table 3
Training and work for mental health professionals in Kiribati

	Training available in Kiribati		Total numbers Currently working in Kiribati	Number currently working in mental health
	Degree courses	Continuing Professional Development (number/training years)		
Health workers				
Psychiatrists	No	No	0	0
Neurosurgeons	No	No	0	0
Neurologists	No	No	0	0
Physicians	No	Yes through short courses and workshops	1	0 however one physician visits the mental health facility twice a week
Nurses	3 year basic nurse training	No	5	5
Medical assistants		1 year post basic training	48	0
Psychiatric nurses	No	No	2	2*
Psychologists	No	No	0	0
Occupational therapists	No	No	0	0
Social workers	No	No	0	0
Orderly	No	No	39	19
Pharmacists	No	No	4	3 with a degree and 1 with a diploma

* One is working as a Principal Nursing Officer supervising medical services in the southern Kiribati and the other is working in Tungaru Central Hospital

MEDICATIONS

Psychotropic medications are available in Kiribati to treat mental illness and guidelines have been developed for the administration of these medications. People with schizophrenia are treated with oral chlorpromazine or haloperidol and oral Benzhexol is prescribed in order to counter the side effects of antipsychotics. For people with bipolar disorder, haloperidol or oral chlorpromazine is prescribed. Lithium is not used in Kiribati as plasma concentrations cannot be monitored. Kiribati's Essential Medicines List was updated in 2011.

Table 4

Comparison of recommended psychotropic medications, official policy and practical availability in Kiribati (see Appendix for more detail on WHO EPM List)

Drug	WHO Essential Psychotherapeutic Medicines 2009	Kiribati Essential Medicines List	Dosage	Prescription Requirements
Chlorpromazine	✓	✓	25mg (tablet) 100 mg (tablet) 50mg/2ml (amp)	
Haloperidol	✓	✓	5 mg (tab) 5 mg/ml (amp)	
Fluphenazine	✓	✓		
Amitriptyline	✓	✓	25mg (tab)	
Fluoxetine	✓			
Diazepam	✓	✓	25mg (tab)	
Clomipramine	✓		200 mg (tab)	
Carbamazepine	✓	✓	200 mg (tab)	
Sodium Valproate	✓	✓	200 mg (tab)	
Lithium Carbonate	✓			
Methadone	✓			
Nicotine replacement therapy	✓			
Olanzapine		✓✓ ✓	5mg (tab (10 mg (tab)	Prescription by psychiatrist only
Procyldine (as HcL)		✓	5mg (tab)	Prescription by psychiatrist only
Trioridazine		✓	50mg (tab)	Prescription by psychiatrist only
Trifluoperazine		✓	5mg (tab)	

Source: references (24, 25)

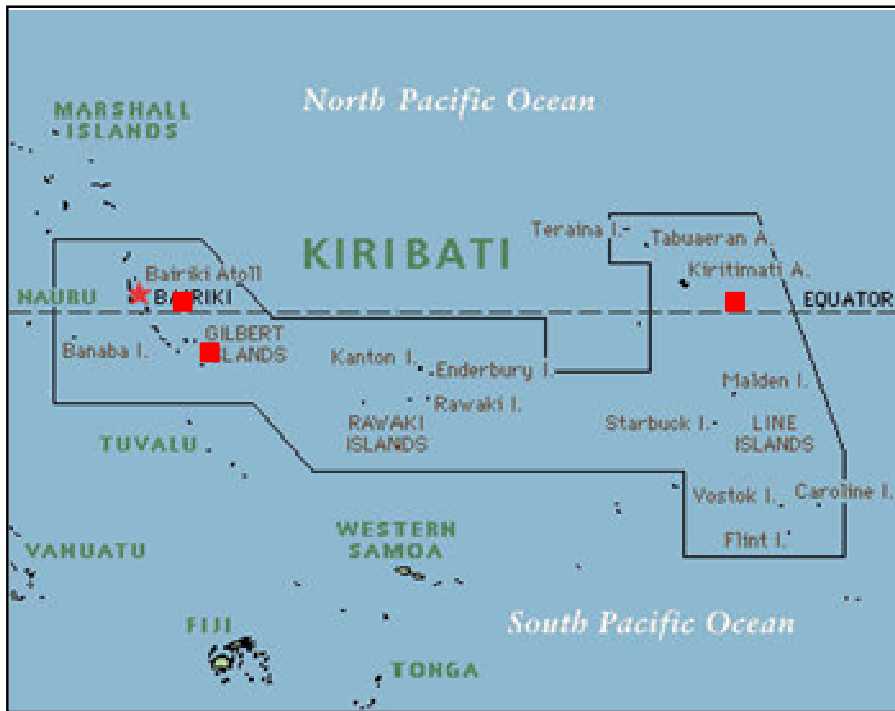
INFORMATION SYSTEMS

The government has established a medical library; however mental health data is not routinely collected. Data collection is limited to physical health.

PUBLIC EDUCATION AND LINKS TO OTHER SECTORS

One example of inter-sectoral collaboration is the Health Service Commission Improvement Fund (HSCIF), which is coordinated by the Ministry of Home Affairs and Rural Development of the Island Councils. The aim of this fund is to cover costs for the hire, maintenance and repair of motorcycles used as a means of transportation for primary health care workers in Kiribati. The Ministry of Health covers the costs (20).

Figure 11
Mapping Health Care Services in Kiribati



- The Mental Health Unit in Tungaru Central Hospital (Tarawa only)
- Southern District Hospital in Tabiteuea North (Gilbert islands)
- Kiritimati Hospital in the Line islands (London = main township)

FACILITIES AND SERVICES

Longstay facilities and specialist services

The main mental health facility is considered to be part of the Tungaru Central Hospital, however it is located in the old hospital in Bikenibeu. Tungaru's mental health unit has 25 beds and provides inpatient assessment and treatment for people with severe mental illness. It is the only facility with specialist mental health beds in the country. This unit is staffed by 5 nurses and 19 orderlies. The only psychiatrist left in 2010 to Fiji. There is one Principal Nursing officer and one nurse who have mental health training, and both work at the mental health unit at Tungaru Hospital until the end of 2010. The unit is poorly maintained and overcrowded. The 4 seclusion cells are frequently used without basic supplies like mattresses.

Following the visit of a WHO consultant from April to July in 2010, regular outpatient clinics were held on a Tuesday and Thursday, as well as inpatient reviews on Mondays, Wednesdays and Fridays. These services are provided by registered nurses. A medical doctor who is trained in mental health provides services there on an irregular basis.

Psychiatric services within general hospitals

Tungaru Central Hospital is the main referral hospital in Kiribati and has 120 beds. There are three district general hospitals in Kiribati, Betio Hospital has 15 beds, Southern Kiribati District Hospital, Tabiteuea Hospital has 25 beds, and Kiritimati Hospital has 15 beds. None of these hospitals provide mental health services except Tungaru Central Hospital.

Nawerewere Hospital has a weekly mental health outpatient clinic (stress clinic).

Formal community mental health services

There are no formal community health services nor community mental health services available in Kiribati.

Mental health services through primary health care

There are 34 health centres across Kiribati providing diagnosis, treatment and management of common health problems. Basic medical examinations, surgeries, and laboratory tests are performed at the health centres. The network of 34 health centres is headed by medical assistants, one per health centre. A medical assistant is a registered nurse who has undertaken an additional one year of training. The registered nurses who staff the services have basic training in the identification, assessment or treatment of mental health conditions.

There are 66 dispensaries in the country which are staffed by registered nurses and nurse aids employed by island councils. A medical Assistant supervises up to eight dispensaries. The dispensary services do not have the capacity to provide mental health care. People with a severe form of mental illness are referred to the inpatient unit in Tungaru Central Hospital.

Informal community care/ Traditional healers

Traditional health practices are conducted by traditional healers who use local medicines, massage, and provide antenatal, childbirth and postnatal care. The majority of people in Kiribati utilize both traditional and formal health services, however there is limited coordination between the formal and informal health care services (26).

Non-government organizations (NGOs)

NGOs are currently not involved with mental health in a formal way but several NGOs do provide counseling for mental health problems. For example:

- The Alcoholic Awareness and Family Recovery Association (AAFR) is a Catholic church organization to assist people achieve sobriety and to assist families who are suffering with an alcoholic member. The mission is to provide educational courses/training programs to assist in Alcohol Awareness and Family Recovery. There will be an outreach to villages and outer islands. Importance is given to training of personnel, e.g. one member of the team has recently undergone training at the AAFR Centre in Darwin, Australia.
- Kiribati Counsellors' Association (KCA) is located in South Tarawa and provides guidance and support through counseling and training. The Kiribati Counsellors' Association (KCA) was registered as an NGO with the Ministry of Internal and Social Affairs (MISA) in 2001 and as an Incorporated Society in 2004. The organization works with individuals and families who want and need help to solve problems they cannot solve by themselves. KCA counselors assist people in the community, at school, at home, in the workplace or through churches. It intends to extend its outreach to people and the community in need in the outer islands (27). The KCA also carries out counseling training for a number of NGO's and government personnel, although there remains a need for accreditation and formalization of counseling services provided (28).

Faith-based organizations

There are three Church groups - Roman Catholic, Kiribati Protestant Church and Assembly of God, who conduct Sunday prayers with inpatients of the mental health unit. In addition, the Youth Christian Leaders (Bikenibeu) organize outdoor games every Saturday. The Good Samaritans from the Roman Catholic Church and Irekenrao (a women's organization) provides gifts, and Saint Vincent de Paul provides food and drink during celebrations.

Mental health services users or family associations

There are no mental health service user associations and/or family associations in Kiribati.

Self-care and family-care

Family members are known to provide care at the Mental Health Unit. Relatives attend to the personal care needs of service-users and stay with them in the unit where allowed. This is standard practice in the general hospital. People with mental health conditions and their families are not given sufficient information about their mental health conditions and their long-term management.

Table 5. Service Utilization in Kiribati

Facility/Level	GENERAL HEALTH	MENTAL HEALTH INPATIENT				MENTAL HEALTH OUTPATIENT	
	Total Number of Beds	Total Number Beds	Average length of stay	Number of Individual Patients seen per year	Number of contacts per year (i.e. number of total consultations)	Number of Individual patients seen per year	Number of contacts per year (i.e. number of total consultations)
TERTIARY LEVEL CARE							
Tungaru Central Hospital	120						
Tungaru Central Hospital Mental Health Unit	0	25	910 days (5 days- 5 years)	208	228	156	166
SECONDARY LEVEL CARE (3 district hospitals)							
Kiritimati District Hospital	15	0	0	0	0	0	0
Southern Kiritibati District Hospital	25	0	0	0	0	0	0
Betio hospital	15	0	0	0	0	0	0
PRIMARY LEVEL CARE							
Health Centre (34 health centers)							
Total	0	0	0	0	0	0	0
Typical Small Health Centre*	0	0	0	0	0	0	0
Typical Large Health Centre *	0	0	0	0	0	0	0
Typical Average Health Centre *	0	0	0	0	0	0	0
Dispensaries (66 dispensaries)							
Total	0	0	0	0	0	0	0
Typical Small Dispensary*	0	0	0	0	0	0	0
Typical Large Dispensary *	0	0	0	0	0	0	0
Typical Average Dispensary *	0	0	0	0	0	0	0

Table 6
Distribution of health facilities across Kiribati

Facility/Level	Gilbert island	Phoenix islands	Line island
TERTIARY LEVEL CARE			
Tungaru Central Hospital (√)	√		
Tungaru Central Hospital Mental Health Unit	√		
SECONDARY LEVEL CARE			
Southern Kiribati (√)	√		
Kiritimati (√)			√
Betio Hospital (√)	√		
PRIMARY LEVEL CARE			
Health Centre (34)	√	√	
Dispensary (66)	√		√

Table 7
Number of health centres and dispensaries on each island

ISLANDS	HEALTH CENTERS	DISPENSARY
Makin	1	2
Butaritari	1	7
Marakei	1	4
Abaiang	1	7
Banaba	1	0
North Tarawa	1	5
Tarawa	12	0
Maiana	1	4
Kuria	1	1
Aranuka	1	2
Abemama	1	5
Nonouti	1	7
Tabiteuea North	1	7
Tabiteuea South	1	2
Onotoa	1	4
Beru	1	2
Nikunau	1	2
Tamana	1	0
Arorae	1	0
Kiritimati	1	3
Teraina	1	0
Tabuaeran	1	2
Canton	1	0
Total	34	66

Figure 12(a) and (b). **The WHO Pyramid of Care and the reality in Kiribati**
 Source: reference (29)

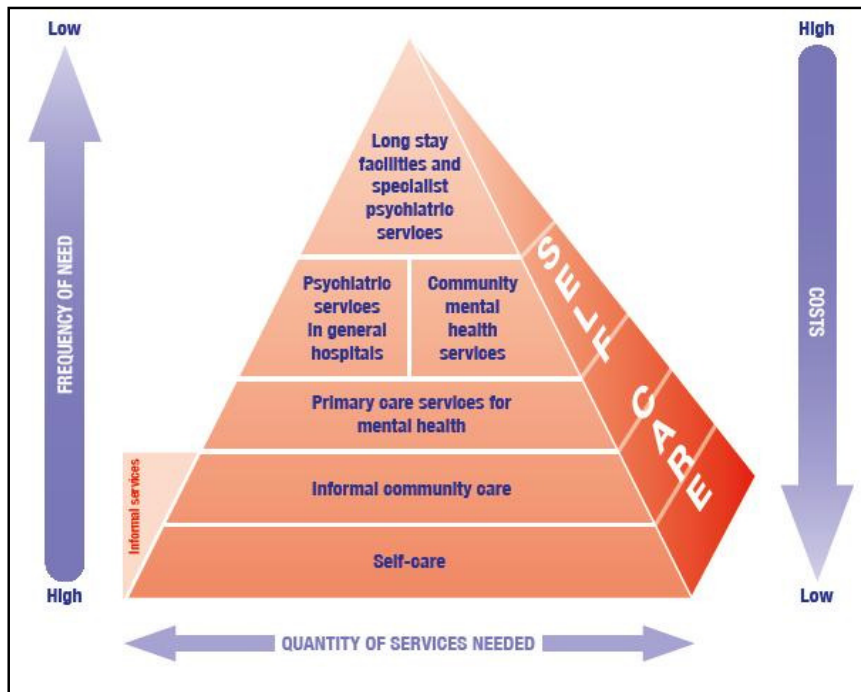


Figure 12(a)
The ideal structure for mental health care in any given country

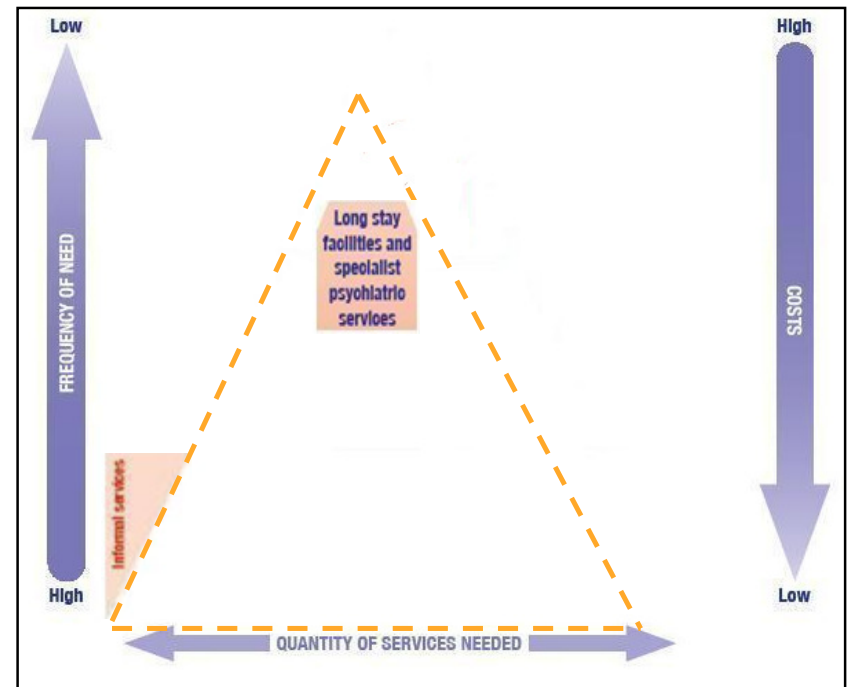


Figure 12(b)
The reality of mental health care in Kiribati
 The levels of care that are non-existent, poorly developed or inappropriate have been removed from the pyramid of care

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Mental health and development: Targeting people with mental health conditions as a vulnerable group

http://www.who.int/mental_health/policy/mhtargeting/en/index.html

Improving health systems and services for mental health

http://www.who.int/mental_health/policy/services/mhsystems/en/index.html

WHO/Wonca joint report: Integrating mental health into primary care - a global perspective

http://www.who.int/mental_health/policy/Integratingmhintopriarycare2008_lastversion.pdf

WHO Resource Book on Mental Health, Human Rights and Legislation

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The WHO Mental Health Policy and Service Guidance Package

http://www.who.int/mental_health/policy/essentialpackage1/en/index.html

- [The mental health context](#)
- [Mental health policy, plans and programmes - update](#)
- [Organization of services](#)
- [Planning and budgeting to deliver services for mental health](#)
- [Mental health financing](#)
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- [Advocacy for mental health](#)
- [Quality improvement for mental health](#)
- [Human resources and training in mental health](#)
- [Improving access and use of psychotropic medicines](#)
- [Child and adolescent mental health policies and plans](#)
- [Mental Health Information Systems](#)
- [Mental health policies and programmes in the workplace](#)
- [Monitoring and evaluation of mental health policies and plans](#)

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APPENDIX

Essential psychotherapeutic medicines

(WHO Model List of Essential Medicines, 16th list, March 2009)

Where the [c] symbol is placed next to the complementary list it signifies that the medicine(s) require(s) specialist diagnostic or monitoring facilities, and/or specialist medical care, and/or specialist training for their use in children.

Psychotic disorders	
Chlorpromazine	Injection 25 mg (hydrochloride)/ml in 2ml ampoule Oral liquid 25 mg (hydrochloride)/5 ml Tablet 100 mg (hydrochloride)
Fluphenazine	Injection 25 mg (decanoate or enantate) in 1ml ampoule
Haloperidol	Injection 5 mg in 1ml ampoule Tablet 2 mg; 5 mg
Complementary list [c]	
Chlorpromazine	<i>Injection: 25 mg (hydrochloride)/ml in 2 - ml ampoule Oral liquid: 25 mg (hydrochloride)/5 ml. Tablet: 10 mg; 25 mg; 50 mg; 100 mg (hydrochloride)</i>
Haloperidol	<i>Injection: 5 mg in 1 - ml ampoule Oral liquid: 2 mg/ml Solid oral dosage form: 0.5 mg; 2 mg; 5 mg</i>
Depressive disorders	
Amitriptyline	Tablet 25 mg (hydrochloride)
Fluoxetine	Capsule or tablet 20 mg (present as hydrochloride)
Complementary list [c]	
Fluoxetine	<i>Solid oral dosage form: 20 mg (present as hydrochloride) a >8 years</i>
Bipolar disorders	
Carbamazepine	Tablet (scored) 100 mg; 200 mg
Lithium carbonate	Solid oral dosage form: 300 mg
Valproic acid	Tablet (enteric coated): 200 mg; 500 mg (sodium valproate).
Generalized anxiety and sleep disorders	
Diazepam	Tablet (scored): 2 mg; 5 mg
Obsessive-compulsive disorders and panic attacks	
Clomipramine	Capsule 10 mg; 25 mg (hydrochloride)
Medicines used in substance dependence programmes	
Nicotine replacement therapy	Chewing gum: 2mg, 4mg Transdermal patch: 5mg to 30mg/16 hrs; 7mg to 21mg/24 hrs
Complementary list [c]	
Methadone*	Concentrate for oral liquid 5 mg/ml; 10 mg/ml Oral liquid 5 mg/5 ml; 10 mg/5 ml <i>*The square box is added to include buprenorphine. The medicines should only be used within an established support programme.</i>

Source: reference (24)

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