Evaluation of New Zealand's Health Sector Support in Kiribati: Final Report

Betio Hospital phase 1 Maternal and Neonatal facilities

DT Global Ltd

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Acronyms

ADB	Asian Development Bank
AMA	Activity Management Assessment
CDs	Communicable Diseases
CCNOP	Child Community Nursing Outreach Programme
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CSO	Civil Society Organisation
DFA	Direct Funding Arrangement
DFAT/AHC	Australia Department of Foreign Affairs and Trade/Australian High Commission
DP	Development Partner
DPF	Development Partners Forum
ECP	Emergency Contraceptive Pill
GBV	Gender Based Violence
GFA	Grant Funding Arrangement
HRH	Human Resources in Health
HSS	Health Sector Support/Health System Strengthening
IDC	International Development Cooperation
ICESD	International Cooperation for Effective Sustainable Development
IMCI	Integrated Management of Childhood Illness
IPPF	International Planned Parenthood Federation
KFHA	Kiribati Family Health Association
KFHSS	Kiribati Family Health and Support Study
KHFP	Kiribati Healthy Families Project
KIT	Kiribati Institute of Technology
KEQs	Key Evaluation Questions
KNHPF	Kiribati National Health Promotion Foundation
KNHSP	Kiribati National Health Strategic Plan
KPAs	Key Priority Areas
KV-20	Kiribati Vision 2016-2036 (Kiribati 20-year Vision)
MA	Medical Assistant
MERL	Monitoring, Evaluation, Research, and Learning
MFAT	New Zealand Ministry of Foreign Affairs and Trade Manatū Aorere
MFED	Ministry of Finance and Economic Development (Kiribati)
MHMS	Ministry of Health and Medical Services (Kiribati)
MWYSSA	Ministry of Women, Youth, and Social Services (Kiribati)
NCDs	Non-communicable diseases
MFOR	Ministry of Fisheries and Ocean Resources (Kiribati)
NGO	Non-government organisation
NZHC	New Zealand High Commission to Kiribati
OECD/DAC	Organisation Economic Cooperation and Development/Development Assistance Committee

PEN	Package of Essential NCD Interventions
PHC	Primary Health Care
PM	Programme Manager
PPU	Policy and Planning Unit
PPTC	Pacific Pathology Training Centre
RMNCAH	Reproductive, maternal, newborn, child and adolescent health
SDG	Sustainable Development Goal
SP	Strategic Priority
SPC	Pacific Community
SRHR	Sexual and reproductive health and rights
STO	Short-term outcome
SWA	Sexual Wellbeing Aotearoa
UNICEF	Pacific United Nations Children's Fund Pacific
TA	Technical Adviser
TB	Tuberculosis
TCH	Tungaru Central Hospital
ToR	Terms of Reference
UNICEF Pacific	United Nations Children's Fund Pacific
UNFPA	United Nations Family Planning Association
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization

Contents

Executive Summary

Kiribati faces major health challenges, including a dual burden of communicable and non-communicable diseases (NCD). Kiribati ranks second highest among low-middle-income countries worldwide for NCD, compounded by high rates of diabetes and infant mortality, placing sustained pressure on the health system.

New Zealand has a long-standing partnership with Kiribati to improve health outcomes. Since 2020, MFAT has expanded its support to strengthen links between NCD prevention and control and broader primary health care, including reproductive, maternal, newborn, child and adolescent health. MFAT's total health commitment for 2018–2027 is approximately NZD 66.5 million, in addition to significant investment in health infrastructure, including NZD 26.6 million for Betio Hospital and public health clinics.

MFAT commissioned DT Global to undertake an independent evaluation of its health support in Kiribati for the period 1 July 2021 to 30 June 2025. The evaluation covered all MFAT-funded health activities, with a particular focus on bilateral support delivered through the Kiribati Ministry of Health and Medical Services, UNICEF Pacific, and the Kiribati Family Health Association.

Overall, the evaluation found that MFAT's health support is relevant and valued, and is contributing to improved services, but would be stronger with a clearer strategic framework, improved monitoring, and more coherent alignment across its different funding streams.

EVALUATION APPROACH

The purpose of the evaluation is to provide an independent assessment that will:

- assess progress towards the current Kiribati Plan short-term outcome (STO) 4: "The quality, coverage and inclusivity of health services is improved";
- examine the coherence of MFAT's health sector support in Kiribati; and
- generate insights and recommendations to inform the design of future health sector support.

In the absence of an overarching strategic design document or Monitoring, Evaluation, Research, and Learning (MERL) framework for New Zealand's health sector support in Kiribati, the evaluation adopted a qualitative approach to answer the key evaluation questions. This drew on stakeholder interviews and a review of relevant documents. A total of 33 semi-structured interview sessions were conducted with 47 key stakeholders, both in person in Tarawa from 24 October to 3 November 2025 and remotely by videoconference between 24 October and 3 December 2025. The document review considered secondary reporting from implementing agencies, relevant MFAT documents, and independent reviews.

KEY FINDINGS

The key findings are discussed using the three evaluation objectives:

Objective 1: the extent to which MFAT's health programming has contributed to improved quality, coverage and inclusivity of health services in Kiribati.

There is moderate evidence to demonstrate the contribution of MFAT-funded investments to the improved quality and coverage of health care in Kiribati through training of Ministry of Health and Medical Services (MHMS) personnel, construction of facilities, improved standards of care, and direct service delivery. Nevertheless, it is too early to specifically assess progress against the 2025-2027 Kiribati Plan STO4. In part, this relates to data availability and reliability but is also compromised by indicator selection and definition.

MFAT's bilateral health programme consists of eight investments implemented between 2018 and 2026. Three have been completed and five are due to finish by the end of 2026. Using the evaluation's effectiveness rubric, two investments were rated good, three adequate, and three less than adequate. Lower ratings largely reflect implementation delays — including workforce constraints, slow funding flows within MHMS, and procurement challenges — as well as, in some cases, weak reporting. With the exception of the nursing curriculum redesign, all activities were significantly affected by COVID-19, with some delayed by up to two years.

Based on New Zealand's International Cooperation for Effective Sustainable Development (ICESD) policy statement for Inclusivity, we have assessed that MFAT's bilateral health programming partially addresses inclusivity by its focus on funding activities for women and children, with a focus on remote and harder-to-reach locations. While no MFAT-funded activities were reported to be exclusionary, evidence of focused analysis on barriers to participation by vulnerable groups was limited in this evaluation. There is clear scope for MFAT funding partners to take a more intentional approach to inclusion, particularly regarding people with disabilities in Kiribati, LGBTQIA+ and other vulnerable groups, as well as to mainstream Gender Based Violence (GBV) considerations more systematically across health programmes.

Long term sustainability of outcomes is a consideration for all of MFAT's activities, but with staffing shortages across the MHMS at all levels and budget constraints in a geographically challenging context, support from donors will remain necessary to 'fill gaps' in MHMS capacity for the foreseeable future.

Going forward, there are clear indications of the value of investing in a more fulsome design process for MFAT's support to the health sector in Kiribati, inclusive of a programmatic-level Theory of Change (ToC) and overarching MERL framework. Such an investment could not only improve progress monitoring, identify bottlenecks and allow for adaptive change, but also strengthen reporting on the overall impact and effectiveness of MFAT's health funding. This may require additional contracted support, particularly for MERL and reporting.

Objective 2: the extent to which MFAT's health programming in Kiribati is relevant and cohesive.

MFAT's bilateral health activities are highly relevant and closely align with five of the six strategic priorities in the current Kiribati National Health Strategic Plan (KNHSP) 2024-2027. The activities also line up with the previous plan (2020-2024) through five of the six key priority areas. The regional and multi-country activities broadly align with the overall intent of the KNHSP (through NCDs and RMNCAH strategies). The overall majority of MFAT's funding support has been on service delivery and infrastructure.

While stakeholders thought that MFAT's health programming is complementary and well-coordinated across Government of Kiribati priorities, strategies, plans, and systems, some added that it was not always clear what New Zealand was funding and through which government ministry. MFAT has multiple funding streams and this has exacerbated the existing silos within the Kiribati health system, and put an increased burden on MHMS in terms of donor coordination in the sector.

MFAT's health support is coordinated to some extent with other development partners in Kiribati, including the Governments of Australia and Japan, World Health organization (WHO), Asian Development Bank (ADB), and United Nations Population Fund (UNFPA). However, coordination could be strengthened, particularly through a redesign of the MHMS Health Sector Coordination Committee, although any such changes sit outside MFAT's direct control. Awareness across partners and implementing agencies of who is funding what also remains uneven. At present, MHMS discussions with partners typically identify MFAT's support for most NCD activities and some RMNCAH activities, before turning to gaps that other partners may be able to fill.

Objective 3: learnings and recommendations to inform future decisions on support to the health sector in Kiribati.

New Zealand is looking to more efficiently deliver its funding for health in Kiribati. Some stakeholders suggested that a higher-level outcomes-based modality, such as a type of sector budget support and fewer output-focused grant funding agreements (GFAs), would allow MFAT to engage with the MHMS at a strategic level and with implementing partners at a community level. We note there is a risk that a sector budget approach may increase programme-level workload, leading to increased oversight on budgeting and financial flows, procurement processes, and reporting systems, which may require additional contracted support. However, it would also provide targeted, planned, flexible funding directly to MHMS to enable it to implement critical health policy reforms, align funding support with national priorities, and improve efficiency in a resource-constrained environment. The benefits of making this change may outweigh the short-term costs, as it could also be a more sustainable approach in the medium to long-term.

Stakeholders suggested several initiatives, including the continuation of the Health Policy Adviser role to continue capacity development in terms of governance and leadership, the strengthening of MHMS systems through support to the MHMS Policy and Planning Unit (PPU) and Kiribati National Health Promotion Foundation (KNHPF), and improving health governance through supporting a review of the HSCC. They also stressed the importance of using an appropriate mechanism to support local NGOs and CSOs to better enable them to implement health services in the community, such as through a separate fund, or bilateral funding to some NGOs managed under Partnerships.

MFAT's health regional/multi-country and bilateral programming is viewed by some external stakeholders as "fragmented". While internally MFAT's health programming may be well-coordinated and complementary, implementing partners do not have a good understanding of how the Kiribati health regional and multi-country activities are coordinated across MFAT, or how they complement the bilateral activities.

Stakeholders suggested that a better understanding by implementing partners could mean more efficient delivery of activities in the outer islands. Addressing this lack of coordination will need to be a particular focus of the design of the next phase of MFAT's health sector support to Kiribati.

The use of multiple GFAs has increased contract management demands on Post's small team. Stakeholders nevertheless described the relationship with Post as strong and constructive. They also noted opportunities for New Zealand to build more strategically on its reputation in international development, including its support

for good governance, policy engagement and people-to-people links. Doing so could also strengthen the visibility of New Zealand's contribution to the health sector.

ASSESSMENT OF OECD DAC CRITERIA

As set out in the evaluation ToR, MFAT's quality standards and its International Cooperation for Effective Sustainable Development policy are aligned with the OECD DAC evaluation criteria. Against these criteria, the evaluation finds that MFAT's support for RMNCAH and NCD initiatives is strongly relevant to Kiribati's health priorities and highly valued by MHMS and the wider health system. MFAT is also seen by implementing partners as pragmatic, responsive, flexible and constructive, with Post's relationship management regarded as a key strength. However, opportunities exist to strengthen donor coordination including across MFAT's bilateral, regional, multi-country programs.

- **Effectiveness -** There is adequate evidence that demonstrates the programme of support has achieved or is achieving some of the intended STOs. There is also adequate evidence that demonstrates the support is values-driven and partnership-focused.
- **Efficiency -** Implementation of activities was impacted in the early 2020s due to COVID-19. There are still ongoing delays due to the complexity and cost of logistics of transport to the outer islands, access to supplies, and understaffing.
- **Coherence -** MFAT Kiribati health activities are perceived to be "fragmented" by MHMS and other implementing partners and they would like to better understand how they align and complement each other.
- **Relevance -** MFAT's health sector support in Kiribati is closely aligned with KNHSP and its focus on reducing NCDs, enhancing health equity, and improved access to RMNCAH services.
- **Impact -** We are beginning to see some behavioural change with better understanding by the community of sexual reproductive health rights (SRHR) and use of family planning. It is too early to see behavioural change that would lead to the reduction of NCDs, noting the funding timeframe for NCD initiatives and the evaluation.
- **Sustainability -** Long-term sustainability of outcomes is a consideration for all of MFAT's activities, but with staffing shortages across the MHMS at all levels and budget constraints in a geographically challenging context, support from donors will remain necessary to fill gaps in MHMS capacity for the foreseeable future. That said, considerations in design and construction for the Betio Hospital and Public Health Clinics will ensure these structures are climate resilient and sustainable well into the future.
- **Inclusivity -** MFAT's bilateral health programming partially demonstrated inclusivity by its focus on funding activities for women and children, with a focus on both South Tarawa and remote and harder-to-reach locations. There is scope for a more intentional approach to inclusion by MFAT funding partners, particularly regarding people with disabilities in Kiribati, LGBTQIA+ and other vulnerable groups, as well as a more considered approach to mainstreaming GBV initiatives across health programmes.

RECOMMENDATIONS

1. Maintain an approach to funding NCD programmes that **prioritise Prevention and a Primary Health Care approach**, including increased attention to community-level engagement in health promotion for behaviour change (with a focus on youth and the family unit), and the strengthening of civil society, including better connection between community and primary level of care.

2. **Continue support to SRHR and RMNCAH initiatives**, including funding supplies, and funding programmes that incorporate system strengthening and capacity development for long term sustainability, in addition to service provision and advocacy; and activities that target youth/adolescents (teen pregnancy/youth-friendly spaces).

3. **Support implementing partners to take a more intentional approach to inclusion,** particularly regarding people with disabilities in Kiribati, LGBTQIA+ and other vulnerable groups, as well as to mainstream Gender Based Violence (GBV) considerations more systematically across health programmes.

4. Continue the sustained support to the **development and retention of Human Resources for Health (HRH)** to better address NCDs, SRHR, and the need for community health workers in remote locations.

5. **Develop an MFAT Kiribati Health strategic framework, including a theory of change and MERL framework, to improve reporting, coherence and complementarity across bilateral and regional/multi-country health support.** The framework should align with available data, the KNHSP, and relevant SDG 3.8.1 indicators. It should also strengthen outcome monitoring, provide clearer strategic oversight, support multisectoral collaboration, and ensure all health investments have fit-for-purpose monitoring and reporting arrangements.

6. **Provide tailored support to strengthen the functionality of the MHMS PPU,** based on priorities identified by MHMS. This could include funding for a MERL or leadership role, targeted consultancy support, and a more programmatic MERL position to improve administration, project management, monitoring, reporting and data quality.

7. **Introduce annual MFAT Kiribati health sector meetings** to strengthen collaboration, including strategic policy dialogue and an annual partner mapping exercise to improve coordination across MFAT's bilateral and regional health support.

8. **Integrate workplans by MFAT** for its health activities by country. This would include both bilateral and multi-country/regional funded activities.

9. **Improve alignment across MFAT's multiple funding streams to strengthen coordination.** Implementing partners do not always see bilateral and regional or multi-country support as well coordinated, and clearer communication would help reduce the donor coordination burden on MHMS. This could include annual partner mapping and regular progress discussions between MFAT and implementing partners.

10. **Move to a higher-level outcomes-based modality** to allow MFAT to engage with MHMS at a strategic level. This could be through fewer output GFAs to support MHMS to deliver the KNHSP. This would allow MHMS to take a 'whole of basket' approach and integrate NCD and RMNCAH services with other services to be able to better reach the outer islands. It would still allow MFAT to **directly support implementing partners, in particular local NGOs and CSOs, at a community level.**

11. **Commit to longer-term investment** in NCDs and RMNCAH (in particular maternal and child health), and a programmed approach to infrastructure support. This would confirm New Zealand's long-term commitment and enable the Government of Kiribati to better coordinate and negotiate infrastructure priorities with other funding partners.

12. **Fund a strategic health policy adviser role** to leverage its special relationship with Kiribati. This role would focus on governance, policy, and leadership for HRH and health strategy. It would be embedded in MHMS with its senior counterparts and also support the review and coordination of HSCC.

1 BACKGROUND

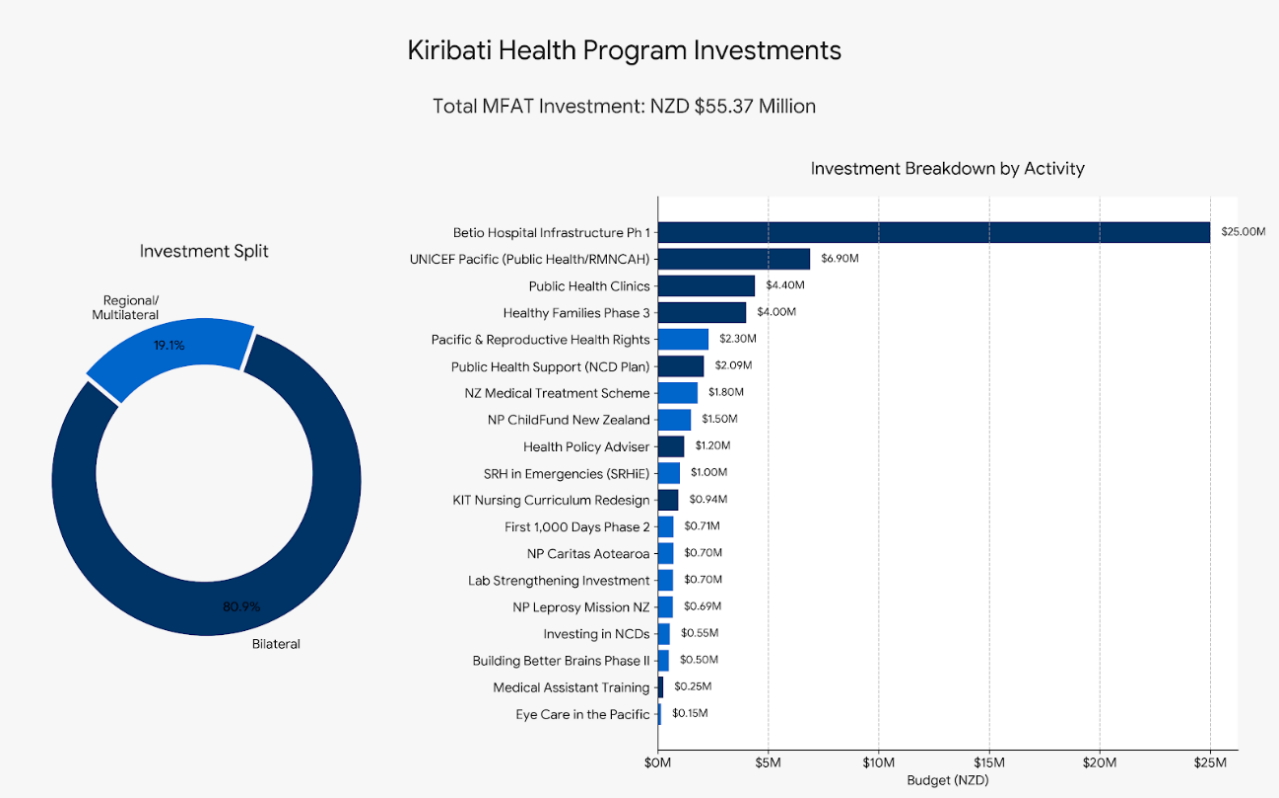
1.1 New Zealand Health Sector Support in Kiribati

New Zealand and Kiribati have a long-standing partnership aimed at improving health outcomes for Kiribati. Although there is no overarching strategic document for New Zealand's health sector support in Kiribati, this evaluation covers MFAT's current and previous country plans. Both plans include short-term health outcomes of improved quality and coverage of health services (see Appendix A).

In 2020 New Zealand expanded its partnerships in the Kiribati health sector to ensure stronger linkages between NCD prevention and control, and broader primary health care, including RMNCAH. The Evaluation terms of reference (ToR) notes that MFAT's current commitment is approximately NZD 66.5 million from 2018-2027, including a NZD 9.33 million commitment that was approved in 2020. This expanded funding was in addition to NZD 26.6 million for health infrastructure through improvements to the Betio Hospital and public health clinics.

Figure 1.1 shows the amount MFAT has committed to the health sector for all activities currently being implemented, regardless of their start date. The total value of all health sector activities in Kiribati (both those currently in implementation as well as those that are now closed) from July 2021-June 2025 (the evaluation period) was NZD 51,037,946. The NZD 66.5 million figure is how much MFAT has committed in the health sector for all activities currently being implemented, no matter their start date.[1]

Figure 1.1: Kiribati Health Programme Investments



1.2 Country Context

Kiribati is a low-lying island nation in Micronesia in the central Pacific. It consists of 33 coral atolls of which 32 are low-lying with land less than two metres above sea level. Kiribati is spread across a vast ocean area, spanning the equator and the International Date Line, with three island groups (Gilberts, Phoenix, Line Islands). The small land area (811 km^2) is dwarfed by its huge maritime territory, making it highly vulnerable to rising sea levels, coastal erosion, and climate change. Much of its population of about 120,000 is concentrated in

[1] Email correspondence with MFAT, 7 October 2025

the Gilberts, particularly around the capital, South Tarawa,[2] with a significant portion living in urban areas (see Figure 2). Kiribati's geographical spread and remoteness significantly impact its ability to provide comprehensive health care to its population.[3]

1.3 Health Context

Kiribati faces complex healthcare challenges with a high prevalence of both CDs and NCDs.[4] Kiribati ranks second highest among low-middle-income countries worldwide for NCD prevalence and this presents a major public health concern, compounded by some of the highest rates of diabetes and infant mortality in the Pacific region.

The double burden of CDs and NCDs continues to place immense strain on the national healthcare system. Recent data show that CDs and NCDs are leading causes of mortality in Kiribati, highlighting the urgent need for targeted, multi-faceted health interventions.[5] NCDs account for 65.6 per cent of all deaths[6] and 23 per cent of the total population have at least one NCD.[7] The adult and child obesity rates exceed 40 per cent. Risk factors such as poor diet, high tobacco and alcohol use, and physical inactivity are widespread, while access to early detection and treatment remains limited, especially in the outer islands.[8]

RMNCAH outcomes are also concerning. Kiribati has high adolescent birth rates (31.8 births per 1,000 15–19-year-olds in 2023) and limited access to contraception and maternal health services. Cultural norms and logistical barriers hinder uptake of services relating to SRHR, particularly for young people and those in remote communities.[9]

Kiribati has the highest rates of under-five mortality in the Pacific, and high rates of stunting. This is caused by factors that range from lack of access to antenatal care for pregnant women, poor maternal and childhood nutrition, repeated infections from an unhealthy environment, and inadequate psychosocial stimulation.[10]

Health infrastructure and workforce constraints further compound these issues. Many health facilities are outdated or under-resourced and need refurbishment. Laboratory services are improving, with the main Tungaru Central Hospital (TCH) achieving 66 per cent compliance with international standards in 2024, which is an improvement from 52 per cent in 2023.[11] TCH provides the largest laboratory service in Kiribati but it is faced with significant knowledge gaps due to recent staff resignations.

Kiribati's concerning morbidity and mortality health indicators are due to the challenges faced by PHC services as well as many other factors, including social and environmental determinants of health. Poor sanitation, overcrowding, and contaminated water supply contribute to repeated infections. High levels of food and water insecurity lead to nutrition deficiencies in pregnant women and children that increase the risk of complications in later life.[12]

Alongside harmful impacts to life and well-being, these largely preventable health issues have significant social and economic impacts on social cohesion, workforce participation, reduced productivity, and excess preventable health costs.[13]

While fertility rates are high across the region, the key differentiator is migration, which acts as a pressure release for some populations but is less accessible for others like Kiribati. Kiribati has lower migration and higher population growth compared to some other island states. Figure 1.2 below shows that Kiribati has experienced steady population growth of around 1.5 per cent a year, resulting in a 54 per cent increase over 25 years. It also stands out in the Pacific for its high population density, particularly on South Tarawa, where around 30 per cent of the population lives (40,311 people). While its growth is consistent, Kiribati faces unique

[2] Kiribati National Statistics Office. 2020 Population and Housing General Report and Results. Ministry of Finance, pg. 18. https://nso.gov.ki. Note that the World Health Organization 2026 data.who.int, Kiribati [Country overview]. (Accessed on 25 February 2026) cites the population in 2023 as 132,530

[3] Medecins Sans Frontieres. 2024 Annual Report, pg.20 . https://msf.org.au/country-region/kiribati Kiribati has high rates of Tuberculosis (TB) and Leprosy, frequent outbreaks of Dengue fever, and ongoing issues with diarrheal diseases, STIs, and neglected tropical diseases like Lymphatic Filariasis, exacerbated by climate change, poverty, and limited healthcare access

[4] Top NCDs include diabetes (type 2), Cardiovascular Diseases, and high blood pressure.

[5] https://data.who.int/countries/296

[6] Ibid

[7] Ortega-Avila, Ana G. (2025). Kiribati 2023 Health Report. Kiribati National Statistics Office (KNSO) and The Pacific Community (SPC). Suva, Fiji

[8] Ibid.; Kiribati Annual Health Bulletin, 2023, pg.7; https://data.who.int/countries/296.

[9] Sexual Wellbeing Aotearoa. (2024). Identifying Future Priorities to Improve Sexual and Reproductive Health in Kiribati. Sexual Well-being Aotearoa. Wellington, N.Z.

[10] https://www.unicef.org/pacificislands/media/5191/file/The_situation_of_children_in_Kiribati.pdf

[11] Pacific Pathology Training Centre Six Monthly Report (January–June 2025 to MFAT, pg. 44

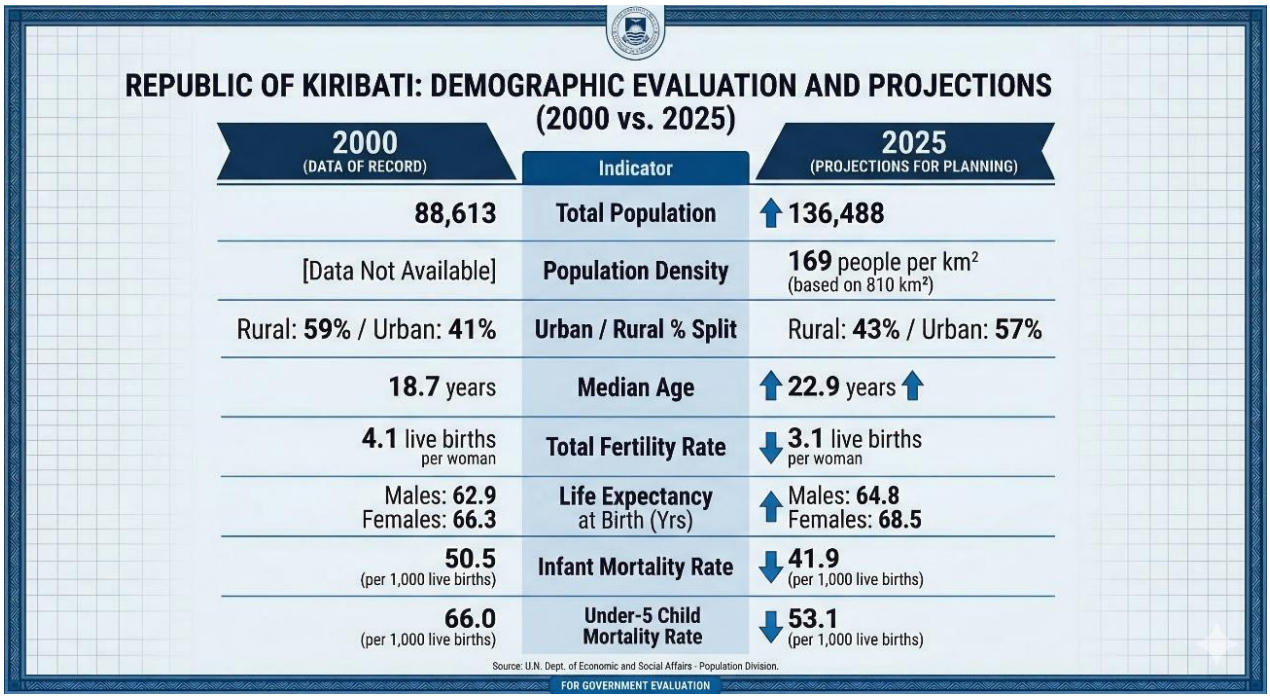
[12] https://www.unicef.org/pacificislands/media/5191/file/The_situation_of_children_in_Kiribati.pdf

[13] World Bank. (2023). The Primary Health Care System of the Republic of Kiribati: A Primary Health Care Performance Initiative Assessment, World Bank: Washington, D.C.

pressures from limited land and climate change, driving both internal urbanisation and external migration to countries like New Zealand and Australia.[14]

Figure 1.2 also shows that birth rates have slightly fallen, from four live births per woman in 2000 to three live births in 2025. Life expectancy has slightly improved (by three per cent) for both males and females over the 25-year period. Infant mortality rate has recently plateaued, but over a 25-year period there is a reduction by 17 per cent. Deaths of children under 5 years has also reduced by 20 per cent over the 25-year period but progress has plateaued in the last five years.[15]

Figure 1.2: Kiribati Demographics from 2000 and 2025



Kiribati's dispersed geography across many islands creates major challenges for the equitable and cost-effective delivery of healthcare. A 2023 World Bank assessment identified four priorities for strengthening health system performance: improving governance for integrated primary health care, strengthening information systems for resource management and performance monitoring, investing in quality of care, and improving facility management. Despite these constraints, Kiribati has been making progress in reorienting its health system towards preventive primary health care to respond to the combined pressures of CDs, NCDs and climate change. The current Kiribati National Health Strategic Plan reflects this direction, with a stronger emphasis on prevention, improved health outcomes, and a more resilient, family-centred and community-based model of care.

The Government of Kiribati remains the main provider of health services, operating four hospitals, 22 health centres and 94 village clinics. In addition, 10 other health service providers report to the Health Information Unit, including specialist and targeted services such as the IMCI clinic, TCH outpatient clinic, gynaecology clinic, Kiribati Family Health Association, diabetic, antenatal and postnatal care, tuberculosis and leprosy clinics, youth-friendly health services, and the Healthy Family Clinic for gender-based violence. Public health services are provided free to Kiribati residents, and out-of-pocket spending on health remains limited. However, the system continues to face significant nursing shortages driven by high disease burden, geographic remoteness, limited resources, and the migration of experienced nurses to Australia and New Zealand. These pressures contribute to understaffed facilities across the country, with a national nurse-to-population ratio of around 1:279.

1.4 Gender Landscape

The right to health is generally viewed as an economic, social and cultural right, contained within the International Covenant on Economic, Social and Cultural Rights (Article 12). Kiribati is party to the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), the Convention on the Rights of

[14] https://www.populationpyramids.org/kiribati
[15] https://devpolicy.org/child-mortality-in-kiribati-a-wake-up-call-for-urgent-action-20241101/

the Child, and the Convention on the Rights of Persons with Disabilities. These all impact on policies and legislation related to SRHR and GBV in Kiribati.[16]

Under CEDAW, Kiribati health-related obligations include the obligation to take all appropriate measures to "eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning" and to "ensure to women appropriate services in connection with pregnancy, confinement and the postnatal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation" (Article 12).

Women in Kiribati have higher rates of secondary school completion than men, but there are critical gender gaps in economic opportunity, health, and decision-making. The 2019 Household Income and Expenditure Survey shows that female labour force participation is low (28.7 per cent) and significantly lower than the rate for men (43.1 per cent). The survey estimates that women represent 38 per cent of paid employees in the country and are more likely than men to be in vulnerable employment.

Strong patriarchal norms, prominent in rural areas, have been identified as a main deterrent to women's participation in paid employment and decision-making. In 2020 women represented only 6.7 per cent (three women) in Kiribati's 45-member Parliament, 4.2 per cent of representatives in local island councils, and about 5 per cent of police officers.[17]

Women in Kiribati play a central role in family and community wellbeing. They are the primary caregivers for children and families and make up most of the frontline health workforce. While women generally live longer and have better educational outcomes than men, they continue to face serious and deeply embedded health and social challenges.[18]

Gender-based violence remains one of the most significant of these challenges. Intimate partner violence is widespread, with around 68 per cent of ever-partnered women aged 15–49 reporting physical or sexual violence by an intimate partner during their lifetime. Social norms remain a major concern, with more than 70 per cent of women and 59 per cent of men surveyed believing that wife-beating is justified in some circumstances.[19]

Women also face major sexual and reproductive health and rights challenges. Rates of unplanned pregnancy, unsafe abortion and complications during delivery remain high, particularly for teenage girls and women in rural areas. Family planning services are available, but knowledge and uptake are mixed and are often influenced by religious beliefs. Access is also more difficult in the outer islands because of logistical barriers. Sexual coercion and women's limited agency in negotiating sex further contribute to poor sexual and reproductive health outcomes.[20]

Maternal and nutritional health issues add to this burden. Women experience high rates of gestational hypertension and pre-eclampsia, while obesity among adult women is also very high. More broadly, nutritional health is being undermined by climate change and food insecurity, with 90 per cent of children living in food poverty.[21]

Non-communicable diseases are a major concern for both women and men, but they affect each in different ways. Diabetes is the leading cause of death for women, and 43.7 per cent of female deaths are linked to NCDs. Men have higher rates of tobacco (75.6% vs 40.5% for women) and alcohol use, and a greater share of male deaths is linked to NCDs. Even so, women continue to live longer than men, with life expectancy estimated at 72.3 years compared with 64.3 years for men.[22]

Climate change further intensifies these pressures. Rising sea levels and the contamination of freshwater sources disproportionately affect women and children, increasing the risk of waterborne disease and compounding existing health vulnerabilities.[23]

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[16] Ibid., p.8

[17] Ibid

[18] Banda, L.O.L., Mwaene, E., Banda, C.V. et al. Breaking the cycle: How educational inequality and gender norms fuel intimate-partner violence in Kiribati. BMC Public Health 25, 3906 (2025)

[19] Secretariat of the Pacific Community. (2010). Kiribati Family Health and Support Study: A study on violence against women and children. SPC: Noumea; Spiteri-Staines A, Gomez LVS, Letch J, Bornemisza A, Diemer K. The intersection of intimate partner violence with sexual reproductive health in the Pacific: findings from a Kiribati population study. BMC Women's Health. 2025 Feb 5;25(1):52

[20] Sexual Wellbeing Aotearoa. (2024). Identifying Future Priorities to Improve Sexual and Reproductive Health in Kiribati. Sexual Well-being Aotearoa. Wellington, New Zealand

[21] Doctors Without Borders (MSF). "Health workers on island nation of Kiribati face extraordinary challenges, including climate change." (Published: July 3, 2025)

[22] World Health Organization 2026 data.who.int, Kiribati [Country overview]. (Accessed on 25 February 2026)

[23] Medecins Sans Frontieres. https://www.doctorswithoutborders.org/latest/health-workers-island-nation-kiribati-face-extraordinary-challenges-including-climate-change

2 FINDINGS

This section responds to the three evaluation objectives through answering each KEQ and sub-question (see Appendix B for detailed methodology). Recommendations are provided under each objective.

2.1 Objective 1: The extent to which MFAT's health programming has contributed to improved quality, coverage, and inclusivity of health services in Kiribati. [24]

There is moderate evidence to demonstrate the contribution of MFAT-funded investments to the improved quality and coverage of health care in Kiribati through training of MHMS personnel, construction of facilities, improved standards of care, and direct service delivery. MFAT's bilateral health programming partially demonstrated inclusivity through its focus on funding programmes for women and children, with a focus on remote and harder to reach locations.

MFAT's bilateral health programme comprises eight separate investments, with varying durations, and covering a range of timeframes between 2018 and 2026. All activities are broadly consistent with MFAT's Kiribati Country Plan goals, notably Strategic Goal 2: Kiribati has a healthier population and benefits from greater shared prosperity, and the KNHSP. These eight investments cover a range of focus areas, including NCDs, service delivery infrastructure, human resources for health, and sexual and reproductive health. Each partner under the bilateral programme reports independently against its own framework e.g. relevant strategy or design document.

There are no common indicators linking bilateral activities to the MFAT Country Plan or indicators for its Strategic Goals, and there is no overarching MFAT framework or design for its investment in health in Kiribati, with corresponding monitoring and evaluation indicators or targets by which to cohesively report or aggregate progress toward MFAT's strategic outcomes.

Bilateral activities are at times 'grouped together, for example, 'Public Health' (ACT-0101311) without an obvious Theory of Change. While each grouped programme under this investment is valuable in its own right, activities are not necessarily complementary, working with the same target populations, or toward similar outcomes. This compromises the scope for assessing the complementarity and/or combined impact of these activities.

Sections below therefore reference each separate investment's progress (where possible) against its own stated outcomes – although almost without exception, partner reports remained focused on activity and or output level reporting, compromising the ability to fully assess effectiveness and impact.

Of the bilateral activities reviewed, three are now complete, with the remaining five due for completion at the end of 2026. Using the evaluation effectiveness rubric for this evaluation (Appendix E), two were assessed as having good effectiveness overall, three as adequate, and the remaining three as less than adequate.

Lower scores for effectiveness are mostly related to unanticipated delays (for example, due to human resource availability, delays in funding flows within the MHMS, or procurement challenges), but also less than adequate reporting. All activities (with the exception of the revised nursing curriculum) were significantly impacted by the COVID-19 pandemic, delaying activity commencement in some instances by up to two years.

Going forward, there are clear indications of the value of investing in a more comprehensive and strategic design process, inclusive of a programmatic ToC and overarching MERL framework for MFAT's support to the health sector in Kiribati. Such an investment could not only better monitor progress, identify bottlenecks, and allow for adaptive change, but also better report on overall impact and effectiveness. Based on evidence sighted at the evaluation, additional contracted support to manage MERL, support data analysis, and reporting would be advisable.

[24] Objective 1 aligns with KEQ1 and KEQ2: To what extent has MFAT's health activities in Kiribati achieved (or is achieving) expected outcomes? How are these outcomes contributing to progress against the 2025-2027 Kiribati Plan STO4?

Table 2.1: Progress and effectiveness of Bilateral Activities

Activity Name	Partners	Activity Dates	Stage	Progress	Effectiveness Score
BILATERAL					
NCD Strategic Plan	MHMS	2020-2026	Ongoing Implementation – NCE		3 – less than adequate
Medical Assistant Training	MHMS	2020-2026	Ongoing Implementation – NCE		3- less than adequate
Public Health	UNICEF	2020-2026	Ongoing Implementation – NCE		4- adequate
Healthy Families Phase 3	KFHA/SWA	2020-2026	Ongoing Implementation		4-adequate
Betio Hospital	Reeves Int.	2019-2025	Completed		5- good
Public Health Clinics	MHMS	2021-2026	Ongoing Implementation		3- less than adequate
Health Policy Adviser	Contracted Consultant	2020-2025	Completed		4- adequate
Nursing Curriculum Redesign	Te Pukenga (Wintec)	2018-2023	Completed		5- good

2.1.1 Progress of health activities against Outcomes[25]

As noted above, five of the eight activities remain ongoing. No activity-based evaluations have been undertaken to date, thus limiting data for end-of-programme (i.e. outcome) reporting. Appendix G summarises key changes and achievements against stated outcomes for the eight key bilateral investments.

The MHMS is managing three MFAT-funded bilateral programmes. Support for implementing the **NCD Strategy (2020-2023)** is guided by a detailed plan, but implementation is shared across multiple non-MHMS stakeholders (including WHO, Ministry of Finance and Economic Development (MFED), Attorney General's Office, NGOs etc), making it complex to track accountability for implementation progress.

The NCD Strategy includes a list of key health indicators for tracking progress (largely based on WHO STEPS data), but these have not been used in annual reports to MFAT to date. Reporting overall has been highly variable in detail and quality for this activity. Nevertheless, as summarised in Appendix F, the programme has achieved some commendable results for NCD control. The recent WHO STEPs report (2024) demonstrated positive trends in terms of a reduction in high-risk behaviours in Kiribati (e.g., smoking, alcohol, and kava consumption) since 2015.

However, given the delays in commencing the activities under this programme, it would be difficult to attribute much of this change to activities undertaken under MFAT's support to the NCD Plan. Reviewing the suite of plans and reports produced by the MHMS, the evaluation team identified scope for improved design of activity MERL frameworks, and investment in more focused data collection, analysis, and reporting. This may be addressed to some extent through the PPU, but stakeholders suggested that additional donor support and/or advisory personnel would likely be required going forward to ensure its maximum functionality.

MHMS is also responsible for the **MA training programme**. While challenged by the availability of key trainers for this piece of work, leading to significant delays, the training is now on track for completion by the end of 2026, when 12 nurses will become qualified MAs working in the outer islands.

The third activity under the auspices of the MHMS is the construction or refurbishment of **Public Health Clinics** in the outer islands. As of December 2025, this activity was 25 per cent complete (six fully operational clinics), with an additional three due to open imminently after minor repairs are completed.

From an initial plan for 18 clinics, via a GFA with the MHMS in 2024, it was agreed to add a further seven clinics previously to be funded by the Government of Kiribati; additional funds were allocated but the MHMS expressed concerns that due to significant increases in transport and procurement of materials, the remaining funds may not be adequate to cover remaining clinic construction (n=11 as at December 2025) – MFAT has

[25] KEQ1

advised that it will ensure that funds are made available to ensure completion. MFAT's 2024-2025 Activity Management Assessment (AMA) for this activity estimates that almost 17,000 people in rural areas have increased access to improved and timely health care as a result of these activities.

A second infrastructure activity was for the construction of maternity and paediatric wards (phase 1) of the **new Betio Hospital** in South Tarawa – servicing a population of 20,000. This investment was completed in January 2025 with an official opening in October 2025. The Government of Japan has funded the necessary fitout of the unit constructed with MFAT funding, and the Asian Development Bank (ADB) will fund phase 2 (adult inpatient ward, outpatient unit, and emergency department). While only recently opened, there has already been "... *great feedback locally because it's fundamental to some of the key problems that Kiribati has, child mortality is high*".[26]

UNICEF's Public Health Care activity (implemented together with the MHMS) provided clear and detailed reports against outcomes, although data against a number of key baseline indicators was not yet available (e.g., exclusive breastfeeding, coverage of micronutrient supplementation, and percentage of mothers with knowledge of at least five essential family practices). These reports nevertheless demonstrated a doubling of the number of facilities adhering to National Standards and receiving supporting supervision. Integrated management of Childhood Illness training was provided, and micronutrient powder committees were established on 19 islands, with the usage of micronutrient powder increasing from 38 to 3,603 children[27].

While modest in number, the subcontracted **Community Child Nursing Outreach Programme** (CCNOP) reportedly achieved significant positive outcomes by identifying and treating severely malnourished infants with Ready to Use Therapeutic Food (RUFT).

MFAT also funded a **Health Policy Adviser** to provide high-level policy advice and advocacy to the MHMS in a manner that would improve Kiribati's health service infrastructure and systems. The role had no direct role in coordinating or supporting other MFAT-funded health investments, although the Business Case for the MFAT Public Health Investments leaned heavily on the incumbent's potential role in mitigating risks, for example, as regards supporting the MHMS's activity monitoring, reporting, and MFAT health sector coordination. These expressed risks and the need for support have been well-evidenced and will need to be addressed going forward through additional MFAT-funded consultants, in addition to any strategic adviser for policy and governance. While annual and completion reports for this investment were not available, stakeholders reported that the Health Policy Adviser played an important advisory role to MHMS directors.

MFAT has also continued to provide bilateral funding to Sexual Wellbeing Aotearoa (SWA) and its in-country partner, Kiribati Family Health Association (KFHA) for phase 3 of its **Kiribati Healthy Families Program** (KHFP). Currently in its fifth year of a six-year program, the KHFP reports largely describe activities and outputs, demonstrating its significant reach (particularly on the outer islands) in terms of service delivery and community awareness on SRHR. Reports are yet to provide data and analysis against most long and medium-term outcomes, although it was noted that 100 per cent of Island Development Committee Plans now include an SRHR indicator, and 92 per cent of community leaders can articulate two impacts that accessing SRHR has for i-Kiribati. Results of community surveys are also positive in terms of knowing where to access SRHR services. Despite significant challenges, including the death of three staff over this period and an eight-month period of no funding flow (due to challenges in establishing a bank account), KFHA maintained activities throughout and remains the principal provider of SRHR services in Kiribati.

The final activity included under the MFAT-funded support to the health sector was the redesign of the **Nursing Curriculum,** contracted to the Waikato Institute of Technology (in association with James Cook University). This activity, completed in December 2021, revised an out-of-date curriculum and progressed the Advanced Diploma of Nursing to level 6 on the Pacific Qualifications Framework, delivered by the Kiribati Institute of Technology (KIT). Importantly, the revised curriculum integrates the Kiribati Nurse Council Competencies and the new i-Kiribati Cultural Framework for nurses and Maneaba-i-Kiribati Model of Nursing Care.

A further 14 activities are funded by MFAT under multilateral and regional programmes. Of these, all were assessed as being 'on track' and providing evidence of adequate progress against outcomes, except for one partner. That partner had experienced significant staff turnover and acknowledged some shortcomings in their original design, including untested assumptions regarding local partner capacity. Their programme is currently under re-design for the next phase, incorporating lessons learned from phase one. Overall reporting on this suite of activities was satisfactory (and very good for New Zealand NGO partners), but similar to the bilateral activities, these reports did not include any shared or higher-level outcomes to inform MFAT's investment in health overall.

[26] ID. No. 019

[27] There was significant confusion for the evaluation team around UNICEF activities (and subcontracted activities to two New Zealand groups) as to under which programme these subcontracted activities fell, i.e., bilateral public health, or multilateral/regional under the 1,000 Days activity, how these were being reported on, and who was responsible for these activities (UNICEF or MHMS).

2.1.2 Improved quality and coverage[28]

Almost all of MFAT's investments contributed to improved quality and coverage, whether through training of MHMS personnel, construction of facilities, improved standards of care, or a focus on service delivery in the rural and remote locations of Kiribati.

Under the MFAT-funded support to the **NCD Strategy**, the MHMS has addressed quality through a focus on training, delivering refresher training on Preventable NCDs (PEN; a WHO package of essential NCD interventions for primary health care) to health workers in five outer islands (Butaritari, Aranuka, Kuria, Maiana, and Tabiteuea North). They also assessed the implementation of the PEN protocols; assessment of the knowledge and skills of the health workers for managing NCDs; and an assessment of the availability of essential NCD tools and medications. This was followed by training and coaching, distribution of essential tools and medications for NCD management at the clinics, and collection of NCD-related data. Additional training included cervical screening and retinopathy screening to further improve the quality and effectiveness of detection and early treatment.

In 2024/25 the MHMS focused on reaching populations in remote locations, including Health promotion activities and cervical cancer screening. MHMS visited the more remote islands of Tabuaeran (Fanning) and Teraina (Washington) in the Lines and Phoenix Island group, as well as Tamana Island, to conduct awareness raising of NCDs and their risk factors. To further enhance coverage, the MHMS ran a community awareness programme on the four key NCD risk factors, using multi-pronged strategies through radio, roadshows, training sessions, including roll-out of the PEN, and outreach activities promoting good nutrition, physical activity, reduced consumption of alcohol and kava, tobacco and kouben.[29] However, the MHMS reports contained limited quantitative detail on the number and type of participants (i.e., no disaggregation).

The goal of the **Public Health Clinic** construction programme is to decrease the burden of preventable health issues through the provision of more sustainable, climate-resilient, safe and patient-friendly health clinics that are aligned to the National Infrastructure Standards. Quality is assured through formal sign-off at completion. The improved design means that clinics are expected to be more sustainable and climate resilient. These clinics are exclusively in the outer islands, and an estimated 17,000 people in these remote locations (where clinics to date have been completed and opened) have access to improved and timely health care.

The **new Betio Hospital** (phase 1) has only recently become operational, providing services in Betio and South Tarawa for maternal, neonatal, and child health. The new Betio Hospital has the potential to substantially raise the standard of health facilities and care available and provide improved access to the catchment population of 20,000. As a referral facility, the Betio Hospital has the potential to improve coverage of tertiary care services more broadly in Kiribati.

Once the **MA Training** has been completed, it is expected that the MAs will play a critical role in improving the quality and coverage of health services, as there are no doctors permanently on the outer islands.

The **UNICEF Public Health** activity has an explicit objective of strengthening the quality (and availability) of maternal, neonatal, and child services. It also strives to strengthen institutional capacity at the district level and address bottlenecks. Through training and supportive supervision, this has already resulted in 51 per cent of health facilities across five districts assessed as applying national service quality standards (compared to the 26 per cent baseline).

Capacity building and service delivery are the cornerstones of **KHFA's KFHP** – using training to build the capacity of nurses, community-based health promoters, and youth volunteers to improve the equality of SRHR service provision, with clinical training focused on the outer islands.

Service delivery coverage is enhanced through a range of strategies including fixed, mobile and after-hours clinics as well as outreach programmes to the outer islands. Stakeholders reported that without KHFA, *"there would be no provision of SRHR services in Kiribati"*.[30]

Thus, despite reported procurement delays, KHFP is contributing to improved quality and coverage as outlined in responses from youth, single mothers, and young couples in the 2024 research.[31]

MHMS stakeholders consider that the **redesign of the nursing curriculum** is leading to a more relevant qualification that is now specific to Kiribati's cultural and health needs. These stakeholders also added that the **Health Policy Adviser** played an important advisory role, with vast knowledge aiding in the reviewing and updating of relevant health legislation.

[28] KEQ1.1: To what extent has the support contributed to improving the quality and coverage of health services in Kiribati?
[29] Kouben is a form of chewing tobacco common in Kiribati
[30] ID. No. 053
[31] Sexual Wellbeing Aotearoa. (2024). Identifying Future Priorities to Improve Sexual and Reproductive Health in Kiribati. Sexual Wellbeing Aotearoa. Wellington, NZ

2.1.3 Inclusivity[32]

MFAT's ICESD policy statement describes inclusivity as addressing exclusions and inequality created across all dimensions of social identity, while promoting human rights and equitable participation in the benefits of development. It requires identification and response to the drivers of inequality, and where children and youth may be excluded. It involves advocates for gender equality, including addressing GBV.

While no MFAT-funded activities were reported to be exclusionary, evidence of focused analysis on barriers to participation by vulnerable groups was limited in this evaluation. The exception to this was the New Zealand NGOs operating under the Partnering for Impact programme; these demonstrated consistent attention to inclusion at all stages of their design, implementation, and evaluation.

Bilateral activities predominantly focused on women, and in some instances their children, with a smaller number providing a focus on youth, gender diverse groups, and a yet smaller number on the purposeful inclusion of people with disabilities. There is scope for a more intentional approach by MFAT funding partners to inclusion particularly as regards people with disabilities in Kiribati, as well as a more considered approach to mainstreaming considerations of GBV across health programmes.

Bilateral activities targeting women's and youth health include the Betio Hospital, KHFP, and UNICEF's Public Health Program. Phase 1 of construction for the Betio hospital focused on facilities for women and children, with the construction of maternal and neonatal facilities. While providing services and awareness to men, KHFP predominantly works with women and youth.

According to stakeholder interviews, KHFA works directly with organisations that are tapped into vulnerable groups, including people with disabilities, single mothers, Binabinaine Association (BIMBA), sex workers, and provides specialised services to the LGBTQIA+ community undertaking tailored targeted training and service provision to these groups, a process that reportedly takes time and involves the building of trust.

> *"There have been positive changes in our lives. We feel with the increase in our knowledge from the KFHA workshops we are more empowered and better able to protect ourselves. We know where to go to get treatment for STIs and HIV, and these appointments are confidential" (LGBTQIA+, pg. 53)[33]*

SWA's 2024 research report describes targeted strategies to engage youth and adapt KFHA's approach across different faith groups.[34] KFHA's reports and evaluations did not directly reference disability inclusion or GBV, only noting that their office was not currently accessible for people with a physical disability. Interview respondents, however, stated that KFHA is working in collaboration with a Canadian group on GBV with a view to launching a new project called 'Empower Her' on Abaiang island.[35] It was through KFHA advocacy that GBV was included in the KNHSP – providing formal recognition by MHMS and a mandate for all implementing health agencies to mainstream GBV in health programmes.[36]

The MHMS January to June 2024 NCD Strategy report references a Women's Resilience to Disasters on Maiana Island (workshop funded by UN Women and implemented by AMAK37 where 29 women received not only information about NCDs and nutrition, but also a presentation on GBV prevention and promoting gender equity. No other mentions of GBV were noted in MHMS reports for the bilateral programme, although one interview respondent described that GBV was one of three focus areas for the MHMS MFAT-funded aspects of the RMNCAH programme – providing support for GBV counselling. MFAT funding was also being used to fund a toll-free helpline for teenage girls requiring emergency contraception under the RMNCAH initiative.[38] Disability inclusion was noted in the RMNCAH design, targeting vulnerable people/adolescents and people with HIV.

The Jacob's Functional Brief for the new Betio Hospital highlights GBV as one of the top five health priorities for the Government of Kiribati (based on the Kiribati MHMS Digital Health Roadmap) and lists GBV (alongside family planning, youth-friendly services and sexually transmitted infection (STI) testing etc) as one of the key services to be provided at the hospital. No mention was made of any focused considerations of safety and/or privacy for GBV services but Women's groups and Youth groups were listed as key stakeholders for consultation in the Jacob's Stakeholder and Engagement Plan September 2021.

The Functional Brief also notes the prevalence of disability in Kiribati and quotes text from the Kiribati National Policy and Action Plan (2018-2021), notably Policy Area 4 on improved accessibility. Further, the Brief

[32] KEQ1.2: To what extent has the support contributed to improving the inclusivity of health services in Kiribati?
[33] Sexual Wellbeing Aotearoa. (2024). 'Identifying Future Priorities to Improve Sexual and Reproductive Health in Kiribati: Research Report'. Sexual Wellbeing Aotearoa. Wellington, NZ
[34] Ibid
[35] ID. Nos. 053, 054, 059
[36] ID. Nos. 036 & 037
[37] Aia Maea Ainen Kiribati known as AMAK is the former National Women's Federation of Kiribati.
[38] ID. No. 45

describes accommodations for staff with a disability (e.g., in terms of wheelchair-compatible workstations) and the need for the design to incorporate ease of access for patients with a mobility or other disability.

Proposals and reports from UNICEF Pacific do not directly discuss GBV, although the need to review MHMS guidance on this topic was noted for forward planning in its 2024 Annual Report.

The same report noted UNICEF's efforts to revise and update a 'How to Guide for Community Engagement Activities' (developed by UNICEF in collaboration with the MHMS) to "*ensure it reflects gender, equality, disability and social inclusion*" (pg. 14). The 2024 Report also notes that a toilet is not accessible and contains no menstrual bin – with a plan to inform the island council.

Negotiated Partnership Programme NGOs (notably ChildFund NZ, Leprosy Mission NZ, and Fred Hollows Foundation NZ) are broadly much more considerate of inclusivity (gender diversity, disability etc). For example, ChildFund NZ has been providing focused capacity building support to Te Toa Matoa, the umbrella organisation for persons with disabilities in Kiribati. From design process to proposal and reporting, all New Zealand NGOs provided good narrative on the consultation with and inclusion of people with disabilities in Kiribati health programming.

In 2013, the Government of Kiribati ratified the United Nations Convention on the Rights of Persons with Disabilities, and in 2017 developed a Kiribati National Disability Policy and Action Plan. While conceived as a four-year framework, the vision and policies of this Action Plan remain relevant today. The 2020 disability Monograph[39] (based on the 2020 census using the Washington Group Short Set on Functioning) estimated the prevalence of disability in Kiribati at 6 per cent, a rise of 2.1 per cent on 2015 figures of 3.9 per cent.[40] In 2020, visual disabilities were most prevalent, followed by physical impairments (perhaps in part explained by diabetic retinopathy and diabetes related amputations, respectively).[41] Future programming funded by MFAT should ensure adequate disability analysis during design, ensuring that people with disabilities (and/or their representative organisations) are consulted to ensure activities are designed to ensure maximum participation for all.

The Kiribati Family Health and Support Study (KFHSS) found that 68 per cent of ever-partnered women aged 15 to 49 in Kiribati have experienced physical and/or sexual violence by an intimate partner. This finding from the KFHSS highlights that more than 2 in 3 women in the country have experienced such violence, which is considered one of the highest prevalence rates in the world.[42]

While Kiribati has developed Action Plans and a national database on GBV, and is participating in the Pacific Partnership to End Violence Against Women and Girls (Pacific Partnership), these statistics indicate greater attention is needed from all donors and their implementing partners to better mainstream GBV across all programmes. Once again, the New Zealand NGOs operating under the Negotiated Partnership Programme provided robust examples of such mainstreaming of GBV (notably ChildFund NZ, Leprosy Mission NZ, and Fred Hollows Foundation NZ). We note that Sexual and GBV is a key focus of International Planned Parenthood Federation's (IPPF's) Niu Vaka II Strategy funded in part under MFAT's SRHR programme.

2.1.4 Sustainability

Long term sustainability of outcomes is a consideration for all of MFAT's activities, but with staffing shortages across the MHMS at all levels and budget constraints in a geographically challenging context, support from donors will remain necessary to fill gaps in MHMS capacity for the foreseeable future[43]. That said, considerations in design and construction for the Betio Hospital and Public Health Clinics will ensure these structures are climate resilient and sustainable well into the future.

MFAT's support to the NCD strategy has resulted in changes in policy and legislation, which will be enduring. While limited, taxation revenue from cigarettes will provide a welcome contribution to the activities of the KNHPF[44] and its proposed focus on NCDs. MHMS is currently working to establish the KNHPF and stakeholders report that the MHMS may require technical advisory support to best manage this fund and to identify priorities to focus on. In addition, funding may be required to complete the establishment of the KNHPF.

[39] Kiribati National Statistics Office (KNSO) and the Pacific Community (SPC) (2025), Kiribati Disability Monograph, From the 2020 Population and Housing Census

[40] The Kiribati National Disability Policy and Action Plan 2018 – 2021 quotes a figure of 9% based on the 2025 census

[41] Although the most prevalent disability varies depending on source document

[42] Government of Kiribati. National Approach to Eliminating Sexual and Gender Based Violence 2011-2021

[43] KEQ1.3: How likely are the investments made by MFAT likely to be sustainable, i.e. that the benefits will endure beyond the support funding cycle?

[44] The KNHF is an initiative aimed at supporting the government to address the NCD crises in Kiribati. The activities will be funded from an earmarked tax from 'sin' goods (tobacco, kava, sugary drinks). Health promotion/prevention activities will be the main focus of the foundation. There will also be consideration of an in-country dialysis service

While some limited activities under the NCD strategy have focused on awareness of risk factors, overall, the focus would appear to have been on improving screening, detection and subsequent treatment of NCDs. Given the burden of disease in Kiribati, this appears well justified.

However, stakeholders interviewed for this evaluation resoundingly called for equal if not greater emphasis on the prevention of NCDs through a focused primary health care[45] approach, particularly for youth. That is, the current perception is that activities are currently weighted toward clinical and facility-based elements of PHC (screening, detection, treatment), while population-level prevention and youth-focused health promotion are comparatively underemphasised. This is consistent with the Kiribati Development Plan 2024-2027.[46] The Plan identifies NCDs as a "*significant health concern, driven by risk factors like tobacco use, excessive alcohol consumption, unbalanced diets, physical inactivity and obesity. To address these issues, an emphasis on behavioural change through partnerships and community awareness programs is essential … requiring prioritised concrete action to enhance sport and physical activity. While concurrently focusing on maximising community engagement … fostering widespread and behavioural change through active participation".*

MFAT's investment in HRH provides a much-needed, if modest, boost to staffing in the remote islands, where the limited number and availability of health workforce continues to hamper the effective delivery of activity. The MA training programme will be completed in 2026, but stakeholders reported that there is a risk that MAs will move to Tarawa for better career opportunities, perhaps indicating the need for continued support for training additional MAs going forwards, and/or supporting the MHMS to explore incentives that may support retention in remote locations.

Despite this investment, overall HRH shortages remain, particularly of MAs, nurses and midwives, and the healthcare workforce is concentrated in the National Referral Hospital, which is not the most efficient distribution. According to the Kiribati Health Workforce Strategic Plan 2019-2028, health workforce projections required a net total of 54 new posts to be added between 2018 and 2028 to address knowledge and skill gaps, and yet more to fill vacant positions.[47] While the revised nursing curriculum has improved the standard and cultural relevance of nurse training, one of the two objectives of the programme was to "*Provide potential employment for Kiribati educated nurses internationally*". It was not possible to ascertain whether the revised curriculum had contributed to the net outflow of nurses from Kiribati. A number of stakeholders interviewed reported on the net loss of health personnel (particularly specialist doctors and ophthalmologists), attracted by higher remuneration working with multilateral organisations overseas. One respondent described the impact of the emigration of i-Kiribati nurses to Australia, taking on roles in aged care support.

Physical infrastructure resilience, and ongoing maintenance capacity:

- The Betio Hospital construction was designed with sustainability in mind, as described in the Jacob's Sustainability Report.[48] The design not only considered climate change adaptations but also the environmental impact of sourcing materials, material reuse at end of life, water usage and conservation, and waste management. Additionally, the design was amended to make it easier to maintain and repair using local MHMS maintenance staff, e.g. use of above-ground water tanks rather than underground water tanks. Detailed guidance on maintenance is provided in an Asset Maintenance Manual.
- Similarly, the public health clinics funded by MFAT are required to meet National Infrastructure Standards, ensuring climate resilience and sustainability. Completion requires formal sign-off to ensure that each facility has met the required standard.

Programmatic sustainability:

- UNICEF Pacific expressed its focus on long-term programmes and working with local NGOs and CSOs, and staff from the MHMS. Its Public Health Program focuses on complementary strategies of strengthening institutional capacity, community engagement (and accountability), and quality of care. In the short term these are sustainable, but activities such as supported supervision are unlikely to be sustained in the medium-term without continued support to the MHMS.
- Long-term sustainability of SRHR programmes in Kiribati is identified as a significant challenge, particularly in light of global changes in funding for SRHR. KFHA acknowledges the urgency and importance of this

[45] Definition of PHC is *"a whole-of-society approach to health that aims to maximize the level and distribution of health and well-being through three components: (a) primary care and essential public health functions as the core of integrated health services; (b) multisectoral policy and action; and (c) empowered people and communities.* UHC30. (2021). Action on Health Systems for Universal health coverage and health security, pg. 6 https://www.uhc2030.org/fileadmin/uploads/uhc2030/02._Advocacy/Health_systems_strengthening/UHC2030_Health_systems_narrative__actions_paper.pdf accessed online 21 January 2026

[46] Government of Kiribati. (2024). Kiribati Development Plan 2024-2027, A Wealthy, Healthy and Peaceful Nation

[47] University of Sydney. (2019). Kiribati Health Workforce Strategic Plan 2019-2028

[48] Jacobs. (2023). New Betio Hospital Stage 1 Sustainability Report

issue and remains committed to advocating for funding for SRHR initiatives and exploring options for greater sustainability. Sustainability remains a topical issue in all planning and review processes, and KFHA remains committed to focused capacity building.

- To enhance sustainability (for NCDs and more generally in health) going forward, the MHMS recognises the importance of:
    - Implementing a robust MERL framework that tracks progress, measures impact, and provides timely feedback for programme implementation.
    - Gradually transferring responsibility for health programmes to local health care workers and community organisations through providing training, resources, and support.
    - Investing in local leadership, creating a culture of health promotion within communities.
    - Utilising participatory approaches and moving beyond awareness campaigns to actively involve communities in the design, implementation, and evaluation of NCD programmes.
    - Investing in training and deploying Community Health Workers who can act as a bridge between the health system and communities.
    - Integrating NCDs screening, management, and health promotion into routine primary healthcare .[49]

2.1.5 Contribution of Outcomes to progress against the 2025-2027 Kiribati Plan STO4[50]

Overall, it is too early to assess progress against MFAT's 2025-2027 Kiribati Plan STO4. In part, this relates to data availability and reliability, but it is also compromised by indicator selection and definition.

Strategic Goal 2 of MFAT's 2025 Country Plan is "*Kiribati has a healthier population and benefits from greater shared prosperity*". Reference is made to a range of SDG indicators[51] including the following, which are intended to inform this:

SDG 3.1.1 Maternal mortality rate

SDG 3.2.1 Under 5 mortality rate

SDG 3.4.1 Mortality rate attributed to NCDs

SDG 3.8.1 Coverage of essential services

SDG 8.1.1 Annual growth rate of real GDP per capita; Gini index

The quality, coverage and inclusivity of health services are improved

MFAT's 2025 Country Plan's STO4 for health is "*The quality, coverage and inclusivity of health services are improved*". Indicators for measuring change are:

- Number of people benefiting from sexual and reproductive health services
- Evidence of coverage by health services within Kiribati, with an emphasis on non-communicable disease and early childhood.

It should be noted that these goals and STOs were only released in 2025, with most activities included in this evaluation having been designed concurrently with MFAT's 2021 Kiribati Four-Year Plan. While having a similar goal, the indicators against the health STO in 2021 were a reduction in mortality in under-fives, and a reduction in adult mortality from NCDs.

The table below summarises some relevant key health data from 2022 to 2024. In-country data from 2025 was not available at the time of the evaluation, with Kiribati Health Bulletins averaging almost one year before publication.

Table 2.2 Selected Health Indicators 2019-2024[52]

Indicator	2019	2020	2021	2022	2023	2024
Maternal mortality rate (per 100,000)	**60.9**	**95.8**	**0**	**118**	**58**	**104**

49 MHMS. Six Monthly Report to MFAT, June to December 2024
50 KEQ2
51 https://unstats.un.org/sdgs/indicators/Global-Indicator-Framework-after-2025-review-English.pdf
52 MHMS Health Information Unit. Kiribati Annual Health Bulletins 2022, 2023, 2024 – noting that figures differ moderately from data published by WHO

Indicator	2019	2020	2021	2022	2023	2024
Under 5 mortality rate (per 1,000)	**48.1**	**42.5**	**33**	**35**	**60**	**47**
Mortality rate due to NCDs (per 1,000)	**38.9**	**52**	**59**	**53.6**	**55.2**	**54.5**
Contraceptive Contacts (per 1,000 (contacts)	**399.5**	**19**	**57.4**	**64.1**	**52.5**	**72.7**

Maternal mortality rate (SDG 3.1.1) is a notoriously complex indicator of (shorter term) change, particularly in small populations; what is clear is that the rate remains high in Kiribati,[53] one of the highest in the region. Studies report persistently high prevalence of NCDs, with more than 70 per cent of the population experiencing more than three co-morbidities. Diabetes and hypertension are more prevalent in women than men in Kiribati, including pregnant women. Nevertheless, recent figures published by the United Nations Family Planning Association (UNFPA) estimate MMR as having dropped to 80 per 100,000 live births in 2025, a significant improvement but still above the SDG Target of 70 per 100,000.[54]

Similarly, under-five mortality (SDG 3.2.1) has remained stubbornly high for the past decade; compared to other Pacific Island Nations, Kiribati's U5MR is almost twice the regional average of 27.

Some authors state that a key factor contributing to Kiribati's ongoing child mortality crisis is the misallocation of donor resources – failing to directly address Kiribati's most pressing healthcare needs, namely maternal and child health services.[55]

SDG 3.8.1 measures coverage based on an assessment across 14 different indicators across four domains of reproductive, maternal, newborn and child health, infectious diseases, NCDs, and service capacity and access. The WHO provides a consolidated Universal Health Care (UHC) service coverage index every five years. The most recent figures for Kiribati (2023) show it to have reached a score of 51, comparable to a majority of Pacific Nations (where New Zealand has a score of 80), however the score for Kiribati has remained static over the past ten years.

While useful to broadly to track progress toward UHC and the SDG 2030 Agenda, donors may be better served to focus on sub-indicators for each domain, for example, immunisation rates, exclusive breastfeeding, contraceptive prevalence, smoking rates, and service availability etc. Certainly, a focus on preventative behaviours as well as key morbidity data (disaggregated for age and gender) would likely better inform progress for a four to five-year plan than mortality data. However, MFAT will need to ensure that information is collected and or available from the MHMS prior to nominating its key indicators of change.

In terms of the *Number of people benefiting from sexual and reproductive health services,* there has been progress with KHFP towards improved coverage of health services, with an increase of (4,488) SRHR appointments for KHFP clients from July 2024 to June 2025 (year five), from the previous year (1,007)[56]. Over 7,500 people have benefited from improved SRHR services and 2,851 people received SRHR training and capability building support.[57]

As noted in Table 2.2 above, the Kiribati Health Bulletin 2024 estimated a 10 per cent increase in contraceptive contacts between 2022 and 2024.[58] A key contributing factor for KFHA (through multiple funding streams) was reported to have been the community dialogues with provincial councils, leading to the development of memorandum of understandings (MoUs).[59] This increase was undoubtedly also supported through MFAT's concurrent Pacific Sexual and Reproductive Health and Rights programme, funding UNFPA commodity supplies, IPPF's roll out of its Niu Vaka Strategy (including grants to KFHA), and the MHMS implementing its RMNCAH Policy and Strategic Plan 2022-2027.

[53] https://data.who.int/countries/296
[54] UNFPA World Population Dashboard estimates MMR at 80/100,000 live births in 2025
[55] Rachel Nunn, Tinte Itinteang, Nabura Loteba, William Tan (2024) : Child mortality in Kiribati: a wake-up call for urgent action, DevPolicy, accessed online 26 January 2026 at https://devpolicy.org/child-mortality-in-kiribati-a-wake-up-call-for-urgent-action-20241101/
[56] Some of this increase could be explained by a slowdown in KFHA activities when funding flows were paused for eight months due to a banking issue experienced in the previous period
[57] SWA 2025 Annual Progress KHFP Report
[58] MHMS Health Bulletins only count women in this indicator, despite there being 20,000 condoms distributed in 2024 – it remained unclear if these were being provided to women or men, as this would not appear to be recorded. It was interesting to note that no vasectomies have been recorded in the last three years
[59] ID. Nos. 036 & 037

While three types of contraceptives (modern methods) are 'generally' (but not always) available on the outer islands, significant issues with procurement and timely supply chains remain.[60] While significant investment has been made in improving data systems with a Logistics Management Information System (LMIS), Contraceptives Logistics Management System (CLMS), and interactive dashboards, this remains a work in progress.[61] This is an area being specifically supported under the UNFPA Supplies program (as part of the Pacific SRHR Activity).

MHMS stakeholders referred to the Awareness and Emergency Contraception (ECP) Advocacy where they are seeing teenagers in South Tarawa beginning to ask for the ECP now they are reassured of confidentiality and some restrictions are reduced.[62] *"Demand is growing for the ECP helped by the Ministry's mobile clinic and restrictions have been loosened*."[63] However, stakeholders noted that ECP is not easily available on the outer islands, and acceptability on religious and cultural grounds remains a barrier.

Evidence of coverage by health services within Kiribati with an emphasis on early childhood mortality and NCDs

The second indicator for ST04 (2025 MFAT Four Year Plan) is *Evidence of coverage by health services within Kiribati with an emphasis on early childhood mortality and NCDs.* While the data from the Kiribati Health Bulletin (presented in Table 3.3 above) show mortality from NCD-related causes remains at a similar level, there are indicators of progress. For example, the recently released *WHO STEPS* Survey (comparing 2015 with 2024), shows a reduction in the rate of smoking behaviour (2015 47.7 per cent and 2024 32.7 per cent), and the rate for binge drinking alcohol has halved (2015 9.8 per cent and 2024 4.7 per cent).[64]

However, the survey showed that dietary habits and rates of obesity remained unchanged, and the number of people not engaging in physical activity has increased from 39.8 to 60.6 per 1,000.[65] Overweight and obesity remain prevalent (78.6 per cent of adults), especially in youth (29.3 per cent).[66] While the STEPS data show that hypertension rates and diabetes are increasing, the percentage of adults with at least three risk factors for NCDs has decreased in the last ten years from 82.8 to 68.2.

However, while there are some mixed results, recent data indicates some positive trends. Annual reports to MFAT from the MHMS report steady results, potentially contributing to some of these changes. For example, these include legislative change for NCDs (amending the Tobacco Control Act and Tobacco Control Regulations), providing community awareness programmes on NCD risk factors, rolling out PEN training, and successfully deploying screening and treatment programmes for cervical cancer, rheumatic heart disease, diabetic retinopathy, and oral health.

With a focus on screening, detection and treatment by the MHMS, one stakeholder noted that *"People are living longer due to treatment they are receiving"*.[67] However, MHMS representatives, MFAT staff and New Zealand NGOs called for much greater investment alongside these strategies to improve community engagement and awareness, giving equal focus to prevention and a creation of an enabling environment for minimising NCD prevalence.[68] A number of these stakeholders suggested the need for a better connection between the community and the lowest levels of the health care system, and the need for engaging with community-based organisations.

Childhood mortality (U5MR) has been considered above, but stakeholders highlighted the fact that even though recent data show that U5MRs have plateaued, rates in Kiribati have almost halved over the last 40 years. Given that rates remain extremely high in Kiribati, this prompted the comment, *"There's still a lot of work ahead, the trend has not been as dramatic as other Pacific countries, Kiribati has plateaued"*.[69]

UNICEF (together with the MHMS) is the main partner for MFAT working on child health. Through its bilateral public health programme funded by MFAT, it seeks to strengthen district-level health and nutrition services. A complementary (regional) programme (First 1,000 days Phase 2) has a focus on improving child and newborn nutrition, care and immunisation rates, and a broader early childhood development programme (Building Better Brains) that includes a focus on working with the MHMS on health and nutrition. A limited number of reports were available for these three programmes, and there was moderate confusion as to which report related to

[60] ID. No.059
[61] ID. Nos. 033 & 034
[62] ID. Nos. 045, 049, 059
[63] ID. No. 059
[64] WHO. (2024). Kiribati STEPS Survey, Comparison Fact Sheet (2015 vs. 2024)
[65] WHO. (2024). NCD Snapshot Report
[66] Golden et al. (2025). Prevalence and Spatio-demographic Variability of Nutrition Related Health Issues in Kiribati, *Scientific Reports, July 2*:15 (1)
[67] ID. No. 046
[68] ID. Nos. 014, 026, 032, 039, 049, 050, 060
[69] ID. No. 055

which of the three activities, indicating perhaps clearer naming protocols for activities could be applied. It was, however, noted that in-country counterparts were also moderately uncertain about the multiple streams of UNICEF activity and funding, indicating scope for streamlining.

Nevertheless, Annual Reports for the bilaterally funded activity note an increase in the percentage of mothers and caregivers with knowledge of at least five essential practices (up from 42 per cent in 2020 to 57 per cent in 2022) and Kiribati Health Bulletins show an increase in measles immunisation from 86.6 per cent in 2022 to 97 per cent in 2024. Immunisation for children under one year, however, remains significantly low, and lower in all outer island provinces compared to Tarawa and Banaba, which is fivefold higher.

Progress, although slow, on the persistently high U5MR and in other areas were potentially contributory to the MHMS engaging with Victoria University Wellington and Plunket Nursing New Zealand, and Te Vaka Atafaga Pacific Nursing in 2023. This partnership, in collaboration with UNICEF Pacific, has led to the establishment of the Child Community Nursing Outreach Program (CCNOP) in Kiribati. This initiative, through home service delivery in Betio, aims to create a culturally appropriate, locally community-nurse-led programme, involving health education, assessment, screening, and early intervention for mothers and children under five years.

The 2025 MFAT AMA for the public health programme reports that CCNOP " … *targets 18,429 people (29% of the South Tarawa population). The programme has engaged with 35 church community groups reaching approximately 1,461 individuals. This involved conducting education sessions around caregiver knowledge and practices for 0-5 year olds, including newborn health check-ups and malnutrition follow up and prevention*."[70]

Stakeholders suggested that given CCNOP has the outreach networks and skills, there should be scope for the programme to expand to the outer islands.[71]

2.1.6 Factors that most supported progress towards STO4[72]

Several factors are supporting progress towards STO4. In the first instance, multi-pronged or complementary activities clearly contributed to success. For example, KFHA could only undertake service provision for SRHR because MFAT and the Australian Department of Foreign Affairs and Trade (DFAT) concurrently fund the UNFPA supplies programme, and are provided with backstop supplies by IPPF (also through MFAT funding) where supplies run short. Similarly, the MHMS NCD programme relies on data, training and other support from the MFAT-funded Investing in NCDs in the Pacific programme (WHO and SPC). As noted elsewhere, this could be further maximised if MFAT could support the MHMS in mapping of donor support and/or additional direct networking or linking of relevant MFAT-funded groups working in health.

Almost all stakeholders reported positively regarding the value and support gained from the NZHC. Despite managing such a large portfolio, stakeholders reported that Post were consistently available and supportive, adding value to their engagement in Kiribati and achievement of milestones; "*Post have their finger on the pulse*".[73] Others stated that "*Bereti has been the stability, she's been around for a long time, very familiar with everything, ably manages the programme. But there needs [to be] some sort of succession planning*".[74]

MFAT is widely viewed by implementing partners as "pragmatic", "responsive", "flexible", "adaptable", and "constructive" with its contract negotiations. Post relationship management is also viewed as critical by MHMS and implementing partners; *"Collaboration with MFAT has not been anything short of remarkable"*.[75] In terms of contracting approach, *"MFAT's contracting model … ECI* (Early Contractor Involvement) *followed by a negotiated contract meant we were able to use our Kiribati experience and have input into the design phase of that project. We were able to make sensible choices and trade-offs about materials used to deliver the project*".[76]

Nevertheless, some suggested that due to the size and complexity of MFAT's investment, and the involvement of multiple stakeholders, it might be time to have an additional health programme lead and or external firm to facilitate coordination and oversight.[77]

Other enabling factors include using local NGOs, CSOs, and community groups to deliver and implement the 'grass-root' activities. They have community trust and networks, and experience working with island councils and traditional leaders.[78]

[70] MFAT Public Health Support 2025 AMA, pg.7
[71] ID. No. 067
[72] KEQ2.1: What factors (within MFAT's span of control) most supported (or are supporting) progress towards STO4?
[73] ID. No. 032
[74] ID. No. 010
[75] ID. No. 039
[76] ID. No. 023
77 ID. No. 052
78 ID. No. 026

For example, Child Fund NZ implements (through Child Fund Kiribati) a fully local team which is locally led and driven by people who can spend time on the ground and build trust. After programming long-term, KFHA also has strong links to communities, enjoying a very good reputation in the community.

KHFA adapts its approach to each of the different islands it visits, and it looks for opportunities to consolidate activities when on the islands to make best use of resources from different activities, for example, emergency response training, Humanitarian Youth Club, planting 1,000 mangroves, coconut trees etc. As mentioned elsewhere, KFHA's MoUs with island councils have positively influenced its capacity to work and achieve desired outputs on the outer islands.

CCNOP, Teitoiningaina Women's Centre, Caritas NZ, and Leprosy Mission NZ also use targeted awareness campaigns (using community volunteers) for different groups in the community. Stakeholders also positively reported that the construction group recruited to engage in the Betio Hospital build had experience working in Kiribati and had a good understanding of local conditions, culture, and climatic concerns. Stakeholders further highlighted the importance of "*being there on the ground",* highlighting *"the need to see the context and meet the partners - getting out there is key*".[79]

Under an alternative model, UNICEF Pacific is a custodian of grants and provides TA and quality assurance. Bilateral funding gives it the ability to provide targeted support at a national level. It also receives MFAT funding through its regional programme activity, First 1,000 Days. This expands UNICEF's scope of work and provides the opportunity for subcontracted entities to build skills and maintain standards.

2.1.7 The most significant challenges to achieving these short-term outcomes

Stakeholders highlighted multiple complex challenges to achieving improved coverage and an inclusive health service[80]. These include:

- MFAT's Kiribati health programming:
  - Without an 'overarching' health programme design, strategic framework, Theory of Change and associated MERL framework for MFAT's programme of health activities in Kiribati, it is hard to assess STOs. Most reporting is against discrete activities and not progress against expected outcomes.
  - Indicators selected for MFAT Country Plan strategic outcomes are not always well defined, considerate of data availability, and/or timeframes. A more considered selection based around SDG 3.8.1 domains may elicit better ability to track progress against routine data available from the MHMS or implementing partners.
  - A perception that MFAT's programme of health activities in Kiribati is fragmented. This is discussed further in Section 3.7.1.
- Environmental, financial, social, and regulatory issues within Kiribati:
  - Social and environmental factors that are outside of the health sector, including poor air quality, poor sanitation, access to safe drinking water, increase in the importation of processed foods. Stakeholders reported on the difficulty of promoting healthy foods when none were available.[81] All reported that COVID-19 had a significant impact on health and health programming.
  - Kiribati's geographic location means there are often logistical, capacity, and resourcing challenges, and the cost of travel to the outer islands can be prohibitive; "*due to the travel, logistics and DSAs (daily stipends) – costs are really significant – majority of costs go to DSAs and travel/flights"* and it is difficult *"Getting supplies to the outer islands before they expire"*;[82] "*Logistically, Kiribati is one of the most difficult and costly places to operate*".[83]
  - Behaviour change to reduce NCDs is complex, takes time, and requires a long-term health promotion strategy with appropriate resourcing; "*How you track health – is a hard sector – these are long-term behavioural changes we are trying to make – is a struggle – telling the story is part of our job"*[84]; and "*change in these contexts takes a lot of time*."[85]
  - Planning for adverse events does not fully consider the impact on women giving birth, or on domestic violence, during a crisis.
  - Cultural and religious views on SRHR.
  - Challenging regulatory environment in Kiribati, which can lead to delays and additional cost to infrastructure builds.
  - Retaining health workers - the outer islands don't have a doctor and so the burden is placed on MAs. The limited number and availability of health workforce continues to hamper the effective delivery of

79 ID. Nos. 028 & 032
80 KEQ2.2: What were the most significant challenges to achieving these short-term outcomes?
81 ID. No. 026
82 ID. No. 059
83 ID. Nos. 033 & 034
84 ID. No. 032
85 Ibid

public health support activities; "*remuneration is an issue – leading to specialist nurses seeking employment overseas*"[86]; "*MHMS just don't have the resources*".[87]
    - Consistency in recording progress – *"Hard to monitor when ... staff are not on the island all the time"*.[88] Data is often incomplete or inconsistent. There are also significant delays in the processing and analysis of data, both within the MHMS and by external stakeholders.
- Donor coordination within MHMS:
    - MHMS does not have an effective system to coordinate donor activities, leading to funding, warranting, and reporting issues between MFED, MHMS, and MFAT.
    - HSCC is not functioning as it was designed. "*Obstacles have been that people involved in SRHR* [are] *not sitting around the table together, talking about method availability, what each party is doing, planning, etc., because the committee stopped happening"*.[89]
    - Procurement delays of equipment for health clinics; *"3-4 years ago all facilities were equipped, but now many are lacking resources".*[90]
    - Different priorities within the MHMS and limited multisectoral collaboration to combat NCDs, so there is no holistic overarching structure in place to tackle child mortality or NCD rates.

2.1.8 The extent to which MFAT's health activities has contributed to strengthening the health system in Kiribati[91]

The core functions and building blocks of a health system, as outlined in WHO's Framework for Action, include: 1) service delivery, 2) health workforce, 3) health information systems, 4) access to essential medical products, vaccines and technologies, 5) financing, and 6) leadership and governance.

Health system strengthening (HSS) has further been defined by WHO as 'improving these six health system building blocks and managing their interactions in ways that achieve more equitable improvements across health services and health outcomes.'[92] HSS moves beyond disease-specific, vertical, short-term or siloed approaches, aiming to improve system-wide performance, efficiency, and preparedness for health challenges. Critically, authors advise that it is imperative to distinguish activities that *support* the health system from those that *strengthen* the health system.

> "*Supporting the health system can include any activity that improves services …. These activities improve outcomes primarily by increasing inputs. Strengthening the health system is accomplished by more comprehensive changes to performance drivers such as policies and regulations, organizational structures, and relationships across the health system to motivate changes in behaviour and/or allow more effective use of resources to improve multiple health services*."[93]

While MFAT does not express an explicit HSS approach, there was some evidence of efforts to consider multiple domains (or building blocks) as described by the WHO framework. For example, under Leadership & Governance, the Health Policy Adviser has contributed towards improved policies and regulations. For Health Service Delivery, MFAT has provided significant funding to infrastructure and the support of service delivery in maternal and child health, and Health Workforce has been addressed through both health worker training within each programme as well as the support to upgrade 12 nurses to become MAs, and support the improvement of the Nursing curriculum.

Table 2.3 below shows how MFAT-funded activities align with the WHO health systems strengthening framework.

Table 2.3: Assessment against the Health Systems Strengthening Framework

Health Systems Strengthening Framework	MFAT-funded activities
Leadership & Governance	Health Policy Adviser
Health Service Delivery	Betio Hospital (phase 1) Refurbishment of health clinics

[86] ID. No. 031
[87] ID. No. 026
[88] ID. No. 054
[89] ID. No. 032
[90] ID. No. 045
[91] KEQ 2.3: To what extent has the impact of MFAT's health activities contributed to strengthening the health system in Kiribati?
[92] World Health Organization. (2007). Everybody business: strengthening health systems to improve health outcomes: WHO's framework for action. Geneva
[93] Grace Chee et al. (2013). Why differentiating between health system support and health system strengthening is needed, *International Journal of Health Planning and Management, 28* (85-94)

Health Systems Strengthening Framework	MFAT-funded activities
	KHFP – outreach/mobile services UNICEF RMNCAH & CCNOP services
Health System Financing	n/a
Health Workforce	Capacity building through MA training and the improved Nursing Diploma UNICEF District level nurse training
Medical products, vaccines, and technologies	UNFPA Supplies / Fred Hollows
Health Information Systems	Inputs into KNHSP (WHO)

There is no specific requirement for adopting an HSS approach, although it is one way of achieving a more strategic, coherent and sustainable investment. Such an approach would need to be explicitly stated, planned, and monitored, and would serve as the primary mechanism for achieving the ultimate goal of universal health care (UHC).

Stakeholders suggested "*taking a systems approach is better, like the WHO model around Health Systems Strengthening with a focus on Primary Health Care approaches … with a view to improving Universal Health Care but allow for a broader focus, including vulnerable populations / outer islands and not focus down too much on a couple of thematic areas which could silo success – think about the system*".[94]

2.2 Concluding Summary for Objective 1

There is adequate evidence that most MFAT-funded health activities are in progress toward achieving their stated outcomes, albeit after significant disruptions and delays. This conclusion is largely based on an assessment of completed activities and outputs, which are the focus of partner annual reports. Given both the quality of reporting and timing of the evaluation, most implementing partners had not yet completed activities or assessed the effectiveness of activities against outcomes. Partners did not utilise proxy indicators of progress against outcomes and were under no obligation to provide explicit data against MFAT's indicators for STO4.

It is therefore too early to specifically assess progress against MFAT's 2025-2027 Kiribati Plan STO4 indicators. In part, this relates to data availability and reliability but it is also compromised by indicator selection and definition. The evaluation nevertheless concluded that there was sufficient evidence to demonstrate the contribution of MFAT-funded investments to the improved quality and coverage of health care in Kiribati. This was demonstrated through training of MHMS personnel, construction of facilities, improved standards of care and direct service delivery. MFAT's bilateral health programming addressed inclusivity by its focus on funding programmes for women and children, with a focus on remote and harder-to-reach locations.

All evidence indicates the need for a more considered, overarching, and strategic design for MFAT's investment in health, incorporating clearer and relevant indicators based on data quality and availability. Such a design framework would likely extend to strengthening MERL capacity within the MHMS (for example, through support to the PPU) and would likely require dedicated contracted personnel to bolster support from Post.

2.3 Recommendations for Objective 1

To improve the quality, coverage, and inclusivity of health services in Kiribati, we recommend MFAT, in consultation with MHMS:

1. Maintain an approach to funding NCD programmes that **prioritise Prevention and a Primary Health Care approach**, including increased attention to community-level engagement in health promotion for behaviour change (with a focus on youth and the family unit), and the strengthening of civil society, including better connections between community and primary level of care.
2. **Continue support to SRHR and RMNCAH initiatives**, including funding supplies, and funding programmes that incorporate system strengthening and capacity development for long term sustainability, in addition to service provision and advocacy; activities that target youth/adolescents (teen pregnancy/youth-friendly spaces).
3. **Support implementing partners to take a more intentional approach to inclusion,** particularly regarding people with disabilities in Kiribati, LGBTQIA+ and other vulnerable groups, as well as to

94 ID. No. 032

mainstream Gender Based Violence (GBV) considerations more systematically across health programmes.

4. Continue the sustained support to the **development and retention of Human Resources for Health (HRH)** to better address NCDs, SRHR, and the need for community health workers in remote locations.

5. **Develop an MFAT Kiribati Health design process that includes the development of an overarching strategic framework** (including a Theory of Change and MERL framework) to enhance reportability, cohesion and complementarity across the bilateral and regional/multi-country health programme. Such a framework should align with data availability and the KNHSP (and some of its indicators) and SDG3.8.1 and its sub-indicators. Health goals in MFAT's Kiribati Country Plan would improve the monitoring of outcomes, provide a cohesive plan across MFAT and provide strategic oversight for bilateral activities, and improve multisectoral collaboration. It would also ensure all health activities have a MERL framework and process in place for monitoring and reporting.

6. **Provide tailored support to the functionality of the MHMS PPU.** As guided by the MHMS but potentially including funding of a MERL or leadership (Director) role, and/or providing consultancy inputs as identified by the MHMS PPU team. Also, adding a more programmatic MERL position to support administration, project management and reporting, and data improvements in the PPU would help with improved monitoring and reporting capability.

2.4 Objective 2: The extent to which MFAT's health programming in Kiribati is relevant and cohesive.[95]

MFAT's health programming is very relevant to Kiribati's health sector needs and government priorities. The bilateral health activities closely align with five of the six strategic priorities (SP) in the current KNHSP:

SP1 - Strengthen leadership and governance to improve efficiency, quality and responsiveness of the health care system - through the bilateral funding of a Health Policy Adviser for MHMS.

SP2 – *Strengthen health systems for comprehensive primary and secondary healthcare services* – through building of the new Betio Hospital phase 1 comprising a maternity ward, children's ward, and hospital management facilities. This came from a direct request from the Government of Kiribati in 2019 during the visit by New Zealand's Foreign Affairs Minister. MFAT also funded the refurbishment of public health clinics, the re-establishment of the MA training programme, and the KIT Nursing Curriculum Redesign.

SP3 – Promoting healthy lifestyles and reducing preventable morbidity, mortality, and disability related to NCDs and mental health and their complications - through funding MHMS to implement its NCD Plan.

SP5 – *Advancing health outcomes through family-oriented health strategies* - through the bilateral funding of NGOs - UNICEF Pacific to work on Public Health Support and RMNCAH with MHMS, and SWA/KFHA to implement KHFP.

SP6 – Strengthen health protection and preparedness to address environmental health issues, outbreaks, emergencies and climate resilience – through Partnership-funded activities such as with ChildFund NZ and Kiribati, Teitoiningaina and Caritas NZ, Leprosy Mission NZ, and other regional activities such as UNICEF Pacific's First 1,000 Days.

The bilateral activities also align with the previous plan (2020-2024) through five of the six key priority areas (KPAs):

KPA1 – Reduce morbidity, mortality and disability related to non-communicable diseases and communicable diseases – through funding MHMS to implement its NCD Plan.

KPA2 – Improve access to and utilization of quality reproductive, maternal, newborn, child and adolescent health, health promotion and high impact nutrition intervention services – through funding UNICEF Pacific and SWA/KFHA.

KPA3 – *Improve the quality and range of hospital and allied health services* – though the new Betio Hospital phase 1 and refurbishment of public health clinics.

KPA4 – *Improve the quality of nursing management, practice and essential health services* – through funding the KIT Nursing Curriculum Redesign and supporting the reestablishment of the MA training programme.

KPA6 – Strengthen health system leadership, management, governance and accountability and health facility development – through funding of a Health Policy Adviser for MHMS.

95 KEQ3: To what extent is MFAT's health programming aligned with sector needs and Government of Kiribati priorities?

We note that while KPA5 – Strengthen health protection and improve community empowerment to address environmental health issues and health security including climate change, disaster risk management and outbreak control is out of scope for the health activities that are being evaluated, MFAT does provide funding for WASH and climate change in the Kiribati Country Plan under STO7 – to ensure Kiribati public infrastructure and land use is more resilient to climate change.

The below table shows MFAT bilateral activities, their implementing partners, areas of work, and their alignment to the current KNHSP priorities.

Table 2.4: MFAT Bilateral activities alignment to the current KNHSP

BILATERAL Activity Name	Partners	Broad area of work	Principal alignment - KNHSP priorities
1. Public Health Support Package			
1.1 Kiribati NCD Strategic Plan	MHMS	NCDs	NCDs (3)
1.2 Medical Assistant Training programme	MHMS	Workforce capacity improvement	Health services (2)
1.3 UNICEF Pacific work on public health and RMNCAH (incl. CCNOP)	UNICEF	Maternal and Child Health (MCH)	Family Health (5)
2. Healthy Families Phase 3	KFHA/SWA	SRHR	Family Health (5)
3. Betio Hospital infrastructure phase 1	Reeves International/Egis Ltd	Infrastructure (service availability and facility construction)	Health Services (2)
4. Public Health Clinics	MHMS	Infrastructure (facility repair/ refurbishment	Health Services (2)
5. Health Policy Adviser	MFAT managed contract	Health Policy and Governance	Governance (1)
6. KIT Nursing Curriculum Redesign	Te Pukenga (Wintec Business Division)	Human Resources for Health (workforce capacity improvement)	Health Services (2)

Table 2.5 below shows the 11 MFAT regional/multi country activities and how they are broadly aligned with the KNSHP priorities. The table shows that the regional and multi-country activities with Kiribati's Health Strategy broadly align with the overall intent of the KNHSP (including MHMS's NCD and RMNCAH strategies). These activities indicate a return to a more deliberate primary healthcare approach. For example, focusing on detection, screening, and treating NCDs, but investing very little in preventing them from occurring, apart from community-level work being undertaken in the Negotiated Partnership activities (Leprosy Mission NZ, Caritas Aotearoa/Teitoiningaina Women's Centre ChildFund New Zealand and Kiribati).

Table 2.5: MFAT regional/multi country activities aligned with the current KNHSP

REGIONAL/ MULTILATERAL Activity Name	Implementing Partners	Broad area of work	Principal alignment - KNHSP priorities
1. Pacific and Reproductive Health Rights	MHMS, IPPF, UNFPA, Pacific Feminist Fund	SRHR	Family Health (5)
2. Sexual and Reproductive Health in Emergencies (SRHiE)	IPPF	SRHR	Family Health (5)
3. Investing in NCDs in the Pacific	SPC, WHO	NCDs	NCDs (3)
4. First 1,000 days Phase 2	UNICEF Pacific	MCH	Family Health (5)
5. Building Better Brains Phase II	UNICEF Pacific	MCH	Family Health (5)

REGIONAL/ MULTILATERAL Activity Name	Implementing Partners	Broad area of work	Principal alignment - KNHSP priorities
6. NZ Medical Treatment Scheme	NZ Ministry of Health	Medical Referral & Treatment	Health Services (2)
7. Lab Strengthening Investment	Pacific Pathology Training centre	Laboratory Services	Health Services (2)
8. Eye Care in the Pacific	Fred Hollows Foundation NZ	Eye health	Health Services (2)
9. Negotiated Partnership (NP) Leprosy Mission NZ	Leprosy Mission NZ	Preventative Health and Community Empowerment	NCDs (3)
10. NP Caritas Aotearoa	Teitoiningaina Women's Centre	Community Empowerment and Nutrition	Family Health (5)
11. NP ChildFund New Zealand	ChildFund Kiribati	Health promotion and behaviour change	Family Health (5)

In monetary terms, the overall majority of MFAT's bilateral expenditure has been on service delivery and infrastructure. Instructure builds are a high-value long-term investment; they meet a need (and government request) and also meet political needs regarding visibility and public diplomacy, but this can also be met through increased spending on leadership and governance. The table below shows that 68 per cent of expenditure is targeted to strengthening health systems and improving service delivery, and 24 per cent is targeted to family health.

Table 2.6: KNHSP Strategic Priorities aligned with MFAT Bilateral Expenditure

	KNHSP Strategic Priorities	Core Key areas included	MFAT Bilateral Expenditure %
1	**Leadership and Governance**	Governance and accountability systems, policy, planning & budgeting, legislation, leadership, finance, workforce planning, development partner coordination, procurement and supply chain	2.7%
2	**Health Systems strengthening/service delivery**	Routine data collection for MEL, (digital) Health Information Systems, communication, medical technology, guidelines and protocols, service availability, traditional medicine	68.3%
3	**Healthy Lifestyles and Prevention (NCDs focus)**	Multisectoral partnerships, NCD risk factors, prevention and screening, road safety, mental health	4.67%
4	**Communicable Disease**	Prevention, Detection, Mgmt. – TB, STI, Hep B, leprosy, scabies, trachoma, filariasis etc + mechanisms for preparedness/surveillance and outbreak response	0%
5	**Family Health**	MNCH quality and accessibility, nutrition (incl. breastfeeding), vaccination, SRHR, (incl. FP & SGBV), men's health, inclusive care for people with disabilities	24.35%
6	**Health Protection & preparedness**	Climate change, surveillance for food, water & vector borne disease, WASH, waste management, food safety legislation	0%

We note that the KNHSP remained in draft form from April 2020 until October 2022, when it was endorsed, but staff turnover has meant coordination has not progressed as well as planned. However, as there is little change between the current and previous KNHSP, the delay in finalising the current plan has not impacted on the alignment of MFAT's health programming with the Government of Kiribati priorities and its health sector needs.

2.4.1 To what extent is MFAT's health programming complementary and well-coordinated across Government of Kiribati priorities, strategies, plans and systems?[96]

While stakeholders thought that MFAT's health programming is complementary and well-coordinated across Government of Kiribati priorities, strategies, plans and systems, some added that it was not always clear what New Zealand was funding, and through which government ministry. "*NZ is a very humble donor and it's hard to see what's happening in the health sector, what NZ is supporting"* (ID. 056).

Examples provided by MHMS stakeholders of complementarity included the RMNCAH strategy, NCD Plan, and KV20. Some of these stakeholders noted that there have been some challenges with the NCD Strategic Plan as it is seen more as a guiding document. Some MHMS NCD activities may be outside the plan but MHMS officials have been instructed to undertake them by senior government officials. Other NCD activities have not been implemented due to an administrative change within MHMS.

The KHFP and RMNCAH bilateral activities and the regional 'Pacific and Reproductive Health Rights' activity align with the Government of Kiribati's KV20, which is Kiribati's long-term development blueprint for 2016-2036.

> "*An improved healthcare system that is acceptable will reduce the fertility rate from 3.1 to 2.7 by 2019 and to 1.8 by 2036. Looking at the complexity of the population growth, the diversity of our culture and religious beliefs, the reduction rate is set at the minimum rate of 0.3*" (pg. 33).

Some stakeholders noted that the different divisions within MHMS could coordinate better, which would help MFAT health activities to be more effectively implemented. They added that MHMS is beginning to better coordinate with other government agencies (MWYSSA and Ministry of Education) and NGOs (KFHA and UNICEF Pacific) regarding activities that involve youth health, and that this cooperation will help the MFAT-funded activities to be implemented more efficiently.

> "*We take a complementary approach, we don't work in silos, for outreach we divide up the islands. MWYSSA train youth to advocate and for outreach in the community. KFHA – advocacy and community outreach for family planning. UNICEF – immunisation, newborn, under 5s, and PMSRC (perinatal, maternal care, surveillance and response)".*[97]

Stakeholders noted that:

> "*MFAT's funding streams are multiple and not always well coordinated. This has exacerbated existing silos within the Kiribati health system and has put an increased burden on MHMS in terms of donor coordination in the sector."*[98]

Stakeholders referred to KFHA (rather than KHFP) as a local NGO that works hard to coordinate with government agencies on SRHR, regardless of where the funding is sourced. KFHA will alert MHMS when its staff plan to go to the outer islands so that MHMS can provide support when KFHA is on the island. Sometimes they *"piggyback"*[99] with MHMS. KHFA has also reviewed the Ministry of Education's school curriculum on family health, and works with local authorities and island councils so they can advocate for broader community wellbeing.

Participants in the SWA research stated that KFHA's work with government agencies (including the Ministry of Education, MYSSWA, and MHMS) needs to continue, together with better collaboration between MHMS and other government agencies, UNFPA, and MFAT to avoid duplication of services. They suggested cost-effective approaches such as using government programmes already in place, e.g. MWYSSA's male behaviour change programme which raises awareness about violence against women and children.[100]

2.4.2 To what extent is MFAT's health programming coordinated with other development partners working in Kiribati, avoiding duplication of resources and efforts?[101]

MFAT's health programming is to some extent coordinated with other development partners (Governments of Australia and Japan, WHO, ADB, and UNFPA) working in Kiribati, but it could be improved with a redesign of

[96] KEQ3.1
[97] ID. No. 045
[98] ID. No. 010
[99] ID. No. 054
[100] Sexual Wellbeing Aotearoa. (2024). 'Identifying Future Priorities to Improve Sexual and Reproductive Health in Kiribati: Research Report'. Sexual Wellbeing Aotearoa. Wellington, NZ., pg. 30, 36
[101] KEQ3.2

the HSCC as not all development partners or implementing agencies we spoke to were aware of what MFAT is funding.

Currently, when MHMS has discussions with partners, they flag that MFAT is providing support for most of their NCD programmes. MHMS acknowledges that New Zealand cannot support every need in improving RMNCAH or preventing NCDs and it discusses where there are gaps that other donors may wish to support. This complements New Zealand's support rather than duplicating support; *"we're doing this X, Y, and Z with MFAT but if you want to come into the NCD space, this is what the Ministry needs …".*[102]

The Australian High Commission (AHC) has semi-regular meetings with the NZHC, and they are aware of what areas New Zealand is supporting. The AHC stakeholders added that DFAT has an open, strong, and reliable partnership with MFAT, helped by both being on the ground in Kiribati so they can work closely to align their health programmes. "*We complement each other quite well in terms of our focus and the delivery".*[103]

The Government of Kiribati is using parallel financing to fund phases 1 and 2 of the new Betio Hospital, with New Zealand funding the design of both phases and construction of phase 1, and ADB funding construction of phase 2. ADB noted it worked well with MFAT on planning and coordination of the redevelopment of the hospital, and added that "*ADB, MFAT, DFAT, World Bank share information and coordinate on programmes".*[104]

MFAT's implementing agency UNICEF Pacific (Kiribati Field Office) and MHMS have a charter to ensure there is consultation between MHMS and UNICEF Pacific in the early planning and implementation phases of the public health and RMNCAH activities. The charter outlines that there is an expectation for UNICEF to consult with MHMS over plans, updates, and implementation.[105] The CCNOP team works with other programmes and units within the MHMS, such as maternity wards and health clinics in Betio, to ensure synergy and coordinating actions to avoid duplication.[106]

Stakeholders added that a PM role within the PPU could ensure MFAT's health programming is better coordinated with other development partners, thereby avoiding future duplication of resources and efforts.

In addition, MFED ensures complementarity at the 'high donor level', through the Development Partners Forum (DPF), hosted by MFED every two years. The next DPF is expected to be in 2026.

2.5 Concluding Summary For Objective 2

MFAT's bilateral health activities are very relevant and closely align with five of the six strategic priorities in the current KNHSP. The activities also line up with the previous plan through five of the six key priority areas. It is difficult to fully align regional and multi-country activities with the current plan, although they are aligned with the overall intent of the plan (through MHMS's NCD and RMNCAH strategies). The overall majority of MFAT's support to date has been on service delivery and infrastructure, meeting real needs as expressed by the partner government. However, it should not be service delivery and infrastructure builds over health systems strengthening. Support for leadership and governance should be part of every MFAT-funded activity.

While stakeholders thought that MFAT's health programming is complementary and well-coordinated across Government of Kiribati priorities, strategies, plans and systems, some added that it was not always clear what New Zealand was funding and through which government ministry. MFAT's multiple funding streams have exacerbated existing silos within the Kiribati health system and put an increased burden on MHMS in terms of donor coordination in the sector.

MFAT's health programming is to some extent coordinated with other development partners working in Kiribati, but it could be improved with a redesign of the HSCC as not all development partners or implementing agencies were aware of what MFAT is funding. Currently when MHMS has discussions with partners, they flag that MFAT is providing support for most of their NCD programmes and some RMNCAH activities, and then discuss where there are gaps where other development partners could provide support.

2.6 Recommendations For Objective 2

To ensure New Zealand's programme of health activities in Kiribati remain cohesive and relevant we recommend MFAT:

1. **Introduce annual MFAT Kiribati health sector meetings,** which would include strategic sector policy dialogue and **annual mapping exercises** with current implementing partners to help better coordinate

[102] ID. No. 039
[103] ID. No. 049
[104] ID. No. 051
[105] ID. Nos. 042 & 056
[106] CCNOP Annual Report, 2025, pg.3

the bilateral and regional activities within MFAT. This could help lead to improved collaboration by implementing partners working in the outer islands.

2. **Integrate workplans by MFAT** for its health activities by country. This would include both bilateral and multi-country/regional funded activities.

3. **Improve consolidation and alignment of MFAT's multiple funding streams** to improve coordination. MFAT's multiple funding streams are perceived by implementing partners as not always well coordinated, and improving this perception through better communication would help reduce the burden on MHMS in terms of donor coordination in the sector. This could be through annual mapping exercises as discussed above, along with regular communication on progress between MFAT and the bilateral and regional/multi-country implementing partners.

2.7 Objective 3: Identify learnings and recommendations to inform future decisions on support to the health sector in Kiribati.[107]

This section examines how MFAT can ensure New Zealand's support is optimally balanced across priorities and implementing partners in order to achieve impact. Learnings are discussed in Section 4, and as previously noted recommendations are considered throughout the findings section by each evaluation objective.

MFAT can ensure New Zealand support is optimally balanced across priorities and implementing partners in order to achieve impact though strengthening MHMS systems and supporting local NGOs

Stakeholders for this evaluation reported several initiatives that MFAT could consider for a better balance across priorities and implementing partners to achieve impact, and long-term sustainability through better targeting of preventive and primary health care services.

These include **strengthening MHMS systems, improving health governance** through the continuation of the Health Policy adviser role to continue capacity development in terms of governance and leadership**, and supporting NGOs and CSOs to implement health services in the community**. Examples provided by stakeholders include:

- New Zealand supporting or leading the reconfiguration of the HSCC and its working groups to ensure effective governance of donor funding. Suggested support includes the mapping of current external support to identify any gaps and/or overlaps.
- Targeted support through the PPU and the KNHPF, such as funding a PM for the PPU, and a health promotion adviser for the KNHPF.
- An appropriate mechanism to support local NGOs and CSOs, such as through a separate fund, or better use of the Negotiated Partnerships Fund or regional partnerships programme to support NGOs and CSOs to implement 'small budget – high community impact' activities. For example, exploring the possibility of bilateral funding to some NGOs managed under Partnerships, such as with The Leprosy Mission New Zealand's Bougainville Healthy Communities Programme with the training of village health volunteers and village leaders on community health development, leadership, and governance.
- Regular communication with implementing partners, including joint sessions between MFAT and all health-funded implementing partners operating in Kiribati. This could encourage better coordination and reduce the risk of overlapping between bilateral and multi-country activities.
- Commitment to longer-term investment in NCDs and RMNCAH (in particular maternal and child health) for sustainable change, including maintaining funding for SRHR to ensure future designs incorporate sustainability plans.
- A strategic approach to infrastructure (e.g. 5-year programme). Suggestions provided for structures needing renovation include the Kiribati School of Nursing and one of the phases of the Tungaru Central Hospital. Construction of new public health clinics not funded by World Bank (e.g. Tabiteuea North) were also proposed. Stakeholders added that a 'quick fix' maintenance budget would need to be considered alongside any infrastructure funding.

2.7.1 To what extent is MFAT's health programming complementary and well-coordinated internally within MFAT? [108]

MFAT's health regional/multi-country and bilateral programming is viewed by stakeholders as fragmented. While there may be good communication and coordination between the different divisions within MFAT (Development – People and Prosperity Division (technical advice), Pacific Melanesia and Micronesia Division (country plan), and Post (relationship and bilateral contract management etc)), external stakeholders do not

[107] KEQ4: How can MFAT ensure NZ support is optimally balanced across priorities and implementing partners in order to achieve impact?
[108] Sub-question 4.1

have a good understanding of how the Kiribati health regional and multi-country activities are coordinated across MFAT, or how they complement the bilateral activities.

In addition to UNICEF Pacific and CCNOP, we note that at least three of the Negotiated Partnership NGOs (Caritas NZ, Child Fund NZ, and Leprosy Mission NZ) are engaged in aspects of child nutrition and community awareness around healthy foods, with a number of activities in the same catchment area. It is perhaps not surprising therefore that stakeholders called for:

> "*A deep dive or mapping to see who is doing what … not just the contract holder (e.g. UNICEF), but the next level down [and the suggestion that MFAT] engage more proactively in coordination, bringing New Zealand actors together, re-launching round tables or similar on a semi regular basis*".[109]

There is a desire by stakeholders to "*see what MFAT is funding … a clearer communication and transparency between New Zealand-funded activities to increase opportunities for collaboration*".[110] This is because "*at the moment everything is in piecemeal, it's all happening in different spaces when it shouldn't, because it's all under MFAT … it's just the coordination is fragmented*".[111]

As discussed under Objective 2, MFAT's multiple funding streams are not always well coordinated and this has put an increased burden on MHMS in terms of donor coordination in the sector.

In addition, the HSSC has not been effective during the scope period of the evaluation, and oversight of the different activities being undertaken by MFAT and other development partners has been less than ideal. As discussed, MHMS and implementing partners in Kiribati noted that they valued the excellent relationship management by the NZHC, along with MFAT's constructive partnership approach, but they would like to have better visibility regarding what other health activities are being funded by MFAT.

For example, some stakeholders did not understand why UNICEF Pacific was receiving funding from different MFAT funding sources for the First 1,000 Days multi-country activity and its bilateral work on public health and RMNCAH as part of the Kiribati Public Health Support Activity, or why KFHA is receiving bilateral funding directly and not via the Negotiated Partnership Fund.

Improving communication with both bilateral and regional/multi-country implementers on why and how MFAT uses its different funding sources should help reduce this confusion. Annual mapping sessions would also provide opportunities for efficiencies and better collaboration between implementing partners in the outer islands.

2.7.2 Are there more effective and efficient approaches for NZ to deliver health support in Kiribati? [112]

As discussed in the Recommendations for Objectives 1 and 2 there are more effective and efficient approaches for New Zealand to deliver health support in Kiribati. We note the MFAT's 2024 Activity-based Review of New Zealand's International Development Cooperation Programme emphasised the need for strategic realignment, advocating for higher-order funding modalities, and partnerships with regional agencies and civil society. A higher-level outcomes-based modality would allow MFAT to engage with MHMS at a strategic level, and with implementing partners at a community level, although this may require additional contracted support.

MFAT support of UNICEF Pacific and KFHA through bilateral funding has added to the number of GFAs for Kiribati, and this has prompted some stakeholders to note that there are too many GFAs. MHMS stakeholders commented on the ease of working with DFAT through its DFA, which is a type of sector budget support, and they suggested that to improve efficiency, MFAT may wish to consider a similar arrangement. The majority of DFAT's bilateral programme is delivered through government systems, but they also have a 'smaller bucket' for TAs, a strategic health adviser who supports their programme, and funding for multi-country/regional activities that include Kiribati. However, MFAT stakeholders noted that DFA does not have the same level of flexibility that a GFA has, and it could increase the level of administration for the NZHC which has fewer staff than the AHC.

The annual approvals, e.g. for MHMS NCDs, was just a succinct budget spreadsheet with no detail. Future approvals will need to be more detailed, incorporating the potential to be performance-based, and possibly incorporating incentives, as used by DFAT.

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[109] ID. No. 26
[110] ID. No. 062
[111] ID. No. 039
112 Sub-question 4.2

Some stakeholders also noted potential risks with a less targeted approach, and added the importance of 'tagging' bilateral funding to specific initiatives, such as providing TA capacity for PPU (for managing GFA, governance, policy, monitoring and reporting), and providing health promotion support to the KNHPF.

There was general support for NGO implementing partners to get better access to direct funding for 'whole of family' community initiatives. Examples included either a better use of Negotiated Partnerships, or a targeted NZHC fund for local NGOs and CSOs responding to NCDs and RMNCAH.

There was also support for MFAT's funding approach to the Kiribati Ministry of Fisheries and Ocean Resources (MFOR), where New Zealand funds the Ministry's strategic plan and relies on Ministry indicators to demonstrate progress against outcomes. Significant investment in improving capacity in MERL would be required in the first instance if such an approach was to be considered for MHMS.

If MFAT considers a similar model to that used for MFOR, it would need to be able to deliver impact in specific areas through specifying particular areas of support (e.g. NCDs and RMNCAH) but also allow flexibility for the MHMS to respond to emerging priorities within the KNHSP. The GFA would make it clear what MHMS can spend MFAT funds on in terms of priorities, and these would relate to indicators in the GFA framework. MFAT would rely on relevant MHMS indicators from the KNHSP to show progress against outcomes, and these would be linked to the GFA to trigger new tranches.

We note there is a risk that a sector budget approach may increase programme-level workload, leading to increased oversight on budgeting and financial flows, procurement processes, and reporting systems, which could require additional contracted support. However, it would also provide targeted, planned, flexible funding directly to MHMS to enable it to implement critical health policy reforms, aligning funding support with national priorities, and improving efficiency in a resource-constrained environment. This approach would provide an opportunity for the Biannual partnership meetings to become more strategic and discuss progress against indicators in the GFA, emerging challenges, and where there might need to be changes in funding or in the indicators to reflect changed strategic priorities. Tagging of funds to specific outcome-focus initiatives would be important to ensure funding is not diverted to internal MHMS operations, such as outer island team-building exercises.

2.8 Concluding Summary for Objective 3

Stakeholders reported a very positive relationship with Post and there is a recognition of opportunities for New Zealand to leverage its international development reputation, including its support for good governance and policy, and people-to-people links. This could also improve the visibility of New Zealand's contributions in the health sector.

However, the multiple GFAs have increased the contract management workload for the small team at Post. This suggests the delivery of funding for MHMS-led services should use a higher-level outcomes-based modality. This would allow MFAT to engage with the MHMS at a strategic level and with implementing partners at a community level. We note there is a risk that a sector budget approach may increase programme-level workload and may require additional contracted support. However, it would also provide targeted, planned, flexible funding directly to MHMS to enable it to implement critical health policy reforms, aligning funding support with national priorities, and improving efficiency in a resource-constrained environment. The benefits of making this change may outweigh the short-term costs, as it could also be a more sustainable approach in the medium to long-term.

Fewer targeted outcome-focused GFAs will help MFAT support MHMS to focus on its system-level challenges, including its current MERL capacity, and leadership and governance constraints.

New Zealand is looking to more efficiently deliver its funding for primary health care, including preventive services. MFAT can ensure New Zealand support is optimally balanced across priorities and implementing partners in order to achieve impact though strengthening MHMS systems and supporting local NGOs to deliver health services in the community, in particular in the outer islands. Stakeholders suggested several initiatives, including strengthening MHMS systems through the MHMS PPU and KNHPF, and improving health governance through supporting a review of the HSCC. They also stressed the importance of using an appropriate mechanism to support local NGOs and CSOs to better enable them to implement health services in the community, such as through a separate fund, or bilateral funding to some NGOs managed under Partnerships.

Improved coordination and visibility across MFAT funding streams will help its health regional/multi-country and bilateral programming. Implementing partners, including MHMS, lack visibility of who the different actors are and how the different MFAT-funded activities complement each other. There were calls for MFAT to get the multi-country/regional and bilateral implementing partners to get together at a country level to share awareness and learnings. While internally MFAT's health programming may be well-coordinated and complementary, implementing partners do not have a good understanding of how the Kiribati health regional

and multi-country activities are coordinated across MFAT, or how they complement bilateral activities. Stakeholders also suggest that a better understanding by NGOs could mean more efficient delivery of activities in the outer islands. Addressing this lack of coordination will need to be a particular focus of the design of the next phase of MFAT's health sector support to Kiribati and may require additional contracted support.`.

2.9 Recommendations for Objective 3

In addition to the recommendations already discussed, we recommend that future decisions on support consider:

1. **Move to a higher-level outcomes-based modality** to allow MFAT to engage with MHMS at a strategic level. This could be through fewer output GFAs to support MHMS to deliver the KNHSP. This would allow MHMS to take a 'whole of basket' approach and integrate NCD and RMNCAH services with other services to be able to better reach the outer islands. It would still allow MFAT to directly support implementing partners, in particular local NGOs and CSOs, at a community level.
2. Commit to longer-term investment in NCDs and RMNCAH (in particular maternal and child health), and a programmed approach to infrastructure support. This would confirm New Zealand's long-term commitment and enable the Government of Kiribati to better coordinate and negotiate infrastructure priorities with other funding partners.
3. Fund a strategic health policy adviser role to leverage its special relationship with Kiribati. This role would focus on governance, policy, and leadership for HRH and health strategy. It would be embedded in MHMS with its senior counterparts and also support the review and coordination of HSCC.

3 LESSONS LEARNED

As discussed, Objective 3 asks the evaluation to identify learnings to inform future decisions on support to the health sector in Kiribati.[113]

The following insights are framed around implementation successes and challenges, and what will be important to continue for the future design of the new health programme of MFAT support in Kiribati.

3.1 Implementation Successes

The NZHC plays an important positive role with MHMS and other implementing partners with stakeholders reporting that Post were consistently available and supportive, adding value to their engagement in Kiribati and achievement of milestones.

Regarding its contracting approach, in particular ECI followed by a negotiated contract, MFAT is widely viewed by implementing partners as "pragmatic", "responsive", "flexible", "adaptable", and "constructive" with its contract negotiations.

Other **enabling factors include using local NGOs, CSOs, and community groups to deliver and implement the 'grass-root' activities.** They have community trust and networks, and experience working with island councils and traditional leaders. For example, Child Fund NZ implements (through Child Fund Kiribati) a fully local team which is locally led/driven by people who can spend time on the ground and build trust.

The new Betio Hospital phase 1 infrastructure activity with the construction of maternity and paediatric wards is a tangible example of MFAT's contribution to strengthening Kiribati health systems for comprehensive primary and secondary healthcare services. Discrete activities, like the new Betio Hospital phase 1, with support by external management are likely to have contributed to implementation success.

There is also an example of complementary activities contributing to success. KFHA is able to undertake service provision for SRHR because MFAT (and DFAT) concurrently fund the UNFPA supplies programme, and are provided with backstop supplies by IPPF (also through MFAT funding) where supplies run short. It is likely that KFHA's long-term relationships with UNFPA and IPPF contributed to KFHA's access to supplies. KFHA also has strong links to communities, and has a good reputation in the community.

[113] This aligns with KEQ 4.3: What lessons learned could MFAT consider in the design of future health sector support (including other health initiatives MFAT is supporting in the Pacific and elsewhere that could be adapted to Kiribati)?

3.2 Implementation Challenges

Stakeholders reflected on the enormity of the health crisis in Kiribati and the political, cultural, and logistical challenges that need to be considered by New Zealand when consulting with Kiribati on the design of the next round of support.

Each partner under the bilateral programme reports independently against its own framework (e.g., relevant strategy or design document) as there is **no overarching MERL framework for MFAT's support to the health sector in Kiribati**. This has led to a perception of 'fragmentation' by implementing partners as they **lack visibility of the different activities being undertaken through bilateral and regional/multi-country funding** covering a range of focus areas (including NCDs, service delivery infrastructure, human resources for health, and sexual and reproductive health).

Multi-donor funding of the NCD strategy means New Zealand has little control over what activities are implemented and the quality of those activities (e.g. outside of NCD strategy scope).

3.3 Considerations for future design

Allowing time to invest early in the design of New Zealand's bilateral health programme of activities in Kiribati e.g. starting one year before the end of the current design, will help to overcome the logistics and cost of travel to outer islands, and regular staff turnover at MHMS.

The indicators selected for MFAT Country Plan strategic outcomes are not always well defined, considerate of data availability, and/or timeframes. A more considered selection based around SDG 3.8.1 domains could elicit better ability to track progress against routine data available from the MHMS or implementing partners. An **overarching MFAT Health Design Document and MERL framework** for Kiribati with relevant indicators, e.g. from KNHSP and/or SDG 3.8.1, would have provided a more cohesive reporting mechanism for MFAT to identify progress toward MFAT's strategic outcomes.

Regular and clear communication between donors and implementing agencies, such as annual mapping exercises with current implementing partners, would have addressed any lack of coordination and helped to better coordinate the bilateral and regional activities within MFAT. Regular communication may have also helped improve collaboration by implementing partners in the outer islands.

4 CONCLUSIONS

MFAT's funding support of RMNCAH and NCD initiatives aligns with the Government of Kiribati's current and future priorities in health. They are highly valued by the Kiribati health system and MHMS. MFAT is widely viewed by implementing partners as "pragmatic", "responsive", "flexible", "adaptable", and "constructive" in its contract negotiations. Post relationship management is also viewed as critical by MHMS and implementing partners.

However, there is a perception from implementing partners that MFAT's different funding mechanisms (bilateral and regional/multi country) do not appear coordinated or coherent. In addition, the effectiveness of MFAT-funded activities has been exacerbated by challenges faced by MHMS in donor coordination.

As outlined in the evaluation terms of reference (ToR), MFAT's quality standards and International Cooperation for Effective Sustainable (ICESD) policy are based on the OECD-DAC Principles for Evaluation of Development Assistance (OECD DAC) criteria, and the overall evaluation assessment against these criteria are:

- **Effectiveness -** There is adequate evidence that demonstrates the programme of support has achieved or is achieving some of the intended STOs. There is also adequate evidence that demonstrates the support is values-driven and partnership-focused.
- **Efficiency -** Implementation of activities was impacted in the early 2020s due to COVID-19. There are still ongoing delays due to the complexity and cost of logistics of transport to the outer islands, access to supplies, and understaffing.
- **Coherence -** MFAT Kiribati health activities are perceived to be "fragmented" by MHMS and other implementing partners and they would like to better understand how they align and complement each other.
- **Relevance -** MFAT's health sector support in Kiribati is closely aligned with KNHSP and its focus on reducing NCDs, enhancing health equity, and improved access to RMNCAH services.
- **Impact -** We are beginning to see some behavioural change with better understanding by the community of sexual reproductive health rights (SRHR) and use of family planning. It is too early to see behavioural change that would lead to the reduction of NCDs, noting the funding timeframe for NCD initiatives and the evaluation.

- **Sustainability -** Long-term sustainability of outcomes is a consideration for all of MFAT's activities, but with staffing shortages across the MHMS at all levels and budget constraints in a geographically challenging context, support from donors will remain necessary to fill gaps in MHMS capacity for the foreseeable future. That said, considerations in design and construction for the Betio Hospital and Public Health Clinics will ensure these structures are climate resilient and sustainable well into the future.
- **Inclusivity -** MFAT's bilateral health programming partially demonstrated inclusivity by its focus on funding activities for women and children, with a focus on both South Tarawa and remote and harder-to-reach locations. There is scope for a more intentional approach to inclusion by MFAT funding partners, particularly regarding people with disabilities in Kiribati, LGBTQIA+ and other vulnerable groups, as well as a more considered approach to mainstreaming GBV initiatives across health programmes.

Annex 1 MFAT Kiribati Country Plans

2024-27 MFAT Kiribati Country Plan – STO4:

The quality, coverage and inclusivity of health services is improved.

The country plan's Goal Two is Kiribati has a healthier population and benefits from greater shared prosperity.

Key indicators of progress are:
- Number of people benefitting from sexual and reproductive health services (M/F)
- Evidence of coverage by health services within Kiribati with an emphasis on non-communicable diseases and early childhood.

2021-2024 MFAT Kiribati Four Year Plan - STO1:

The quality and coverage of health services is improved.

The plan's Goal One is: Kiribati has a healthier population.

Key indicators of progress are:
- Reduction in the under-5 mortality rate
- Reduction in the adult mortality rate from NCDs.

Annex 2 Evaluation Design

As outlined in the Evaluation Plan the evaluation design is informed by an initial document review, an inception meeting with MFAT and the New Zealand High Commission to Kiribati (NZHC), and the Evaluation ToR. The purpose, scope, and objectives are from the ToR.

Purpose

The purpose of the evaluation is to provide an independent analysis that will be used to:

- Assess progress against the current Kiribati Plan STO4 - 'The quality, coverage and inclusivity of health services is improved'.
- Provide insights as to the coherence of MFAT's health sector support in Kiribati.
- Provide insights and recommendations to inform the design of future health sector support in Kiribati.

Scope

The time period being evaluated is from 1 July 2021 to 30 June 2025.

The evaluation included all MFAT-funded activities listed in the ToR and discussed in the Findings section. The primary focus of the evaluation is on bilaterally-funded activities, with a secondary focus on multi-country and regional activities (including NGO partnerships). This is because:

- Bilaterally-funded activities have typically lacked clear MERL frameworks and have not been evaluated at an activity level, whereas most multi-country and regional activities have had evaluations completed in recent years.
- The majority of funding available for new health activities sits within the bilateral funding allocation. This evaluation will inform how that funding will be programmed.
- Giving equal attention to all activities is not realistic or achievable within the funding envelope and timeframe required by this evaluation.

Out of scope

The evaluation excluded activities that address the social and environmental determinants of health (i.e. waste management, food security, water security (WASH)), which informed the evaluation but were not directly in scope. Climate change was also not a major focus in this evaluation. However, where relevant in relation to specific activities such as the Betio Hospital (phase 1), we note that it was built to specifications to allow for resilience in the face of future sea level rise.

Objectives

Objective 1: to examine the extent to which MFAT's health programming has contributed to improved quality, coverage and inclusivity of health services in Kiribati.

- To what extent has MFAT's health programming achieved activity outcomes and how have these contributed to progress against the Kiribati Plan STO4?
- What factors (within MFAT's span of control) most supported progress towards STO4 and what were the most significant challenges?

Objective 2: to examine the extent to which MFAT's health programming in Kiribati is relevant and cohesive.

- To what extent is MFAT's health programming well aligned with sector needs and Government of Kiribati priorities?
- To what extent is MFAT's health programming complementary and well-coordinated internally and with other development partners working in Kiribati?

Objective 3: to identify learnings and recommendations to inform future decisions on support to the health sector in Kiribati.

- What lessons learned could MFAT take in to account in the design of future health sector support?
- How can MFAT ensure New Zealand support is optimally balanced across priorities and implementing partners in order to achieve impact?

Methods

As there is no overarching strategic document or MERL framework for New Zealand's health sector support in Kiribati, the evaluation took a qualitative approach and used key stakeholder interviews and a review of relevant documents to answer the KEQs and sub-questions (in Appendix B).

33 semi-structured interview sessions with 47 key stakeholders were undertaken in-person in Tarawa from 24 October to 3 November 2025, and remotely via video conference from 24 October to 3 December 2025. A list of stakeholder organisations who participated in the interviews is in Appendix C.

The document review involved secondary-source reporting data from implementing agencies, relevant MFAT documents, and independent reviews. A list of relevant documents is in Appendix D.

As outlined in the ToR and Evaluation Plan, the evaluation drew on the OECD-DAC Principles for Evaluation and MFAT's ICESD policy. Where relevant the evaluation also used the Health Systems Strengthening (HSS) Framework and an effectiveness assessment framework (see Appendix E).

Our approach was collaborative, participatory and utilisation-focused, and designed for the evaluation team to work closely with MFAT. This was to ensure the evaluation provided MFAT with findings and recommendations that will help them make evidenced-based decisions, in consultation with the Government of Kiribati, on how it will provide support to Kiribati's health sector.

Further details of the Evaluation Methodology including the Interview guide, Information sheet and Consent form, are outlined in the Evaluation Plan.

Ethical Considerations

We were led by our in-country consultant on the most appropriate approach for engaging with stakeholders in Kiribati. Most of the key stakeholders to be interviewed were senior officials and were able to speak both official languages of English and te taetae ni Kiribati, and the Evaluation Team was able to respond to the interviewee preference to be interviewed in person or as part of a group.

We have only collected information that is needed for the delivery of this evaluation and this information has been securely stored and kept confidential by the Evaluation Team. In countries with a small population there can be sensitivity with data collection so the evaluators assured interviewees that interview responses (written and audio recordings) will be destroyed when the evaluation report is finalised.

Responses have remained confidential to the Evaluation Team and their source has not been identified in the report. If a quotation is used to illustrate a finding an identification number has been applied. As noted above, only the names of organisations participating have been listed in the report (Appendix C).

Participation was voluntary and consent was provided either in writing or verbally prior to the interview commencing. More information on our approach to Ethical considerations can be found in the Evaluation Plan.

Limitations

We note the following limitations for this evaluation:

- There is no ToC or associated MERL framework and indicators for MFAT's overall programme of health activities in Kiribati.
- MFAT-funded projects addressing the social determinants of health (waste management, WASH, food security, and water security) were out of scope.
- There is no consolidated reporting against health STOs.
- There is a lack of proxy indicators for progress toward outcomes in partners' activity reports.
- Some key stakeholders were unavailable for interview due to pressing travel and other business, and some declined to be interviewed.
- Last minute changes to the scheduled in-country interviews meant it was not practical for the Evaluation Health Lead to participate in any of these interviews as had been previously anticipated.
- There were quality issues with some partner reporting, and also unavailability of some relevant partner reports.
- There was some inconsistency in data recorded by the MHMS.

Annex 3 Key Evaluation Questions

KEQ1: To what extent has MFAT's health activities in Kiribati achieved (or is achieving) expected outcomes?	**Sub-question 1.1: To what extent has the support contributed to improving the quality and coverage of health services in Kiribati?** **Sub question 1.2: To what extent has the support contributed to improving the inclusivity of health services in Kiribati?** **Sub question 1.3: How likely are the investments made by MFAT likely to be sustainable, i.e. that the benefits will endure beyond the support funding cycle?**
KEQ2: How are these outcomes contributing to progress against the 2025-2027 Kiribati Plan STO4?	Sub-question 2.1: What factors (within MFAT's span of control) most supported (or are supporting) progress towards STO4? Sub-question 2.2: What were the most significant challenges to achieving these short-term outcomes? Sub-question 2.3: To what extent has the impact of MFAT's health activities contributed to strengthening the health system in Kiribati?
KEQ3: To what extent is MFAT's health programming aligned with sector needs and Government of Kiribati priorities?	Sub-question 3.1: To what extent is MFAT's health programming complementary and well-coordinated across Government of Kiribati priorities, strategies, plans and systems? Sub-question 3.2: To what extent is MFAT's health programming coordinated with other development partners working in Kiribati, avoiding duplication of resources and efforts?
KEQ4: How can MFAT ensure NZ support is optimally balanced across priorities and implementing partners in order to achieve impact?	Sub-question 4.1: To what extent is MFAT's health programming complementary and well-coordinated internally within MFAT? Sub-question 4.2: Are there more effective and efficient approaches for NZ to deliver health support in Kiribati? Sub-question 4.3: What lessons learned could MFAT consider in the design of future health sector support (including other health initiatives MFAT is supporting in the Pacific and elsewhere that could be adapted to Kiribati)?

Annex 4 Organisations Consulted

- Asian Development Bank (ADB)
- Australian High Commission, Tarawa (AHC)/Australia Department of Foreign Affairs and Trade (DFAT)
- Caritas New Zealand
- Child Community Nursing Outreach Programme (CCNOP)
- ChildFund Kiribati
- ChildFund NZ
- Fred Hollows Foundation NZ
- International Planned Parenthood Federation (IPPF)
- Kiribati Family Health Association (KFHA)
- Kiribati Institute of Technology (KIT)
- Kiribati Ministry of Finance and Economic Development (MFED)
- Kiribati Ministry of Health and Medical Services (MHMS) Health Policy Adviser
- Kiribati MHMS - Hospital Services
- Kiribati MHMS - Nursing Services
- Kiribati MHMS - Public Health (NCD Department)
- Kiribati MHMS - RMNCAH
- Kiribati Secretary of Health
- Leprosy Mission NZ
- New Zealand Ministry of Foreign Affairs and Trade (MFAT)/NZHC Tarawa
- Sexual Wellbeing Aotearoa (SWA)
- Teitoiningaina Women's Centre
- United Nations Children's Fund (UNICEF) Pacific (Kiribati Field Office)
- UNICEF Aotearoa
- United Nations Population Fund (UNFPA)
- World Health Organization (WHO).

Annex 5 Relevant Documents

Bilateral Activities

Health Policy Adviser TA	SKR Enterprises	Contract for Services (CFS)
Health Policy Adviser TA	SKR Enterprises	CFS LOV1
Health Policy Adviser TA	SKR Enterprises	CFS LOV2
Health Policy Adviser TA	SKR Enterprises	CFS LOV4
Health Policy Adviser TA	SKR Enterprises	CFS LOV6
Health Policy Adviser TA	SKR Enterprises	CFS LOV7
Healthy Families Phase 3	SWA	Activity Design HFP Phase 3
Healthy Families Phase 3	SWA	Grant Funding Arrangement with Sexual Well-being Aotearoa
Healthy Families Phase 3	SWA	Annual Progress Report 2022
Healthy Families Phase 3	SWA	Evaluation of KHF Phase 2
Healthy Families Phase 3	SWA	Annual Report 2025
Healthy Families Phase 3	SWA	Mid-Term Review Report October 2023
Healthy Families Phase 3	SWA	Evaluation of MERL for HFP November 2024
Healthy Families Phase 3	SWA	Research Report 2025
Healthy Families Phase 4	SWA	Annual Progress Report 2021
Healthy Families Phase 5	SWA	Annual Progress Report 2023
Healthy Families Phase 6	SWA	Annual Progress Report 2024
Healthy Families Phase 7	SWA	Annual Progress Report 2025
Healthy Families	KHFA/SWA	Healthy Families Phase 3 AMA 2020-2021
Healthy Families	KHFA/SWA	Healthy Families Phase 3 AMA 2021-2023
Healthy Families	KHFA/SWA	Healthy Families Phase 3 AMA 2023-2024
Healthy Families	KHFA/SWA	Healthy Families Phase 3 Business Case
UNICEF Public Health Support 2020-2025	UNICEF	Annual Report 2021
UNICEF Public Health Support 2020-2025	UNICEF	Funding Agreement
UNICEF Public Health Support 2020-2025	UNICEF	Proposal for funding
UNICEF Public Health Support 2020-2025	UNICEF	Journal article Appleford et al. (2021)
UNICEF Public Health Support 2020-2025	UNICEF	Costed workplan Jan 2024-Jun 2025
UNICEF Public Health Support 2020-2025	UNICEF	Costed workplan Mar 2025-Jun 2026
UNICEF Public Health Support 2020-2026	UNICEF	Annual Report 2021 (financials)
UNICEF Public Health Support 2020-2027	UNICEF	Annual Report 2022
UNICEF Public Health Support 2020-2028	UNICEF	Annual Report 2022 (financials)
UNICEF Public Health Support 2020-2029	UNICEF	Annual Report 2023

UNICEF Public Health Support 2020-2030	UNICEF	Annual Report 2023 (financials)
UNICEF Public Health Support 2020-2031	UNICEF	Annual Report 2024
UNICEF Public Health Support 2020-2032	UNICEF	Annual Report 2024 (financials)
UNICEF Public Health Support 2020-2033	UNICEF	Annual Report 2025
UNICEF Public Health Support 2020-2034	UNICEF	Annual Report 2025 (financials)
NCD Strategic Plan 2020-2023	MHMS	Grant Funding Arrangement
NCD Strategic Plan 2020-2023	MHMS	Kiribati NCD Strategic Action Plan 2020-2023
NCD Strategic Plan 2020-2023	MHMS	LOV1 (extension to end date)
NCD Strategic Plan 2020-2023	MHMS	LOV2 (extension to end date)
NCD Strategic Plan 2020-2023	MHMS	MHMS GFA Budget 2023
NCD Strategic Plan 2020-2023	MHMS	MHMS GFA Budget 2024
NCD Strategic Plan 2020-2023	MHMS	MHMS GFA Budget 2021
NCD Strategic Plan 2020-2023	MHMS	MHMS NCD Workplan 2021
NCD Strategic Plan 2020-2023	MHMS	MHMS Progress Report 2020 Jul-2021 Jun 2020
NCD Strategic Plan 2020-2023	MHMS	MHMS Progress Report 2020 Jul-Dec
NCD Strategic Plan 2020-2023	MHMS	MHMS Progress Report 2021 Jul-2022 Jun
NCD Strategic Plan 2020-2023	MHMS	MHMS Progress Report 2022 Jul-Dec
NCD Strategic Plan 2020-2023	MHMS	MHMS Progress Report 2023 Jan-Jun
NCD Strategic Plan 2020-2023	MHMS	MHMS Progress Report 2023 Jul-Dec
NCD Strategic Plan 2020-2023	MHMS	MHMS Progress Report 2024 Jan-Jun
NCD Strategic Plan 2020-2023	MHMS	MHMS Progress Report 2024 Jun-Dec
Medical Assistant Training	MHMS	Financial reconciliation May 2025
Medical Assistant Training	MHMS	Grant Funding Arrangement
Medical Assistant Training	MHMS	Progress Report (Establishment) 2023 Nov
Medical Assistant Training	MHMS	Progress Report 2024 Jan-Jun
Medical Assistant Training	MHMS	Progress Report 2024 May-Dec
Medical Assistant Training	MHMS	Whole of life budget
Medical Assistant Training	MHMS	LOV1 (extension to end date)
Medical Assistant Training	MHMS	Public Health Support AMA 2021-2023
Medical Assistant Training	MHMS	Public Health Support AMA 2023-2024
Medical Assistant Training	MHMS	Public Health Support Business Case
Medical Assistant Training	MHMS	Public Health Support - Ministerial submission for funding approval
Public Health Clinics	MHMS	Funding proposal
Public Health Clinics	MHMS	Grant Funding Arrangement
Public Health Clinics	MHMS	LOV2 (extension to end date)
Public Health Clinics	MHMS	MHMS technical design
Public Health Clinics	MHMS	Progress Report 2021 Jun-2022 May
Public Health Clinics	MHMS	Progress Report 2022 Jul-Dec
Public Health Clinics	MHMS	Progress Report 2023 Jul-Dec

Public Health Clinics	MHMS	Progress Report 2024 Jan-Jun
Public Health Clinics	MHMS	Progress Report 2024 Jul-Dec
Public Health Clinics	MHMS	Progress Report 2025 Jan-Jun
Public Health Clinics	MHMS	Project Status Report August 2025
Public Health Clinics	MHMS	Public Health Clinics Business Case
Public Health Clinics	MHMS	Public Health Clinics AMA 2021-2023
Public Health Clinics	MHMS	Public Health Clinics AMA 2023-2024
Public Health Clinics	MHMS	Public Health Clinics Activity Variation Request
Review of Kiribati Diploma of Nursing Curriculum	Wintec	Contract for Services (CFS)
Review of Kiribati Diploma of Nursing Curriculum	Wintec	Review of Kiribati Nursing Curriculum 2017
Nursing Curriculum Redesign	Wintec	Additional Support Phase Completion Report
Nursing Curriculum Redesign	Wintec	Additional Support Phase Evaluation Report
Nursing Curriculum Redesign	Wintec	Advanced Diploma of Nursing Level 6 Tech Doc
Nursing Curriculum Redesign	Wintec	Needs Analysis and Implementation Report
Nursing Curriculum Redesign	Wintec	Clinical Placement Plan
Nursing Curriculum Redesign	Wintec	Benchmarking Report
Nursing Curriculum Redesign	Wintec	LOV
Nursing Curriculum Redesign	Wintec	Inception Report
Nursing Curriculum Redesign	Wintec	Contract for Services (CFS)
Nursing Curriculum Redesign	Wintec	Proposal
Tarawa Hospitals Master Plan and Design	Jacobs	NBH Clinical Services Plan
Tarawa Hospitals Master Plan and Design	Jacobs	NBH Jacobs Kiribati Hospital Business Case Final
Tarawa Hospitals Master Plan and Design	Jacobs	NBH Jacobs Kiribati Hospital Masterplan
Betio Hospital - Construction Management	Egis NZ	NBH Incinerator Environmental Licence
Betio Hospital - Construction Management	Egis NZ	NBH Stage 1 Asset Maintenance Manual
Betio Hospital - Procurement, Design Services & PM	Jacobs NZ	NBH Geotechnical Investigation and Analysis Report
Betio Hospital - Procurement, Design Services & PM	Jacobs NZ	NBH Building Compliance Assessment
Betio Hospital - Procurement, Design Services & PM	Jacobs NZ	NBH Clearance Letter NBH Sustainability Report
Betio Hospital - Procurement, Design Services & PM	Jacobs NZ	NBH Concept Design Report
Betio Hospital - Procurement, Design Services & PM	Jacobs NZ	NBH Endorsement Letter EIA Report
Betio Hospital - Procurement, Design Services & PM	Jacobs NZ	NBH ESIA Stakeholder and Management Plan
Betio Hospital - Procurement, Design Services & PM	Jacobs NZ	NBH ESIA
Betio Hospital - Procurement, Design Services & PM	Jacobs NZ	NBH Fire Engineering Report

Betio Hospital - Procurement, Design Services & PM	Jacobs NZ	NBH Functional Brief
Betio Hospital - Procurement, Design Services & PM	Jacobs NZ	NBH Sustainability Report
Betio Hospital - Procurement, Design Services & PM	Jacobs NZ	NBH MHMS Additional Scope Prioritisation
Betio Hospital - Procurement, Design Services & PM	Jacobs NZ	NBH Schedule of Accommodation for Concept Design
UXO Investigation	Milsearch	NBH Certificate of UXO Clearance
Betio Hospital - ECI Services Supplier	Reeves Construction	NBH Detailed Survey Temakin Hospital
Betio Hospital - ECI Services Supplier	Reeves Construction	NBH Developed Design Buildability & Delivery Report
Betio Hospital - ECI Services Supplier	Reeves Construction	NBH Workshop 1 Outcomes Report
Betio Hospital - ECI Services Supplier	Reeves Construction	NBH Workshop 2 Outcomes Report
Betio Hospital - ECI Services Supplier	Reeves Construction	NBH Workshop 2 Outcomes Report
New Betio Hospital - Construction Contract	Reeves Construction	NBH Certificate of Occupancy
New Betio Hospital - Construction Contract	Reeves Construction	NBH Incinerator Site UXO Certificate Report
New Betio Hospital - Construction Contract	Reeves Construction	NBH O&M Manual - DRAFT

Multilateral Country activities

UNFPA	**6 Month Report 2025 Jan-Jun**
UNFPA	Annual Report 2024
UNFPA	Annual Report 2023
IPPF	Annual Report 2024
IPPF	Annual Report 2023
IPPF	Niu Vaka Strategy
MHMS	AMA 2023
MHMS	AMA Sept 2023
MHMS	Business Case
MHMS	Theory of Change
PPTC	Business Case
PPTC	AMA 2023
PPTC	AMA 2024
PPTC	Progress Report 2025 Jan-Jun
PPTC	Progress Report 2024 Jan-Jun
PPTC	Annual Report 2024
UNICEF Pacific	AMA 2024
UNICEF Pacific	AMA 2023
UNICEF Pacific	Annual Report 2024
UNICEF Pacific	Progress Report July 2025
UNICEF Pacific	Annual Report 2023
UNICEF Pacific	Business Case
Pasifika Medical Assoc	2025 Q2 Report
Pasifika Medical Assoc	2025 Q1 Report
Pasifika Medical Assoc	2024 Annual Report Kiribati Country Summary

Pasifika Medical Assoc	2024 Annual Report
Pasifika Medical Assoc	Design (Kiribati Aide Memoire)
Pasifika Medical Assoc	Theory of Change
Pasifika Medical Assoc	MERL workplan
Pasifika Medical Assoc	MERL Framework
Pasifika Medical Assoc	AMA 2024
Pasifika Medical Assoc	AMA 2025
Pasifika Medical Assoc	Previous Activity Completion Report
Pasifika Medical Assoc	Business Case
Pasifika Medical Assoc	Design
SPC	Annual Report
SPC	Annual Report PPTX
WHO	Draft MERL Framework
Leprosy Mission NZ	AMA Year 1
Leprosy Mission NZ	Kiribati Design Docs
Leprosy Mission NZ	AMA Year 2
Leprosy Mission NZ	Year 1 Report
Leprosy Mission NZ	Year 2 Report
ChildFund NZ	AMA 2023
ChildFund NZ	Annual Report 2023
ChildFund NZ	AMA 2022
ChildFund NZ	Annual Report 2022
ChildFund NZ	Business Case
ChildFund NZ	Design
ChildFund NZ	Mid-term review Kiribati
ChildFund NZ	2025 Case Studies
ChildFund NZ	2025 Programme Review
ChildFund NZ	Draft Evaluation Report
CARITAS Aotearoa NZ	Kiribati Design
CARITAS Aotearoa NZ	AMA 2023
CARITAS Aotearoa NZ	AMA 2024
CARITAS Aotearoa NZ	Annual report 2023
CARITAS Aotearoa NZ	Annual report 2024 MERL
CARITAS Aotearoa NZ	Annual report 2024
CARITAS Aotearoa NZ	Mid-term review
UNICEF NZ	AMA 2022
UNICEF NZ	AMA 2023
UNICEF NZ	Annual Report 2024
UNICEF NZ	Human Interest Stories
UNICEF NZ	Kiribati Design
UNICEF NZ	MERL Framework with progress
UNICEF NZ	Six-month report 2025 Feb
Fred Hollows Foundation NZ	AMA 2023
Fred Hollows Foundation NZ	AMA 2024
Fred Hollows Foundation NZ	Annual Report 2023

Fred Hollows Foundation NZ	Annual Report 2025
Fred Hollows Foundation NZ	Design (Kiribati Aide Memoire)
Fred Hollows Foundation NZ	Annual Report 2024
Fred Hollows Foundation NZ	Annual Report 2025 results framework

Other relevant documents

Year	Title	Organisation
March 2025	Kiribati Health Sector Coordination Committee - Development Partner Matrix -	MFAT
2025	MFAT Kiribati Country Plan	MFAT
2021	MFAT Kiribati Four Year Plan	MFAT
n.d.	Kiribati National Health Strategic Plan 2024-2027	Government of Kiribati
n.d.	Kiribati National Health Strategic Plan 2020-2023	Government of Kiribati
n.d.	Kiribati Vision 2016-2036 (KV-20)	Government of Kiribati
n.d.	Kiribati National RMNCAH Policy, Strategy and Implementation Plan	Government of Kiribati
2025	RMNCAH Strategy Annual Report 2025	Government of Kiribati
2025	RMNCAH Strategy Annual Report 2025 (financials)	Government of Kiribati
n.d.	RMNCAH Strategy Grant Funding Arrangement	Government of Kiribati
2023	Kiribati Health Report	SPC
2023	Primary Healthcare System in Kiribati	World Bank

Annex 6 Evaluation Analytic Frameworks

Matrix for Effectiveness Assessment Criteria

Score	Description
1 - Very poor	There is no evidence, or the evidence demonstrates that NZ's Health Sector Support 2021-2025 (the Support) is not meeting any of the intended outcomes.
2 – Poor	There is little evidence, or the evidence demonstrates that the Support achieved very few of the intended outcomes and/or had some negative effects that somewhat compromised delivery of, or benefits of, the intended outcomes.
3 - Less than adequate	The evidence is weak, or it demonstrates that the Support achieved or is achieving few of the intended outcomes.
4 – Adequate	There is adequate evidence that demonstrates the Support achieved or is achieving some of the intended outcomes.
5 – Good	There is strong evidence that demonstrates the Support achieved or is achieving almost all the intended outcomes.
6 - Very good	There is strong evidence that demonstrates the Support achieved or is achieving all the intended outcomes.

WHO Health Systems Strengthening Framework

Domain	Definition
Leadership & Governance	
Health Service Delivery	An integrated, primary-health care-oriented approach to providing health services
Health System Financing	The funds and payment mechanisms needed to support the health system and ensure access to services
Health Workforce	The trained and motivated health workers required to provide services
Medical products, vaccines, and technologies	The reliable supply and management of essential medicines, vaccines, and other healthcare technologies
Health Information Systems	The systems for collecting, processing, analysing, and reporting health data, crucial for monitoring progress and making evidence-based decisions).

Annex 7 Progress Against Outcomes[114]

Activity	Partner	Progress against outcomes
NCD Strategic Plan	MHMS	To improve NCD prevention and control through coordinated multisectoral interventions Establishment of the National NCD Multi-sectoral Committee and Physical Activity Committee Establishment of a framework for the KNPHF The new Tobacco Bill 2025 has been read in Parliament Completion of a survey on kava drinking. To improve health system capacity for early detection and management of NCDs including through improved implementation of clinical guidance Capacity building has been undertaken for Package of Essential NCD (PEN) health care workers for early detection and management of NCDs, diabetic foot care, and diabetic retinopathy training. Improved systems for monitoring progress on NCD prevention and control leading to improved capacity to manage NCDs at all levels of the health care systems The STEPS survey has been completed.
Medical Assistants Training	MHMS	• *A higher number of certified MAs are providing health care in outer island health centres* Approx. 50% progress in training 12 MAs Theory component of training completed in July 2025 MHMS is delivering a supervised practical component.
Public Health	UNICEF	Primary health system capacities in five districts are strengthened to deliver quality Maternal Child Health and nutrition services Supportive supervision, incl. IMCI training etc 51% of health facilities are applying national service quality standards (up from 26% in previous reporting) 83% of health facilities are receiving routine supportive supervision (up from 40% in previous reporting). Caregivers in five districts have improved knowledge and skills to adopt recommended health and nutrition practices 64% of children aged 0-5 months old were exclusively breastfed. Community Based PHC or COP, Island Mgmt. Committees.
Healthy Families 3	KFHA/SWA	• *Sustained knowledge and skills through high quality professional development* Capacity building (48 nurses, 24 community-based health promoters, 35 youth volunteers trained) Workshops for Ministry of Education staff (82 teachers trained), schools (950 students trained), church youth (100 youth reached), and key groups (96 community members reached). • *Reduction in unmet need for contraception (Service Delivery)* Continued provision of clinical services and commodities, incl. condom distributions. Improved community access through mobile, after hours, and outer islands clinics, and home visits, In the last year KHFP (KFHSA/SWA)

114 Progress as reported in Annual Reports to MFAT and or AMAs.

Activity	Partner	Progress against outcomes
		worked in partnership with communities across South Tarawa and Betio, and six outer islands, to improve access to SRHR and FP. • *Community leaders advocate for sexual and reproductive health in their communities* Advocacy meetings (64 reached), engagements with island councillors and traditional leaders for island development plan support on all six outer islands, and the Tarawa and Betio urban councils on South Tarawa (308 leaders engaged). 91.7% of the community leaders can accurately articulate two (2) impacts that accessing SRHR has for I-Kiribati.
Betio Hospital		The overarching strategic project objectives (development outcomes) for MFAT and the Government of Kiribati were: *a) To achieve a healthy population with reduced burden from the impacts of over-crowding and disease.* *b) To improve health outcomes by providing quality, effective health services consistent with community needs. Functional, effective, and efficient hospitals are an important element in achieving this objective.* *c) To improve the condition of the facilities so that health care can be delivered in a way that is safe for patients, their families and for staff.* *d) To provide capacity that is sufficient to meet high and growing demand in the short to medium term.* *e) To improve resilience through mitigating risks to patients and service delivery at the facilities following a coastal flooding event.* This investment was completed in January 2025 with an official opening in October 2025.
Public Health Clinics		• *More sustainable, climate resilient, safe, and patient-friendly health clinics that are aligned to National Infrastructure Standards* 6 health clinics have been completed (25% of total) 3 health clinics almost complete, requiring minor amendments 5 health clinics are underway, with completion in early 2026 3 are to have started by end of 2025, and 8 have yet to be contracted with procurement (32%).
Health Policy Adviser	Contracted Consultant	Activity and Completion reports not available for this activity Provided inputs to the KNHSP 2024-2027 Reviewed the Medical Services Act and Nursing Act; reviewed MHMS policies Provided advice on the redesign of MHMS policies and standards; and strengthened the compliance of MHMS standards and internal health systems and governance mechanisms.
Nursing Curriculum Redesign		• *To support high quality education of nurses for employment in Kiribati to meet local health needs* The Associate Degree in Nursing is now more relevant to Kiribati's specific health needs. It incorporates the Nursing Cultural framework (developed with support from MFAT in 2020). • *To provide potential employment for Kiribati-educated nurses internationally.*