The gift of health:
Cuban medical cooperation in Kiribati

A thesis presented in partial fulfilment of the requirements for
the degree of

Master of Philosophy

in

Development Studies

at Massey University, Turitea, Palmerston North,
New Zealand

Cristine Werle

2020

Abstract

Since its 1959 Revolution, Cuba has assisted more than 160 countries to deliver health care to the poorest and most remote communities in the world. Cuba draws on its experience of expanding primary care and building health workforce capacity with limited resources to help partner countries to develop their own comprehensive health systems. This example of South-South Cooperation reached Kiribati, a Pacific nation at the forefront of climate change where a combination of scattered geography, public health issues and insufficient health workforce continue to be barriers to the achievement of universal health coverage and the fulfilment of the right to health. Cuba has offered scholarships for I-Kiribati[1] students to undertake medical education at the *Escuela Latinoamericana de Medicina* (Latin American School of Medicine, or ELAM) and nearly doubled Kiribati's health workforce. While much of the literature on the Cuban medical cooperation analyses the programme itself, less has been said about the way it functions in particular contexts, particularly in small nations such as Kiribati.

This thesis analyses how the Cuban health care model aligns with understandings of health in Kiribati, focusing on the similarities and differences between the countries' health care systems, on the experiences of I-Kiribati doctors in translating the training received in Cuba to the Pacific context, and on the successes and limitations of the Cuban outreach. I argue that the Kiribati health system, and most of health assistance offered through traditional aid channels to Kiribati, focuses on a curative model of care that is not sufficiently responsive to the reality of the country. Drawing on Maussian gift theory to explore the value of reciprocal exchanges in international development, this study concludes that the Cuban approach to foreign assistance is primarily oriented by an ethos of solidarity that differs from conventional aid and which has the potential to provide an alternative way forward to deliver the gift of health to the global community. However, this approach does not always translate easily into Pacific health contexts and more work is needed to integrate the skills and knowledge of the Cuban-trained graduates and best use the gift of health they represent.

[1] A native or inhabitant of Kiribati (Teiawa, 2015).

Acknowledgements

My heartfelt appreciation to my supervisor, Dr. Sharon McLennan, for her words of encouragement, her valuable insights and for generously giving her time throughout this research journey. I am thankful to Dr. Helen Leslie and Dr. Robert Huish for sharing their knowledge about the Cuban medical cooperation and the Pacific development landscape during this research. I am also grateful to the Massey Development team for their help with contacts and accommodation arrangements in Kiribati and for their unwavering enthusiasm with every student's project.

I would like to acknowledge the Ministry of Health and Medical Services of Kiribati and express my gratitude for the support received for this research. I am grateful to the Cuban and Cuban-trained doctors, the supervisors of the Kiribati Internship Training Programme, the I-Kiribati health workers and community for gifting me their time and attention during my visit to Kiribati. A special thanks to Teikarawa Tekinene for his friendship and for his assistance during fieldwork.

I am grateful for having received financial support from Massey University and the Ministry of Foreign Affairs and Trade of New Zealand, which enabled me to complete fieldwork in Tarawa and to dedicate more time to this research. I would also like to acknowledge the staff of the New Zealand Embassy in Kiribati, who were always ready to help.

As always, I thank my family for loving me and always being there for me.

Korabwa, muito obrigada, muchas gracias and thank you!

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Abbreviations

ADB	Asian Development Bank
DAC	Development Assistance Committee
DFAT	Department of Foreign Affairs and Trade, Australia
ELAM	Escuela Latinoamericana de Medicina
FTMG	Foreign Trained Medical Graduates
GoK	Government of Kiribati
IMF	International Monetary Fund
KITP	Kiribati Internship Training Programme
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
MDG	Millennium Development Goal
MFAT	Ministry of Foreign Affairs and Trade, New Zealand
MINREX	Ministerio de Relaciones Exteriores, Cuba
PHC	Primary Health Care
PICS	Pacific Island Countries
SDG	Sustainable Development Goal
SIDS	Small Island Developing States
SSC	South-South Cooperation
UHC	Universal Health Coverage
UN	United Nations
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Chapter 1: INTRODUCTION

Despite the geographical distance, Kiribati and Cuba share multiple coincidences. The Pacific and the Caribbean island nations develop at the fringe of globalisation, are particularly vulnerable to climate change and have to deliver health care in a low resource setting. Although facing similar adversities, while I-Kiribati people suffer from a triple burden of disease, Cuba has one of the most equitable health systems in the world, and Cubans enjoy a life expectancy on par with developed countries (Pineo, 2019). Cuba is not in a position to give away assets or resources. Nonetheless, its medical cooperation reached the Pacific region. Working through bilateral cooperation with host governments, Cuba draws on its experience of building health care capacity with limited resources to help recipient nations with the development of sustainable health care services and systems of their own (Huish, 2014). This example of South-South-Cooperation (SSC) has global reach and is considered a major driver for improvement of health sector in countries that face critical challenges, including in the Pacific (MINREX, 2013). Cuba's emphasis on rural, primary and preventative health care and focus on the development of human resources rather than expensive technology is a strategy responsive to the realities of developing countries and largely considered as key element for the success of the cooperation (Anderson, 2010b).

In Kiribati, Cuba's medical outreach works in two fronts. First, Cuba sends medical brigades to Kiribati to deliver much-needed health care services and to build capacity of local medical colleges. At the time of writing there were 5 Cuban doctors in Kiribati. Second, I-Kiribati students receive scholarships to study at ELAM. The students spend their first year in Cuba in a pre-medical course where they study Spanish and engage in an internship training programme for two years upon return to the Pacific. The completion of the internship aims to consolidate graduate's clinical knowledge and skills and to assist them into gradually take responsibility for safe and quality delivery of health care (Condon, Duvivier, Kafoa, Kirition, McKimm & Roberts, 2013). There are currently 23 Cuban-trained I-Kiribati graduates, with a further 10 still training in Cuba (Alzugaray, 2018), and these will replace the Cuban doctors working in Kiribati and significantly increase the number of doctors in the country. While the work done by Cuban doctors has been highlighted by the Government of Kiribati (GoK) as instrumental to improving health outcomes and strengthening the country's health system (MINREX, 2013), issues related to language barriers, costs of accreditation tests, insufficient

practical training and limited local capacity to assess interns have been reported across the Pacific (ABC News, 2015, 2018).

Much of the literature on the Cuban approach to medical cooperation analyses the programme itself. Less has been said about the way it functions in particular contexts, particularly in small nations such as Kiribati. This research therefore aims to analyse how the Cuban health care model aligns with understandings of health in Kiribati. The research seeks to interpret and understand similarities and differences between the countries' health care models, how they are translated to practice through the Cuban programme and how they integrate with meanings of health in Kiribati. This study is underpinned by a framework of reciprocity and solidarity based on gift theory (Mauss, 1990) and draws on work on solidarity and SSC by Huish (2014) and Mawdsley (2014). It is centered on the principle that access to the highest attainable level of health is a fundamental right to every human being (WHO, 1948).

The relevance of the research rests on its potential to provide a deeper account of the understandings and perspectives of actors involved in the implementation of the Cuban programme, with special focus on the views of Cuban-trained graduates and I-Kiribati community. This thesis offers perceptions about the intersection of Cuban and I-Kiribati health approaches and the impact of Cuban medical aid cooperation. This work also provides insights about the benefits and the institutional and cultural challenges of providing medical outreach within the scope of international development cooperation. Ultimately, I hope to contribute to knowledge about how Cuba's model of SSC can represent an alternative to the traditional aid paradigm.

1.1 Research aim, questions and objectives

Research Aim: To analyse how the Cuban health care model aligns with understandings of health in Kiribati.

1: What is the Kiribati health care context?

Objective 1.1: Describe the structure of the health sector in Kiribati.

Objective 1.2: Identify current issues and needs in the delivery of health care in Kiribati.

Objective 1.3: Explore similarities and differences between Cuba's and Kiribati's approach to health care.

2: How is the Cuban approach to health translated by Cuban-trained doctors in Kiribati?

Objective 2.1: Explore the scope of practice of Cuban-trained doctors in Kiribati.

Objective 2.2: Explore Cuban-trained doctors' experiences of transitioning into medical practice in Kiribati.

Objective 2.3: Describe the interaction between Cuban-trained doctors and the I-Kiribati community.

3: How is Cuba's solidarity model expressed in Kiribati?

Objective 3.1: Examine the incorporation of ideas of reciprocity and solidarity in Cuba's cooperation with Kiribati.

Objective 3.2: Investigate how ideas of reciprocity are expressed in the practice of Cuban-trained doctors.

1.2 Thesis outline

This thesis consists of 8 chapters. This chapter started with an introduction of the research topic and an explanation of the significance and the relevance of investigating the Cuban medical cooperation in Kiribati. The previous section discussed the aim, questions and objectives of the research, and this section presents a thesis outline.

Chapter 2 explores the context in which Cuba provides medical outreach, the emergence and significance of SSC and the role of aid in constructing postcolonial regimes of power. The chapter presents the gift theory and explains how various understandings of reciprocity and solidarity sustain different development agendas and produce distinct outcomes.

Chapter 3 introduces the principle of health as a fundamental human right. The chapter investigates health ideologies, discusses the importance of the Declaration of Alma-Ata and examines connections between normative understandings of health and rampant global health inequities. The chapter then offers a review of the literature about the origin and evolution of the Cuban health model. It explores how Cuba organises a health care system that has prevention as the backbone and the fulfilment of the right to health as an underlying principle. The chapter then discusses the beginning of Cuban internationalism and examines how different understandings of reciprocity produce distinct opinions about the possible motivations behind Cuba's internationalism.

Chapter 4 discusses the purpose and the logic behind the selected methodological approach for this study. Research design will cover the reasons behind the selection of field site and participants, the chosen methods of data collection and analysis, and how those plans developed in practice. The chapter will also explain the ethical considerations that underpin this research and that guided both the writing and the fieldwork processes.

Chapter 5 offers background information and research findings about health and health care delivery in Kiribati. It introduces the Pacific nation's historic and geographic context, the main health challenges and how climate change affects social and environmental determinants of health. The chapter investigates the structure of Kiribati's health system, the priorities of health strategies, the main barriers to strengthen health care delivery and the role of Official Development Assistance (ODA) donors in helping the Pacific nation to achieve better health outcomes.

Chapter 6 presents data collected about the Cuban programme during fieldwork in South Tarawa. The chapter shares the perceptions of research participants about the Kiribati health care system, the Cuban medicine, the medical cooperation in Kiribati and the establishment of the Kiribati Internship Training Programme (KITP). To develop an understanding about how the Cuban medical cooperation aligns with understandings of health in Kiribati, the chapter examines the implications of the influx of Cuban-trained doctors in the Pacific nation, the similarities and differences between both countries' health care models and approaches to medicine and the impact and potential for contribution of the Cuban medical cooperation.

Chapter 7 ties the themes that emerged in previous chapters with reflections about the place of Cuba in the global health landscape and the potential held by the cooperation to provide an alternative to mainstream aid approaches. The chapter uses gift theory to analyse how the valorisation of reciprocal exchanges can distinguish the Cuban and traditional aid approaches in the Pacific. Chapter 8 draws on previous chapters to discuss themes in relation to the research aim and to present conclusive reflections prompted by the broader research questions.

Chapter 2: THE GIFT AND DEVELOPMENT APPROACHES

This chapter demonstrates how power is embedded in aid structures and mechanisms and contextualises the emergence and significance of SSC, of which Cuba is an important but often unacknowledged actor. The chapter explains how Maussian (1990) gift theory can be used as theoretical basis to study the nature of donor-recipient relationships and discusses what the transition of many nations from the position of recipient to donor means to the development landscape.

2.1 Aid and regimes of power

Many countries classified as developing share the experience of being colonised by countries classified as developed (Rist, 2002). The much-cited 1949 inaugural speech of American President Harry Truman, arguably considered the inauguration of development, captures the idea that the world is divided between the wealthy and industrialised global North and the primitive and stagnant global South. Truman's speech was pivotal because it incorporated aid to poor nations as an important component of foreign policy and because it understood aid according to modernist ideals that equate progress and wellbeing with industrialisation, urbanisation and capital accumulation.

The United States of America's (USA) aid commitment to poor countries grew into a highly organised structure with global reach. This began prior to Truman's speech, with the USA playing a dominant role among leading allied nations on the establishment of the Bretton Woods system in 1944 (Rist, 2002). Established towards the end of World War II to set up rules, institutions and procedures for international economic cooperation, the system's objective was to harmonise its members' monetary policies and maintain exchange stability. Following this, in the 1960s along with other high-income, mostly European states, the USA founded the Development Assistance Committee (DAC) at the newly formed Organisation for Economic Co-operation and Development (OECD). The OECD was created as a platform to facilitate the coordination of policies and the identification of best practices and solutions to common problems between developed countries. DAC's objective was to enable the

coordination of aid to poorer countries (Kothari, 2005). In 1969, DAC adopted the term Official Development Assistance (ODA) to refer to aid provided by donor governments to developing countries (Rist, 2002). Most DAC nations approach ODA through bilateral programmes, or through multilateral organisations, where assistance provided by many governments is pooled and then distributed to aid initiatives in developing nations (Kothari, 2005).

Institutions created during the now extinct Bretton Woods system (1944–1973), namely the International Monetary Fund (IMF) and the World Bank, occupy a central position in the allocation of aid funds. As multilateral organisations need the IMF's approval to release money to developing nations, commercial, political and military conditionalities that serve the interests of donors and that massively affect developing countries are common practice (Farmer, 2005; Reality of Aid, 2010). Schemes like the Structural Adjustment Programs (SAPs), implemented in the 1980s in Latin America and Africa, imposed economic reforms as conditions for loans that lowered even more the standard of living of poorer nations and increased their dependency on foreign assistance.

The past two decades have seen significant shifts in the focus of development aid, reflected in the OECD's endorsement of the Paris Declaration[2] (2005) and of the ensuing Accra Agenda for Action[3] (2008), which aimed to make aid more effective by aligning strategies with local systems, increasing donor coordination and accountability. However, these mechanisms were criticised for being technocratic and for measuring aid ownership according to Western standards (Kothari, 2005). The widely endorsed 2011 Busan Partnership for Effective Development Cooperation was also considered by some to have marked the evolution of aid approaches and recognised the importance of sustainable development (South Centre, 2009). Principles of sustainability, inclusiveness, equity and justice were further developed and crystallised in the Millennium Development Goals[4] (MDGs) and the Sustainable Development Goals[5] (SDGs) (UNDP, 2015). Bilateral donors and multilateral organisations increased their

[2] The Paris Declaration, endorsed at the Second High Level Forum on Aid Effectiveness (2005), is a roadmap to improve the quality and impact of aid based on the principles of ownership, alignment, harmonisation, managing for results and mutual accountability (OECD, 2020).
[3] The Accra Agenda for Action, endorsed at the Third High Level Forum on Aid Effectiveness (2008), both reaffirms commitment to the Paris Declaration and calls for greater partnership between different parties working on aid and development (OECD, 2020).
[4] MDGs are a collection of 8 goals that were adopted by all UN member states in 2000 as a global call to combat poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women by 2015 (UNDP, 2015).
[5] SDGs are a collection of 17 global goals adopted by all UN Member States in 2015 as a universal call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity by 2030 (UNDP, 2015).

foreign aid contributions, organised in part around the MDGs and the SDGs (Mawdsley, 2019; UNDP, 2015).

Although providing a platform to make countries accountable, MDGs were criticised for focusing almost exclusively on poor countries and for being an agenda produced by developed to developing nations (Horner & Hulme, 2017). Among the critiques towards the SDGs, idealised to not leave anyone behind, are the use of financial terms to measure the effectiveness of partnerships and the lack of targets addressing the need for changes in wealthier populations (Donald & Saiz, 2017; Esquivel, 2016). Although providing platforms to enhance accountability, the MDGs were particularly criticised for being produced by developed to developing nations, and the SDGs for not addressing the need for changes in wealthier populations and for measuring the effectiveness of partnerships in financial terms (Donald & Saiz, 2017; Esquivel, 2016; Horner & Hulme, 2017).

These are the traditional aid structures and mechanisms that still largely in place in the current development landscape. For Dijkstra (2015), traditional aid allocations are still embedded in problems of selectivity, ownership and accountability. That happens because transnational corporations are still heavily involved in discussions that help shape international agreements governing trade, investment and property rights. Polanyi (2003) agrees and explains that, while some mechanisms have been developed for civil society to hold governments accountable, their leverage power is still limited in relation to transnational capital and large corporations with great capital capacity.

2.2 South-South Cooperation

Calls for emancipatory models became prominent as it became clearer that ODA donors translated historic power imbalances into structures that dictated the direction, term and volume of aid transfers (Spratt, 2018). Developing countries questioned the authority of multilateral organisations to shape international agreements and policies and their power of interference in sovereign nations' affairs (Kothari, 2005). These ideas were influenced by scholarly work that problematised the invisibility of poor people in social systems and questioned the use of the concept of development as a tool for Western geopolitical and ideological expansion (Binns, 2006; McGregor, 2009). That is the context in which SSC emerged and gained traction (South Centre, 2009).

Established at the Bandung Conference[6] in 1955, SSC aimed to consolidate a strong solidary force for self-initiated development and social justice between countries with a shared history of colonisation and vulnerability to neoliberal globalisation (Mawdsley, 2012). SSC's fundamental principles include mutual interest, peaceful co-existence, respect for national sovereignty, non-interference in internal affairs, equality amongst developing partners, respect for national independence, for cultural diversity and identity (South Centre, 2009). These critical fundamentals were established through technical cooperation, military alliances, cultural exchanges and the formation of negotiating blocs within multilateral institutions (The Reality of Aid Management Committee, 2010).

Since the Bandung Conference, Southern countries have increasingly been playing the role of donors, gaining greater voice on the resolution of international issues and gradually redefining development geographies (Mawdsley, 2019). According to Mawdsley (2019), the rise of SSC in terms of visibility, resources and ideational legitimacy led DAC donors to actively and strategically build relations with Southern partners through bilateral and trilateral cooperation. Issues of ownership were brought to the center of the global agenda and resulted in the creation of global mechanisms to address the effectiveness of aid in furthering human and economic development while respecting beneficiary countries' autonomy.

As observed by Mawdsley (2019), the rise of SSC has simultaneously created challenges that are resulting in a new set of imperatives and contexts for international development. Mawdsley (2017, p.114) argues that the "rise of the South" (UNDP, 2013) and other non-DAC development partners has "driven a genuine re-balancing – if a partial and still resisted one – in the international development architecture, development financing approaches and actors, and in shifting paradigms of aid, development and partnerships. For Mawdsley (2018), in the recent years the rhetoric and aid strategies of DAC nations are sounding more like SSC's discourses, as evidenced by the rhetoric of the MDGs and SDGs.

As aid geographies change and networks of assistance become more complex, developing countries have increased access to alternative resources and partnerships and no longer occupy the same subordinate position as in the past. A number of traditional donors, on the other hand, are experiencing higher levels of poverty and becoming especially wary of larger Southern economies, leading them to adopt Southern countries' discourse of mutual

[6] The Bandung Conference gathered representatives from 29 governments of Asian and African nations in Indonesia to promote Afro-Asian economic and cultural cooperation and to oppose colonialism or neocolonialism (South Centre, 2009).

benefit and solidarity. Mawdsley (2018, p. 179) places the nature of donor-recipient relationships at the core of the discussion, however, and emphasises that the DAC donors' approach will not enable them to appropriate the "claims to solidarity and mutual experience of colonial and post-colonial subordination".

The discourses of solidarity and challenge to the traditional aid paradigm have also been critiqued by some scholars who argue that SSC is excessively idealised and based on pragmatic principles that are less connected to ideals of solidarity (Bergamaschi, Moore & Tickner, 2017; Hickling-Hudson, 2004; Keijzer & Lundsgaarde, 2018). According to Mawdsley (2019), there are enough shifts in narratives and practices within and across SSC to support the idea that a more pragmatic and outcome-oriented phase is emerging, with less of the affective framing characteristic of earlier narratives. Most debates question whether Southern nations are more interested in securing resources, opening access to markets and strengthening diplomatic relations than in positively impacting other countries (The Reality of Aid Management Committee, 2010). A main point of contention is that, as non-members of OECD/DAC, Southern donors are not obliged to follow the principles of the Paris Declaration (Dijkstra, 2015). Cold-Ravnkilde, Fejerskov and Lundsgaarde (2016), as well as Kragelund (2019), highlight that Southern countries vary markedly in terms of resources and contributions, economic and political positionings, in past and present relations with partners, in discourses of assistance and experiences as aid recipients. Literature on SSC demonstrates that approaches to assistance are more nuanced than often portrayed, and specific country-based research like this study can help to reveal what determines the transformative potential of development models and the many forms of SSC in this new aid landscape.

2.3 Foreign aid and the gift

Mauss' (1990) essay The Gift explores how bonds are created in relationships of reciprocity. Despite being an anthropological approach, a number of authors have used gift theory to analyse international relations (Funaki, 2018; Henkel & Stirrat, 1997; Kapoor, 2008; Mawdsley, 2012). This makes sense when a state is understood as a wholesome entity, much like an individual, as proposed by Wendt and Duvall (as cited in Mawdsley, 2012). The interplay of states therefore can be subjected to concepts that are concerned with social relations. Hattori (as cited in Mawdsley, 2012) argues that international relation analysts often

focus on what aid does, but not enough attention is given to what aid is. If the grant element of assistance is categorised as 'gift', as explored in this thesis, Mauss' schema can reveal how power relationships are constituted in traditional aid approaches.

Mauss' (1990) conceptualisation of reciprocity is fundamentally connected to notions of social cohesion. His work is based on Malinowski's (as cited in Mauss, 1990) study of the kula exchange system, created by Melanesian clans and tribes to exchange bracelets and necklaces across the islands. He observed that groups had an obligation to reciprocate gifts with countergifts and that the quantity of items owned by a group indicated the number of partnerships established with other bands, reflecting the scale of one's influence in the network. Malinowski argued that it was the enhancement of political authority, and not the material value of the goods, that motivated people to travel long distances for those transactions. Mauss associated Malinowski's work with the potlatch, a ceremonial feast of American Indians marked by the extravagant distribution of valuable gifts by high-ranking groups to their guests. This exercise led Mauss to the conclusion that the distribution of items in both systems were a display of abundant wealth and generosity that served to validate higher status over rivals.

Mauss (1990) observed in the kula system and the potlatch ceremony an obligation to give, to receive, and to repay. This repayment was not exclusively expected in a tangible manner, but also in the form of expression of recognition of the gift giver's superiority by the gift receiver. He realised that there is no such thing as a free gift, and that the ability to reciprocate should be valued. For Mauss (1990, p.72), to accept a gift without "returning or repaying is to face subordination, to become a client and subservient". Mauss reflected that openly exploring shared interests with the potential of generating mutual satisfaction can replace dependence for exchange and help gift receivers to achieve liberation.

The power imbalance in gift exchanges was categorised by Sahlins (1997) as negative reciprocity, which entails the gift giver maximising its gains while enjoying impunity for harmful actions. This form of interaction was described by Mauss (1990) as the violence of the gift, which takes place in an unlevelled field where the gift giver demands a return from the gift receiver while denying that the exchange occurs under clear and negotiated terms. It is the gift giver who determines what forms of reciprocity are acceptable, and with the obligation to repay, gift receivers are entrapped in a position of perpetual obligation. Positive reciprocity, on the other hand, occurs when both parties agree on exchange conditions that are mutually beneficial (ter Meulen, 2017). Mauss believes that denying reciprocity turns the recipient into

a dependent of charity. Conversely, valuing reciprocal exchanges stimulates the creation of opportunities for gift receivers to exercise their autonomy. Gift theory allows us to see that general perceptions about international development are sustained by the idea that receivers of the gift of aid are inherently inferior. However, this notion of aid conveys a narrow understanding of poverty as an innate shortcoming, rather than the result of historical processes such as slavery, colonialism and the imposition of economic policies (Mawdsley, 2012).

In alignment with the discussion about the role of aid in constructing regimes of power (section 2.1), Hattori (as cited in Mawsley, 2012) identifies the features of negative reciprocity (Sahlins, 1997) in ODA. For him, the traditional donor-recipient relationship arises from a condition of material inequality that valorises (supposed) unreciprocated giving. While portrayed as fortunate beneficiaries, aid recipients often reciprocate the gift of aid by accommodating donor's harmful impositions, coated in a language of altruism. Fukuda-Parr, Lopes and Malik (2002) complement his idea when arguing that unequal access to resources is a functional requirement of the modern global system. Altruism is driven more by politics than by sustainable results, thus acting as a force on the establishment of hierarchies and the creation of cycles of dependency. Without the opportunity to actively engage in an honest exchange process, recipients of the gift of aid do not have space to self-development, becoming dependent on charity. Moreover, they are trapped in a system that rewards that dependence, consolidating existing structures of power that are maintained by traditional aid discourses. The irony of aid, as commented by Savedoff (2017), is that countries can often make a stronger case to receive assistance when they perform poorly and remain in a marginal position. As explained by Mauss (1990), the recognition of the gift giver's superiority repays and incentivises continuous generosity, but at the cost of the receiver's independence.

The positive view on reciprocity sees value on the recipient's ability to reciprocate the gift of aid and opens room for relationships based on mutual benefit. Mauss (1990) emphasises that relationships are a condition for the realisation of autonomy, instead of considering this autonomy as already given. This recognition is required for the creation of transparent mechanisms that enable those occupying subordinate positions in gift relations to negotiate terms of exchange on an equal footing. While altruism can obstruct self-development, positive reciprocity can support strategies that overcome constraints by enabling, easing and encouraging the development of resources already in power of disadvantaged actors. For this to be possible, however, development theorists and practitioners must be open to debate about new instruments and processes that address the causes rather than the symptoms of inequality.

2.4 Building solidarity through reciprocity

The language of solidarity is utilised by many development players to justify a range of agendas. Solidarity is usually understood as mutual support within a group and associated with ideas of altruism and charity (Featherstone, 2002). Based on Featherstone's (2002) and Mauss' (1990) work, this section argues that if we accept that solidarity has to be about unreciprocated giving, we undermine the role reciprocity plays in building transnational relations between places, activists and social groups. If we accept the value of reciprocity and the idea that, like inequality, solidarity can be built, marginalised players like Kiribati and Cuba can work together to challenge global systems of oppression.

Like Mauss (1990), Bourgeois (as cited in ter Meulen, 2017) claims that reciprocal exchanges create a bond between individuals and society. For him, individuals should help and support others against risks and injustices in recognition of the advantages they are able to enjoy for being part of that society. Bourgeois' idea of reciprocity allowed an expansion of the notion that solidarity emerged just among individuals and groups to the perception that it also occurred between generations. The relevance of this exercise lies in the realisation that each generation has a debt towards a previous one, and that is paid again to the future generations. The acknowledgement that social interrelationships have an atemporal dimension highlights the issue of inequality. This broader understanding of society led Bourgeois to argue that benefits and burdens should be shared in recognition that both the good and evil conditions in which individuals are born are determined by intergenerational dependencies. Featherstone's (2002) perception that solidarity is not a given, but that it emerges when individuals and societies work together on a common task, fosters the idea that marginalised nations should create ways to share those burdens and benefits with the global community.

The rationale for building solidarity through reciprocity has acquired a new meaning given the recent shifts in conventional donor's discourses discussed on section 2.1. While historically the traditional aid model had a negative view of reciprocity and was based on the valorisation of charitable approaches given their supposedly altruistic nature (Mawdsley, 2012), the current discourse is increasingly one of building solidarity through reciprocity, an approach traditionally advocated by SSC (Mawdsley, 2018). However, the utilisation of the gift theory suggests that this shift from a negative to a more positive view of reciprocity is based on a simplified understanding of reciprocity. Open negotiations about the terms of

exchange, meaning the conditions for the gift of aid to be given, are left out of the equation and, despite the rhetoric, reciprocal exchanges are not seen as avenues to contribute to the realisation of the gift recipient's autonomy (Mawdsley, 2012).

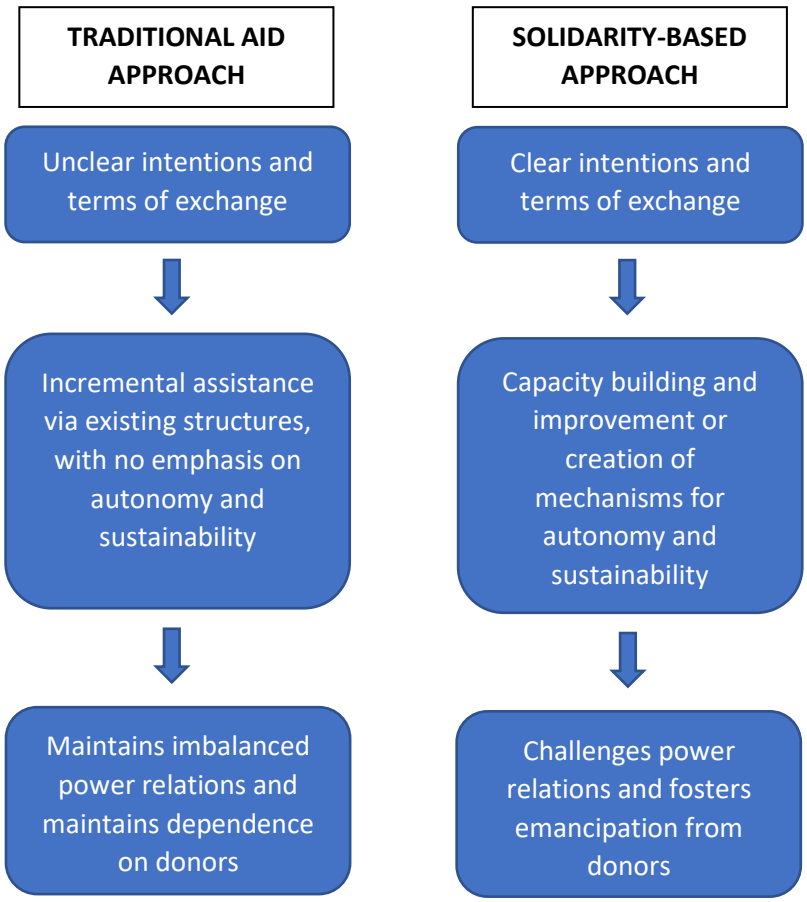
A simplified understanding of positive reciprocity, for instance, can be applied to justify tied aid. As Kothari (2005) explains, donors may provide aid to address social and economic development needs of developing countries while reducing the overall value of that transfer by ensuring that donor suppliers capture a component of the aid provided. The Prosperity Fund, launched in 2017 as part of the United Kingdom (UK) government's cross-government aid strategy, is a recent example. The Fund claims to reduce poverty by promoting inclusive economic growth while at the same time creating business opportunities for UK companies. Despite efforts to increase transparency, experts have been expressing major doubts about the fund's poverty impact given that its report includes no results data. Although middle-income countries (MICs) are home to nearly 60 per cent of the world's poor, the Fund's focus on providing assistance exclusively to MICs such as China, India and emerging markets also raises questions about its legitimacy (Edwards, 2019).

Keijzer and Lundsgaarde (2018, p. 212) posit that the classical ODA definition requires expenditure to have "promotion of the economic development and welfare of developing countries as its main objective". They argue that following this definition, mutual benefit cooperation would only be formally reportable as ODA if the donor's interest is of a secondary nature, as well as consistent with the main objective of producing developing country benefits. For them, that incentivises DAC donors to downplay self-interested motives in their programming documents, meaning that recipient countries are not fully aware of all the ways in which development programmes can reverberate and affect them. As tied aid has become more criticised, there is extra reason for real interests to be concealed. As argued by Keijzer and Lundsgaarde, that means that effects considered to be 'unintended' from the perspective of promoting development goals may, in fact, be intentional or already anticipated from a 'mutual' benefit perspective. Keijzer and Lundsgaarde observe that these are hinted at in overall strategies yet are not articulated and operationalised in planning documents. If objectives of donor countries' interventions are not made explicit, they cannot be properly evaluated. That means that donor's excesses can be concealed.

A framework that clarifies the conditions for positive reciprocity to take place, as well as the process by which solidarity is built is appropriate for an accurate representation of the current development landscape. I propose the following framework (Fig. 2.1) to differentiate

traditional aid approaches from solidarity-based approaches, which will serve as theoretical basis to analyse the potential of the Cuban medical cooperation to contribute to the development of Kiribati:

Fig. 2.1: Solidarity framework



Source: Author

As Bourgeois' (as cited in ter Meulen, 2017) conception of solidarity understands inequality as socially constructed, it shares with donors the responsibility to create new spaces for aid receivers to express agency through the exercise of reciprocity. If this reciprocity is conceived based on gift theory (Mauss, 1990), the intentions and terms of the exchange must be clear. Foreign assistance that seeks to build capacity and improve or create mechanisms for autonomy and sustainability challenges power relations and fosters emancipation from donors.

Concealing intentions and terms of exchange, on the other hand, accommodates hegemonic ideas that require development to occur within established boundaries. Perceiving inequality as an inherent characteristic of society and associating solidarity with ideas of pure altruism does not open room for the aid receiver to exercise reciprocity. As argued by Mauss (1990), this reinforces the superiority of the gift giver over the gift receiver. If the provision of assistance is incremental and delivered via traditional aid channels, no mechanisms will be created for gift receivers to exercise autonomy and develop sustainable solutions to their challenges. That means that imbalanced power relations persist and that the dependency cycle is maintained (Funaki, 2018).

2.5 Conclusion

This exploration about aid and regimes of power allows us to understand how traditional aid structures can change, while the nature of donor-recipient relationships remains the same. Gift theory helps us comprehend how traditional aid relations based solely on the valorisation of altruism limit scope for action and maintain developing countries in a marginal position. The theory also helps us to understand that the appropriation of SSC's discourse of solidarity by ODA donors has happened in a distorted manner. The conditions in which exchanges take place are often blurred, and the development initiatives seldom aim to build capacity and improve the agency of gift receivers in the global landscape. The solidarity framework illustrates how approaches that perceive solidarity as a movement that can emerge in opposition to regimes of power have the potential to transform the recipient-donor relationship and create a more balanced aid geography. This critical reflection helps to situate SSC in the development landscape and to understand the importance of investigating partnerships that appear to be based in solidarity, such as Cuban medical cooperation.

Chapter 3: CUBAN MEDICAL INTERNATIONALISM

Before exploring how the Cuban medical cooperation functions in Kiribati, it is necessary to understand the Cuban perspective in relation to medicine and international cooperation. As the Cuban health care model rests on the principle that health is a fundamental human right, the Cuban medical outreach can be seen as a gift of health that enables nations with insufficient capacity to provide adequate health care to their population. The first sections of this chapter explore how the right to health is expressed in the Universal Declaration of Human Rights (UDHR) (1948) and translated in curative and preventive health ideologies. The sections that follow examine the significance of the Declaration of Alma Ata (WHO, 1978) for upholding the right to health and the connections between normative understandings of health and rampant global health inequities. Sections 3.5 – 3.7 investigate how the solidarity principles that served as ideological basis for the 1959 Revolution guided the ethos of Cuban medicine and the establishment of a comprehensive health system model that has been extended to other nations. The section that follows shows how different understandings of reciprocity (see Chapter 2) produce distinct perceptions about the motivations behind the Cuban cooperation and explains how internationalism gives an additional dimension to Cuban solidarity.

3.1 The right to health

In 1948, the UDHR was adopted as a universal achievement for all peoples and all nations. The preamble to the Declaration declares that human rights and dignity are self-evident, the "highest aspiration of the common people", and "the foundation of freedom, justice and peace" (UN, 1948, p. 1). These rights are inherent because they are human, they apply to all people around the world and principally, they involve the relationship between the state and the individual. As observed by Brennan et. al (1994), nation states have invoked the UDHR legally and politically at the national and international level, despite the declaration not being of legally binding nature.

One of the key rights identified in the UDHR is the right to health. Brennan et al. (1994) suggest that the objective of linking health and human rights is to contribute to advancing well-

being beyond what could be achieved through an isolated health- or human rights-based approach. For Farmer (2005), the promotion and protection of health are fundamentally linked to the promotion and protection of human rights and dignity. This important connection is especially visible in Article 25 and Article 27 of the UDHR. Article 25 states that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control" (UN, 1948, p. 7). Article 27 enshrines that "everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits" (UN, 1948, p. 7). Together, these two articles call for universal health coverage (UHC) and the right to access to advanced medical treatments.

This link between health and human rights is also espoused by the World Health Organization (WHO), a multilateral institution with the primary role of directing international health within the UN system and leading partners in global health responses (WHO, 2018c). The Constitution of the WHO came into force in 1948, and presents the most far-reaching statement about the expanded scope of health for three main reasons. First, its preamble declares that "health is not merely the absence of disease or infirmity, but a state of complete physical, mental and social wellbeing". Second, it recognises that the enjoyment of the highest attainable standard of health is a fundamental human right. Third, it attributes to the state the responsibility of enabling all people to have access to health care. Together, WHO's affirmations establish UHC as a matter of ethical concern and political choice (Ghebreyesus, 2017).

3.2 Health ideologies

There are many nuances in ideologies of health, but a longstanding and polarised debate revolves around curative and preventive approaches to health care. The curative approach treats people after they fall ill, are injured or become impaired. The preventive approach aims to improve and maintain health before people fall ill (Agyepong, 2018). The curative approach to health is considered more efficient by the hegemonic health ideology, which rests on neoliberal principles and emphasises individual responsibility over state care (Baum et al., 2016). The counter-hegemonic ideology considers preventive care as the best way to achieve a healthy

population and places responsibility on the state for enabling all people to fulfil their right to health (Monheit, 2007).

The hegemonic health ideology views health as a commodity and associates market competition with overcoming bureaucratic hurdles and government corruption (Agyepong, 2018; Andrews, Basu, Kishore, Panjabi & Stuckler, 2012; Monheit, 2007). Proponents of this ideology argue that the understanding of the private sector as intrinsically efficient, and the definition of this efficiency mainly in relation to costs, places the measurement of results in the center of the health agenda. In this case, direct clinical work with clients is more valued than health promotion because its outcomes are more immediate, measurable and accountable (Baum et al., 2016).

Agyepong (2018) associates the preference for quantifiable approaches with the role played by multilateral institutions. As major financiers of health programmes in developing countries, multilateral institutions demand measurable results that can be demonstrated in short-term funding commitments. Curative, vertically controlled and technology-driven programmes are suitable as they offer the lure of quick visible wins on limited budgets with limited unpredictability. Baum et al. (2016) argue that a focus on clinical service provision, while highly compatible with neoliberal reforms, will not on its own produce the shifts in population disease patterns that would be required to reduce demand for health services and promote health. For them, comprehensive primary health care (PHC) is much better suited to that task.

The understanding of health as a human right and the achievement of UHC are central tenets of the counter hegemonic ideology. This rationale emphasises holistic and bottom up community engagement and social justice. The strengthening of health systems through the state is seen as the foundation on which sustainable interventions and health improvements rest (Agyepong, 2018). Monheit (2007) argues that government intervention in health care is especially appropriate when informational asymmetries and gaps in knowledge impede or distort individual choices (as in decisions to engage in risky health behaviours such as smoking and unhealthy eating or in the failure of health insurers to make coverage broadly available); when individual actions yield external benefits and costs that are not accounted for in private decision making (as in the decision to obtain a vaccination against a contagious disease or in production decisions that contribute to air and water pollution) and when informational asymmetries and gaps in knowledge impede or distort individual choices (as in decisions to

engage in risky health behaviours such as smoking and unhealthy eating or in the failure of health insurers to make coverage broadly available).

The ideologies of health presented in this section are a simplistic outline of the more complex and dynamic frameworks that determine ways in which global health problems are framed and inform health strategies. As development geographies change through movements like the 'Southernisation' of aid (see Chapter 2), health discourses seem to move from a curative to a preventive approach to care. PHC and UHC are now embedded in many health aid programmes, including those implemented by New Zealand (MFAT, 2019). The recent reaffirmation of commitment of many countries to the principles of the Declaration of Alma-Ata, explored in the next section, signals that preventive strategies could be moving to the centre of global health agendas (WHO, 2018a). How those discourses and commitments translate into practice is a debatable issue, and one that this thesis seeks to address.

3.3 Declaration of Alma-Ata

The Declaration of Alma-Ata emphasised the societal and environmental dimensions of health and called for a new international economic order that would benefit developing countries and empower democratic participation in health systems (Birn, 2018). Baum et al. (2016) note that the vision was developed during the rise of progressive social movements in the global North and a period of decolonisation in the global South, both of which challenged established power bases and embodied optimism for a less exploitative future.

Adopted in 1978 by 100 countries, the declaration underscores the WHO Constitution's principles of universal accessibility, community participation, intersectoralism and self-determination. More critically, Alma-Ata explicitly identifies PHC as a key point to be addressed if those values are to be honoured. It associates the provision of strong primary care with continuity for patients, improvement of access and quality of care, reduced costs and overall enhancement of community connectedness and social cohesion (Kendall & Maeseneer, 2018; Roland, 2019). Alma-Ata placed disease prevention and health promotion in the center of health strategies and endorsed the idea that health services should be multidisciplinary and aligned with local needs (Baum et al., 2016).

The potential of Alma-Ata to bring about required changes in the global health landscape divided opinions during its 2018 revision (Birn, 2018). Participants agreed that the Declaration increased appreciation of the role of the state as both funder and coordinator of health care systems (Roland, 2019). Critics argued, however, that Alma-Ata lacks explicit articulation about publicly funded and delivered care, opening room for co-optation (Birn, 2018). The current challenge of integrating different parts of health-related systems reflects that observation, as donors are often more interested in short-term projects rather than broadly defined health programs that might require changes to the social and economic spheres (Roland, 2019). The gradual downsising of the public health sector and the large-scale privatisation of public services due to the bias towards curative care and neoliberal approaches are indicators that there is ground for concern. In view of that, the revised Alma-Ata now does acknowledge that if global health inequity is to be addressed, world's resources must be directed to interventions underpinned by human rights principles rather than to actions involving private interests, armaments and military conflicts (Roland, 2019).

3.4 Inequities in global health care

According to WHO (2018d), there remains a 31-year gap between the countries with the shortest and longest life expectancies in the world and it is estimated that approximately one billion people do not have access to the health services they need. Despite the call for UHC in Article 25 of the UDHR, the commodification and privatisation of health care continues to punish the vulnerable. While the access to adequate food, clothing, housing, medical care, social services, and social security are included in the text of the Alma-Ata, health aid programmes implemented by developed countries too often address symptoms rather than causes of weak health systems in developing nations (Farmer, 2005). The right of all to share in scientific advancement and its benefits, as enshrined on Article 27 of the UDHR, is in direct contrast to the role played by the biomedical industrial complex. The discrepancy between the connection of global poverty and poor health and the fact that over 90 countries now have the UDHR's principles embedded in their Constitutions deserves serious attention (UN, 2018).

Inequities in health care are partially attributable to the out-migration of health professionals from developing countries (Garett, 2007). Internationally, developed countries have benefited to a great extent in receiving health care professionals from developing nations.

While low-income countries' health professionals make the decision of migrating in search of better remuneration and work conditions, developed countries often actively incentivise the recruitment of foreign workers through immigration-control exemptions for health care personnel (Garett, 2007). This dynamic helps to explain why Canada and the USA operate with one physician for every 450 people, while Malawi has only 266 physicians for its population of 13 million people (Huish, 2013). Aid programmes often further deplete national human capital by recruiting local economists, accountants and other professionals in order to comply with financial and reporting requirements imposed by the IMF, the World Bank and other donors (Garett, 2007). If the global community is to address these inequities, wealthy nations must become less dependent on foreign doctors and nurses and help to build human resources in developing countries.

Another factor in global inequities in health is access to medicines. The WHO (2017) estimates that 10 million lives could be saved each year if access to essential medicines was improved. For Farmer (2005), the global focus on accumulation of capital is what makes the prices of medicine prohibitive. According to the WHO, the excessive cost of health care is a giant barrier that pushes an average of 100 million people into poverty, most of whom live in low-income countries. The preference of philanthropic organisations for directing funding to internationally acknowledged health issues over improving access to basic medicines directly affects the poorest populations. While billions of dollars do bring worthy benefits through HIV/AIDS aid programmes, the lack of access to essential medicines like penicillin and painkillers leads to deaths from easily preventable or treatable diseases, especially in poor communities (Farmer, 2005; Huish, 2013).

Sell and Williams (2019) contend that the contemporary period is marked by the expansion of vertically integrated global value chains and the consolidation of particular institutional and regulatory approaches to trade and investment that generate negative health impacts. Sell and Williams (2019, p. 5) argue that capitalism is an "overarching and underlying historical and global structure that produces and co-produces 'vectors' (transmitters) of disease and ill health". They denominate these vectors as inequality and poverty, transnational capital, global markets and harmful products, and the conditions under which we work and produce. For them, welfare capitalism has done far from enough to subdue market logic in global policy and human development, especially in terms of access to health care services and essential medicines.

The pervasiveness of health inequity has been referred to as the elephant in the room in discussions of medical ethics (Agyepong, 2018; Farmer, 2005). Mawdsley (2014) highlights that while human rights are often considered an essential element of development, few mainstream actors fully commit to a rights-based development approach. A key problem pointed by Farmer (2005) is that despite being enshrined in the UDHR, health care has been placed under the umbrella of social and economic rights. These include but are not limited to the right to health care, housing, clean water and education, and are also known as the 'rights of the poor'. As the vulnerable population is trapped in a subaltern position in a system that violates these social and economic rights, they cannot achieve enough political representation to participate on policy decision-making or to hold human rights violators accountable. Hence, as long as health care is treated as a social and economic right and as long as it is permissible for those to be violated, the abuse of civil and human rights will remain a reality and the health of the poor will suffer.

3.5 The ethos of Cuban medicine

Considered by some as an "anomaly" – a poor country with impressive public health care – Cuba shows what can be achieved when the notion of health as a fundamental human right goes beyond rhetoric and starts to effectively guide government's plans and actions. This focus on public health was first evident in 1902 when Cuba created a Ministry of Health, the first in Latin America and the Caribbean (Pineo, 2019, p.16). The island reached UHC well before the Alma-Ata Declaration (1978) was adopted and realised all the MDGs' objectives in advance (Gorry, 2019; Pineo, 2019). Today, Cuba's main health indicators rank alongside those of many developed countries, despite the scarcity of resources (Gorry, 2019; Huish, 2014; UCCM, 2017).

Dependency and inequality are part of Cuba's history. As Pineo (2019) argues, USA Presidents were in constant negotiation (from 1853-1877) to buy Cuba from Spain, of which the Caribbean nation was a colony. After a strenuous and successful fight to gain independence in 1898, Cubans witnessed USA forces take control of their nation multiple times. Fulgencio Batista, military man strongly supported by the USA, first came to power in a coup in 1933 and exercised control over Cuban affairs until the Revolution in 1959. According to Pineo

(2019), those developments gave the USA control of 80 per cent of Cuba's trade and of two-thirds of food production, as well as ownership of half of the arable land on the country.

During this time unemployment was a reality for at least a quarter of the Cuban population, rates of illiteracy were high and access to basic services was poor, especially in rural areas. The provision of health care was concentrated in urban areas, mainly in the capital Havana, home to less than a fifth of Cuba's population. Meanwhile, medical care to half of the country's population living in rural areas was provided by a single hospital with 10 beds (Huish, 2013). As support for the Revolution started to gain momentum, approximately half of Cuba's 6,000 doctors, the majority from wealthier families who opposed the movement's ideals, were in the process of leaving the island (Kirk, 2012). The ratio of physicians to patients dropped from 9.2 doctors per 10,000 people in 1958 to 5.4 by 1962 (Pineo, 2019). For Feinsilver (2010), the medical brain drain was an important force that drove the subsequent government to prioritise the development of human resources for health.

Medicine is deeply connected with the ideals of the Cuban Revolution (Andaya, 2009; Clayfield, Kirk & Story, 2018; Feinsilver, 2010; Huish, 2013; Kirk & Erisman, 2009; Rojas Ochoa, 2004). Revolutionary Fidel Castro, who assumed military and political power as Cuba's President in 1959, constantly referred to the legacy of 19th Century independence leader José Martí and his ideals of unity and solidarity (Anderson, 2010b). Martí's work critiqued forms of repression that prevent that all individuals within a society access basic needs, including health and education (Huish, 2013; Ripoll, 1994). Thus, Castro referred to Cuban health workers as "the very essence of the Revolution" (as cited in Andaya, 2009, p. 358). For Andaya (2009), universal access to health care has been a central tenet of Cuban discourses about the triumph of social justice over capitalism's materialism, utilitarianism and inequality. The translation of this essence to the medical profession was expressed by Argentine Ernesto Che Guevara, a major supporter of the Revolution and doctor himself, in a famous speech delivered to the Cuban militia a year after Castro assumed power:

> *"The life of a single human being is worth a million times more than all the property of the richest man on earth (...) far more important than good remuneration is the pride of serving one's neighbour. Much more definitive and much more lasting than all the gold that one can accumulate is the gratitude of a people. And each doctor, within the circle of his activities, can and must accumulate that valuable treasure, the gratitude of the people"*

(Andaya, 2009, p. 357)

The association of public health with processes of social transformation is connected to a broader idealism of Pan American solidarity and a call for Latin American movements against imperialism (Huish, 2013). Salvador Allende, the first socialist elected to govern Chile, had identified the interrelationship between health and social determinants as early as the 1930s (Anderson, 2010b; Bencomo, Choonara, González & Vásquez, 2016). A friend of Guevara, Allende developed the concept of social medicine grounded on the study of social roots of illnesses and on ideas of emancipation from hegemonic structures (Anderson, 2010b). Allende valued the health of the population as an end on itself and advocated that changes in health need to go beyond the medical realm. His ideas of social medicine influenced the Cuban approach to health and to medical cooperation.

The Cuban government's approach to health care provision during a period of crisis evidences its commitment to the principle of health as a fundamental human right. The imposition of an economic blockade by the USA since the 1960s and the fall of the Soviet Union, who provided US$5 billion in aid to Cuba every year, are major events in the Cuban history that posed and continue to pose significant challenges for the country's development, including in the medical field (Pineo, 2019). The Soviet Union began to implode in 1989 and halted its support to Cuba, plunging the island into a devastating economic crisis known as the Special Period (Andaya, 2009).

A public health crisis followed. Lack of access to water, sanitation and transportation systems, shortage of fuel and frequent power cuts became routine. Vector-borne diseases, tuberculosis, infections and malnutrition were prevalent, and deaths from diarrhoeal diseases increased (Andaya, 2009; Pineo, 2019). The fall of the Soviet Union also led Cuba to lose 87 per cent of its exports and have its food imports cut by half (Huish, 2013). The lack of vitamins caused a series of health complications, such as ophthalmological degeneracy, affected 60 thousand people (Huish and Kirk, 2007). The availability of medical supplies was also affected,

as the Soviet Union provided 94 per cent of Cuba's medical equipment, and disposable medical products had to be recycled in emergency situations (Kirk and Erisman, 2009; Pineo, 2019).

Pineo (2019) argues that as no relationship was cultivated with the IMF or the World Bank, Cuba did not have to comply to these institutions' demands of introducing austerity measures, which was usually the case for other nations. Pineo notes that Cuban expenditure in public health care actually increased during the Special Period and significant cuts were made in military spending, a strategy not commonly deployed by developed countries facing an economic, political and public health crisis. Attention to community-based preventative strategies was also increased, as well as investments in health infrastructure and human resources. To address food shortage, previous prohibition on farmers' markets were lifted and vegetables became more available. The emphasis on prevention and the shift on the population's diet to healthier home-grown options led to a significant decrease on rates of heart diseases and hypertension. Due to the government's commitment to the right to health Cuba managed to improve its health indicators during a time of crisis, an achievement that is not often registered in the global North and in the global South (Huish, 2013; Pineo, 2019).

Today Cuba is considered a global benchmark on provision of quality health care (Feinsilver, 2010; Gorry, 2019; Huish, 2013; Kirk, 2012; Pineo, 2019; Reed, 2008; Rojas Ochoa, 2004; Serrate, 2019; Suri, 2016; UNOSSC, 2018). Cuba was the first country in the world to eliminate the transmission of HIV/AIDS from mother to child; the country with the highest budget for health (10.6 per cent of the GDP); the country with the highest number of doctors per 10,000 people (67.2), and the lowest infant mortality rate for infants under a year of age (four per thousand born alive) (UNOSSC, 2018). With a Gross Domestic Product (GDP) of about one-tenth that of the USA and about half of that of Mexico or Brazil, Cuba spends about one-twentieth per capita on health care compared to the USA, and roughly one-tenth of what Mexico and Brazil spend per capita. Nonetheless, Cubans enjoy a life expectancy of 79 years, in comparison to USA (78 years), Mexico (77 years), Brazil (75 years), Latin America as a whole (75 years) and in the developing world as a whole (66 years) (Pineo, 2019). Today, the leading causes of death in Cuba are long-term debilitating diseases, such as heart disease, strokes and cancer, the same found in the developed world (Pineo, 2019).

3.6 Cuban health system: Prevention as the cornerstone

"We talk about health, but all we are addressing is disease." (Farmer, 2005)

Cuba promoted the vision of the Alma-Ata before it was made official, despite its economic and political challenges. UHC was already underscored in 1976 and reaffirmed in the recently reviewed Cuban Constitution. Article 72 of the Public Health Law, in accordance with the Constitution, places the responsibility for free, quality medical care, health protection and rehabilitation on the State (Serrate, 2019). To honour these commitments and advance the revolutionary quest of building a more egalitarian society, addressing health inequities between rural and urban areas was made a key priority of Castro's government (Andaya, 2009). As a low resource country with limited access to technological innovations, the implemented solution was to concentrate on primary and preventative medicine rather than developing strategies to expand curative care. Cuban law recognises that health is much more than the absence of disease or infirmity. As posed by Serrate (2019, p. 74) it is "an instrument of social cohesion that includes all people and depends on the interrelation and conscious, active, committed participation by all actors and sectors of society".

Since the 1970s, the division of Cuba's health system into three tiers has enabled the country to provide UHC. The first tier, primary care, involves the practice of preventive medicine so patients are not required to be referred to secondary care. Primary care is practised in polyclinics, family medicine offices and clinics (*consultorios*), covering 80 per cent of the population's health concerns (Pineo, 2019). A primary care facility is available in every neighbourhood, administered and operated by at least a doctor and a nurse. In the recent years, a public health expert has been added to the team to concentrate on mosquito abatement, the monitoring of potable water supplies and the inspection of sewer line hookups (Pineo, 2019). Preventive measures such as early pre-natal care and screening programmes to detect illnesses like cervical cancer before they evolve are provided in this level of service.

Covering around 15 per cent of population's health concerns, the secondary level is composed mainly of hospitals to care for people who are already sick. The tertiary level includes specialised hospitals and institutes designed to treat chronic conditions and complications, looking to cover about 5 per cent of health concerns in the country. This comprehensive and well-structured health system is governed by the public health department, while carers administer the facilities at the different levels. The 11 million population is served

by around 10,000 neighbourhood family doctor-and-nurse offices, nearly 450 community polyclinics, 150 hospitals and various research institutes (Serrate, 2019).

All Cubans have the right to access any level of care, including sophisticated procedures like open-heart surgery, free of cost. Patients are, however, responsible for bringing their own soap, bed sheets and towels when admitted for surgery, and required to pay for items like medical drugs, crutches and wheelchairs (Pineo, 2019). Nonetheless, Atun et al. (as cited in Pineo, 2019) notes that an average of 10 per cent of all health costs are estimated to require out of pocket expenditure, the lowest amount among all Latin American countries.

The achievements of the Cuban medicine have been especially attributed to the high level of intersectoral coordination pertaining legal, strategic and operational frameworks to continue to sustain PHC and UHC at the health system's foundation (Serrate, 2019; Suri, 2016). The synergy of health promotion, disease prevention, treatment and rehabilitation policies and programs within the sectors of education, agriculture, road infrastructure, waterworks, communications, culture, sports and recreation, science, technology, environment, housing and transportation forge a coherent approach to address pressing problems. Decisions take into account the social determinants of health and recognise the importance of mobilising participation of broad societal actors to promote the idea that health is the responsibility of both, the individual and of the society as well (Gorry, 2019, Serrate, 2019).

Ultimately, the elements that have been widely recognised as fundamental for the Cuban health system to function with efficiency and efficacy are: the practice of family medicine; the expansion of PHC and the development of health workforce.

3.6.1 The practice of family medicine

Cuba's people-centered approach was introduced in the early 1960s through *el servicio médico rural*, or the Rural Social Medical Service (RSMS) (Huish, 2013). The RSMS started by offering contracts for 750 physicians and medical students to serve for a 6-month period in the mountains and coastal communities, where there was little or no access to medical services. The objective of RSMS was to provide "disease prevention and to revitalise health services for those most in need, whether because they are poor, in precarious health or live far from urban centres" (Reed, 2008, p. 327). The 6-month contract progressed to a 2-year commitment, and by 1973 there were 1265 enrolled in the service (Huish, 2013). As highlighted by Rojas (as cited in Huish, 2013), renouncing private practice in the graduation's oath became a tradition.

The ability of polyclinics to deliver health care was enhanced by the introduction of the family doctor-and-nurse team in the mid-1980s (Huish, 2013). The programme is based on the practice of *Medicina General Integral* (Comprehensive General Medicine), a humanistic and holistic approach based on the bio-psycho-social health care model that seeks to understand patients in all their dimensions (Cruz & Perea, 2008). While the common practice in conventional medicine is to wait for patients to feel ill and seek treatment, Cuban health workers visit people in their homes and often live in the same community. In this way they can detect risk factors before they develop into an illness, make suggestions for the household and remind residents of the importance of taking prescribed medications, exercising and having a healthy diet. This social medicine approach allows health workers to gain a deeper understanding of the social and environmental factors that can affect a patient's health, enabling the doctor to design a treatment that is more responsive to individual preferences, needs and values. This system also offers great value for data mapping, as the collection of information by health workers enriches epidemiological analysis and can contribute for more accurate public health initiatives, such as vaccination and mosquito control. Health care teams are assigned catchment areas of about 1000 patients per physician in urban areas and every household is visited at least once a year, whether sick or healthy (Campion, 2013; Gorry, 2019; Pineo, 2019; Suri, 2016).

One of the key preventive tools utilised by Cuban doctors is the Continuous Assessment and Risk Evaluation (CARE). Information is gathered on the individuals and families' environment, and a community health analysis is prepared. The analysis is a fundamental tool that reflects every problem the doctor needs to treat not only in a household, but in the community as a whole (Field, 2006). Patients are then categorised according to level of health risk, from I to IV. Risk category II includes smokers, while patients with stable, chronic lung disease belong to category III. Medical workers regularly prepare reports indicating how many individuals in their catchment area belong to each risk category, including information on the number of patients suffering of conditions like hypertension, diabetes, asthma, immunisation status, date since last Pap smear and a list of pregnancies requiring prenatal care (Campion, 2013). A local Group Health Team supports teams of 15 to 20 health workers to facilitate discussions about common local issues on the communities they serve, including public health concerns, and to prepare reports to the Ministry of Public Health (Pineo, 2019).

Cuba also integrates the practice of Natural and Traditional Medicine (NTM) and folk medicine into the curriculum of medical schools, clinical practice, pharmaceutical production

and medical research (Appelbaum et al., 2006). NTM includes herbal therapies, acupuncture, moxibustion, massage, mind/body modalities, and hypnosis. The Cuban health system incorporates practitioners of *Santeria*, one of Cuban indigenous religions, who typically provide spiritual guidance and use herbal medicine. *Yerberos*, or herbalists, some of whom are *santeros* and others not, are granted a license to provide and sell herbs for medicinal and spiritual healing. As mandatory requirement to be granted the license, the Ministry of Agriculture mandates a course that addresses the benefits and potential dangers of certain herbs. *Santeros* and *Yerberos* also participate of health promotion and education campaigns. These services are delivered at the first tier of care, meaning that they reach eighty per cent of the population through the clinics and polyclinics. As argued by Appelbaum et al. (2006), the approach works because in Cuba NTM is not something to be learned in addition to medical training, but it is considered a valid body of knowledge that does not require health professionals to abandon their Western, scientific training.

3.6.2 The expansion of primary health care

A polyclinic is a more complex health facility in comparison to the family medicine offices and *consultorios*. Still focused on community medicine but going beyond primary care attention and diagnosis, polyclinics have an average of 12 physicians and a team of professionals specialised in areas like paediatrics, sanitation, epidemiology and family medicine. This integrated approach is pro-active in dealing with health concerns, developing health education campaigns and administering vaccination programmes in the community they serve. Polyclinics are better equipped than *consultorios*, often availing themselves of x-rays, ultrasounds and electrocardiograms, and offering services like gynecological exams, obstetrics and minor surgeries. Each polyclinic services a designated zone of about 15,000 to 30,000 people. From 140 polyclinics established in the country in 1958, Cubans now have 498 polyclinics providing medical services (Feinsilver, 1993; Huish, 2013; Pineo, 209; Rojas Ochoa, 2004).

3.6.3 The development of human resources for health

Cuba has proved that building capacity for health human resources is its national strength (Huish, 2013). As more than 3000 physicians fled from Cuba to the USA between 1958 and 1962, Cuba needed to improve not only the country's health infrastructure, but to invest in people as well. After the Revolution, the number and scope of schools and training centres for doctors, nurses and health technicians was expanded, with 24 specialties being covered by free training programmes (Márquez, 2009).

The equitable distribution of health workforce across the country following graduation was made a priority. Special efforts were made to train general, paediatric and obstetric nursing assistants and health technicians to work in rural areas and underserved communities (Márquez, 2009). The development of a diversified health workforce had a great impact on the provision of quality services at all levels and on the achievement of positive health outcomes. Coordination of this new cadre of professionals was improved by changes in protocols for maternal–child health, epidemiological surveillance and control, chronic and communicable diseases, older adult health and integrative medicine (Gorry, 2019).

In 1990, doctor-patient ratio was of 36.1 per 10,000 people, a ratio that resembled that of most nations in the world. The number progressed to 59 per 10,000 people in 2000, and to 64 per 10,000 in 2007. This was a better doctor-to-patient ratio than that of USA or Western Europe. Today, Cuba's ratio is about double that found in developed nations, with a doctor for every 150 people. For comparison, in Latin America as a whole, the ratio is 0.2 doctors per 10,000 people (Pineo, 2019). As Cuba gained experience of developing human resources for health, the nation broadened its commitment to a global level.

3.7 Cuban medical outreach

Cuba began its medical outreach right after the 1959 Revolution. The country helped other nations to develop medical human resources and systems as they worked to transform their own public health structure. This approach represents the Cubans translating to practice the Revolution's maxim "to share what we have, not what is left over" (UCCM, 2017, p.32).

Cuban medical cooperation is particularly targeted at the provision of health care in areas where services are poor or even non-existent (Erisman, 2012). As of 2012, it is estimated

that a total of 1.7 million lives have been saved, 85 million patients have been treated, 2.2 million operations have been performed, 768,858 births have been assisted and more than 9.2 million people have been vaccinated with complete vaccine courses (Erisman, 2012; Kirk, 2012). As of 2017, 407,419 health professionals and technicians, of which 183,338 are doctors, contributed for better health outcomes in 164 nations (UCCM, 2017). By the end of 2018, more than 400,000 Cuban medical professionals had served in missions to over 107 countries, making Cuba's medical outreach greater than the offered by all the developed nations of the world combined (Gorry, 2019; Pineo, 2019). During the past six decades Cuba has been realising medical internationalism through bilateral and multilateral accords, the majority being through SSC (Gorry, 2019). There are several ways in which Cuba provides medical assistance, and most of the country's cooperation accords fit under one or more of the categories below:

3.7.1 Henry Reeve Emergency Medical Contingent

The Henry Reeve Contingent consists of specialised teams trained to provide medical assistance in disaster scenarios and epidemics. In most cases, Cuba covers the costs of the operation. The embryo of the Henry Reeve started in 1960 when Cuba sent a medical team to Chile, despite dealing with the exodus of half of the Cuban doctors during the same period and not having diplomatic ties with the Chileans (Feinsilver, 2010; Gorry, 2019). The Cuban brigade was integrated by doctors, nursing professionals and health technicians of a number of different specialties (Diario de La Juventud Cubana, 2010).

Three years later and under the USA embargo, Cuba officially began to conduct medical diplomacy by sending a team of 56 health professionals for fourteen months to assist Algeria as the country struggled after the war for independence from the French colonialism (Feinsilver, 2010; UCCM, 2017). It was the first bilateral accord in medical cooperation and long-term initiative organised by the Cuban government (Gorry, 2019). The medical outreach continued and in 1986 Cuba assisted at no charge the Ukrainian population suffering with the effects of the Chernobyl nuclear meltdown. According to Grogg (2009, as cited in Kirk, 2012), while there was no charge to Ukraine, the medications provided have costed approximately $350 million to Cuba. It was around that time that Cuba started to expand its health workforce specifically to staff overseas missions (Pineo, 2019).

Cuba was the first country to provide medical assistance to Haiti in 1998 after Hurricane Georges, an assistance that was scaled up after a horrific earthquake hit Haiti in 2010 (Kirk, 2012; Pineo, 2019). Over 50,000 people were assisted, 3,000 surgeries were conducted, 280

babies were safely delivered, 20,000 people were vaccinated against tetanus, 9 rehabilitation wards were established, some of which were destinated to provide mental health care for the Haitian population (Feinsilver, 2010). In 2005, Cuba offered to send medical assistance to the areas in the USA affected by the Hurricane Katrina but this was rejected. In the same year, the Caribbean nation provided emergency medical aid services to Pakistan, despite not having diplomatic representation in that country at the time (Gorry, 2019). From 2005 to 2017, 27 brigades with 7551 professionals and technicians have been dispatched, and 3.5 million of patients have been cared for.

3.7.2 Comprehensive Health Programme (Programa Integral de Salud)

The Henry Reeve Contingent is organised to aid countries in need of assistance for up to 6 months, but this help is often extended for a period of 2 years through another form of cooperation, the Comprehensive Health Programme (*Programa Integral de Salud* – PIS). After providing medical relief to a number of nations, the Cuban brigades realised that vulnerable populations, especially the poor, elderly and children, have to bear brunt of natural disasters. They also realised that public health systems are often dismantled during major weather-related events and that once they returned home, the people would be left with no access to medical care (Gorry, 2019). To address these issues, Cuba decided to provide staffing support for public health facilities and work in conjunction with national governments and agencies to develop and strengthen sustainable health systems (UCCM, 2017).

This form of cooperation was launched after the 1998 disaster-relief mission in Haiti, when the Cuban brigades began implementing the PIS model and provide scholarships for Haitian nationals to study medicine in Cuba, all in a coordinated effort to build local health capacity (Feinsilver, 2010). Strategies to strengthen public health system and PHC during and after the recovery phase entails visits by primary care professionals to remote areas, including those outside disaster zones, the transport of patients in need of urgent and specialised care for treatment in Cuba, the donation of surplus medical supplies and field hospitals and the active pursue of opportunities for collaboration in other areas, such as technology transfer and joint pharmaceutical manufacture (Gorry, 2019). PIS teams have been deployed to help staff public health systems in 30 countries, among them are Honduras, Bolivia, Belize, Dominica, Guatemala, Suriname, Paraguay, Niger, Lesotho, Congo, Chad and Kiribati (Feinsilver, 2010; Gorry, 2019).

3.7.3 Remunerated Technical Assistance

Remunerated technical assistance involves similar services to those provided by PIS, but for nations that are in a position to pay for the assistance. This form of cooperation staffs institutions in the Caribbean, Latin America, Africa and Asia (UCCM, 2017). According to Feinsilver (2010), part of the funds is destined to remunerate health professionals and half or more is absorbed by the Cuban government to reinvest in the upgrade of equipment, the repairing and building of health and social welfare facilities and to further extend medical services throughout the country. Feinsilver also notes that in 2018, $6.4 billion pesos/dollars in funds from such remunerated assistance have been incorporated into Cuba's national budget, and that over 27 per cent of that revenue was spent on health and social welfare initiatives.

3.7.4 Vision Restoration and Improvement Programme (Operación Milagro)

Operación Milagro (Miracle Operation) is a joint initiative from Cuba and Venezuela that offers free surgical interventions for reversible eye conditions. This is one of the most significant examples of the Cuban cooperation operating under a trilateral agreement (UCCM, 2017). Cuban ophthalmologists offer their services and Venezuela provides resources through nationalised petroleum revenues that fund transport, treatment and accommodation to thousands of patients (Huish, 2013). Since its inception, *Operación Milagro* restored or improved eyesight of over 3 million patients, collaborated with the opening of hospitals specialised in ophthalmology and enabled more than 2.9 million of ophthalmological surgeries to be performed, benefiting people from 34 countries in the Latin America, Caribbean and Africa (UCCM, 2017).

3.7.5 Medical Education and Training

The most significant development of Cuban medical cooperation is the establishment of ELAM. ELAM is the largest medical school in the world and plays a central role on Cuba's medical internationalism (Blue, 2010; UNOSSC, 2018). This is the form of cooperation that has been provided to Kiribati and that will be analysed in detail in this thesis. This form of cooperation entails the provision of full medical scholarships for foreign students to complete medical education in Cuba and the establishment of medical schools in partner countries. Three out of four ELAM students come from poorer backgrounds, meaning that the majority of the

school's graduates would not otherwise have the opportunity to pursue medical education (Pineo, 2019). ELAM was founded in 1999 in Havana, primarily designed to increase the number of health workers available to integrate PIS teams in missions abroad (UCCM, 2017). In 2019, ELAM graduated nearly 30,000 doctors (Gorry, 2019). Including the medical schools operated by Cuba overseas, the number of medical students in training has reached 50,000 a year, which is a larger workforce than the Red Cross, Médecins Sans Frontières and UNICEF combined (Huish, 2014; Pineo, 2019).

Scholarships are offered through Cuban diplomatic missions in participating countries, NGOs, governments, political parties, Cuba Friendship Societies and other avenues. Criteria for enrolment includes that applicants are from a low-income or underserved community, between 18 and 25 years of age, and that they pass the admission tests (MEDICC, 2019c). Scholarships cover full tuition, room and board, school supplies, textbooks in Spanish, school uniform, basic toiletries and a modest monthly stipend in Cuban pesos. Lifestyle is simple and students live in shared dormitories (Suri, 2016).

Most of courses and study materials are in Spanish, with the exception of a sister institution in Santiago, Cuba that serves around 500 French-speaking students (Erisman, 2012, Pineo, 2019). Foreign students are given support to learn the Spanish language in a pre-medical course and intensive Spanish language instruction (MEDICC, 2019c). The pre-medical program serves to facilitate their transition and ensure that all incoming students have basic knowledge in science and humanities, including classes on Chemistry, Biology, Physics, Math, Spanish Composition and Literature, History of the Americas, Introduction to Health Sciences and Medical Geography. Classes also serve to familiarise students with the Cuban context and include work in practical issues, such as handling laboratory equipment (MEDICC, 2019b). The pre-medical course can add up to a year to the six-year program (MEDICC, 2019c).

After completing the first 2 years at ELAM students move on to study at one of the 26 provincial medical schools in the island, with special focus in community-based primary care orientation (Huish, 2013). The first three semesters are dedicated to learning basic biomedical and social sciences. This is the stage when students have their initial contact with Cuba's health system through the module *Introduction to Family Medicine*. The course has a practical component and the community itself becomes a laboratory, as students are trained in consulting rooms and polyclinics alongside Comprehensive General Medicine specialists (Huish, 2013; Kirk, 2012; Pineo, 2019). The teaching emphasises placing an individual, ill or healthy, within her/his social context.

After this first experiential community learning ends, students start the basic clinical sciences module. This phase lasts a couple of semesters and covers diseases that have been eradicated in Cuba but that remain prevalent in some developing countries, such as cholera and polio. Clinical sciences are taught through clerkships from the sixth to the tenth semester, and the final year is dedicated to an internship. Evaluations are based on specific learning objectives, assessed through oral and written exam questions, seminars, hands-on and laboratory practices, projects, mid-term and final exams. The exams can be theoretical or practical, and in the case of both, passing the practical exam is a prerequisite for taking the theoretical exam. After the final internship, students are required to pass a Cuban national examination test in order to practice the medical profession (UCCM, 2017).

A central aspect of ELAM's philosophy is the encouragement of students to return to practise medicine in their home countries once graduated, preferably in underserved communities. The idea is for graduates to eventually replace the Cuban doctors working on the establishment of PIS in their home countries (UCCM, 2017). It is hoped that the training will enable graduates to actively engage in changing structures and operations that prevent universal access to health care and help to rehabilitate non-functional health systems (Erisman, 2012). ELAM graduates have led a number of projects in that pursue, such as carrying on ground-breaking research into a new form of chronic kidney disease targeting poor farmers in Central America (launched by an ELAM graduate, with support from El Salvador's Ministry of Health, Cuba's Ministry of Health and PAHO), establishing the first indigenous hospital in Ciriboya, Honduras, and implementing clinical coverage for the poorest of the poor during health emergencies and beyond (led by various Haitian ELAM graduates) (MEDICC, 2019a). As highlighted by Huish (2013), more than half of graduates return to their home communities for medical practice, and those who decide to stay in Cuba do pursue a specialisation.

Medical education at ELAM is grounded in the humanistic principles cultivated since the Revolution and in the practice of social medicine. The training received at the school is aligned with developing countries' realities and based on Cuba's own experience of building a health system in adverse conditions. Emphasis is placed in public health, preventive and community care and on analysis of specific regional health risks, especially those grown out of poverty. The idea is to provide hands-on learning about social and economic determinants of health and promote the integration of graduates into local health systems (Gorry, 2019; Suri, 2016). The aim of the approach was captured by Dr. Margaret Chan (2009), former Director-General of the WHO, when speaking to a class of ELAM graduates:

> *"You are being trained to return the practice of medicine to the basic values of people-centred, compassionate care, guided by need, and not by the patient's ability to pay. (...) to be engaged members of the communities you serve, and not just doctors in white jackets waiting for the problems to show up, preferably by appointment, in your offices."*

This understanding of doctors as active agents in ensuring the healthy state of individuals and the development of healthy communities contrasts with conventional perceptions on what role a doctor should play in advancing health outcomes (Huish, 2013). As resources are available and there is easy access to advanced technology, medical practice in the global North emphasises specialisation and promotes a curative approach – as discussed in section 3.2. Medical education at ELAM, on the other hand, does not teach students to operate the latest medical equipment and provides less instruction on curative methods, as this is not the reality for developing countries (UCCM, 2017).

This approach can cause problems of accreditation for ELAM graduates who wish to practise in the global North if medical federations refuse to recognise their medical training in Cuba. At times, this was the case in Argentina, Brazil, Guatemala, Peru and Antigua (Kirk, 2012; Pineo, 2019). As pointed by Astor (as cited in Huish, 2013), many medical schools in the global South tailor their curriculum to teach highly specialised skills in order to meet market demand and earn prestige in the global North. As their skills can be better utilised in developed countries, and there is a higher probability of being offered generous remuneration packages, doctors leave to practise in wealthier nations. As a key aspect of brain drain lies in the motivation to choose the medical profession, ELAM promotes from the onset that health is a human right, encourages graduates to service poorer communities and address health inequities in the health systems they find themselves practising their profession (Feinsilver, 2010, MEDICC, 2019a).

3.8 Motivation

The different understandings of reciprocity explained on Chapter 2 produce distinct perceptions about the motivations of the Cuban medical cooperation. Some consider aid as a one-way relationship, and see the political and commercial benefits gained by Cuba as indicative of a relationship that is not solidary enough (BBC News, 2019; Frank, 2019; Teixeira, 2018; Telesur, 2019). The contrasting view understands solidarity as a force that challenges systems

of oppression, and sees the ability of gift receivers to exercise reciprocity as an assertion of their autonomy (Featherstone, 2002; Mauss, 1990).

Many scholars note the political motivations that may underpin Cuban cooperation internationally. Feinsilver (2010, p. 85) argues that medical diplomacy has been a "cornerstone of Cuban foreign policy since the outset of the Revolution". For Feinsilver, Cuba has increasingly been able to project abroad an image of technologically sophisticated and especially morally superior, given that it sends medical rather than military personnel to developing countries. Feinsilver (2010) and Kirk (2012) stress that the Cuban outreach has helped the country to garner influence and prestige in a scale that is difficult for a small, developing nation to achieve, and that the outreach improved relations with countries that had not been sympathetic with the Revolution. For them, this goodwill translated into political support in arenas like the UN General Assembly, especially concerning the economic sanctions imposed by the USA. For Nye (as cited in Huish, 2014), the relationships developed through medical internationalism have not only opened opportunities to deepen bilateral and trilateral cooperation but have facilitated economic partnerships.

Economic motivations are also considered a key motivator for Cuban medical cooperation. One of the most cited examples in discussions about the commercial motivations of Cuba's internationalism is the oil-for-doctors deal with Venezuela. Since 2003, over 14,000 Cuban health workers helped build Venezuela's '*Misión Barrio Adentro*' (Inside the Neighborhood), a local clinic-based health system where doctors and dentists live in their neighbourhoods and serve as practitioners of communities (Afzal, Birn & Muntaner, 2017). As part of a broader cooperation framework, Venezuela compensates Cuba through discounted oil imports. For 2008 alone, it is estimated that the total value of the Venezuelan trade, aid, investments, and subsidies to Cuba was US$9.4 billion (Feinsilver, 2010). While some consider the commercial aspect as a characteristic that delegitimises the Cuban outreach, others believe that the substantial economic compensation filled mutual needs by openly establishing the 'exchange' of Venezuelan oil for Cuban doctors (Afzal et al., 2017; Feinsilver, 2010; Huish, 2014).

Kirk (2012) argues that the success of Cuba as an exporter of pharmaceutical products despite harsh economic sanctions can be partially attributed to the broadening of market enabled by the medical cooperation. As explained by Campion and Morrissey (2013), the isolation of Cuba after the USA economic embargo led the government to focus on the development of its own pharmaceutical industry, rather than acquiring medical products at international prices. According to Pineo (2019), today Cuba has 58 drug manufacturing

facilities that produce 83 percent of the medicines used in the country, including meningitis B and C, leptospirosis and typhoid fever. The Cubans have also pioneered the hepatitis B vaccine and continue to conduct cutting-edge work on AIDS and cancer vaccines. As of 2018, it is estimated that the Cuban biopharmaceutical industry holds about 1,200 international patents and sells medicine and equipment to more than 50 countries (O'Farrill, 2018).

Kirk (2012) makes the point that Cuba sells its pharmaceutical products at substantially lower prices than those charged by transnational drug corporations. A 2015 WHO report on the Cuban health system noted that "in Cuba, products were developed to solve pressing health problems, unlike in other countries, where commercial interests prevailed". This was the case with Cimavax, a therapeutic vaccine for non-small cell lung cancer that presents initial promising results (BBC News, 2017; Jacobs, 2018). Cuban researchers began working on Cimavax in the 1990s, prompted in part by the high rate of lung cancer in the country, and have made the vaccine available to Cubans for free since 2011 (NY Times, 2016; Patel, 2015).

The perception that health workers are yet just another lucrative source of export earnings for Cuba is motive for contentious debates. According to Bencomo et al. (2016) and Pineo (2019), the largest share of Cuba's export earnings (more than a quarter) comes from revenue of medical missions abroad, even though Cuba only receives financial contribution from governments that can afford to pay, such as China, Qatar, Saudi Arabia and South Africa. Countries in the position to compensate for the medical services make payments directly to the Cuban government, which retains a significant share of that revenue.

In a study about doctors' experiences in South Africa, Hammett (as cited in Blue, 2010) observed that the South African government paid Cuban workers according to its national health system pay scale, which was US$ 1500 per month in 2004. An average of 57 per cent tax of that amount was levied by the Cuban government, meaning that Cuban health workers earned a US$645 monthly stipend. Critics see this contractual situation as "indentured servitude" and argue that a growing number of Cubans doctors sent overseas are looking to defect to other countries because of working conditions and freedom of movement (Erisman, 2012, p. 278). This understanding led to the creation of mechanisms that oppose Cuban medical outreach, such as USA's special visa scheme for Cuban defectors named Cuban Medical Professional Parole Program (CMPP), and to the recent withdrawal of Cuban health workers from Brazil, Bolivia and Ecuador (BBC News, 2019; Frank, 2019; Pineo, 2019; Teixeira, 2018; Telesur, 2019).

Another key driving force for Cuban cooperation may be pragmatism, particularly in relation to the decisions of Cuban health workers and the Cuban government (Blue, 2010;

Erisman, 2012; Feinsilver, 2010; Kirk, 2012). For Erisman (2012), Cuban doctors decide to work abroad because they earn more and have the opportunity to advance professionally. Beyond higher salaries, Blue (2010) and Kirk (2012) argue that Cuban medical personnel benefit from the chance to advance their knowledge and skills through working in a new environment, the professional merit that accompanies humanitarian service and foreign travel and the ability to purchase and import consumer goods not affordable at home.

Huish (2014) associates misconceptions about the Cuban internationalism to broad tendencies to understand international health outreaches as purely altruistic or entirely self-interested. As explored on Chapter 2, these perceptions are based on the idea that the free gift exists, and that there is no value in reciprocity. However, that understanding traps the gift receiver in a position of perpetual subordination. The political and economic benefits are part of the Cuban internationalism, but they are underpinned by an ethos of solidarity that makes it different from self-interested gains that are common in ODA approaches (see Chapter 2). For Mawdsley (2012, p. 266), the Cuban cooperation is approached "not as philanthropic aid, but as conscious development investment in the pursuit of mutual benefit between emerging nations".

UNOSSC (2018) highlights that internationalism gives an additional dimension to Cuban solidarity, one that is grounded on the words of Cuban national hero José Martí: "Homeland is humanity". Feinsilver (2010) argues that free universal health care as a basic human right and responsibility of the state have been espoused from the initial days of the Cuban revolutionary government, and that Cuban health ideology always has had an international dimension. Feinsilver explains that Cuba has considered SSC to be the country's duty as a means of repaying its debt to humanity for support it received from others during the revolution. Kirk (2012) states that in good times and bad, humanitarian needs have always been seen by Cuba as more important than basic financial considerations, and that many of these projects do not provide any financial or political gain for the Cubans, but are nevertheless pursued at the request of the host government. This view is supported by Huish's (2014) and Pineo's (2019) claims that, historically, Cuba has offered medical scholarships and humanitarian assistance to politically hostile countries and to nations where reciprocal benefits are limited. Kiribati is one of those nations, and the nature of the Cuban-Kiribati relationship will begin to be explored in Chapter 5.

3.9 Conclusion

This chapter argued that the promotion and protection of health are fundamentally linked to the promotion and the protection of human rights and dignity. Sections 3.2 and 3.3 explained why the Declaration of Alma Ata is a milestone in the field of public health and argued that, as long as health ideologies perceive health as a commodity, national and global health inequities will persist and the right to health will not be fulfilled. The investigation about the origin and scope of Cuban health system makes clear that, with intersectoral coordination and emphasis on the development and equitable distribution of human resources, the practise of preventive medicine in the community leads to significant improvements in health outcomes. The examination of Cuban internationalism and the debates about Cuba's motivation highlight that it is possible for a country to benefit from cooperation while respecting the principle of solidarity and contributing for the emancipation of countries trapped in a cycle of aid dependence. This chapter highlights the place of Cuba in the aid landscape and demonstrates what can be achieved when there is political commitment to the value of health as a right. Most of available literature and examples debated in this chapter focus around the Cuban cooperation in Africa, Central and Latin America, which reflects how little has been published about the Cuban medical outreach in the Pacific region. Before exploring research findings and the Kiribati health context, the next chapter will outline the methodological approach adopted in this study.

Chapter 4: METHODOLOGY

This research sought to learn themes, distinctions, motifs and perspectives about health and health care from the point of view of actors directly and indirectly involved with the Cuban medical cooperation in Kiribati. The first section of this chapter outlines the research methodology used to achieve this, and the purpose and the logic behind the selected approach. The section that follows explains the structure of the research design, including site and participant selection and limitations. In the following section I explain why I decided on particular methods for data collection and explore how they helped to answer research questions. I then provide an overview about the process of data analysis considered most appropriate for drawing rich, authentic and relevant information for this investigation. Of major importance is the final section on ethical considerations, where I explore my positionality and the principles that guided both the writing and fieldwork processes.

4.1 Methodology

In order to establish connections between peoples, contexts and processes and explore boundaries between concepts, this research required an approach that could appreciate the subjectivities of the human experience. For Hesse-Biber and Leavy (2010), qualitative methodology is the most appropriate to understand complex social phenomena that takes place in real settings. As argued by Desai and Potter (2006), qualitative methodology has its origin in social sciences. As this research uses an anthropological approach to analyse aid relations, it seems particularly appropriate to adopt a qualitative approach.

In this research I aimed to identify existing issues and needs of the Kiribati health sector and to explore similarities and differences between the Cuban and Kiribati's health care practices and models. This exercise helped me to build the foundation for a better understanding of the transition of Cuban-trained doctors into medical practice in Kiribati. As little has been published about the way the Cuban cooperation functions in specific settings, an exploratory study was considered most appropriate (Desai & Potter, 2006).

The adoption of a qualitative methodology was also considered appropriate as this research discusses how imbalanced power relations are imbedded in aid structures and connect with

global health inequities. As argued by O'Leary (2014), the qualitative tradition does not shy away from political agendas. The objective of the study is not to present a single version of truth, but to offer an honest, fair and balanced account of the processes involved in the implementation, scope and ramifications of the Cuban programme in Kiribati from the viewpoint of the people who live it every day. My interest was in establishing meaningful connections between informant's ideas about health and health care and the role of the Cuban programme in their worlds. As recommended by O'Leary (2014), I remained flexible about re-examining ideas and concepts at the field and did make design changes during the course of the study, which are explained in the next section.

4.2 Research Design

Research methods used in this study included fieldwork with semi and unstructured interviews, non-participant observation, the maintenance of a fieldwork diary, the review and analysis of textual data and non-academic written sources and a focus group, which was not originally planned. Prior to commencement of the fieldwork, in April/2019 I had the opportunity to make a preliminary visit accompanied by the main supervisor of this project, Dr. Sharon McLennan, and Associate Investigator, Dr. Robert Huish. At that time, we determined the scope and boundaries of the project and established initial contact with key health officials, which greatly facilitated fieldwork. In August/2019 I visited Tarawa, the capital of Kiribati, for four weeks to undertake data collection. The plan developed as follows:

4.2.1 Site selection

Kiribati was chosen for this case study because the country was the first PIC to send medical students to Cuba and because it is a location where the programme has significant potential impact (KIP-SP, 2016). Kiribati also developed the KITP, where Pacific graduates trained in Cuba and overseas complete training to transition to medical practice in the region. During the visit to Tarawa in April/2019, officials from Tungaru Central Hospital (TCH) gave verbal consent to conduct research in their premises and an expression of support for obtaining a research visa. TCH is a major site of interest of the project as the majority of Cuban-trained

doctors work at their premises. I planned to investigate if there were other care facilities in the islands that had engaged with the Cuban programme but learned that Cuban-trained doctors were allocated to work at TCH or at the Ronton Hospital in Kiritimati. It would have been very useful to include the voices of health practitioners and the people working and living in remote locations, but time and logistical constraints prevented me from spending time researching the outer islands.

4.2.2 Participant selection and access

In order to construct a nuanced account of the scope of the Cuban programme, I considered important to gather the perspectives of actors involved in different ways with the Cuban programme. Cuban and Cuban-trained doctors were central sources of information for this research as they are personally involved with the Cuban outreach. I also collected data from KITP supervisors, I-Kiribati nursing representatives and health workers and the I-Kiribati community (Table 4.1). This research utilised the snowball technique to select participants. As anticipated, the snowball approach was culturally appropriate and a feasible means of recruitment in a small place like Tarawa (Liamputtong, 2010; Uriam, 1995; Vaioleti, 2006). As Tarawa is a small place the people who are or have been engaged with the Cuban programme knew each other, meaning that the referral nature of the technique greatly facilitated access to the network.

Table 4.1: Methods and research participants

Interviewee	Focus Group	Semi-structured interviews	Unstructured interviews
Cuban-trained interns/registrars	8	4	2
Cuban doctors	-	2	-
KITP supervisors	-	5	-
I-Kiribati health workers	-	1	1
I-Kiribati nursing representatives	-	2	-
I-Kiribati community	-	-	3

Source: Author

4.2.3 Limitations

As health practitioners have a heavy workload in Kiribati, their unavailability prevented me from interviewing some respondents. As fieldwork duration was limited to a month, only the views of informants who were in the country at the time are included in this study. I was not familiar with the Kiribati language and not all people were comfortable to express themselves in English.

4.2.4 Data collection methods

Review and analysis of textual data and non-academic written sources (Table 4.2): Secondary data is standard practice for doing fieldwork in developing countries as it helps to contextualise research topics and objectives (Diermen & Overton, 2014). Local and regional reports, statistics and health strategies helped me to identify current issues and needs in the delivery of health care in Kiribati and the structure of its health system. The analysis of similar documents pertaining the Cuban medical cooperation and the KITP provided the basis for the exploration of similarities and contrasts between both countries' approaches to health care. Mawdsley (as cited in McLennan & Prinsen, 2014) observes that websites can be useful for development researchers as they have a clear focus on the present. As this study sought to gain a fuller understanding about the Kiribati and Cuban contexts and explore discourses about the Cuban cooperation in Kiribati, media reports were integrated into the research. I searched online for the terms “Cuba”, “Kiribati”, “health” and “doctors”, and narrowed or broadened the search as necessary. Zeitlyn (as cited in McLennan & Prinsen, 2014) notes that when analysing textual data, caution should extend beyond a consideration of what is written to a concern with what is omitted. For this reason, I have actively engaged with the data and considered the context and purpose of the written record. To increase reliability and validity, textual data was triangulated with primary research data.

Table 4.2: Non-academic written sources

Document type	Number of documents
Kiribati's national health strategies	2
Kiribati's development and policy reports	6
Regional health and development strategies	5
Reports about the Kiribati Internship Training Programme	5
MEDICC (Medical Education Cooperation with Cuba) reports	4
MINREX (Ministerio de Relaciones Exteriores, Cuba) publications	3
Pacific media reports	6
Latin America media reports	5
Other media reports	20
Bilateral and multilateral donors' reports about Kiribati	8
Working papers and meeting's summaries	5
Reports about SSC	4
World Health Organization reports	11

Source: Author

Semi-structured and unstructured interviews: Interviews were key instruments of data collection and provided meaningful verbal and non-verbal qualitative data. This method was considered appropriate as Kiribati has a strong oral culture and because I intended to draw specific data about the Cuban medical cooperation (Uriam, 1995). According to O'Leary (2014), semi-structured interviews allow the interviewer to start with a defining questioning plan but also to pursue interesting perspectives that come up during the conversation. As I was interested in eliciting specific descriptions, feelings, thoughts and opinions about health care and the transition of graduates returning from Cuba into medical practice in Kiribati, 14 interviews were semi-structured. I focused on individual interviews to capture independent thoughts from actors occupying different positions in the healthcare system (Table 4.1). O'Leary observes that unstructured interviews create space for an open conversation where attitudes, opinions and beliefs can be freely expressed. For this reason, it felt particularly appropriate to use this method in conversations with 3 members of the I-Kiribati community, assisted by a research assistant, 2 Cuban-trained doctors and a I-Kiribati health worker.

Focus Group: As noted by Banks, McGregor, Meo-Sewabu and Stewart-Withers (2014), focus groups are instructive as we can learn from group dynamics and the way people discuss things as much as what they say. A focus group was not originally planned but, as time was a

constrain, a KITP supervisor suggested that I met a number of Cuban-trained interns at once rather than meeting them individually. The session was attended by the current cohort of Cuban-trained doctors undertaking the KITP, a group composed of interns from Kiribati (3), Tuvalu (3) and Nauru (2). I observed that the format of the focus group and the collegial nature of the relationship between participants made them feel comfortable to share their opinions and to discuss different points of view, which added a lot of value to research findings.

Non-participant observation: Observation is essential and inherent to qualitative research and can help a researcher to collect rich and in-depth verbal and non-verbal data (Crang & Cook, 2007; O'Leary, 2014). This method is premised on the notion that individuals construct their idea of self-based on the interactions they have with others (Newman, 2014). These perceptions and relationships are expressed through vocal pace, pitch and tone, gestures, facial expressions, eye contact, personal space and overall demeanour. As a researcher, I made the effort to attribute significance to actions according to the context in which they were taking place. I do, however, recognise that the quality of the observations relied on my ability to gather data through my senses and on how I utilised that information to construct a narrative (O'Leary, 2014). I performed non-participant observation at the TCH. Although verbal confirmation to conduct research at TCH had been given, I consulted with key health officials to confirm that I was welcomed to do ward rounds in public areas. I gained an understanding about the general state of health and identified health workforce routines, roles and responsibilities. The engagement of the research assistant in this exercise was instrumental to obtain a more accurate understanding of the situations I encountered, as insufficient familiarity with the Kiribati language and cultural cues of behaviour can influence understanding of responses.

Fieldwork diary: The maintenance of a fieldwork journal was adopted as a method as it constitutes an efficient strategy to increase reflexivity. Sultana (as cited in Murray & Overton, 2014) states that reflexivity is the process of thinking deeply about the self, processes and representations. The examination of power relations and politics in the research process and of my accountability as a researcher in data collection and interpretation were critical aspects of this process. Storey's (as cited in Leslie, McLennan & Storey, 2014) advice of working on separate personal and research diaries was incorporated. Having a channel for release of emotional steam was helpful to organise and generate new ideas. The research diaries

stimulated reflections about my positionality, the development of relationships and the meaning of experiences and events. This process was useful to regularly reassess the methods and methodology utilised and align them to fieldwork developments as necessary.

4.3 Data processing and analysis

To commit to standards of credibility, authenticity and integrity, this study incorporated methods that allow triangulation of data. In regard to analysis, O'Leary (2014) points that the logic of qualitative information involves inductively uncovering and deductively discovering themes that run through raw data. After transcribing the interviews and fieldwork notes from the observation at THC, I utilised primary data and performed a thematic analysis based on the research objectives and conceptual framework. To manage subjectivities, I analysed personal and research fieldwork journals in relation to findings. This exercise helped me to explore the meaning of experiences and relationships and to identify possible assumptions given my positionality. Finally, I reviewed this information in relation to documents about Kiribati's health care delivery and the Cuban programme. This final step helped me to contextualise findings in relation to the research objectives and the current global development landscape.

4.4 Ethical considerations

While respecting the uniqueness of Kiribati culture I acknowledge that Pacific nations share common values. These principles are reflected in the Pacific Research Guidelines and Principles, or PRGP (PRPC Massey, 2017), considered the most appropriate to guide this study. The major ethical principles espoused in Massey University's Human Ethics Code (2017) are incorporated in the Pacific framework. PRGP establishes the following values:

4.4.1 Respect for relationships

Pacific peoples affirm their sense of familiarity and connectedness by finding common genealogical, historical, cultural and socio-political links (HRCNZ, 2014). This aspect

highlights the importance of creating a bond with research participants. It was especially noted that, when trust was developed, people were more likely to share their genuine opinions and feelings about the research topic. I believe that finding commonalities between theirs and my experiences, interests and background (discussed later in this chapter) helped to build rapport with interviewees. Although I did not collect personal medical information, I was aware that these subjects could be a sensitive matter of discussion. For this reason, prior to fieldwork I had informal meetings with a I-Kiribati national to learn more about cultural and social norms.

4.4.2 Respect for knowledge holders

In the Pacific, the collective ownership of knowledge is central for cultivating national identity and sense of wellbeing (HRCNZ, 2014). This principle highlighted the importance of adopting appropriate methods to seek informed consent from research participants. Before interviews and the focus group, sometimes with the help of the research assistant, I verbally explained the nature of the study and gave the opportunity for informants to ask questions. I was careful to explain that respondents had the right to not participate and could withdraw of the process at any time. I explained the consent process and provided an information sheet and a consent form in Kiribati, Spanish or English according to participant's preference.

As information is often communicated verbally, matters of anonymity and confidentiality were given careful consideration (PRPC Massey, 2017). Participants were duly informed about the measures that were put in place to protect their private data. The identity of individuals is concealed in this research but as Kiribati is a small place it is possible that informants are acquaintances, especially in the medical community. For this reason, before obtaining participant's consent I cautioned them that full anonymity was not guaranteed. The period of observation at THC also brought forward issues of confidentiality. To address this aspect, research participants were assured that the collection of personal medical information is out of the scope of this investigation, and that any private medical data inadvertently obtained in the course of this research would not be utilised and would be destroyed. The research assistant signed a confidentiality agreement committing to keep confidential all the information she/he had access to and to not keep any record of research notes or transcripts.

4.4.3 Reciprocity

Reciprocity is a key principle underpinning this research and a major aspect of Pacific culture. In the Pacific, to be reciprocal is ethical behaviour (PRPC Massey, 2017). Thus, dialogue and mutual relationship guided every stage of this study. I identified a few opportunities to exercise reciprocity during fieldwork, including the daily exchange of basic I-Kiribati and English lessons with a I-Kiribati health worker. I am also currently sharing information about scholarship opportunities with the research assistant, who showed an interest in pursuing further studies. When requesting for informants' consent to participate in the research, I asked if they would like to receive a summary report of the findings on completion of the study. Participants were informed that the final thesis will be available electronically through the digital library of Massey University's website. While the dissemination of research findings can be considered a form of reciprocation it was necessary, however, to manage expectations about how much my research would be able to give in return.

4.4.4 Holism

Pacific cultures frame their worldview around an integrated relationship between social life, the environment, spiritual world and cosmology. I was careful to practise self-reflection to increase my awareness about how what I do, feel, say and think can impact people in all areas of their lives. This principle also guided my thinking when analysing data, as understanding information in isolation can undermine people's sense of continuity, community, and wellbeing (HRCNZ, 2014).

4.4.5 Using research to do good

This is a goal that applies to both the integrity of the research process and the potential research outcomes and impact. One way to translate this principle to fieldwork was to respect local social conduct and livelihood strategies (PRPC Massey, 2017). I was careful to check if research findings had the potential of damaging relationships before being made public. Dissemination of research results will also be an opportunity to make the information accessible to appropriate agencies that prioritise the common good.

4.4.6 Positionality

Graham argues that a study cannot be conducted without making choice of a moral point of view (as cited in Murray & Overton, 2014). For Collier (as cited in Newman, 2014), when we forget our philosophical premises, we risk turning these premises into unchallengeable dogmas. Hence the importance of recognising the starting point of a research project and one's positionality.

The researcher occupies an instrumental position in qualitative inquiries. The human element is viewed by existent scholarship as both the approach's strength and weakness. Its strength lies in the human capacity to develop novel ways of understanding the world and its weakness in being dependent on the researcher's skill, training, intellect, discipline, and creativity (Banks et al., 2014; Moses & Knutsen, 2007). Ultimately, the individuality of the researcher will influence the research process in some way. After all, human knowledge of empirical reality is always theory or concept dependent. Both common sense and scientific, our observations and experiences sensitise us to particular aspects of reality (Newman, 2014). Thus, I reflected about possible biases and worked to produce an authentic and neutral account of the collected data.

As pointed by Banks et al. (2014), development studies' research carries a bias towards deeper understandings and emancipatory practices. My personal motivations align with the statement, as I believe that the purpose of social sciences' research is to reveal imbalanced systemic structures in order to help people change conditions and build a better world for themselves. In direct relation to the research topic, I strongly support universal access to health care and the promotion of health as a fundamental human right. As pointed by O'Leary (2014), the collection of truthful responses is highly dependent on the researcher's ability to get respondents to talk with openness and honesty. Contrary to what expected, I do not feel that being a young non-Pacific female represented an additional difficulty in terms of trust building with research participants. I believe that my Latin American upbringing helped to create a sense of familiarity with Cuban and Cuban-trained doctors, which contributed to build rapport and to collect data. I communicated in Spanish and shared some common cultural references with the Cuban doctors and I could understand some of the nuances mentioned by Cuban-trained doctors about their experience in Cuba. With that in mind, I made an effort to constantly negotiate my interpretation of events.

4.5 Conclusion

The exercise of undertaking a methodology and developing a systematic design on how to approach the research contributed for the development of awareness in both the practical and the relational levels of the research. To have a plan helped me to use my time more efficiently and meaningfully during fieldwork. As personal motivations, limitations and my role as a researcher became clearer, I developed a more complex understanding about what the research – and Cuban cooperation – mean to research participants and to me. This gave me structure to reflect about how this thesis can affect the people who gifted me their time and attention during the research process.

Chapter 5: HEALTH IN KIRIBATI

To understand how the Cuban medical cooperation functions in Kiribati, it is necessary to first gain a better understanding of the background of the Pacific nation and its health care context. The first section of this chapter provides a brief geographical and historical contextualisation of Kiribati. The following section offers an overview of the multifaceted ways in which climate change affects Kiribati's health systems. The priorities of health services and delivery systems are investigated and the major barriers and bottlenecks to health system strengthening are identified based on literature and on fieldwork data. The last section examines how Kiribati's main donors respond to the country's health needs.

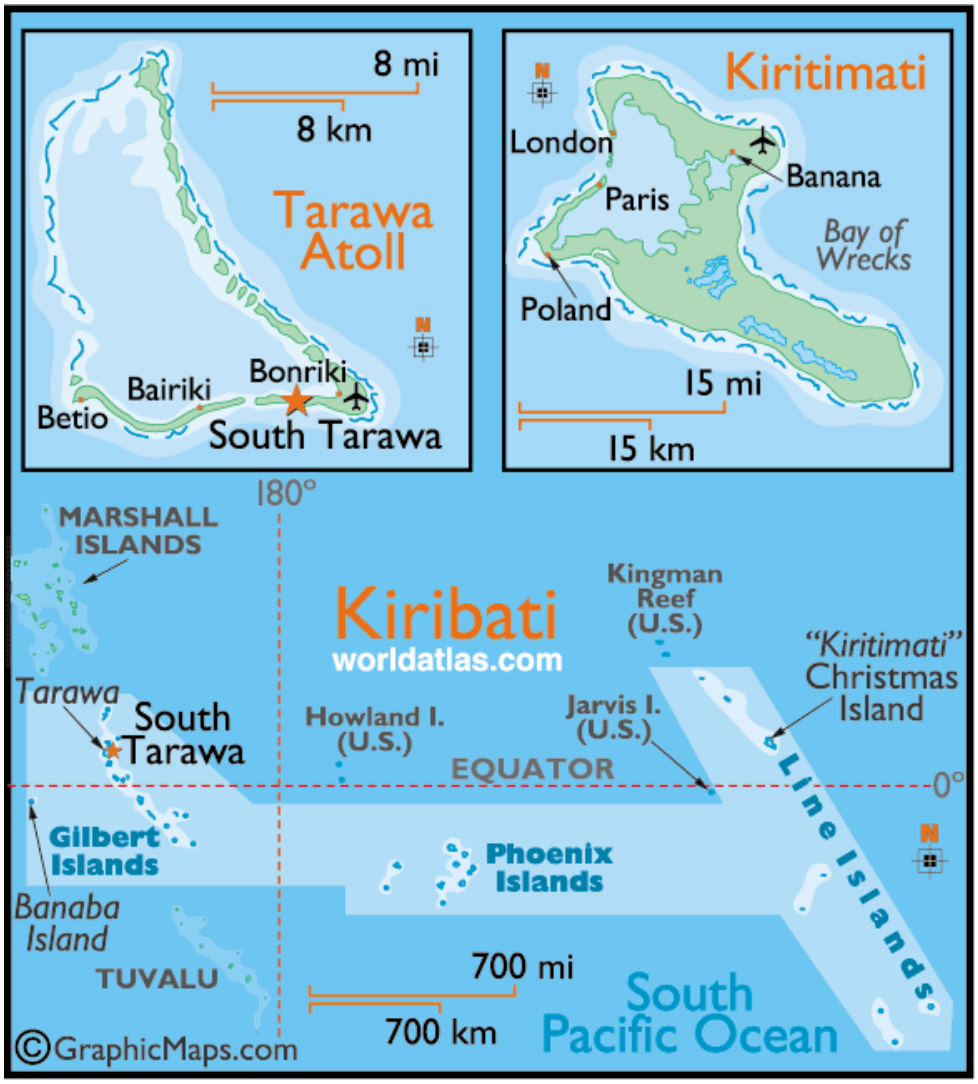
5.1 Kiribati context

5.1.1 Geographic context

Kiribati[7] is an independent republic comprised of 32 atolls, 21 of which are uninhabited, and one elevated coral island (Banaba). This central Pacific nation is spread over all 4 hemispheres and divided in 3 main groups: the Gilbert Islands, the Line Islands, and the Phoenix Islands (Figure 5.1). With a total land surface area of around 811 km^2, the islands are dispersed over 3 million km^2 of the Pacific Ocean (MHMS, 2012; Teaiwa, 2015). The capital Tarawa, which was the main site of fieldwork for this research, is located north of the Equator in the Gilbert Islands.

[7] The name in Kiribati is derived from the indigenous word for "Gilberts", and is pronounced Kiribas (Teaiwa, 2015).

Fig. 5.1: Map of Kiribati



Source: World Atlas, 2020

5.1.2 Historic context

The modern history of Kiribati is thought to begin with the arrival of Micronesians in the South Pacific, which took place between 200 and 500 AD, but evidence suggests that migration from Southeast Asia and Indonesia happened prior to this period. A Micronesian (though not called Micronesian until the Europeans later introduced this name) culture developed within these islands, infused with cultural elements from Samoa, Tonga and Fiji (KNTO, 2020). Kiribati was initially called Gilbert Islands, named after the British Captain Thomas Gilbert, who crossed the atolls in 1788 (Teaiwa, 2015). The Gilbert Islands chain, which included the Ellice Islands, was under British protectorate and became a UK colony in 1916. Occupied by the

Japanese during World War 2, the Gilbert Islands were "a theatre for the expression of British, American, European, Japanese, and later Indonesian martial power" (Teaiwa, 2015). According to Deckker (1996), the pressure from the UN to effect rapid decolonisation led the British to contemplate leaving the South Pacific. In 1978, Ellice Islands became Tuvalu and in 1979, Gilbert Islands and other groups became the Republic of Kiribati (Chappell, 2016; Murray, Overton, Prinsen, Ulu & Wrighton, 2019).

Exploitation is an inherent part of the process of colonisation, and for a long period the colonisers took benefits from Kiribati and offered nothing in return (Chappell, 2016). According to Teaiwa (2015), Kiribati saw its natural resources stretched to their limits to expand the colonies' business interests. Phosphate rock mining, which began to be explored in the island of Banaba in the 1900 and lasted 80 years, removed 22 million tons of land and stripped away 90 per cent of the island's surface (Cranston, 2015). In 1945 most Banabans were moved to Rabi Island in Fiji to make way for mining by the British Phosphate Commission, a joint British, Australian and New Zealand enterprise. Banabans lost their land and livelihoods and received no compensation for their displacement (McAdam, 2013). While farms in New Zealand and Australia received major benefits from the opportunity to purchase cheap agricultural fertiliser and while the British collected royalties, Banabans were charged several times higher than what Europeans paid for goods (Cranston, 2015; Chappell, 2016). Kiribati also occupied a strategic geographic position that served as perfect ground for military bases, and in the late 1950s and early 1960s Christmas Island was used by the USA and the UK for nuclear weapons testing (Chappell, 2016).

Cultural discrepancies and the imposition of foreign values are also part of the nature of the process of colonisation. British colonisers based their notion of progress on modernist ideals that considered industrialisation and urbanisation as synonym of progress, ideas that contrasted with I-Kiribati's world view. As highlighted by administrator and historian Harry Maude (as cited in Chappell, 2016, p. 10) on a 1945 report about Kiribati, island leaders "had no opportunity of advising and sharing in the work of Colony administration" because, among other reasons, "many of them exhibit a striking degree of public spirit". The I-Kiribati communal spirit was not aligned with the vision of *I-matang*[8], the majority of which were professed Christians who viewed their economic activities as directly connected with the inevitable task of bringing civilisation to native populations (Teaiwa, 2015). As explored by

[8] Foreigner in I-Kiribati language (Kiribati Working Group, 2015).

Teaiwa, in the late nineteenth and early twentieth century *I-matangs* were preaching the virtues of capitalism and commerce and spreading industrialisation throughout the South Pacific. This imposition of cultural values was problematised in 1973 by I-Kiribati poet Maunaa Itaia (as cited in Chappell, 2016, p. 20), who warned the I-Kiribati people that "modernity's individualism and money-mindedness were not all they claimed to be". Itaia advocated that its nation should "respect traditions and seek self-sufficiency, through consumer restraint and favoring local cultural skills, instead of depending too much on neo-colonial trade and aid".

Despite Itaia's advice, the delivery of public services in Kiribati was influenced by ideas of urbanisation and centralisation. During colonisation, governmental and commercial agencies were enlarged and concentrated in Tarawa, meaning that development projects were disproportionately concentrated in the capital while the outer islands were underserved and underresourced. As explained by Baraniko, Bate and Beiabure (1980) as well as Chappell (2016), this started a process of inequitable distribution of resources and delivery of services that remains prevalent in contemporary Kiribati. Today, the lack of work and education opportunities and poor access to public services in the outer islands still contributes for a strong rural-urban drift to Tarawa atoll, posing significant problems for health, social cohesion and environmental sustainability and leading to high rates of poverty and inequality (UNICEF, 2014).

This brief contextualisation of Kiribati signals that, for the Pacific nation, independence came when colonisers verified that their major source of income had been exhausted (Yates, 2018). The Western notion of independence, however, is not aligned with the I-Kiribati concept of *inaomata*. As explained by former I-Kiribati government official Roniti Teiwaki (as cited in Chappell, 2016, p. 19), independence for I-Kiribati means "more than political autonomy. It also implies a sense of individual liberty, without being constrained by the formality and legality inherited from the colonial period". Despite that, at the start of the 20th century the overall balance of power and control in the Pacific was still concentrated in the hands of the USA and European governments as imperial control over PICs was formalised in international diplomatic treaties (Murray et. al, 2019). As argued by Firth (as cited in Murray et al., 2019), this launched the Pacific into mercantilist production circuits at the periphery of the evolving global economy. Colonialism left profound cultural, environmental, political and socio-economic consequences that continue to hinder Kiribati's development and to negatively impact health outcomes of the population, which will be explored on the remainder of this chapter.

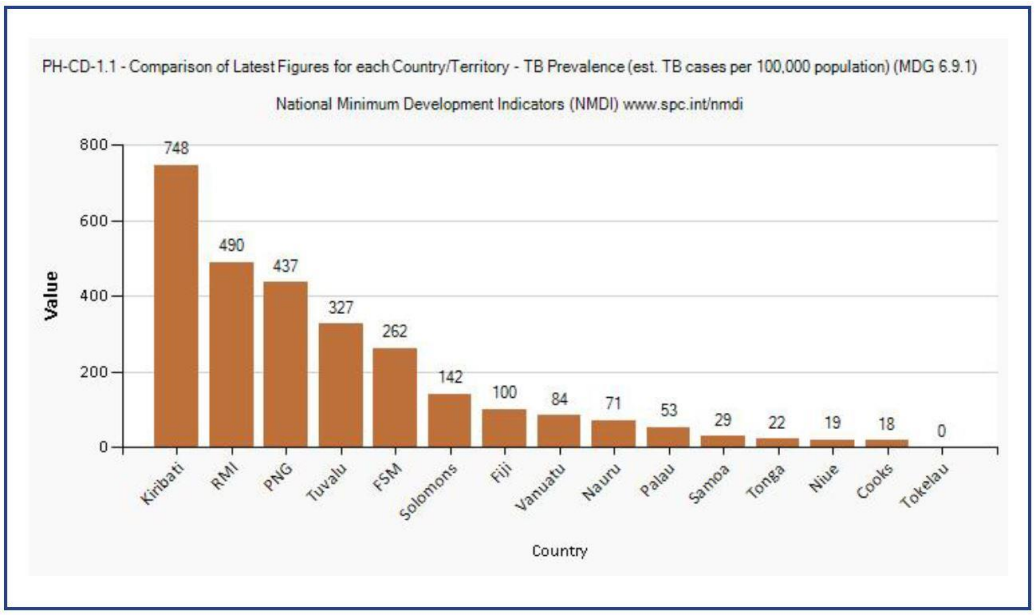
5.2 Main health problems

The combination of public health issues with overcrowding, changes in lifestyle and poor water, sanitation and hygiene (WASH) practices leads to a high incidence of Communicable diseases (CDs) and Non-Communicable diseases (NCDs), and Maternal and Child mortality in Kiribati, which are also known as the triple burden of diseases (WHO, 2014). MHMS (2012) reported that in 2010 the leading causes of death in Kiribati were diseases of the circulatory system, infectious and parasitic diseases, and diseases of the digestive system. Leading causes of morbidity were acute respiratory infections, diarrhoeal diseases and eye diseases. In the same year the main causes of death for children under 5 years of age were pneumonia, prematurity and birth asphyxia.

5.2.1 Communicable diseases (CDs)

Tuberculosis (TB), leprosy and diarrhoea outbreaks are the most common cases of CDs in Kiribati (WHO, 2016a). The atoll nation has the highest rate of incidence of TB in the Pacific (Figure 5.2). According to MFED (2018), TB cases ranged between 366 and 429 per 100,000 population in 2010-2013, with latest data in 2016 showing an increase to 470. Poor living conditions and overcrowding are main factors associated with the spread of TB, a reality in Kiribati where households host in average between 5-7 people (MFED, 2018). A significant number of cases was recorded in Betio, a densely populated area in South Tarawa. On a positive note, in 2015 WHO's estimates suggested that TB treatment coverage stood at 80 per cent, meaning that TB-positive individuals have access to health care (UNICEF, 2017).

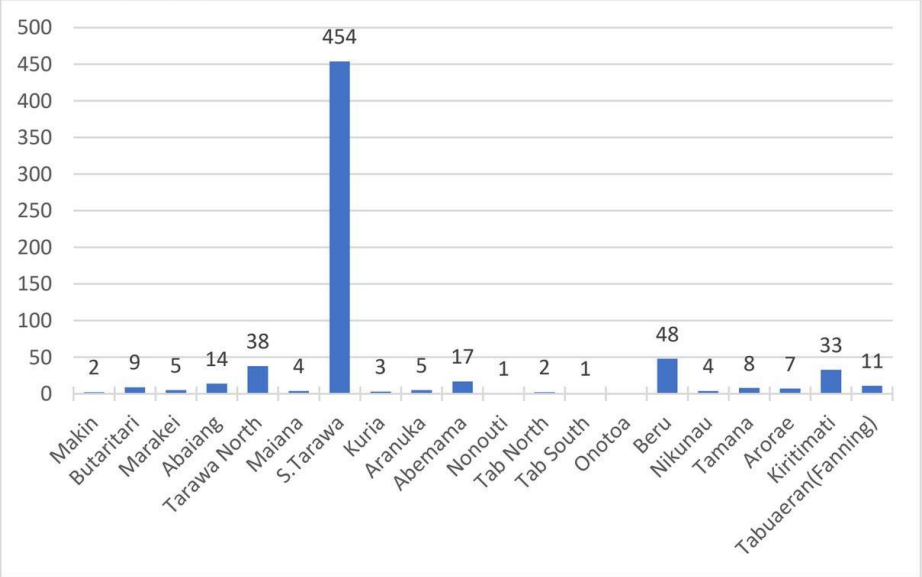
Fig. 5.2: TB prevalence per country



Source: UNICEF, 2017

Leprosy is another CD causing concern in Kiribati. In 2010 there were 182 reported new cases of leprosy in the country, a number that dropped to 155 in 2015 (WHO, 2017). Nonetheless, that makes of Kiribati one of three countries in the Pacific where leprosy elimination status is not yet achieved (MHMS, 2015). The incidence is higher in South Tarawa, at 17 cases per 10,000 population (Figure 5.3). Diarrhoeal disease also remains a key concern. Although the incidence of diarrhoea has declined, it remains one of the leading infectious diseases in Kiribati, especially among children (WHO, 2017). Lack of basic sanitation, hygiene and safe drinking water has been shown to contribute to the spread of water-related diseases and the outbreak of diarrhoeal illnesses (UNICEF, 2017). Finally, HIV/AIDS prevalence is classified as a low level epidemic but Sexually Transmitted Diseases (STIs) rate are very high, especially among young people, suggesting vulnerability (UN, 2017).

Fig. 5.3: Cases of Leprosy by Island in Kiribati (2010-2015)



Source: MFED, 2018

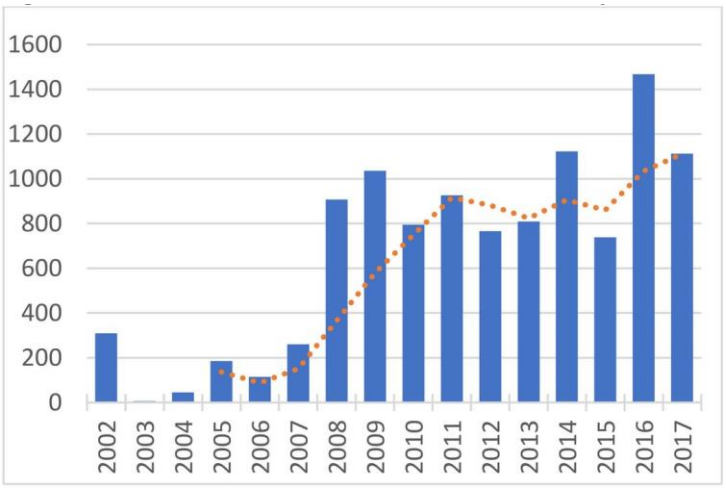
5.2.2 Non-communicable diseases (NCDs)

NCDs are the result of a combination of genetic, physiological, environmental and behaviours factors. Modifiable behaviours that constitute risk factors are physical inactivity, unhealthy diet, harmful use of alcohol and tobacco use. The four main types of NCDs are cancers, diabetes, cardiovascular diseases (like stroke and heart attacks) and chronic respiratory diseases (like asthma and chronic obstructive pulmonary disease) (WHO, 2018b).

WHO (2017) considers Kiribati's current situation an NCD crisis, as the 2016 NCD STEPS[9] survey showed little improvement compared to the 2006 investigation. While the overall disease burden of injuries, CDs and diarrhoeal diseases has been on the decline since the 1990s, the disease burden of NCDs has increased rapidly, with Kiribati witnessing almost epidemic rises in diabetes and chronic kidney disease (UNICEF, 2017). According to the 2015-16 STEPS Survey (as cited in MFED, 2018), the prevalence of diabetes was 20.5 per cent in 2016. The survey notes that although data shows a reduction in the number of cases from 1450 in 2016 to 1100 in 2017, the prevalence of diabetes is still much higher than historical levels pre-2008 (Figure 5.4).

[9] The WHO STEPwise approach to Surveillance (STEPS) is a standardised method for collecting, analysing and disseminating data in WHO member countries (WHO, 2020).

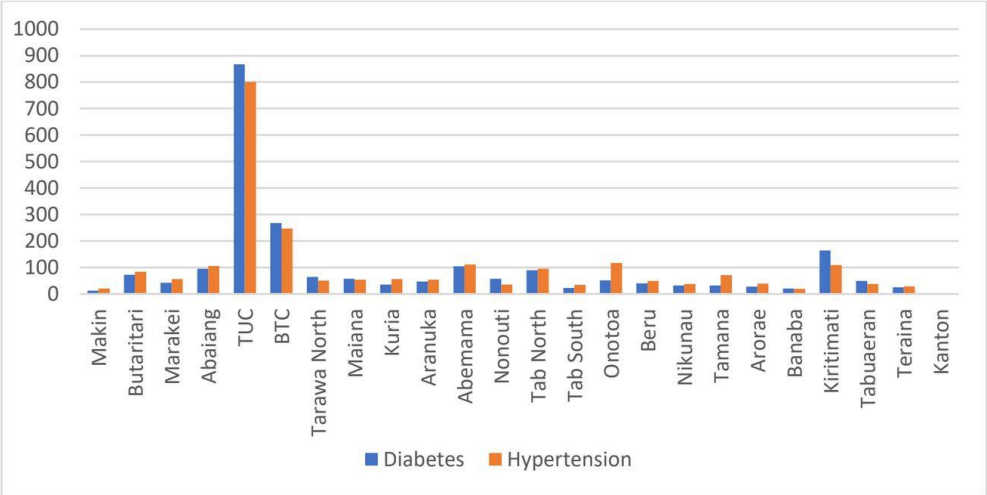
Fig. 5.4: Annual cases of Diabetes 2002-2017 and 4-year moving average



Source: MFED, 2018

The urban areas of TUC and BTC, both in South Tarawa, have registered the highest cases of diabetes and hypertension in Kiribati (Figure 5.5), likely reflecting the increased availability of imported, cheap and low-quality food products high in salt and sugar. The STEPS survey also suggested that obesity, a significant risk factor for other conditions, affects at least 40 per cent of the population aged 15–64. At least 72 per cent are overweight, with rates significantly higher among women. Along with overweight, under nutrition remains a challenge, especially among children. Tobacco use, which is the only risk factor common to all four main NCDs, is high with around 67 per cent of adult men and 37 per cent of adult women being regular users (MFED, 2018). Alcohol consumption is also common among Kiribati's population (UNICEF, 2017).

Fig. 5.5: Cases of Diabetes and hypertension, 2016



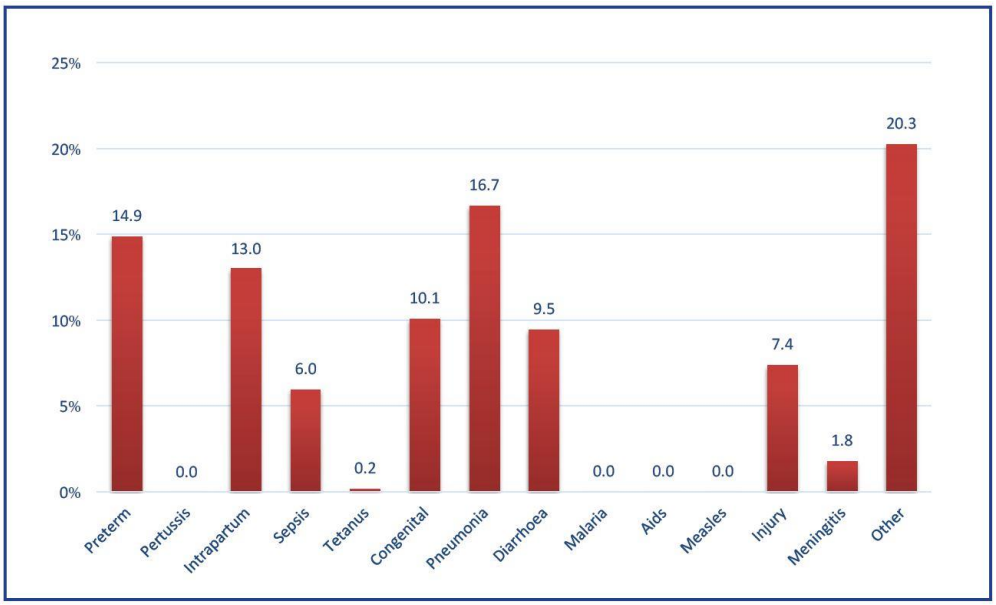
Source: MFED, 2018

5.2.3 Maternal and Child mortality

Kiribati holds the fourth highest under-five mortality rate and fourth highest infant mortality rate in the Asia-Pacific region, in both cases ahead only of Lao, Cambodia and Papua New Guinea (MHMS, 2015). MFED (2018) reported slight improvement in under 5 mortality rates, falling from 52 per 1000 live births in 2012 to 44 per 1000 live births in 2017. Neonatal mortality was 10.2 per 1,000 in 2015 and increased to 11 in 2017. Higher child mortality rates are registered in the outer islands, reflecting lower access to basic services and medical care (UNICEF, 2017).

As of 2015, in children under 5 years of age the main cause of death was pneumonia (17 per cent of all deaths in under-five children), followed by pre-term complications (15 per cent), intra-partum complications (13 per cent), such as birth asphyxia, congenital diseases (10 per cent) and diarrhoea (9.5 per cent) (MHMS, 2015; UNICEF, 2017). UNICEF (2017) observes that the largest category of all causes of death in under-five year olds in Kiribati (18 per cent) is under unspecified ‘other causes’, suggesting problems in the country’s health information system (Figure 5.6). MFED (2018) reports that immunisation is offered to all newborns and infants, but Kiribati still has significant gaps in immunisation coverage for 8 out of 12 universally recommended vaccines.

Fig. 5.6: Causes of death (percentage of all deaths in under-five children)



Source: UNICEF, 2017

Low birthweight and underweight are a major public health issue in Kiribati. According to UNICEF (2017), the combined proportion of children who are underweight or severely underweight is well above the WHO threshold of 10 per cent. UNICEF reports that 15 per cent of children under five years are found to be underweight and 8 per cent to be severely underweight, with little difference reported between urban and rural areas. According to UNICEF (2017), the incidence of nutritionally-related diseases (such as vitamin A deficiency and anaemia among children) is increasing. Inadequate nutrition and recurrent infections or chronic diseases that cause poor nutrient intake, absorption or utilisation are direct causes of child stunting, which is recorded at 34 per cent in Kiribati (UN, 2017). Recent UNICEF (2017) estimates have registered that 69 per cent of children in Kiribati receive exclusive breastfeeding for the first six months after their birth, which is 19 percentage points above the 50 per cent target set out in WHO's Global Nutrition Targets for 2025. However, it has also been estimated that 50 per cent of children aged six to 23 months are not fed frequently enough, according to international standards.

According to UNICEF (2017), the total number of maternal deaths has decreased over the past decades, from six in 1990 to three in 2015. UNICEF also found that maternal anaemia increases the risk of blood loss at delivery and post-partum haemorrhage, the main cause of recent maternal deaths in Kiribati. Anaemic mothers are also at greater risk of delivering premature and low-birthweight babies. The proportion of pregnant women who had at least

one visit to antenatal services was 100 per cent in 2005, with slightly higher proportion of women in urban areas compared to women in rural areas. However, the antenatal care coverage rate for at least four visits is estimated to stand at a lower 71 per cent (MHMS, 2015). While 98 percent of births were attended by skilled health personnel in 2010, according to MHMS (2015) 60 per cent of deliveries take place in a health facility. UNICEF (2017) estimates that traditional birth attendants (TBAs) cater for the needs of 10–30 per cent of women in Kiribati, especially in the outer islands.

5.3 Climate change and health

The dispersed nature of Kiribati and its vulnerability to climate change underlie a series of socio-economic challenges that are interconnected with health outcomes (Davies, Iddings, McIver, Tibwe & Woodward, 2014). Most islands are less than 2 kilometres wide and less than 2 meters above sea level, meaning that climate change impacts all aspects of daily life and is a key constraint to achieve development (MHMS, 2012).

A study by Bambrick et al. (2016) has divided climate sensitive health risks into direct, indirect and diffuse effects, to all of which Kiribati is exposed. The study considers direct effects to be the traumatic injuries and deaths that occur during and after extreme weather events. This is particularly relevant in PICs like Kiribati, at the frontline of severe weather events like cyclones, droughts and rising sea levels (Davies et al., 2014; The Lancet, 2019). As noted by Davies et al., increasing ambient temperatures are likely to increase hospitalisations and deaths of individuals with cardiovascular and respiratory illnesses like asthma, pneumonia and other viruses. Kiribati also has very high rates of smoking and overcrowding, which are additional risk factors for transmission of respiratory infections.

Indirect effects occur through disruption of ecological systems and have a connection with pressing health problems in Kiribati (Bambrick et al., 2016). Inundations are a major climate-sensitive health risk as access to clean water and sanitation is low. This is particularly relevant as open defecation is still practised by 36 per cent of the population, and at 15.2 per cent, Kiribati has the highest rate of this practice in urban areas (UNICEF, 2017). According to the United Nations Pacific Strategy 2018–2022, WASH (Water, Sanitation and Hygiene) infrastructures and practices are one of the least developed in the Pacific region, with national water coverage standing at 67 per cent and at 51 per cent in rural areas. By 2011, Tarawa, the

location with higher diarrhoeal disease prevalence in the country, had connected only 40 per cent of its population to public sewerage system and improved sanitation facilities (UNICEF, 2017). Inundations also expand the range of vector habitats which, along with high temperature and humidity, create the perfect conditions for the proliferation of mosquitoes that transmit malaria, dengue fever and lymphatic filariasis (Bambrick et al. 2016; MFED, 2016). As projections for future climate in Kiribati generally indicate an increase in the days of very heavy rainfall by 2050, the need for measures to protect water supplies and block the transmission of infections is particularly important (Davies et al., 2014).

The potential for climate change to act as an additional driver of NCDs in Kiribati and other PICs is another indirect climate sensitive health risk (Bambrick et al., 2016). Infertile soil, droughts and the lack of land mean that accessibility to food crops and livestock is low (UNICEF, 2017). The acidification of oceans caused by the rise in carbon dioxide emissions means that fish stocks, a major food source in the country, are declining and more likely to be contaminated by the ciguatera toxin (WHO, 2017). As result, food variety and availability has decreased and the consumption of imported and less nutritious food has become more prevalent, having a direct impact on health outcomes (MFED, 2018). Davies et al. (2014) also raise the concern that as a country with high temperatures and limited facilities for refrigeration and secure food storage, Kiribati is at high risk of illnesses due to contamination of food by bacteria, viruses and toxins. There is also an ongoing concern that climate change decreases individuals' willingness and ability to perform outdoor work or exercise in higher temperatures, therefore exacerbating NCD risk factors (Davies et al., 2014).

Kiribati also faces the diffuse effects of climate change, related to societal dysfunction (McIver et. al, 2016). Key examples of the effects, posed by Kjellstrom and McMichael (as cited in Bambrick et al., 2016), are population displacement, disrupted health services and potential conflict over climate-related resources. On top of these effects, climate-related health problems will be borne disproportionately by vulnerable sectors of the population (Davies et. al, 2014; MFED, 2016). This impacts the realisation of human rights, amongst which is the access to timely and quality health care (UNICEF, 2017).

5.4 Health strategies and priorities

The fulfilment of the right to health is recognised in the constitution or national legislation of Kiribati (MHMS, 2012). As well as developing its national strategy, the GoK has agreed to a number of regional and international conventions and initiatives that provide directives and plans of action to improve the quality of health care delivery and enable universal access to medical care in the country. Given the scope of the research it is not possible to explore all health-related programmes in detail, so this description and brief analysis will be centered around the identification of priorities and synergies between health plans that are considered particularly relevant for the overall research investigation.

The national health sector strategy at the time of this research was the Kiribati Health Strategic Plan (KHSP) 2016-2019 (MHMS, 2015). Its primary goal was to "improve population health and health equity through continuous improvement in the quality and responsiveness of health services, and by making the most effective and efficient use of available resources" (MHMS, 2015, p.1). The plan encompassed six objectives and its associated actions, indicators and targets. The areas addressed in the plan remained essentially the same as in the previous national health plan (MHMS, 2012), reflecting the need for further improvement in the following areas: NCDs, CDs, population growth, maternal morbidity and mortality, child morbidity and mortality, health service delivery, gender-based violence (GBV) and youth health (MHMS, 2015). The six strategic objectives are:

1. Strengthen initiatives to reduce the prevalence of risk factors for NCDs, and to reduce morbidity, disability and mortality from NCDs and complications.
2. Increase access to and use of high quality, comprehensive family planning services, particularly for vulnerable populations including women whose health and wellbeing will be at risk if they become pregnant.
3. Improve maternal, newborn and child health.
4. Prevent the introduction and spread of communicable diseases, strengthen existing control programmes and ensure Kiribati is prepared for any future outbreaks.
5. Address gaps in health service delivery and strengthen the pillars of the health system.
6. Improve access to high quality and appropriate health care services for victims of gender-based violence, and services that specifically address the needs of youth.

The previous national health strategy (KHSP 2012-2015) had identified transport and communication, the maintenance of buildings and equipment and the investigation of affordable new equipment and sources of renewable energy as areas that deserved special attention (MHMS, 2012). The KHSP 2016-2019 strategy replaced transport and communication for the expansion of current hospitals and strengthening of hospital and public health services (MHMS, 2015). This is an important change that signals a realisation that health strategies must go beyond investments in infrastructure to include public health initiatives as priorities.

A practical example of a partnership geared towards prevention is UNICEF's programme WASH in Schools. Supported by New Zealand, the programme aims to ensure a minimum level of water, sanitation and hygiene standards and has been successfully implemented in 32 participating schools in 4 targeted islands: Abaiang, Maiana, Marakei and North Tarawa (MFED, 2018). Another initiative has been for subjects such as Health and Family Planning to be taught in both the Primary and Junior Secondary schools, and more specifically at the Senior Secondary levels. MHMS also uses radio, the media with highest reach in Kiribati, to promote awareness on family and health matters. Strategies to strengthen Directly Observed Treatment Short course (DOTS)[10] services, existing diseases surveillance and outbreak responses for TB, leprosy, lymphatic filariasis, STIs, HIV/AIDS and other CDs have been explored since the previous national health plan (MHMS, 2015). To improve the provision of maternal and child health services, strategies like the Integrated Management of Childhood Illness (IMCI) and the Expanded Programme on Immunisation (EPI) have been successfully implemented and responsible for health improvements.

SDG 3 is directly connected to the theme of this research, with the objective of "ensuring healthy lives and promoting wellbeing for all at all ages" (UNDP, 2015). The SDGs build on the MDGs, the previous global agenda. Not only did Kiribati not achieved these established goals, the country regressed in some areas (Pacific Community, 2016). Particularly pertinent to this discussion are the non-achievement of MDG 5 (Improve Maternal Health), especially targets on maternal mortality rate (target 5A) and on contraceptive prevalence rate (target 5B), and of MDG 6 (Combat HIV/AIDS, malaria and other diseases), especially because of the alarmingly high levels of tuberculosis and non-communicable diseases (target 6C) (MFED, 2015).

[10] The WHO recommended strategy for TB control (WHO, 1997).

The coordination of domestic and external resources and initiatives towards the realisation of the SDGs was one of the priorities on the design of the Kiribati Development Plan (KDP) (GoK, 2015). The KHSP (2016-2019) expresses "a strong desire" to align with the priority issues and strategies in the new KDP, which should facilitate the coordination of actions for the achievement of the SDGs (MHMS, 2015, p. 10). Like KHSP 2016-2019, KDP acknowledges the country's poor health performance and the need for action. The strategy is divided in Key Policy Areas (KPAs), with KPA 3 addressing health issues. KPA 3 presents the same overall objective of the country's national health plan, dedicating 6 core issues and 12 strategies for the achievement of better health outcomes (GoK, 2015).

In addition to the KDP and the KHSP, both covering the period 2016-2019, the GoK developed a long-term plan that covers up to 2036, the Kiribati Vision 20, or KV20 (MFED, 2016). KV20 is based on four main pillars: Wealth, Peace and Security, Infrastructure for Development and Governance. The Wealth Pillar considers the development of natural, human and cultural capital a pre-requisite for economic growth and reduction of poverty. The Human Capital subtopic, under the Wealth Pillar, is connected to the development of a highly skilled, qualified and efficient workforce and of an accessible and affordable healthcare system. KV20 envisions to undertake a number of reforms to reduce the skills and qualifications gap from 40 per cent to 20 per cent by 2019 and to zero by 2036. In order to address this gap, it plans to increase the percentage of the total national budget allocation to staff training and human resource development from 0.03 per cent to 1 per cent by the end of 2019 and to 5 per cent by 2036. It does not however, specify which areas will benefit from the implementation of human resource development policy and strategies and how that will take place.

KV20 (MFED, 2016) also recognises that improving the healthcare system will require strengthening the capacity of the hospitals and health centres. It aims to improve the capacity of the health facilities by 50 per cent in 2019 and 100 per cent by 2036. The nurse-patient ratio is envisioned to be reduced to 1:800 by 2019 and 1:300 by 2036. The capacity of the health service delivery, in turn, is to be enhanced by the improvement of the current doctor-patient ratio to 1:1860 by 2019 and 1:1000 by 2036. Achieving the desired capacity will require additional investment in basic hospital equipment, training of more nurses, doctors, public health workers and midwifery and medical officers.

In terms of regional strategies, Kiribati is signatory to the United Nations Pacific Strategy (UNPS) 2018-2022 (UN, 2017), a five-year framework that addresses the

development priorities of 14 PICTs. In alignment with the KDP, this strategy aims to advance localised responses to the SDGs. Kiribati's national health plan is in direct synergy with UNPS' outcome 4, which looks to increase equitable access to and utilisation of inclusive, resilient, and quality basic services. Moreover, UNPS' strategies in the Pacific are underpinned by improvements in four main areas: strengthening policies and legislative frameworks, improving planning and coordination mechanisms for health and nutrition, and improving delivery of quality health and nutrition care services, including at the community level.

With the help of development partners, the Kiribati–WHO Country Cooperation 2018–2022 is another strategy that aims to support the Government of Kiribati in pursuing its national health priorities (WHO, 2017). To facilitate coordination, each KHSP 2016-2019 activity is linked to at least one of the sub regional focus areas that are detailed in the WHO strategy. Among the activities are the revitalisation of primary health care services, the achievement of UHC, the reduction of risk factors and vulnerabilities of the population, the implementation of risk management plans and increased preparedness to respond to public health events such as infectious diseases outbreaks (WHO, 2018c).

Kiribati's national health strategy, as well as the regional and global health agendas of which the country is signatory, are increasingly moving towards preventative approaches and recognising the importance of coordination between national government departments and agencies, the private sector, NGOs, bilateral and international development partners (MHMS, 2015). However, the implementation of activities faces a number of obstacles, some foreseen and others unanticipated. The next sections will explore the structure of the health sector in Kiribati and the main constrains for the delivery of quality health care for all.

5.5 Health services and delivery systems

Kiribati's health network has a total of 30 health centres staffed by medical assistants, (MAs), a nurse practitioner with training to perform more advanced tasks (Campbell, De Silva, Kafoa, Kiriton, McKimm, Newtown & Roberts, 2012c). Public health nurses staff 75 clinics, distributed from Makin to Arorae, including the Line and Phoenix groups. The centres and clinics provide primary health care services and promote outreach activities, such as family planning, NCDs, maternal and child health, child welfare clinic, weighting and vaccination of children and the distribution of TB and Leprosy medications (UNICEF, 2017). The MAs are

in charge of health centres and conduct an outpatient clinic, while the nurses provide support and occasionally organise outreach welfare clinics in maneabas (traditional meeting house). According to a representative of nursing services, one clinic in average is responsible for looking after a catchment area of 4 or 5 thousand people. Most clinics have the services of 1 MA and between 1-3 nurses. Medical services in small islands are usually delivered by one health centre and two clinics, while in larger islands the number of clinics increases to eight. Kiritimati, or Christmas Island, is considered one of the main urban areas of the country and has one hospital, four health centres and around four health clinics (Table 5.1).

Table 5.1. Summary of health services by facility type in Kiribati

Facility	Essential Services		Expanded Services
	Public health, prevention and outreach	**Clinical (primary and secondary)**	
Health Clinics (75)	• Public health education and awareness programs • Immunisation	• Basic primary care	

Health Centres (30)	• *As for health clinics*
	• Family planning
	  ○ Minimal essential package
	  ○ STI prevention and treatment
	  ○ HIV prevention
		• Primary care
		• Midwifery, maternal and child health
		• Limited dental care
		• Laboratory services
		• Ambulance services
		• Medication
			• Outreach to islands with no health facilities (not all centres)

Referral Hospitals (3)	• *As for health centres*	• General outpatient and inpatient care • Emergency care • Betio Hospital (10 beds) • Kiritimati Hospital (7 beds) ○ Specialist maternity care	• Emergency evacuations from Kiritimati by plane to Fiji

Central Referral Hospital (1)	• *As for sub-divisional hospitals*
	• Family planning
	  ○ Infertility counselling
	  ○ Cervical cancer screening and treatment
		• 120 beds
		• General outpatient and inpatient care
		• Emergency care
		• Comprehensive range of secondary curative services
		• Laboratory
		• Radiology
		• Pharmacy
		• Physiotherapy
		• Mental health inpatient unit
			• Emergency evacuations by plane to Fiji
			• Visiting specialised clinical services
			  ○ Cardiology
			  ○ Ophthalmology
			• Overseas referrals (specialised secondary or tertiary care)

Source: MHMS, 2012

Tungaru Central Hospital (TCH), or Central Referral Hospital, is the largest referral facility in the country and main fieldwork site for this research. Located in South Tarawa and

with a capacity of 120 beds, the hospital provides secondary curative services. Patients requiring more specialised secondary and tertiary medical attention are referred overseas by TCH (MFED, 2018). Three other hospitals support health care delivery in Kiribati: Betio hospital (10 beds), also located in South Tarawa, Ronton Hospital (7 beds), located in Kiritimati and delivering health services for the Line and Phoenix Groups, and Southern Kiribati Hospital, located in Tabiteuea North (40 beds) and servicing the isolated islands in the South of the country. Basic maternity, surgical and medical are available at these facilities (MFED, 2016; UNICEF, 2017).

Health services and medicines are delivered free of charge in Kiribati. There is no national public health insurance, social insurance, other sickness fund or private health insurance (MHMS, 2012). A private health system network is not formally established, but more recently a private clinic started to operate in Bairiki, attached to a pharmacy. According to research participants, some patients also seek medical assistance at the Marine Training Centre's (MTC) private doctor. There are also charges for patients admitted to a private ward at TCH. In parallel with the formal health structure, a traditional health system operates.

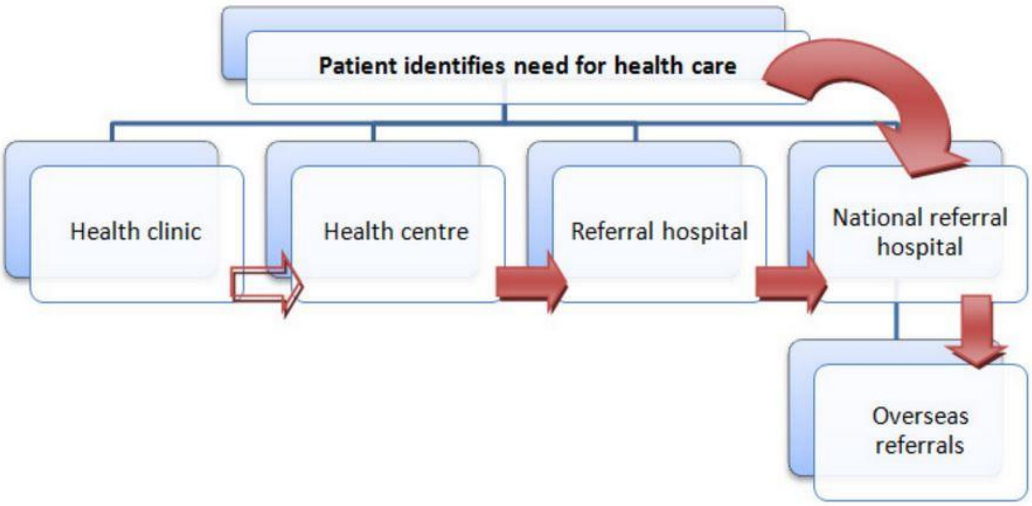
Traditional healers receive money, food and other goods as compensation for their services, with amounts paid in urban areas roughly twice those in rural (MHMS, 2012). While Kiribati's 2012 health service delivery profile (MHMS, 2012) briefly discusses the work of traditional medicine practitioners, the only reference to traditional services in the current national health strategy is related to the work of TBAs, especially in relation to further training on antenatal and postnatal care (MHMS, 2015). Although in 2012 the MHMS stated that numbers of traditional healers were diminishing, fieldwork data suggests that the informal network still very active in providing primary health care in the communities, an observation that carries a number of implications that will be further discussed in this investigation.

MHMS (2015) most recent data shows that 30 doctors, 305 nurses and MAs and around 405 professional/technical roles comprise the country's health workforce, totalising 740 permanent staff. Kiribati currently has 2 paediatricians, 1 physician, 2 surgeons, 2 obstetricians and 1 anesthetic professional. Only 1 surgeon, 2 obstetricians and the anesthetic are local professionals. An average of 155 MAs and nurses work in the health centres and clinics (WHO, 2017). According to UNICEF (2017) none of the remote outer islands, except for Kiritimati and Tabiteuea North, have any doctors. In 2006 the number of doctors increased to 35 with the recruitment of 10 doctors from the Cuban medical brigade, some of which provided medical

services in South Tarawa health centres. The start of the Cuban medical outreach and the provision of scholarships for I-Kiribati students to complete medical education in Cuba, which will be explored in detail in the next chapter, led in 2014 to the establishment of a bridging course, the KITP. The KITP scheme hired a limited number of foreign specialists to work primarily as intern's supervisors, but they also provide clinical services to the I-Kiribati population at TCH. In 2012, specialised clinical services in Kiribati were offered at TCH and Kiritimati hospitals by visiting teams from the Royal Australian College of Surgeons (RACS), Taiwan Medical teams, the Osakawa Eye Team from Japan, and volunteering obstetrics and gynaecology specialists from NZ (through NZ Medical Treatment Scheme – managed by Health Services Limited) (MHMS, 2012).

Referral pathways (Figure 5.7) start with the patient consulting the nurse at a health clinic. If the nurse is unable to look after the case, it will be referred to a health centre to be assessed by the MA. The MA will sometimes consult a specialist, usually based at TCH, to exchange information and decide if the patient needs to be admitted at one of the four referral hospitals that provide secondary level clinical services. In cases where the patient requires more specialised clinical care (e.g. cardiology, ophthalmology), referrals are issued for TCH. Patients residing in outer islands are transported to South Tarawa, usually on commercial flights. In emergency situations, a team of health workers can travel from TCH to the outer island or a plane can be chartered to transport the patient to TCH. If tertiary care is required patients are referred offshore, often to Fiji, India, Taiwan, New Zealand, Australia and USA (only from Kiritimati). All transport and accommodation costs are covered by the GoK, as well a daily allowance for the patient and a caretaker.

Fig. 5.7: Referral pathways in Kiribati



Source: MHMS, 2012

5.6 Barriers and bottlenecks to health system strengthening

Kiribati faces a complex set of challenges for health care delivery. It is out of the scope of this research to perform an in-depth analysis of each shortcoming, especially given the cross-cutting nature of health issues, but this section will draw on themes highlighted in relevant health strategies, and from observation and interview data from this research:

5.6.1 Insufficient health care financing

In 2010, Kiribati's total health budget was approximately US$ 14.1 million. Total government spending on health was estimated to stand at around 9 per cent of the GDP in 2011, which is above the WHO-recommended 5 per cent (UNICEF, 2017). The 2012 Health Service Delivery Profile (MHMS, 2012) identified medical referrals as the primary risk to Kiribati's health budget. Referrals to New Zealand alone, which are funded through development assistance, cost US$ 630,000 for 57 patients in 2010 (UNICEF, 2017). The MHMS (2015) highlights the importance of external assistance and reports that Kiribati's spending on health is still insufficient to cover the high administrative and delivery costs of providing care to a dispersed population.

Insufficient funding means that health care facilities often lack essential medical equipment, drugs and supplies. According to physicians interviewed for this study, the lack of supplies for medical investigation hinders preventative approaches to serious illnesses. TCH's laboratory frequently runs out of key reagents and outer islands are not able to appropriately collect and analyse blood samples. The lack of tumor markers, for example, means that doctors are hardly able to detect early stage cancer, especially those that cannot be identified through screening (e.g.: ovarian cancer, lung cancer, stomach cancer). Research respondents often commented that poor health facilities deter patients from coming to the hospital and can delay much needed medical attention, as explained by this health practitioner:

> *"Even if there is something they need to do at the hospital sometimes they want to leave. The hospital is not attractive enough because obviously there are many standards that are not being met here, and people are around you sick and dying. It's a depressing situation when they want to have their own time and enjoy it with family." (KITP supervisor)*

While outer islands lack appropriate equipment and medical supplies for diagnosis and treatment, the main provider of curative services in the country (TCH) is not able to cater to the high demand and sometimes runs out of simple medicines like paracetamol. According to interviewed physicians, the lack of space and medication leads to the postponement of surgeries and affects emergency and outbreak situations.

5.6.2 Insufficient health workforce

A UNICEF (2017) report highlights that nurses make up the largest group within the health workforce of Kiribati, at 70 per cent of all health sector employees. According to KV20 (MFED, 2016), the doctor-patient ratio and nurse-patient ratio in South Tarawa is still an ongoing challenge high at 1:2240 and 1:1000 respectively. Problematic inequities exist between the outer islands and the main island of Tarawa, with a disproportionate share of human resources, and health care funding, allocated to the central hospital on South Tarawa (MHMS, 2012; MHMS, 2015). The situation is raised as an issue in the 2012 Kiribati Health Service Delivery Profile (MHMS, 2012) and the current national health strategy (MHMS, 2015). According to the MHMS (2012), one of the key underlying causes of the health workforce shortage in Kiribati is the inability of the public health system to retain these professionals. MHMS (2015) also considers an ageing health workforce an obstacle for

developing a healthy patient-doctor ratio. According to KV20 (MFED, 2016), 59 per cent of public service employees are aged between 31-40, while 22 per cent are aged between 18-30, with the remaining 18 per cent of the employees are aged 44 and above.

I-Kiribati medical professionals have access to scholarships through the Kiribati Government, Cuba, New Zealand, Australia and sometimes the WHO (DFAT, 2020; GoK, 2020; MFAT, 2020; UCCM, 2017). A nursing representative highlighted that the recent merging of the Kiribati School of Nursing (KSN) with the Kiribati Institute of Technology (KIT), which currently has 72 students, might increase health workforce capacity. The interviewee also highlighted that a drafted PHC curriculum is being developed jointly with UNICEF and other partners, with focus on the achievement of the SDGs.

While there is common agreement about the need for more opportunities to ensure the ongoing competency of health workers, respondents had mixed views about the rate of health worker retention in Kiribati. While one respondent argued that retention was not an issue because medical interns knew that if they left Kiribati their opportunities for further training would be much smaller, others considered retention a big problem:

> *"At the moment there is a lot of shortage in the region, so the ones that offer better packages attracts more doctors with more qualification. […] The salary for I-Kiribati doctors is not very good. The hours of work, sometimes we are really short. If someone doesn't show up then the other person needs to work 12 plus hours. In the long run that becomes unhealthy." (KITP supervisor)*

Limited incentives for the retention of skilled health workers was an issue articulated by Cuban-trained registrars:

> *"Opportunities that are supposed to be to us are not given. I don't know why, opportunities to get good wages, to study, we don't get that compared to other professions who studied 3 years and they come back with a high salary. Us, we spend 7 years and don't get the same. Maybe that's another way that the system could be improved. How could you improve the system when the people are not improved?" (Cuban-trained registrar from Kiribati)*

> *"We need good human resources, to get more experienced, to get more qualifications, more training. That's what we want it to be improved. I feel sorry about senior doctors who have been here for a long time and they don't get the*

chance to go and do postgraduate studies. I don't know what's the delay, the waiting. They feel tired and frustrated and maybe plan to run away and work in other islands, other countries. We have seen this, some of us went away." (Cuban-trained registrar from Kiribati)

It is clear that a level of frustration underlies the discourse of some Cuban-trained interns. According to a health official, part of the issue lies in the priorities established by the Public Service Office (PSO), responsible for overseeing the development of civil servants across all ministries. Another interviewee highlighted that the lack of a MHMS representative is connected to the heart of the issue:

"We think…per ministry they should have a quota. I think the Ministry of Education sits in the committee, but there is nobody there from the MHMS, so we are disadvantaged, we don't have any representatives. Our health people, even our doctors, when they apply for postgraduate, their programme is not on the priority list. That's the kind of feedback they receive, and this is really frustrating, this should be considered a priority, we are dealing with the health of people." (Nurse representative)

5.6.3 Poor institutional capacity

Poor institutional capacity is a challenge that affects all public sectors of Kiribati. Difficulties in data collection, disaggregation and analysis inhibit the formulation of responsive, coherent and sustainable policies. A UNICEF (2017) report on the situation of children in Kiribati notes that Kiribati currently lacks reliable data on child stunting, gender disparities, children with disabilities and other vulnerable groups. That means that indicators and reports often rely on project data or the national census, leaving behind the people who are disenfranchised and in most need of assistance. According to a health worker, the lack of data extends to patient's medical records, which are not always readily available and sometimes are lost.

5.6.4 Centralisation of health delivery system

Kiribati's 2012 Health Service Delivery Profile (MHMS, 2012) recognised that equity in the delivery of health care is an issue and that curative care competes with preventive health care

for public resources, with a disproportionate share allocated to the central hospital in South Tarawa. The MHMS (2012) reported that funds were used primarily for clinical hospital services and curative care (52 per cent); pharmaceuticals (17 per cent); primary care and public health (16 per cent); and administration (15 per cent). The report observed that the adoption of decentralisation policies to strengthen the role of local-level authorities for over decade has negatively impacted Kiribati's ability to strengthen and streamline its health care system, resulting in poor service delivery and diminished confidence in public health care. It notes that the devolution of responsibilities to local authorities was unrealistic and attributes the negative impact to insufficient funding. The report also acknowledges the need to update laws and develop regulation to meet current and future health situations in Kiribati and to meet international requirements, but it does not explore the issue in depth. The current national health strategy (MHMS, 2015) recognises the need to effectively manage the health system through the use of laws, regulations, accreditation, standards and guidelines and shows an increase in budget allocation to preventive strategies, but the strategy to decentralise the health delivery system seems to be given less importance.

Fieldwork data suggests that, other than the disproportionate allocation of funds to curative services, the insufficient coordination between clinical services and public health might have played an important role in the unsuccessful implementation of the decentralisation strategy:

> *"They try to separate the clinician and public health (…). I was telling them that they should involve us (…). I'm not sure whether they like it or not because sometimes you can kind of tell that they go 'this is public health, that is your own'." (KITP Supervisor)*

> *"We discuss only as doctors, no administration people involved. We don't have a word in those kinds of things. There should be a structure more like that, when we have an audit meeting, we should include someone from administration, so they can take into account issues that we have been discussing (…). We can give ideas but at the end we don't know what happens after." (Cuban-trained registrar from Kiribati)*

Research data also suggests that inconsistent medical protocols influenced the implementation of the decentralisation strategy. Several Cuban-trained doctors mentioned the lack of standardised medical protocols and guidelines for referral practice as persistent barriers for the

delivery of quality health care. A Cuban-trained intern from Kiribati argued that due to insufficient institutional capacity, Kiribati's medical protocol was developed based on guidelines developed by Fiji, New Zealand and Australia. For this reason, the protocol did not accurately respond to Kiribati's issues, such as insufficient health workforce in a scattered geography and a different disease pattern. As expressed below, informants emphasised that health workers have different understandings of what constitutes primary, secondary and tertiary level care in the country's context. According to them, this hinders the coordination of medical referrals and impacts the delivery of quality health care, sometimes in emergency situations:

> "*Cases that need to be seen at the hospital are not seen at the hospital. They treat that in primary care, while sometimes someone with a simple ear infection is referred to the hospital rather than seen at the clinic. If you get doctors in the peripheries, they will only send in patients that actually need secondary and tertiary level care. Sometimes if the clinics are not sure they just refer the patient to the hospital. It causes a big influx of people." (Cuban-trained intern from Tuvalu)*
>
> *"Sometimes people underestimate the stage of the patients. Most of the departments don't have a standardised protocol. It would be good to cover problems like diabetes, insulin infusion. We don't have a standard guideline, it depends on the consultants, medical officers, whatever protocols they are used to." (KITP supervisor)*
>
> *"Here the law can really get involved in medicine. For example, you wouldn't do an operation here if the patient is unstable. But sometimes the only way to solve the problem is to do it, but we can't, and that is frustrating (…) Sometimes the doctors are limited, they want to help but they fear the law." (Cuban-trained intern from Tuvalu)*

Medical protocols also affect drug prescription and the determination of standard medical dosages. Other than institutional capacity, physicians commented that the lack of research about Kiribati's disease pattern is a gap for the development of the country's own guideline for medications. If an antibiotic prescription is considered high, the common practice tends to be

to reduce it, for safety and financial reasons. This approach was criticised by interviewees, with a health worker suggesting that nurses sometimes are too conservative:

> *"Here you don't get drugs if the patient isn't fitting […] They look it, see it is not infected and its fine. Only when it gets infected then they start the antibiotics." (Cuban-trained intern from Tuvalu)*

> *"We are thinking that some of them [nurses] are quite afraid of changing the doses of the medications. I've seen a lot with my diabetic patients. If they have uncontrolled diabetes, I have to consult how long they have been taking that dose, they say that for about 5 months their sugar is in the 20s, but the medication never changed. They are afraid of giving the patients too much." (KITP supervisor)*

Information provided by health workers and the I-Kiribati community suggest that a significant number of international referrals are cancer and cardiac patients. Valvular heart diseases, ischemia, bypasses, CDs, diabetes, hypertension and NCDs in general have been cited as the most common illnesses that require patients to seek health care overseas. According to the WHO (2005) if risk factors were eliminated, 40 per cent of cancer would be prevented and at least 80 per cent of all heart disease, stroke and type 2 diabetes. Cuban-trained doctors explored this link between prevention and domestic and overseas referrals:

> *"We provide four or five maneabas, full of people coming from the outer islands, never empty. (..) That is around 500 people every year. Those are cases that could be prevented." (Cuban-trained registrar from Kiribati)*

> *"Every year we are spending millions sending patients overseas. (…) The reason why we send people overseas is because we don't have the right equipment or the right medicine." (Cuban-trained intern from Tuvalu)*

5.6.5 Culture and role reversal between tiers of care

Data obtained in interviews suggests that, along with inconsistent referrals, culture seems to determine health-seeking behaviour in two ways in Kiribati: patients either seek the services of traditional healers or wait until their health deteriorates to a critical condition to seek care at the formal health system. Traditional healers, or local doctors, often act as PHC providers, while hospital services are used either for simple check-ups or, paradoxical – when the health situation becomes critical:

> *"People always go first to the local doctor, and if it starts getting complicated then they come to the hospital. Sometimes we manage to help but sometimes is too late to save them." (Cuban-trained intern from Kiribati)*

> *"Sometimes people have been ill for 2 or 3 months, and when we ask why they didn't come to the hospital they say is because they were trying some local medicine." (Cuban-trained registrar from Kiribati)*

> *"Yesterday we had a patient who comes here to measure her blood pressure only. We tried to convince her the local treatment was not working because she had been here 5 or 6 times, but she still refused to take the medicine." (I-Kiribati NCD Specialist)*

Herbal medicine is considered by some participants, especially those who received medical training in Cuba, to hold the potential to be effective and to be deserving of exploration:

> *"For me, culture has been here before medicine, so we can't say that traditional medicine doesn't work. Western medicine started off as traditional medicine. But written and studied. So traditional medicine can work." (Cuban-trained intern from Tuvalu)*

> *"Some of them [herbal treatments] are effective, I believe some of them, but not all. These herbal treatments haven't been tested yet, so it would be good to have future research, especially in our situation where we don't have enough medication." (KITP supervisor)*

Although some health workers perceive evidence-based herbal treatment a feasible complement for conventional medicine, other health professionals emphasised the negative outcomes of the practice:

"We have diabetics with wounds who got treated outside, with leaves and things like that. I don't think is effective, it just makes it worse and we end up having to amputate their legs. They sort of delay them coming to the hospital." (KITP supervisor)

Data from interviews indicates that patients' resistance to present themselves at the hospital is connected to understandings of health:

"People don't want to come to the hospital because they don't feel sick. Here people only come to the hospital when they are not feeling well. Even if they don't feel well sometimes they don't come to the hospital, they wait until they can't cope with the pain to come. If they are healthy, they don't feel anything, they don't come to the hospital. Even for medical check-ups, they don't even come for that." ((I-Kiribati NCD Specialist)

The message conveyed throughout interviews is that in I-Kiribati society, to be unhealthy means to no longer be functional. Being functional means to be able to fully participate as a productive member in the family and community life. To be unhealthy, on the other hand, is associated with not being able to contribute to one's group and can even be a source of embarrassment at times. A health worker trained in the Pacific suggested that a higher tolerance to pain is common in harsh environments. One of the informants during fieldwork observation reflected on a different relationship to death. She explained that death and the common misfortune that regularly affects them are natural circumstances that they must accept with resignation. This avoidance to seek medical care means that patients often arrive at the hospital in a critical condition, sometimes requiring more drastic and permanent measures or treatments. For these doctors, this relationship enabled an association of hospitals with negative outcomes, creating a vicious, and harmful, cycle:

"*I think diabetics just want to avoid the hospital as much as possible because they are afraid that they will have their legs amputated. If they came early that wouldn't happen, but because they do come too late then they think when people go to the hospital they get their legs chopped." (KITP supervisor)*

"Sometimes when you advise a patient that a minor procedure is necessary they don't come. That's more of a cultural belief that if they go to the [operating] theatre they are going to die." (KITP supervisor)

The possibility of embracing culture and incorporate traditional medicine into the formal health system was investigated in the past. In 2001, Kiribati's Cabinet approved the appointment of an inter-Ministry Working Group on Traditional Medicine. Terms of reference included the formulation of legislation to govern the practice of traditional medicine and licensing of traditional healers, but as of 2012 the work was considered to still be under development by the Attorney General's Office (MHMS, 2012). Kiribati's 2012 health service delivery profile (MHMS, 2012) briefly discusses the role of traditional medicine practitioners in the country. In the current national health strategy the only reference to the practice of healers refers to the work of Traditional Birth Attendants (TBAs), especially in relation to further training on antenatal and postnatal care (MHMS, 2015).

5.7 Official Development Assistance (ODA) for health

Kiribati is highly reliant on ODA, and while lots of donors means additional funding and variety in type of assistance, it also means that donor space is more volatile and that more human resources are required in the recipient country to coordinate and prioritise aid support (Dornan & Pryke, 2017; MHMS, 2015). The significance of aid places development donors in a key position to work with the GoK on the achievement of UHC, but there are concerns that insufficient attention has been given to adapting and strengthening integrated PHC services (Capuano, Gilbert, Park, Slatyer & Soakai, 2019).

Historically aid has been delivered to Kiribati by DAC member countries and multilateral institutions through bilateral, trilateral and multilateral flows, but Southern partners like Cuba also play a key role in assisting the Pacific nation (MHMS, 2015). In 2016-17, Australia provided an estimated $30.2 million in ODA to Kiribati (almost 20 per cent of its estimated 2017 budget). Kiribati's other long-term partners include Japan ($20 million), the World Bank ($20 million), New Zealand ($14 million), Taiwan[11] ($13 million) and the Asian Development Bank ($11 million) (DFAT, 2017). According to the Kiribati Health Strategic Plan 2016-2019, Kiribati's health sector is relatively dependent on external financing. In 2016, donor partner contribution of AU$5.8 million to the health sector represented nearly 20 percent

[11] Taiwan and Kiribati severed diplomatic ties in 2019 after the Pacific nation switched diplomatic recognition to China (BBC, 2019).

of public expenditure on health. Of this amount some 70 per cent, or AU$4.0 million, flows through donor partners' own systems (Cairns, Flanagan; Ivatts, Ruest & Wallace, 2018).

It is estimated that in 2019-2020 the total ODA provided by the Australian Government to Kiribati will reach $27.3 million, making Australia the country's largest bilateral donor. A major share of that aid is destined to address communicable diseases, especially tuberculosis, leprosy and hepatitis B (DFAT, 2017). Amongst other activities, Australia has worked together with donor partners to construct the Family Health Clinic at TCH and to support students to graduate as nurses from the Kiribati Institute of Technology. Australia also provided financial assistance to the KITP, the bridging course set to facilitate the transition of foreign trained doctors – including those trained in Cuba – into medical practice in the Pacific nation (DFAT, 2017), which will be discussed in the next chapter.

New Zealand is another major donor, having committed 91 million of its development funding for 2018-2021 to Kiribati (MFAT, 2019). Current health related priorities include improving hospitals' facilities and increasing availability of family planning services in South Tarawa and the outer islands. Like Australia, New Zealand helps Kiribati to expand human resources for health by supporting the KITP and the KIT. Japan is another country that made contributions to the health sector, including the construction of Kiribati's main hospital (TCH) and the donation of medical equipment and transport (Connell, 2009; Funaki, 2018).

Multilateral institutions and global health initiatives collaborate on the improvement of health outcomes in Kiribati as well, often through trilateral aid. Although focusing on the implementation of economic reforms, the ADB helped to finance improvements in Kiribati's sanitation system and, in partnership with the World Bank and the Green Climate Fund, has co-financed projects designed to improve water supply in South Tarawa (ADB, 2019). In 2018, UNICEF and MFAT signed a NZ$7 million agreement with the Government of Kiribati to support the prevention and reduction of newborn mortality in the country through immunisation, nutrition and health promotion initiatives (UNICEF, 2018). Most donors are involved in projects that help to address the NCD crisis, such as the upgrade of sanitary systems and the construction of seawater desalination plants for the provision of potable water (DFAT, 2017; MFAT, 2019; MOFA, 2019; UNICEF, 2018).

The disbursement of large amounts of funding for immunisation campaigns and the infrastructural improvement of health facilities in South Tarawa are significant aid contributions that continue to lead to positive outcomes (MHMS, 2015). However, there are

arguments that these initiatives are insufficient to build a sustainable health system and achieve UHC (Connell, 2009; Capuano et al., 2019). Connell (2009) associates donor preference for financing infrastructural projects rather than the development of human resources for health to the political visibility that the former entails. He argues that the disproportionate focus on improving the central health facilities of developing countries results in an inappropriate urban bias, and that areas where health care delivery is already inadequate, such as Kiribati's outer islands, suffer the most. Connell further makes the point that the technological equipment that comes with large hospitals is more costly and difficult to maintain, especially where technicians are scarce, which is again the case of Kiribati.

Despite PHC being considered by the WHO (IBRD, WB & WHO, 2017; WHO, 2016c) as a less resource intensive, and a more equitable, efficient, and effective starting point to achieve UHC than higher levels of care, evidence suggests that the share of resources destined to PHC has fallen in recent times in PICs (Capuano et al., 2019). Capuano et al. (2019) partially attribute that to the current economic outlook and an overall decline in donor support, but argue that governments have a responsibility as investments in developing an integrated PHC system currently depend more on the appropriate allocation of funds than on the amount of resources available. For them, a top to bottom approach often fails to link inputs (such as funding and human resources) with service delivery standards and outcomes, meaning that PICs and donors must address political economy issues associated with an increased focus in PHC. The decrease in aid also highlights the difficulties faced by Kiribati in absorbing costs of activities when projects come to an end, which is the case with the immunisation program (supported by Gavi, UNICEF, WHO and the Australian Government) and the TB programs (supported by the Australian Government and the GF) (Cairns et al., 2018).

In spite of the historical focus of DAC donors in the centralisation of health systems and curative health care, renewed commitment to the Healthy Islands[12] framework is repositioning PHC services at the center of the development agenda (WHO, 2018e). Taiwan and Cuba are examples of non-DAC members that have made specific contributions to strengthen Kiribati's PHC system by offering scholarships for I-Kiribati students to undertake medical training. With the withdrawn of the Taiwanese cooperation as Kiribati restores diplomatic ties with China (Nichols, 2019), Cuba is arguably the partner country that provides

[12] A framework of action for revitalisation of healthy islands in the Pacific, first endorsed by Pacific Islands Health Ministers in 1995 (WHO, 2018e).

not only the opportunity for expansion of human resources for health in a large scale, but a health care model (see Chapter 3) that is more aligned with Kiribati's reality and with the Alma Ata's understanding that a strong PHC system is essential to achieve UHC. A more detailed analysis of how the Cuban programme functions in Kiribati will be unpacked in the next chapter.

5.8 Conclusion

Providing curative and preventative health care in Kiribati is costly and challenging. The scattered and isolated nature of the islands and dispersion of the population makes health care delivery a very expensive and difficult task. Limited financing and poor institutional capacity constrain the ability of the GoK and the I-Kiribati people to address pressing environmental and socio-economic problems without the assistance of development partners, placing the country in a vulnerable position in terms of ownership and decision making. Lacking the workforce to collect and analyse data and to update and improve policies and legislations, bottlenecks in diverse areas of the public sector remain unresolved. It is no different for medical practice, as protocols in need of review act as a barrier for the establishment of a health system that is more responsive to the country's context and challenges. A key finding that emerged from conversations with Cuban-trained interns is that inconsistent medical protocols based on curative health system's guidelines played an important role in the unsuccessful implementation of the decentralisation of the health system.

Fieldwork data aligns with health strategies on the identification of main barriers for health system strengthening, such as the unavailability of essential equipment, medicines and supplies, insufficient health workforce, inconsistent referral practices and medical protocols. The low prioritisation of opportunities for continuing development in the health area as reported by Cuban-trained interns is a theme that is not sufficiently addressed in health strategies and that deserves further investigation. The comments of Cuban-trained interns and health workers show that culture plays a key role on the improvement of PHC delivery. The role reversal between tiers of care is a central issue for the improvement of health outcomes and suggests that the integration of traditional practitioners into the formal health system could bring benefits. This overview highlights main barriers for the fulfillment of the right to health in Kiribati and sets the background for a more detailed analysis about the scope, impact and level of integration of the Cuban programme with understandings of health in the Pacific

nation. The section about ODA for health shows that, although beneficial, the assistance provided by traditional donors does not sufficiently strengthen integrated PHC services or addresses serious problems of equity in the Pacific nation. The next chapter explores whether the Cuban focus on human resources is better placed to deliver the gift of health to the I-Kiribati population.

Chapter 6: CUBAN COOPERATION IN KIRIBATI AND THE KITP

This chapter presents findings about Cuban medical cooperation in Kiribati. Section 6.1 and 6.2 explore the establishment of the Cuban cooperation in the Pacific nation and the design, content and assessment of the KITP. Section 6.3 explores the perceptions and experiences of the actors directly and indirectly involved with the Cuban programme: Cuban and Cuban-trained doctors, KITP supervisors, I-Kiribati nurse representatives and health workers and the I-Kiribati community. The themes here emerged from a focus group exercise, semi and unstructured interviews and fieldwork observation. In order to develop an understanding about how the Cuban medical cooperation aligns with understandings of health in Kiribati, this chapter will analyse the implications of the influx of Cuban-trained doctors for the Pacific nation, investigate the similarities and differences between both countries' health care models and approaches to health and explore the impact of the Cuban medical cooperation in Kiribati.

6.1 Cuban medical cooperation in Kiribati

Former Kiribati President Anote Tong was the first Pacific leader to make a state visit to Cuba, and diplomatic relations between the two nations were established in 2002. The bilateral relationship was consolidated in 2006 when Cuban medical cooperation with the Pacific nation began (Asante, Dewdney, Hall, Negin & Zwi, 2012). Cuban medical outreach was established in two fronts: First, Cuba sent medical brigades to Kiribati to deliver much-needed health care services and to build capacity of local medical education. Second, I-Kiribati students received scholarships to study at ELAM and other Cuban medical institutions. The core idea of the programme is that once graduated, I-Kiribati doctors will return home to replace the Cuban brigade working in their country and to become mentors of new coming medical interns as they return to the islands.

Cuba sent the first medical brigade to Kiribati in 2006, composed of 15 health workers. In 2007, 23 I-Kiribati students received scholarships to undertake medical studies in Cuba (Asante et al., 2012). In September 2008, a group of 10 Cuban doctors returned home after completing two-year contracts in Kiribati, while 5 remained working in the Pacific country

(Radio New Zealand, 2008). As of 2018, 5 Cuban doctors and 23 Cuban-trained I-Kiribati graduates were working in Kiribati, with a further 10 still training in Cuba (Alzugaray, 2018).

According to KITP supervisors and Cuban-trained graduates, potential I-Kiribati candidates for a scholarship learn about the Cuban programme through advertisements in the local newspaper and radio station. Those with a health background and good academic records are at times approached by the Ministry of Education and invited to apply. Selection criteria involves analysis of an application letter, the examination of high school or tertiary level grades, especially in disciplines considered most relevant to medical education, and an interview. Before travelling to Cuba, successful I-Kiribati candidates and their families are invited to attend a one-day orientation about the programme. In this orientation they learn that modest accommodation, food and health services during the 6 years of medical education in Havana are provided and covered by the Cuban government. The first I-Kiribati students to undertake medical education in Cuba had to rely on independent financing to visit their families in the Pacific, but in the current system the government of Kiribati funds a trip home every two years to each I-Kiribati student during the course of their medical education.

6.2 Kiribati Internship Training Programme (KITP)

The KITP started in 2013 as an initiative to address a combination of factors (Roberts & Tudravu, 2019). As explained by the Regional Internship Working Group (2016), new players began to emerge in the provision of medical assistance in the Pacific region in the early 2000s. Previously there was a level playing field for undergraduate and post-graduate medical training, as graduates sent to practice in Kiribati came mainly from the Fiji School of Medicine (FSMed) at Fiji National University (FNU), the University of Papua New Guinea (UPNG), and a smaller number from Australian, New Zealand and other universities. New actors, which include ELAM, Umanand Prasad Medical School (University of Fiji), I-Shou University (Taiwan), Oceania University of Medicine (Samoa) and to a lesser extent institutions from Russia and Morocco, diversified the training received by Pacific students (Condon et al., 2013).

The integration and placement of Foreign Trained Medical Graduates (FTMG) who studied outside the conventional institutions serving the Pacific, and usually not in English, used to happen mainly via FSMed. However, in the same year that the first cohort of Cuban-

trained doctors returned to Kiribati, the Fiji Ministry of Health closed its internship programmes to applicants from other PICs in order to secure places for its own citizens. At the time, even some Fijian nationals were not able to complete an internship in their home country (Roberts & Tudravu, 2019). Concurrently, Cuba started to play an increasingly prominent role as a trainer of doctors in the region, with initial cohorts of students receiving Cuban medical scholarships amounting to 6 in the Federated States of Micronesia, 9 in the Marshall Islands, 25 in Vanuatu, 88 in the Solomon Islands, 8 in Fiji, 6 in Tonga and 19 in Samoa (Regional Internship Working Group, 2016).

A pre-internship programme assessment was undertaken to identify the strengths and weaknesses of the incoming interns so that the KITP could be prepared accordingly. According to a Pacific Island Health Officer's Association (2014) meeting summary, Fiji provided technical assistance to plan the examination in late 2013. The exercise revealed a number of gaps in Cuban-trained intern's knowledge base, especially in the basic and clinical sciences, as well as in hands-on experience. The results, along with the pressing need to increase doctor to population ratio in Kiribati, compelled the country's government to create a mechanism to facilitate the integration of FTMGs into Kiribati's health system model and to establish a pathway to accredit their qualification so they could work in the Pacific region. Since the programme's inception, a total of 42 I-Kiribati interns have been absorbed and divided into 3 cohorts, with 18 interns from the first cohort graduating in 2016 (Island Times, 2017). Between 2013 and mid-2019, KITP has graduated 33 Medical Interns into fully qualified medical doctors (Roberts & Tudravu, 2019).

KITP was implemented by the MHMS, and the Ministry had technical guidance from Fiji, the Department of Foreign Affairs and Trade of Australia (DFAT) and WHO (WHO, 2016c). The programme officially commenced on 31 March 2014 with 15 new graduates from Cuba and 3 from FSMed at Fiji National University (FNU) (Condon, 2014; Island Times, 2017). KITP was the first programme in the region to be formally endorsed by the Postgraduate Committee of the College of Medicine, Nursing and Health Sciences of FNU (Island Times, 2017). That means that upon completion of KITP, graduates will be granted a qualification equivalent to what they would have if they had undertaken medical education in Fiji. If Cuban-trained interns fail or do not attend the KITP, they do not gain entry into postgraduate programmes at FNU and are unable to be accredited as doctors and practice in the Pacific region. At the 16th KITP Governance and Co-ordinating Committee (2018), questions about the possibility of KITP being accredited by New Zealand and Australia have been raised but at

the time of writing no developments had been made in that regard. For Cuban-trained graduates, that means that they are not able to practice in New Zealand or Australia at this time.

KITP interns are appointed as probationary civil servants and are paid a salary during the programme. Upon completion of the KITP, I-Kiribati graduates receive the tile of medical officer. After completing postgraduate studies or gaining more experience, medical officers become registrars, and can start to act as supervisors of new coming medical interns, providing guidance during ward rounds and on the management of cases. Due to the shortage of health workforce in Kiribati, I-Kiribati graduates automatically get a placement at TCH. Cuban-trained graduates are required to stay a minimum of 2 years in Kiribati after returning from Cuba, which is the length of time of the KITP. That means that after graduating from the internship they are free to practice in other countries if they wish to do so. Reportedly, at the time of writing, some of the I-Kiribati KITP graduates were working in the Federated States of Micronesia and Tuvalu. About 8 KITP graduates are working towards their postgraduate diplomas in Fiji and 3 are pursuing their Master of Medicine with specialisations in Paediatrics (1) and Internal Medicine (2). Medical officers and registrars who pursue higher qualification and graduate with a Master of Medicine degree are considered a specialist, or a consultant. The system in Kiribati includes them, as well as the registrars, as potential KITP supervisors. KITP graduates have access to scholarships for further studies through New Zealand, Australia, WHO and the government of Kiribati.

KITP's vision, according to the minutes of the 16th meeting of the KITP Governance and Co-ordinating Committee (2018, p. 3), is "to be the center of excellence of internship training within the region and to support the training of medical graduates from neighbouring small island states/countries/countries". As conveyed on KITP's vision, the programme has extended its scope to other PICs, namely Nauru, Solomon Islands and Tuvalu, who do not have the clinical throughput to run their own national internship programmes (Island Times, 2017; Roberts & Tudravu, 2019). Since its inception, KITP has trained and continues to train more than 60 medical graduates from Kiribati, Tuvalu, Nauru, Fiji and Solomon Islands. The majority of interns from Nauru, Tuvalu and Solomon Islands return to practice medicine in their home countries, some under binding commitment with their governments. This places KITP in a central position on efforts to create a network of doctors and specialists in the Pacific region. According to the KITP Independent External Review (Roberts & Tudravu, 2019), some KITP graduates are awaiting scholarship towards the Master of Medicine degree. These efforts are especially important in the Pacific, as higher qualifications mean that medical practitioners

will be apt to mentor recently graduated interns, increasing the pool of local supervisors in the Pacific without having to rely on external consultants funded by donor partners and/or UN agencies.

The pre-KITP assessment had already identified the shortage of medical specialists as a critical issue for building capacity on health human resources in Kiribati. That meant that not only FTMGs would lack sufficient mentorship, but clinical service provision would also be compromised for the I-Kiribati population. KITP's short-term strategy was to recruit 3 specialists under the internship programme, while the long-term plan entailed the targeted placement of rotating Cuban specialists and short-term teams of visiting Australian, Taiwanese and New Zealand specialists (Condon, 2014). At the time of the review, the Anaesthesia and the Obstetrics and Gynaecology (O&G) blocks were entirely supervised by I-Kiribati graduate consultants who had returned to work in their home country (Roberts & Tudravu, 2019). The postgraduate diploma holders expecting to pursue their Master of Medicine degrees in the next two years also signaled positive changes. The pre-KITP assessment had, however, anticipated that the progressive return of I-Kiribati postgraduate medical trainees would allow the MHMS to achieve sustainable domestic management of the KITP by 2017 (DFAT, MFAT & World Bank, 2014). Contrary to expectations, at the time of writing the Surgery, Medicine and Paediatric blocks still had overseas consultants as clinical supervisors.

Funding

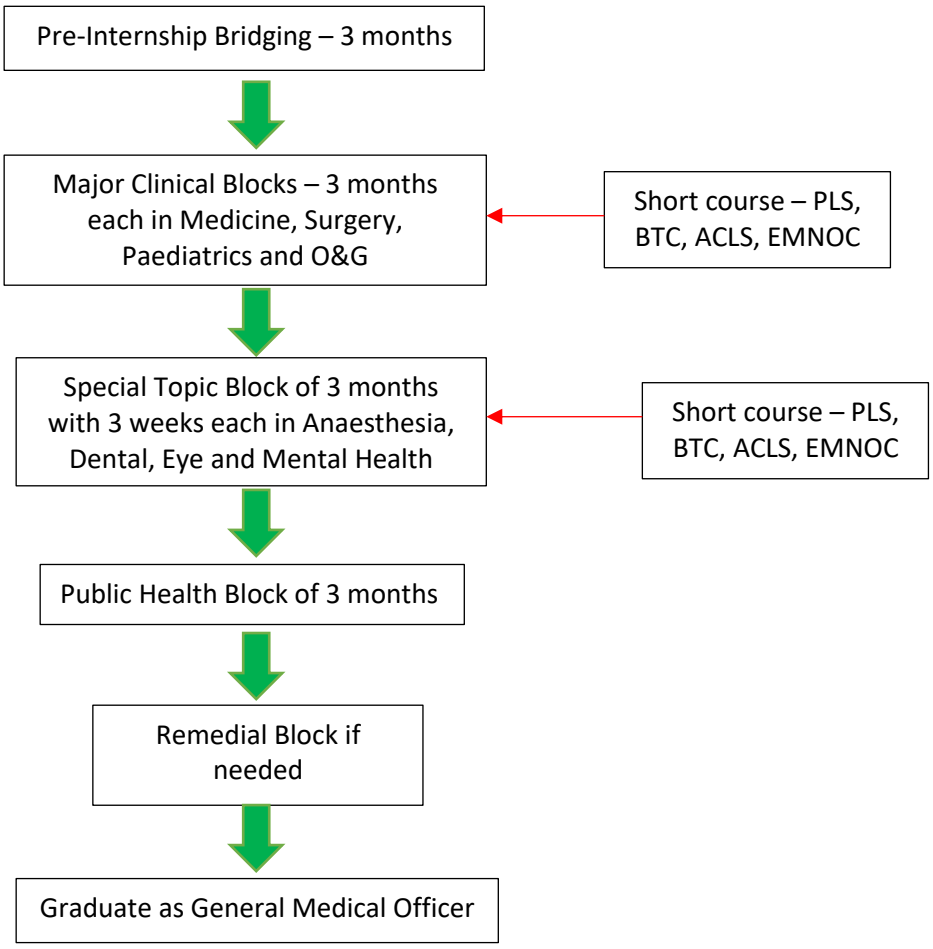
KITP was initially funded by Australia through DFAT and managed by FNU. During the 2-year establishment phase of the KITP (2014-2016), Australia provided AUD1.5 million to facilitate technical assistance and capacity development. That covered some costs towards quality assurance and assistance with assessment of interns and supervisors' performance (Island Times, 2017). For the period of 2017-2019, KITP was mainly supported through a bilateral agreement with New Zealand. During this transitional period of 2 years, MHMS has been progressively taking over KITP's management capacities and has been expected to gradually absorb the costs of the programme into its health budget. Through MFAT, New Zealand financed three consultant supervisors' positions (KITP Governance and Coordinating Committee, 2018). Taiwan also contributed, funding one consultant supervisor position (Roberts & Tudravu, 2019). DFAT continues to support a lot of activities that are relevant to the program through indirect funding (KITP Governance and Co-ordinating Committee, 2018).

As the period of New Zealand's support comes to an end, there are concerns about the sustainability of the programme (Roberts & Tudravu, 2019). As the KITP extends training to medical graduates from other Pacific countries, questions emerge as to whether more funding from bilateral or regional donors would be required for the continuity of KITP. As reported by Roberts and Tudravu (2019), the costs of the programme are expected to reduce as the cadre of local KITP supervisors increases and expatriate consultant supervisors are replaced by the local consultants. This need to recruit additional personnel to Kiribati's workforce is leading donors to emphasise planning towards projects in the infrastructure and expansion of TCH and Betio Hospital.

KITP structure and content

As FTMGs came from different backgrounds, a three months bridging programme was developed to prepare them to join KITP (see Figure 6.1). During the three months, three weeks are dedicated to each in Paediatrics, O&G, Medicine and Surgery. This phase of KITP also rosters students to accompany a medical intern when they are on call for 1 day per week and 1 day for 1 weekend per month.

Fig. 6.1: KITP structure and content



Source: Roberts & Tudravu, 2019

After passing the Pre-Internship Bridging part of KITP, students start their first year as medical interns. This part of the course is divided in 4 major clinical blocks: Medicine, Surgery, Paediatrics and O&G. Short courses on Primary Trauma Course (PTC), Paediatric Life Support (PLS), Emergency Obstetrics and Neonatal Care (EMNOC) and Advanced Cardiovascular Life Support (ACLS) are also provided in the first year of medical intern's curriculum. On passing all the major blocks and short courses of the first year, medical interns progress to complete a Special Topic Block of three months with between 2-3 weeks each in Anaesthesia, Dental, Eye and Mental Health. Short courses on PLS, BTC, ACLS, EMNOC are again offered to all medical interns throughout the year. In order to start the Special Topics Block, students have to pass the 4 Major Clinical Blocks. Short courses depend on the availability of overseas or local tutors to teach those disciplines. For this reason, when short courses can be offered medical interns are excused from their current blocks so they can attend those.

The following step is to complete the Public Health Block. This block has a duration of 3 months and includes 1- 2 weeks attachment in Tuberculosis (TB) clinic, NCD clinic and the Mental Health clinic for a total of six weeks. After that medical interns are assigned for 6 weeks to work at South Tarawa clinics, where they gain experience in primary health care, general outpatient and general admissions' work. The last step is the presentation of a research project at the end of the Public Health rotation. The interns who fail to meet the requirements are provided a Remedial Block, and all repeating students will return to the failed block at completion of the clinical blocks. If an intern performs poorly, they first receive feedback from the KITP Training Committee. If there are no improvements on an intern's performance, the student is suspended for one rotation. If all requirements are met, interns graduate with the title of General Medical Officer.

Assessment

Medical interns are continuously assessed for the duration of the KITP. The assessment of medical interns is divided in four modalities (Table 6.1):

Table 6.1: Format of Assessments

Tools	**Assessments**
Continuous Assessments	Local Supervisors and nursing team
Competency Assessments	Knowledge/Skills/Professionalism OSCE & Short Cases –Mid-Block – Local team OSCE & Short Cases – End Block – FNU team
Log Books	Required to fill in their log books >95%
Research Projects	To present to the KITP training committee end of PH rotation

Source: KITP Governance and Co-ordinating Committee, 2018

Continuous Assessments: At 6 weeks of the major blocks on Medicine, Surgery, Paediatrics and O&G, interns undertake a mid-block assessment so their progress can be tracked. At the end of the 3 months of block, interns must pass an End of Block examination. Supervisors, registrars and nurses produce reports assessing medical interns' technical knowledge,

professionalism, sense of responsibility, punctuality, attendance, history taking, procedural ability and soft skills when interacting with patients and co-workers.

Competency Assessments: The Mid-Block Assessment evaluates intern's competency through a 1 ½ hour short answer written examination prepared by local KITP supervisors. The End of Block examination includes Objective Structured Clinical Examination (OSCE), clinical viva, ward rounds and bedside questions. These are organised and carried on by an external team of FNU assessors. For the exams, the pass mark is 60 per cent. According to Roberts and Tudravu (2019), exam questions are of the same level as those posed at examinations of final year medical and postgraduate diploma students in Fiji. FNU examiners are independent and said to develop the questions so they reflect the scope and complexity of the morbidity and mortality patterns in Kiribati.

Log Book: During the Major and Special Topics blocks, interns are given a log book with a certain amount of procedures that they need to be exposed to. In order to pass, students must complete more than 25 per cent of the required procedures. On this log book, interns document patient-physician encounters, exposure to procedures and data related to the management of cases. The book is marked by local supervisors at the end of the blocks and assessed as part of the continuous assessment.

Research Projects: Research projects are undertaken by graduates through the duration of the programme and presented to an external committee at the end of the PH block.

In the first cohort, 3 of the 18 students were required to extend their initial block by 6 weeks and 3 interns were required to repeat the blocks in full (DFAT, MFAT & World Bank, 2014). Currently, there are only 7 out of 21 medical graduates who never had to repeat a block. Around 14 students failed one or a couple of blocks, and about 8 or 9 have to repeat a lot of the blocks due to lack of understanding. At the time of writing over 30 medical students had graduated through KITP, and another 8 or 9 were expected to present their research papers in September 2019.

6.3 Perceptions of the Cuban programme in Kiribati

6.3.1 The discussion about clinical skills

One of the most contentious themes raised during interviews related to the clinical skills of Cuban-trained doctors. While recognising that with time Cuban graduates 'catch up' with Fijian students, in general KITP supervisors and health workers agreed that returning students were deficient in terms of clinical skills and one suggested that ELAM had no failure rates. Cuban-trained interns shared that they were not as exposed to hands on experience on certain clinical procedures during their training, but the overall sentiment was that this did not make them feel unprepared to practice medicine in the Kiribati context.

The exposure to clinical practice was connected to the attribution of roles, as a number of tasks performed by the nurses in Cuba are expected to be performed by the doctors in Kiribati. The main point of discussions in this aspect was the cannulation, or IV. While Cuban-trained doctors expressed that too much emphasis is given to a simple procedure, KITP supervisors commented that the issue went beyond:

> *"They [Cuban trained graduates] go and they come back still as nurses, then we have to train them again." (KITP Supervisor)*

> "*If they [Cuban-trained interns] don't know how to do basic procedures such as a cannulation they are still stuck in the bottom level. (…) I'm not giving them the best that I could because of their low level of competency." (KITP Supervisor)*

As medical training in Cuba occurs in Spanish and the KITP is taught in English, Cuban-trained interns argued that their ability to speak English influenced perceptions about their level of medical competence. A Cuban-trained intern described KITP as an English course during an unstructured interview and others questioned why they were required to learn English when they would mainly provide services to and communicate with I-Kiribati people in the I-Kiribati language.

The perception that Cuban trained doctors have deficient clinical skills also led some KITP supervisors to question the motivations of students and the selection criteria to receive the Cuban scholarship. Views ranged from those who believed that graduates had a genuine vocation to the medical profession to those who thought that applicants did not want to miss

out on an opportunity to attend medical school overseas and potentially secure a stable and reliable job upon return. Some health professionals and KITP supervisors suggested that the selection process to enter the Cuban programme should be improved, and that students with higher academic achievement are prioritised to undertake medical studies in the Pacific region:

> *"The top 10 per cent of I-Kiribati students would be accepted in Fiji Universities, anyone below that would then go to Taiwan, Cuba and any other places where Kiribati has diplomatic relations with." (KITP supervisor)*

A health worker commented that some community members had a negative perception of Cuban trained doctors, especially at the beginning of the Cuban programme. While it is not the case in Kiribati, interns from Tuvalu and Nauru pointed out that students trained in Taiwan are not required to go through an internship programme in order to practice in their home countries, whereas they do, and that for some interns that feels demoralising. While some interns cherished the opportunity provided by KITP for continuing development, others expressed frustration for being constantly judged primarily for their clinical skills:

> *"There was a paper that said that all the students who went to Cuba should go through the internship programme in order to become safe doctors. That article was a bit painful, but we want to show them we are safe." (Cuban-trained intern from Nauru)*

> *"Sometimes I would suggest something in a way that we did in Cuba, and they [Fiji medical graduate students] would say that it was old age, and that what they learned in Fiji is what happens now, this is the updated knowledge. (…) I think they should open their minds and say: 'they are bringing in new stuff, so we should consider'." (Cuban-trained intern from Nauru)*

> *"In Tuvalu it was more a problem of acceptance. When we got back to Tuvalu there were no more senior doctors from Cuba there. It was only us junior doctors and the FNU seniors from Fiji, and their way of medicine is completely different from our idea of practising medicine. It was a hard time for our seniors to accept the ideas that we were bringing in*." *(Cuban-trained intern from Tuvalu)*

Some Cuban-trained graduates associated the emphasis in clinical skills and the classification of the Cuban training as inferior with politics and a lack of understanding about the ethos of the Cuban medicine:

"Here they are more focused on sparing resources. Cuba lacks resources, but they still prioritise health." (Cuban-trained intern from Tuvalu)

"Most of the problems we are facing are political. In Tuvalu, when we first arrived there was this big shadow over Cuba, nobody knew anything about Cuba. (…) The image of Cuba is an issue, is what is really blocking our position in our own countries. (…) Medicine nowadays is a business and we can't say it isn't. I think Cuba is the only country where medicine is not a business. (…) Medicine is the same, the only difference is how the individual is practicing and the people on top who actually make the decisions, whether they are medical doctors or they are politicians. It doesn't matter where you studied medicine, the idea might be different from what you know but the goal is the same." (Cuban-trained intern from Tuvalu)

6.3.2 Strengths of the Cuban medicine and programme

A variety of perspectives emerged during conversations about the strengths of the Cuban medicine and the Cuban programme in Kiribati. It was interesting to observe that most KITP supervisors hesitated to outline the strong points of the Cuban approach to health. Most positive views were framed in terms of the quantity of health workers, but the majority of comments about improvements in the quality of service provided were attributed to KITP:

"There has been a lot of improvement, increase in the number of doctors. Almost all the departments you have a full team – the consultants, the registrars. They got more 24 hour intern cover in each department. I think it's a big improvement." (KITP Supervisor)

"Strengths…can't think of much. They did give an opportunity for small Pacific islands who couldn't get entry into Fiji Medical School to study medicine. They [ELAM] are producing a lot of doctors, the quantity is there, but the quality, we have to refine them here, to get the quality out of them." (KITP Supervisor)

"In the past, before the start of KITP, if you are lucky you get seen by the doctor once a week. Now patients get seen by the doctors 2 or 3 times a day, so patients

are commenting about that. In terms of patient time and contact with doctors, it is much better since the establishment of KITP." (KITP Supervisor)

In contrast, Cuban-trained graduates offered a more qualitative view about the advantages of the Cuban medicine:

> *"In Cuba, they strengthen the primary attention. The prevention is much better there compared to what we have here. Most of the doctors there are family doctors, they go to the community, rather than the referral hospital. I think they gain a lot from that system, going to the communities, preventing diseases, educating their people on what to do to improve their health. Here in Kiribati our public health system is not that strong compared to Cuba. That's why the people are not aware of their own health situation, the patients don't take it seriously." (Cuban-trained registrar from Kiribati)*

> *"I like the protocol in Cuba better because is more applicable to small islands, it is more about the patient, and the management is good." (Cuban-trained intern from Kiribati)*

During the focus group exercise, Cuban-trained doctors discussed the notion of the doctor as an agent of change, the synergies between what they learned in Cuba and the Kiribati context and made suggestions for the improvement of Kiribati's health delivery system. More dialogue between health practitioners and administration, more integration between clinical services and the public health sector, strategies to control infectious disease outbreaks and the incorporation of alternative medicine in the formal health system were highlights of the conversation.

6.3.3 Insufficient knowledge of the Cuban approach

Conversations about the strengths of the Cuban approach to health indicate that ideas about Cuban medicine often stem more from general perceptions rather than from open dialogue and a comprehensive understanding of the structure of the Cuban health system and the principles of the Cuban medicine:

> *"I'm just talking based on what they [Cuban graduates] tell me. They say that the main focus is on the history side, the history taking, public health, more of it, not sure about the rest. That's what I hear, I can't be too sure." (KITP Supervisor)*

"I think they probably learned a lot more primary health care, a lot more public health stuff...I'm only guessing." (KITP Supervisor)

It was interesting to observe that the only KITP supervisor who described a closer working relationship with Cuban doctors was also the only supervisor who discussed Cuban preventive strategies in detail and had more positive comments about the Cuban programme:

"When you read literature, Cuba has a very good antenatal care, on the top 10 in the world. I think that they [Cuban-trained doctors] are not applying it, they have the knowledge. (…) The Cuban doctors said that one doctor looks after one village. (…) They follow these ladies who never have been to the hospital, and they have their names in a list. (…) They said that all the mothers when they come they bring notebooks with them, and they are responsible for their own health. That's a positive thing about their training." (KITP Supervisor)

The supervisor reported limited success in attempts to increase integration between ante-natal care initiatives and public health and to practice family medicine, which are strategies of the Cuban approach to care (see section 3.6.1). The same supervisor successfully incorporated the research component at the end of the KITP programme to create a mechanism that addresses gaps in information specific to the Kiribati context, such as patterns of disease and the efficacy of traditional medicine. This supervisor noted that some KITP colleagues are reluctant because Cuban-trained doctors are interns, but argued that quality research is produced:

"Some of the [KITP] supervisors were reluctant because they [Cuban-trained doctors] are interns, but some of the interns present quality research and it would be best to publish them. (…) Researches could be published in FNU collaboration papers, Pacific Medical Journal and similar publications. The interns put a lot of effort in those researches, we just have to make sure that they are mentored and the quality is good. It can provide important evidence for us." (KITP Supervisor)

When questioned about causes for the apparent lack of communication, one KITP supervisor mentioned that at the beginning of the medical cooperation a request to receive ELAM's curriculum was made to the then resident Cuban Embassy, but there was no response.

6.4 Implications of the Cuban programme for Kiribati

The return of Cuban-trained doctors to Kiribati has started to change the country's health workforce profile but has a series of implications and challenges, some of which emerged during interviews. Broader concerns have been expressed about issues of accreditation, health workforce planning, delineation of roles and the surge in direct and indirect costs:

6.4.1 Accreditation

To facilitate professional mobility and skills sharing within the region, PICs work together to align accreditation standards for health workforce cadres (Asimus, Lin & Roberts, 2012; Campbell, De Silva, Kafoa, Kiriton, Lin, McKimm, Newtown & Roberts, 2012b). This was the case with the KITP, which counted with had the technical support of FNU to design the programme and to perform end of block examinations. However, as pointed by a Cuban-trained graduate and argued by Campbell et al. (2012b), PICs like Fiji tend to derive medical protocols and formally recognise training and qualifications from institutions teaching the curative health care model, such as the Medical Royal Colleges and nursing schools from Australasia, the UK/Ireland, USA and Canada. That means that, in order to facilitate a pathway for accreditation and continuing professional development of returning Cuban-trained doctors, Kiribati looked to accommodate Fiji's requirements for medical practice. That approach, however, constrains the scope of practice of doctors trained in Cuba.

Nevertheless, a recent comment from the Dean of the Fiji School of Medicine (now the College of Medicine, Nursing & Health Sciences, or CMNHS) suggests more openness towards preventive approaches in the region. The Dean declared that Fiji spends a huge proportion of its health budget on curative health services, and that emphasis should be given to addressing UHC. For this to be achieved, he argued, focus should be shifted towards building resilient strategies for health promotion, prevention and treatment (Pratibha, 2019). His view could indicate a movement of systems of accreditation towards preventive approaches, which would create more upskilling opportunities for Cuban-trained interns and facilitate their integration in the Pacific context.

6.4.2 Health workforce planning and the delineation of roles

Campbell et al. (2012d) argues that scholarship arrangements to medical schools outside the Pacific are often negotiated without a clear national strategy of health workforce development in place. Kiribati had a national health strategy (see Chapter 5) in place when the Cuban medical cooperation began. However, research findings about the insufficient knowledge of the Cuban approach suggest that Kiribati's health workforce plan was not developed to accommodate the influx of Cuban-trained doctors in the Pacific nation.

Campbell et al. (2012c) raise the issue of delineation of roles, and argue that the assimilation of Cuban-trained doctors into medical practice in Kiribati risks changing the balance within Kiribati national health workforce. The comment of a KITP supervisor that Cuban-trained graduates "come back still as nurses" captures the general perception that the training received in Cuba is more aligned with functions carried out by nurses or MAs in the Pacific context. Anticipating issues related to the delineation of roles, Condon et al. (2013) studied the possibility of establishing a two-tier medical workforce prior to the return of the first cohort of Cuban graduates. In a two-tier model, graduates from medical schools with focus on PHC, such as ELAM, would engage as a separate cadre of "community practitioners". Graduates from more traditional courses, meaning those based on the curative approach to health care, could be absorbed into the hospital system and more conventional medical career pathways.

However, Condon et al. (2013) realised that a two-tier workforce could cause the isolation of community practitioners, like the Cuban-trained doctors, from the usual medical career pathways, and affect their eligibility to pursue future training in clinical specialties. Moreover, they added that it would risk displacement of existing MAs, who's role in remote and outer island communities is generally well-established. Research data suggests that the bias towards curative health approaches, the concern about the displacement or substitution of MAs and the wish to facilitate pathways for accreditation and specialisation within the region influenced Kiribati's decision to absorb the new graduates into their existing medical workforce and to encourage them to pursue further qualification through Pacific medical schools based on curative models.

6.4.3 Direct and indirect costs

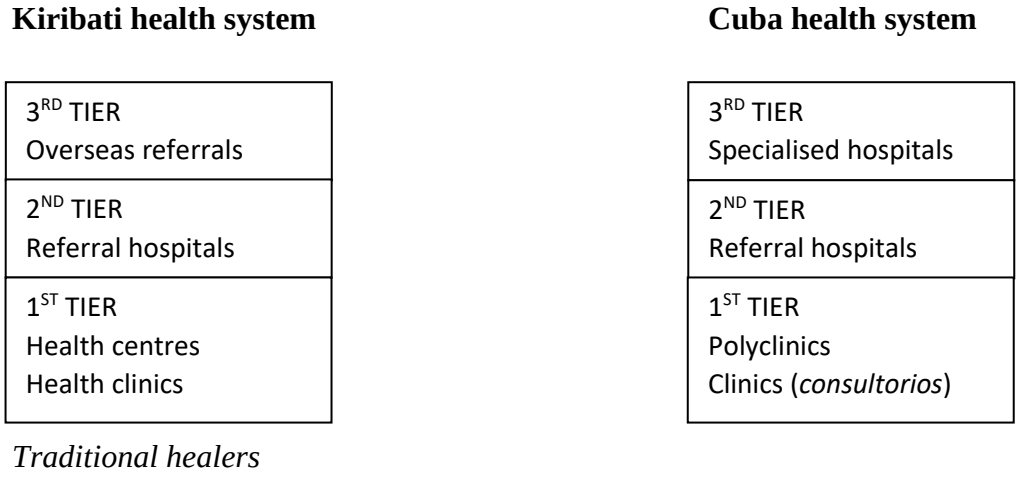
As the support from New Zealand and the transitional period for the absorption of KITP costs into the budget of the MHMS came to an end, funding the internship has become a bigger challenge (see section 6.2). As noted by Campbell, De Silva, Kafoa, Kiriton, Lin, McKimm, Newtown and Roberts (2012a), KITP had to fund the upgrade of qualifications of would-be trainee specialists according to Pacific standards and mobilise funding to enable them to participate in specialist training programs outside the PICs. Other direct costs that have been incurred because of the Cuban programme are the funding of biennial trips from Cuba to Kiribati for I-Kiribati students undertaking training at ELAM and the salaries of KITP supervisors. Campbell et. al (2012a) also note that the increase in the number of medical doctors returning from Cuba means that Kiribati faces continuous rises in salary expenditure. Indirect costs associated with this expansion of health workforce include increased prescribing of pharmaceuticals, increased use of medical supplies, imaging and laboratory services.

6.5 Similarities and differences between Cuba's and Kiribati's health systems and approaches to health

6.5.1 Health systems

Cuba and Kiribati respond differently to the challenge of improving health outcomes with low resources. The architecture of both countries' health models presents some similarities, but they function in distinct ways (Figure 6.2). In Kiribati's health system, PHC is delivered at clinics and health centres (MHMS, 2015). Information obtained during fieldwork indicates that an informal tier of primary care exists, constituted by traditional healers. Kiribati's clinics are staffed by nurses and health centres by nurses and MAs. In Cuba, PHC is delivered at clinics, multi-specialty polyclinics and the homes of patients. While clinics are administered at least by a community doctor and a nurse, multidisciplinary polyclinics are served by nurses and specialist physicians (UCCM, 2017).

Fig. 6.2: Cuba's and Kiribati's health systems



Source: Author

The second tier of care in Kiribati comprises four referrals hospitals and is provided by a cadre of nurses, medical interns and officers and specialist physicians. Some specialities do not have a physician currently assigned and many are served by consultants, who also act as KITP supervisors in temporary contracts (MHMS, 2015). In Cuba, health problems that result in patient's hospitalisation are handled at the secondary tier of care by nurses and specialist physicians. Illnesses that result in severe complications, such as cancer and cardiovascular diseases, are treated at Cuba's tertiary level of care. This tier is composed of specialised hospitals and institutions throughout the country (Pineo, 2019). As there is no workforce and infrastructure to provide that level of attention in Kiribati, patients who require specialised care must be referred overseas.

6.5.2 Preventive and curative approaches to health

Both Cuba and Kiribati have the right to health enshrined in their Constitutions or national legislations and the universal access to health care as a key goal in their national health plans (MHMS, 2015; Serrate, 2019). To pursue that achievement, both nations provide free access to medical care and medical drugs. The fundamental differences are that the Cuban health system has a sufficient workforce and is centered around primary and preventative health care, while Kiribati's health system focuses on curative care and has insufficient human resources.

As explored on Chapter 3, Cubans practise *Medicina General Integral* (Comprehensive General Medicine), an approach that seeks to understand patients in their biological, psychological and social health dimensions. Nurses and doctors live in the communities they serve and make frequent visits to households to detect and record health risk factors, to make recommendations and to monitor progress towards healthy behaviour.

In Chapter 5, I observed that Kiribati's previous and current national health strategies recognise the need to strengthen preventive and public health services (KHSP 2012-2015, KHSP 2016-2019). Research data shows that public health outreach and health promotion activities are considered important to improve health indicators, but that it is not common for health workers to regularly visit households and make recommendations about water and sanitation arrangements, diets and lifestyle, as it is the case in Cuba. Data also suggests that there is no system for nurses and doctors to categorise individuals and communities into risk groups, as it is practiced in the Cuban medicine.

Research findings and reviews of the Cuban programme indicate that the difficulties Cuban-trained doctors experience in the process of integration into medical practice in Kiribati stem from differences between the countries' approaches to health and health care. The KITP itself was conceived as an effort to facilitate the assimilation of medical graduates trained out of the Pacific into the regions' medical practice (see section 6.2). The different points of view expressed in discussions about clinical skills, which have been reported in Vanuatu, Tuvalu, PNG and other PICs, are also relevant to this point (ABC News, 2015, 2018; Asante et al., 2012; Kado, Sweet & Young, 2018). The general expectation that Cuban-trained doctors would return to the Pacific with a higher level of clinical skills are underlined by the idea that, in order to fit in PICs' health systems, Cuban-trained doctors must be transformed from proactive to reactive health workers.

Overall research suggests the existence of a bias towards curative care in Kiribati. This insight is associated with findings on general perceptions about the role of a doctor, the design of the KITP, the difficulty of KITP supervisors in identifying the strengths of the Cuban medicine, the constraints of medical protocols, the association of health system decentralisation with poor service delivery (MHMS, 2012), the disproportionate allocation of funds and human resources to TCH, the problematic inequities in service delivery between Tarawa and the outer islands and the high level of spending in overseas referrals for tertiary care.

The valorisation of clinical specialisation over preventive care explains why Cuban and Cuban-trained doctors indicated that they feel limited to act within the boundaries of the system in which they are integrated. Data suggests that Cuban-trained interns see value in the preventive approach of the Cuban medicine, that they do see themselves as responsible for the health of their community and that they can envision the contributions they could make to Kiribati. Their assimilation into a curative health system, however, limits their ability to act as active agents of health as per the principles of Cuban medicine. The emphasis given by KITP supervisors to the deficiencies of the Cuban approach means that the quality of health care is being measured according to the criteria developed to analyse curative health systems. If rather than clinical skills, the capacity to avert illnesses and deaths from preventable diseases was used as criteria to assess the quality of a health system, Cuban-trained doctors would have more scope to deliver the gift of health.

6.6 Impact of the Cuban medical cooperation in Kiribati

The GoK has highlighted that the work done by Cuban and Cuban-trained doctors is a major driver in the strengthening of the country's health system (MINREX, 2013). The 2016 Concept Paper on Human and Social Development (MLHRD, 2016) observes that Kiribati's doctor-patient ratio improved in 2013-2014, when the Pacific nation welcomed around 21 medical graduates from Cuba and Fiji. According to MFED's (2018) latest data, medical doctor availability has improved from 4.1 per 10,000 in 2015 to 6.0 per 10,000 in 2017. The total number of available health personnel (which includes medical doctor, dentists, assistants, nurses and midwives) increased from 39 per 10,000 in 2015 to 42 per 10,000 in 2017. As of 2018, there were 23 Cuban-trained I-Kiribati graduates, with a further 10 still training in Cuba (Alzugaray, 2018). MFED's (2018) report also highlights that the vast majority (71 percent) of medical staff are nurses. KV20 (MFED, 2016), however, forecasts that the current intake of health workers for training is unlikely to meet future requirements of health strategies.

Qualitative interviews with health professionals and the I-Kiribati community for this research indicate that the increase in health workforce pool is enabling doctors to spend more time with patients and deliver higher value care. KITP supervisors also expressed in the interviews that, since the beginning of the Cuban cooperation, the number of departments at TCH that have a full team (nurse, medical intern, registrar, specialist) has increased and the

ability of the hospital to respond more promptly to afterhours medical care and emergency situations has improved.

Few links have been established between the Cuban programme and improvements in medical services outside TCH, especially in outer islands, although the inability to collect data outside THC was one of the limitations of this research. The delivery of health care in remote areas is a challenge that is widely recognised on Kiribati's national health plan and regional health strategies, and one that Cuba may be able to address through increases in the number of health workers, establishing primary care facilities throughout the country and practising community medicine. The Cuban programme in Kiribati addresses health worker shortage, but the impact of this Cuban-trained cadre of health workers is limited if they practice curative medicine and are placed to work solely in the secondary tier of care. Although the number of primary care facilities is insufficient to cater to I-Kiribati population's health care demands at the moment, the current health system already has a primary care structure in place that can be improved and expanded.

6.7 Conclusion

Sections 6.1 and 6.2 demonstrated the context and the rationale that led to the creation of a medical internship programme in Kiribati. The investigation of the management and the structure of KITP shows the influence of FNU in developing a programme according to the parameters utilised for medical education in Fiji, considered standard for the Pacific region. It becomes clear that Fijian technical assistance has been particularly important to Kiribati. FTMGs, especially those trained in Cuba, do not have access to other pathways that guarantee the accreditation of their medical qualification, which is a fundamental step to enable them to practise as doctors. It also becomes evident that, while contributing markedly to the expansion of human resources for health in Kiribati, the Cuban cooperation was one of the main reasons for the creation of an internship programme, representing an extra challenge to a country with poor institutional capacity and limited resources.

The differences of opinion about Cuban-trained graduates' clinical skills, the strengths of the Cuban medicine and insufficient knowledge of the Cuban approach presented on section 6.3 interact with the examination about the similarities and differences between Cuba's and Kiribati's health care models and approaches. This chapter's discussion showed that Kiribati

faces a number of health challenges successfully addressed by the Cubans. It was clear that despite having similarities in terms of the structure of health systems, the Cuban and Kiribati medical professions operate in a preventive and curative manner respectively, and produce distinct health outcomes. Different understandings of health lead some research participants to classify the Cuban medicine as inferior, which limits the scope of practice of Cuban and Cuban-trained doctors in spite of evidence that a preventive approach is more adequate to a low resource setting with a scattered geography like Kiribati.

The misalignment in perceptions about health brought implications for the assimilation of Cuban-trained graduates into Kiribati's health system, especially in relation to accreditation, health workforce planning, delineation of roles and the surge in direct and indirect costs. This information leads to the conclusion that the impact of the Cuban programme could be maximised if Cuba and Kiribati create space for the exchange of information and if Kiribati remains open to study which Cuban strategies could be applicable to Kiribati if adapted to the local reality. This analysis also indicates that Cuba collaborated with Kiribati in a non-interventionary manner, a discussion that will be expanded in the following chapter.

Chapter 7: THE GIFT OF HEALTH IN KIRIBATI

This chapter uses Maussian (1990) gift theory to explore the research findings and to better understand what Cuban medical cooperation in Kiribati can contribute to the field of international development. That means that the nature of their relations is at the core of the discussion. In order to examine the information, I draw from the conceptual framework developed in Chapter 2. The framework differentiates between the traditional and the solidarity-based approaches to aid. In the traditional approach, gift givers and receivers are unclear about intentions and terms of exchange. The provision of incremental assistance via existing structures does not emphasise the autonomy and sustainability of the gift receiver. As there are no systemic changes, power relations remain imbalanced and gift receivers trapped in a subordinate position. In the solidarity approach, gift givers and receivers are clear about intentions and terms of exchange. The assistance provided emphasises capacity building and the improvement or creation of mechanisms for autonomy and sustainability. As systemic changes are made, power relations are challenged and emancipation is fostered through collaborative action. This chapter will explain why, despite gaining economic and political benefits, the Cuban approach is primarily oriented by an ethos of solidarity that differs from ODA. The discussion contributes to enhanced understanding about the place of Cuba in the global health landscape and supports the argument that there is an alternative way forward to deliver the gift of health to the global community.

7.1 Being clear about intentions and terms of exchange

The first level of the conceptual framework differentiates between the level of transparency that donors and recipients have about their intentions when imbedded in traditional and solidarity-based approaches. Based on research findings and the discussion about the Cuban motivation on Chapter 3, I argue that Cuba seems clear about terms of exchange and that solidarity is the prime driver of its South-South relationships.

One Cuban-trained intern commented that “Cuba is the only country where medicine is not a business” and another stated that “Cuba lacks resources, but they still prioritise health”.

These perceptions indicate that the core value of health as a fundamental human right is expressed through the Cuban medical practice and training and carried on its approach to medical internationalism. The comments align with insights about the Cuban internationalism on Chapter 3, which indicate that the politics of the host nation are not considered in the deployment of Cuban doctors. Literature showed that Cuba has provided aid regardless of negligible, or even hostile, government relations with the country in need. This view is endorsed by UNOSSC (2018, p. 10), who claimed that the "Cuban cooperation prioritises the interests of peoples in need, and is offered unconditionally, based on absolute respect for the sovereignty, laws, culture and religion of the recipient country, and the self-determination of nations".

Another point that illustrates the intentions of the Cuba-Kiribati relationship are the discourses of solidarity. The principle of solidarity was already evident at the signing of the bilateral agreement with Kiribati, when Cuban Health Minister Jose Ramon Balaguer declared: "We are sister nations, two small islands facing big challenges" (Scoop Media, 2008). As mentioned on Chapter 6, former Kiribati President Anote Tong was the first Pacific leader to make a state visit to Cuba, when he discussed mutual friendship and opportunities for cooperation with then President Fidel Castro (Radio New Zealand, 2008). Representatives of the Cuban government have also visited Kiribati many times, consistently highlighting the multiple coincidences with the Pacific region and reiterating Cuba's commitment to broaden relations and to expand collaboration programmes to other areas of development (PIDF, 2016; Radio Rebelde, 2010).

Kiribati and a number of PICs have consistently called for the long-standing USA embargo on Cuba to be lifted. Although this research did not have access to high level government conversations and documents, it suggests that Cuba is open and non-impositive about the benefits it gains from medical internationalism. At the 49th Pacific Islands Forum, Cuba's Deputy Foreign Affairs Minister Rogelio Sierra (2018) stated that "it is imperative to establish a fair and open international cooperation, and to transfer resources, technologies and knowledge without the imposition of political conditions, for the purpose of complementing and developing each other's domestic efforts and capabilities". It is likely that Kiribati has had autonomy to determine if, when and how it would reciprocate Cuba's gift of health. From what we know of Cuba's approach (Anderson, 2010a; Feinsilver, 2010; Huish, 2013; Huish and Kirk, 2007, Pineo, 2019), it is also likely that support for UN platforms in favour of Cuba was

not a condition for the maintenance of a friendly relationship with Kiribati. In this way it was possible for the relationship to be mutually beneficial.

As discussed in section 5.7, in order to receive ODA, donors often request that Kiribati accommodates the demands of systems designed by donor countries to justify aid. The problem is that these reporting systems demand excessive institutional capacity from recipients, which emerged as one of the barriers to health system strengthening in Kiribati (section 5.6) (Murray et al., 2019). This human capital could have been used to create and strengthen structures that generate and assert Kiribati's autonomy, rather than focusing on attending the requirements of external helpers. Communication between gift givers and receivers is essential for the achievement of positive and balanced outcomes, but reporting systems could be negotiated to better respond to the realities of receivers of the gift of aid. In this way the violence of the gift, as discussed on Chapter 2, could be avoided.

7.2 Building capacity and improving or creating mechanisms for the generation and assertion of autonomy and sustainability

Mauss' (1990) emphasis on balancing power relations between gift giver and gift receiver means that his notion of reciprocity is underpinned by the principle of equality. As discussed on Chapter 2, gift theory problematises how donors can occupy the position of gift givers and consider gift receivers as equal partners. The role of external helpers on asserting the autonomy of developing countries becomes, therefore, a key point in development discussions. This level of the solidarity framework shows that mainstream aid approaches like ODA focus mainly on providing incremental assistance via existing structures, while a solidarity based-approach focuses on building capacity and improving or creating mechanisms for the generation and assertion of autonomy and sustainability. Research data suggests that Cuban-trained interns are not fully able to deliver the gift of health to their families and their country in reciprocation to the support received to undertake medical education in Cuba. Their medical practice is limited by negative perceptions about the Cuban approach to health and the constrains of the curative system in which they are integrated.

As discussed in Chapter 3, in order to improve national health outcomes, Cuba had to create and improve mechanisms to better support the expansion of PHC. Besides increasing the number of health workers trained in preventive medicine, the achievements of the Cuban approach are attributed to organisational factors. These include a high level of intersectoral coordination pertaining legal, strategic and operational frameworks that place PHC and UHC at the foundation of the health system. As discussed on Chapter 6, better results could have been achieved in Kiribati if the increase in health workforce capacity was accompanied by similar re-organisation of the health sector.

In the course of this research, Cuban-trained doctors made various comments about how to strengthen PHC and UHC in Kiribati. Their views were mostly underlined by the idea that improvements in the delivery of health care require structural changes linked to the decentralisation of Kiribati's health system. The comment of a KITP supervisor saying that "they [MHMS] try to separate the clinician and public health" and of a Cuban-trained registrar saying that "we discuss only as doctors, no administration people involved" suggest that there is not enough coordination between the clinical and the public health sector.

Cuban-trained doctors discussed the lack of funding to cover supplies for medical investigation, like key reagents to analyse blood samples, and how this hinders preventative approaches to serious illnesses. The comment of a Cuban-trained doctor who expressed that sometimes doctors "want to help, but they fear the law" illustrates a disconnect between Kiribati's needs and medical protocols. The negative perceptions about Cuban medicine and the clinical skills of Cuban graduates was also associated with the scepticism expressed by most KITP supervisors regarding the research produced by interns, which is clear when one KITP supervisor commented that "some of the supervisors were reluctant because they are interns". However, as argued by the same supervisor, researches could provide "important evidence" for Kiribati, especially in terms of disease patterns and the healing potential of Natural and Traditional Medicines, something that Cubans are trained in (see section 3.6.1). As the findings about the design of the KITP in Chapter 6 show, the programme and systems of accreditation were strongly influenced by FNU's curative approach to health, and all the above-mentioned findings constrain the ability of Cuban-trained doctors to practice preventive medicine in Kiribati.

The observations of Cuban-trained interns showed that they can see synergies between the Cuban and Kiribati realities and that they had a number of suggestions about mechanisms

to improve PHC and prevention strategies. However, conversations also showed that their attempts to make contributions encountered resistance. This was especially evident in a comment about a published article that stated that “all the students who went to Cuba should go through the internship programme in order to become safe doctors”. The comments about the difficulty of Pacific-trained senior doctors to accept Cuban-trained intern’s ideas and the comments referring to Cuban medicine as “old age” also indicate that Cuban-trained graduates’ scope for contribution is limited.

The comment of a Cuban-trained registrar illustrates the issue of health worker retention, which is connected to the sustainability of Kiribati’s health sector. The observation of the Cuban-trained registrar captures the shared frustration for not being able to deliver the gift of health back to their country and suggests that, in order to improve health care delivery in Kiribati, mode fundamental changes need to be made to the health system:

> *“I’m determined if I finish [postgraduate studies] to come back and work here. Maybe try to help the government to improve the health system and everything. But if our health system is not working, maybe I will go somewhere else. That’s my thinking all the time. I should help, but if they don’t need us, is time we go somewhere else.” (Cuban-trained registrar from Kiribati)*

The comments of Cuban-trained interns in discussions about the perceived causes of the insufficient health workforce indicate that health workers are not given enough opportunities for continuing professional development. The observation of the lack of a MHMS representative at the PSO meetings that plan human resource development in the country could also contribute to limitations on incentives for retention of health workers and hinder the sustainability of the health sector. The comment of a nursing representative that the development of human resources for health should be considered a priority because "we are dealing with the health of people" and of a Cuban-trained intern arguing that in Kiribati "they are more focused on sparing resources” indicate that health is not at the center of the agenda.

Finally, research findings suggest that an approach that focuses on the assets of Kiribati, rather than the deficiencies, could create opportunities to assert the nation’s autonomy. The findings about the lack of knowledge indicate that if Kiribati and Cuba had communicated more about the structure of Cuba's health system and the benefits of Cuban medicine, more mechanisms could have been created, or existing ones improved, to generate and assert the autonomy and sustainability of Kiribati’s health system. The continued focus on curing rather

than preventing diseases means that Kiribati will continue to require external assistance for the development of clinical infrastructure and expensive technology. That means that, as long as the situation remains the same, Kiribati's health system will continue to be unsustainable and the country will continue to rely heavily in the supposed generosity of ODA donors. As explained by Mauss (1990), however, the recognition of the gift giver's superiority does repay and incentivise continuous generosity, but at the cost of the receiver's independence. Cuba, on the other hand, offers a solution that seeks to free Kiribati from the position of eternal subordination.

7.3 Emancipating from donors and challenging imbalanced power relations

Featherstone (2002) conceptualises solidarity as a relation that seeks to challenge forms of oppression, and that can be built through relations that value reciprocity and have the principle of collectivity at its foundation. The third level of the conceptual framework associates traditional aid approaches with dependence and the maintenance of imbalanced power relations, and solidarity-based approaches as conducive of emancipation and more balanced power relations.

Chapters 3 and 5 made clear that, historically, Kiribati and Cuba have been pushed to the fringe of globalisation. Cuba has had to position itself in a world dominated by neoliberal globalisation and a six-decade trade economic embargo from USA, which has recently been tightened and continues to hinder the country's development (Andaya, 2009; Huish and Kirk, 2007; Kirk and Erisman, 2009; Pineo, 2019; The Guardian, 2019). Kiribati was under imperial control of the USA and European governments at the start of the 20th century, and was launched along with other PICs into mercantilist production circuits at the periphery of the evolving global economy (Murray et al., 2019). The new globalisation combined with independent sovereign rule meant participation in a global economy structured to attend the interests of developed nations (see section 2.1), like ODA donors, and of the relatively few Pacific Islanders who are in a position to benefit from this situation.

The Cuban commitment to counter-hegemonic approaches is expressed on public statements that recognise the common challenges faced by developing countries. In a

conversation that asserted the Cuban commitment to develop relationships with PICs despite pressure from the USA, the Asia Pacific director of the Cuban Institute for Friendship with the Peoples (ICAP) stated: "I think what is happening to Cuba it is common to other countries. It is the powerful countries telling small countries what they should do (…). That is what we all should denounce. Every country has the right to develop itself and be independent" (Pacific Media Watch, 2019). More recently, a Cuban representative in the UN has highlighted Cuba´s resolution to continue its "traditional vocation of providing supportive assistance to the peoples who need it most, without conditions whatsoever and with absolute respect for the sovereignty and self-determination of each nation" (MINREX, 2020). Reports about Cuba speaking in defence of the rights of Small Island Developing States (SIDS) in more than one occasion and about the Cuban support to Vanuatu's independence are other demonstrations of Cuba's commitment to challenging imbalanced power relations in the Pacific region (Asia Pacific Report, 2016; Islands Life, 2018).

A fundamental difference between the Cuban and the traditional approach to international development that was made clear during this research journey is that Cuba publicly acknowledges and values the ways in which Kiribati 'repays' the gift of health. The Cubans have publicly showed gratitude to the GoK for supporting their involvement as a Dialogue Partner in the Pacific Islands Forum (MINREX, 2016a; MINREX, 2016b). On his address at the 49th Pacific Islands Forum, Cuba's Deputy Foreign Affairs Minister Rogelio Sierra (2018) reiterated that the common challenges faced by PICs and Cuba can "only be tackled through solidary cooperation among our countries, on the basis of mutual respect, selfless help and complementarity". In the same occasion, the representative expressed "deep-felt appreciation for the Pacific Islands' unanimous support for the Cuban resolution condemning the US blockade against our small island".

While Cuba recognises the important contribution of PICs, mainstream discourses offer a more passive view of the Pacific (Funaki, 2018). As argued by Ravuvu and Thornton (2016, p. 81), in the past three decades the region has been characterised as a "collection of remote and struggling economies". The widespread discourse of the Pacific region as vulnerable is detrimental as it does not recognise the global contribution made by PICs and their active participation in reciprocal exchanges. For Murray et al. (2019), the superficial view of aid relationships in the region disguises considerable difference and debate about the way Pacific island people experience, negotiate, manage and benefit from aid.

When contributions made by developing nations are not recognised as a gift, aid donors are free from the obligation to reciprocate. Gift theory helps us to see that donors' refusal to

acknowledge the gift as such is a refusal to enter a relationship of reciprocity. This prevents Kiribati and PICs from maximising their leverage power and to negotiate terms of exchanges in an equal foot with aid donors. Not recognising their contributions locks these nations in the position of eternal gift receiver and the donor as a generous giver. Funaki (2018) argues that dependency only occurs when no advantage is expected or observed from the other party in the exchange. As there is no such thing as a free gift (Mauss, 1990), interdependence should be the appropriate description for donor-recipient relationships. If PICs' contributions are appropriately acknowledged and given the importance they deserve, new opportunities will emerge for the completion of the gift giving cycle.

This investigation of the Cuban cooperation in Kiribati suggests that its medical outreach aligns with SSC principles of mutual interest, peaceful co-existence, respect for national sovereignty, non-interference in internal affairs, equality amongst developing partners, respect for national independence, for cultural diversity and identity (South Centre, 2009). It also shows that, for Cuba, international cooperation goes beyond: it is an act of solidarity inherent in the principles laid out in the country's constitution and is an essential component of its foreign policy (UNOSSC, 2018). If conceived as something that can be created and maintained, much like inequality, this solidarity can be built in a spirit of cooperation, rather than competition (Featherstone, 2002).

For Huish (2014, p. 262), the "failure of policy makers and scholars to appreciate the dynamics of solidarity brings about misunderstanding as to Cuba's normative practice in the global health landscape, and its potential impacts". Cuba values the reciprocal exchanges with Kiribati and PICs and seeks to build the capacity of human resources for health so partner nations can transform their health systems from a curative to a preventive approach if they wish to do so. As evidenced by this research, however, the gift of health is undermined if practitioners of preventive medicine do not share their knowledge and are integrated in a health system designed to prioritise clinical skills.

If international development approaches and collaboration are grounded on the understanding of health as a human right, there is a way forward for global health inequities. As explored on chapter 2, the 'Southernisation' of aid is a movement that represents a challenge but can also bring to fore new opportunities for cooperation between Southern and Northern donors (Mawdsley, 2018). The increased involvement of Southern countries in mainstream aid structures can blur even further the line between aid and cooperation and facilitate the development of approaches that build on Kiribati's and PICs' vulnerabilities. On a more

positive note, these new forms of interaction can also create new opportunities for bilateral and triangular cooperation. The key role played by New Zealand as trilateral partner in the development of the KITP and language programs and the emphasis of the Pacific Reset (MFAT, 2019) in PHC and UHC, for example, indicates that there is room for cooperation that aims to not only provide curative services to the I-Kiribati people, but prevent illness in the first place. That will be possible if systemic issues that constrain Kiribati to fully exercise its autonomy in the international fora are genuinely addressed.

7.4 Conclusion

The Cuban experience demonstrates that the understanding of health as a fundamental human right can be incorporated into normative processes of health policies and foreign assistance. The utilisation of gift theory helps us to understand the role played by donors, recipients and partners in Kiribati and in the Pacific region and puts in perspective the distinct approaches to global health assistance. The theoretical framework made clear that the lack of recognition of PICs' contributions can lock these nations in the position of eternal gift receiver and the donor as a generous giver. Ultimately, the reflection proposed by the framework shows that an understanding of the politics of the gift relation and the conception of solidarity as a functional mechanism can help to counter systems of oppression.

Chapter 8: CONCLUSION

Analyses of Cuban medical cooperation are generally more focused on examining how Cuba benefits from its medical internationalism than on studying the potential of the Cuban approach and the synergies between the context of the Caribbean nation and the realities of partner countries. If the principal objective of investigations about the Cuban medical outreach is the identification of strategies that promote the vision of the Alma-Ata, namely the expansion of PHC, the achievement of UHC and the fulfilment of the human right to health, the Cuban experience offers valuable insights that can assist on the elaboration of assertive health policies that are more responsive to local contexts.

This research has shown that there are many institutional and cultural challenges of providing medical outreach within the scope of international development cooperation, and it is not different in the case of Cuba and Kiribati. This investigation into the Kiribati health care context **(Research Question 1)** and how the Cuban approach to health is translated by Cuban-trained doctors in Kiribati **(Research question 2**) made clear that the Cuban health care model is well aligned with health needs in Kiribati, but not with the way in which the Pacific nation translates its understandings of health into its health system **(Research Aim).**

The identification of current issues and needs in the delivery of health care in Kiribati, as proposed on **Objective 1.2,** demonstrates that the I-Kiribati population carries a significant burden of preventable diseases. Malnutrition and poor sanitation lead to high rates of communicable and noncommunicable diseases, aggravated by insufficient health workforce and inadequate health facilities. Kiribati currently faces health burdens and challenges for delivery of medical care that Cuba has addressed in the past. The holistic and preventive nature of the Cuban medicine is suitable for the Kiribati context of low resources, limited access to technology and logistical constraints, and strategies implemented in Cuba could bring positive outcomes in Kiribati if adapted to the local reality. However, this research suggests that Cuban-trained interns are not able to fully exercise reciprocity by giving back to their communities the gift of health **(Objective 3.2)**.

This research has also shown the strong role of culture in determining health outcomes. Fieldwork data revealed that I-Kiribati patients seek medical care at the hospital when their condition is too critical and often irreversible. It was observed that in order to improve health

indicators, the GoK needs to address the delayed health seeking behaviour of the I-Kiribati population. The investigation also unveiled that traditional healers often act as PHC providers and suggests that natural and herbal treatments can be effective, but that the lack of integration of traditional practitioners with the formal health system prevents patients from accessing the full range of treatments they could yield benefits from.

The Cuban health care model aligns with this need because, like Kiribati, Cuba has a history of informal natural, traditional and folk medicine. The Cuban experience of incorporating NTM into the formal system can offer critical lessons about the formulation of legislation to govern the practice of traditional medicine and the licensing of traditional healers that could be adapted to Kiribati's context. Given appropriate mentorship, Cuban-trained interns interested in the subject could produce evidence-based research on traditional medicine and identify opportunities and barriers for its integration in the formal health system. Cubans could also draw from their experience in developing preparedness to health disasters. This is particularly relevant in Kiribati and PICs, as Pacific health workers are among the first in the world required to take leading roles in initiating actions to reduce the adverse effects of climate change on the health of populations, especially vulnerable groups.

The discussion about the interaction between Cuban-trained doctors and the I- Kiribati community **(Objective 2.3)** suggested that there are distinct understandings of health in Cuba and Kiribati. The research revealed that while the Cuban population is embedded in a system that promotes health education and individual health ownership, the I-Kiribati population shows resistance to adhere to conventional medical treatments. While the findings indicate that perceptions of health in Kiribati are holistic and go beyond the physical dimension, it also shows that health in the Pacific is understood as a collective rather than an individual matter. Hence, being healthy means to be functional so one can fully participate as a productive member in the family and community life. Being unhealthy, in turn, is associated with not being able to contribute to one's group and can even be a source of embarrassment at times. In this context, Cuban-trained doctors find it difficult to engage the I-Kiribati population in preventive behaviour.

The description of the structure of the health sector in Kiribati **(Objective 1.1)** shows that the GoK and health workers express a preoccupation with health inequity and see value in expanding PHC. However, the investigation noted that a significant portion of the health budget is allocated to the main hospital, that doctors are deployed to deliver curative care and to follow

curative medical protocols modelled after countries with a curative-orientation to health and health systems. The constant need to cover costs of medical referrals means that insufficient funds are allocated to the continuing development of health workers and to the strengthening of primary attention. The exploration of similarities and differences between Cuba's and Kiribati's approach to health care **(Objective 1.3)** and of Cuban-trained doctors' experiences of transitioning into medical practice in Kiribati **(Objective 2.2)** confirm the disconnect between the medicine practised in Cuba and Kiribati's health system.

The focus in specialisation in Kiribati means that Cuban-trained doctors are expected to return home with a higher level of clinical skills. The differences in perception of Cuban-trained graduates, KITP supervisors and I-Kiribati health workers about the motivation and selection process for the Cuban scholarship, the language barrier and clinical skills illustrate these divergences. The Cuban-trained graduates interviewed for this research acknowledged these difficulties but also saw the strengths of a preventive health system, while the majority of other research participants sees the deficiencies in terms of clinical skills as significant barriers for the exercise of the medical profession. This perception is associated with a bias towards curative care, and it leads to a concern with establishing pathways for continuing professional development and accreditation of Cuban-trained interns so they can practise in the Pacific region, where health systems still predominantly curative-oriented. As the focus of KITP supervisors and health officials is often on the deficiencies of the Cuban training, the graduate's knowledge about community and preventative medicine is underexplored. Together, these insights also lead to the conclusion that the scope of practice of Cuban-trained doctors in Kiribati **(Objective 2.1)** is limited.

The examination of the incorporation of ideas of reciprocity and solidarity in Cuba's cooperation with Kiribati **(Objective 3.1)** suggests that Cuba collaborated with the Pacific nation in a non-interventionary manner. This perception is based on the observation that Cuba was open about the benefits it yield from the relationship with Kiribati but did not establish the way in which Kiribati should express reciprocity; in Cuba's focus on developing human resources for health so Kiribati can be less reliant on external assistance; on Cuba's valorisation of the Pacific nation's expression of reciprocity, on the respect expressed for the voice of the PIC in the international fora and in the recognition of the contribution of Kiribati towards global prosperity.

This examination also uncovered that, despite the critiques, the Cuban medical outreach in Kiribati is an example of SSC that differs from traditional aid approaches that are prevalent in the region. The utilisation of the gift theory to analyse how the cooperation functioned showed that the Cuban solidarity-based model does incorporate self-interest, but in contrast to mainstream approaches, solidarity is the prime driver of the relationship (**Research Question 3**). It was possible to identify that this dynamic occurs because Cuba understands reciprocity as a mechanism to build solidarity among oppressed nations, not as a condition to offer assistance to partner nations. This solidarity acquires a social and political function that enables all actors participating in the exchange to fully exercise their autonomy.

Finally, while this interpretation of solidarity is promoted by the principles of SSC, research showed that some Southern countries are adopting approaches more closely associated with the traditional aid model, which can hinder opportunities for partner nations to develop. It was hopeful to observe, on the other hand, that this process of 'Southernisation' of aid also signals that donors traditionally guided by the hegemonic neoliberal ideology that perceives health as a commodity might be more open to more horizontal collaborations. This process can have positive repercussions in the Pacific, if new opportunities for cooperation that understand health as a fundamental human right are pursued.

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APPENDIX 1: Information Sheet

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
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TE KURA PŪKENGA TANGATA

The gift of health:
Cuban medical cooperation in Kiribati
INFORMATION SHEET

Researcher Introduction & Information

How does the unique Cuban approach to medical cooperation contribute to health and development in Kiribati? This research addresses this question, aiming to expand understanding of Cuba's role in health and development in the Pacific. The principal investigator is Cristine Werle, a Master's student in Development Studies at Massey University. She will be assisted by two supervisors and an associate investigator.

Chief Supervisor: Dr. Sharon McLennan (Development Studies, Massey University, NZ)
Co-Supervisor: Dr. Helen Leslie (Development Studies, Massey University, NZ)
Associate Investigator: A/Prof Robert Huish (Development Studies, Dalhousie University, Canada)

If you have been involved in or have knowledge of the Cuban medical programme in Kiribati, or have studied medicine in Cuba, we would like to draw on your experience and insight to help build our understanding of Cuban cooperation. We would therefore appreciate it if you would consider taking part in this research. Involvement in this research will give you an opportunity to communicate your ideas regarding what you have learned from your involvement with Cuban medical cooperation and training, and the risks and benefits of the Cuban approach.

Project Description: The research will explore how Cuba's approach to medical cooperation functions in Kiribati. It aims to examine similarities and differences between Cuba's and Kiribati's health care models, how they are translated to practice through the Cuban programme and how they integrate with meanings of health in Kiribati. Focusing on issues of development and retention of health workforce, the project is especially interested in the practices, scope and impact of the Cuban cooperation in Kiribati's health care delivery. Primarily, the research aims to produce information that is relevant for the development of policies to attain better health outcomes and universal health coverage, aligning with the vision of the Kiribati Development Plan 2016-2019 and supporting the country's efforts towards the achievement of the Sustainable Development Goals.

Research Objectives

1: What is the Kiribati health care context?
Objective 1.1: Describe the structure of the health sector in Kiribati.
Objective 1.2: Identify current issues and needs in the delivery of health care in Kiribati.
Objective 1.3: Explore similarities and differences between Cuba's and Kiribati's approach to health care.

2: How is the Cuban approach to health translated by Cuban-trained doctors in Kiribati?

Objective 2.1: Explore the scope of practice of Cuban-trained doctors in Kiribati.
Objective 2.2: Explore Cuban-trained doctors' experiences of transitioning into medical practice in Kiribati.
Objective 2.3: Describe the interaction between Cuban-trained doctors and the I-Kiribati community.

3: How is Cuba's solidarity model expressed in Kiribati?
Objective 3.1: Examine the incorporation of ideas of reciprocity and solidarity in Cuba's cooperation with Kiribati.
Objective 3.2: Investigate how ideas of reciprocity are expressed in the practice of Cuban-trained doctors.

Research Methods: This research project will utilise document analysis, non-participant observation, semi and unstructured interviews. The focus will be around learning themes, distinctions, motifs and perspectives about health, health care and the Cuban programme from the point of view of Cuban and Cuban-trained doctors, I-Kiribati health workforce and key civil society officials. Data collection will be undertaken in Tarawa in 2019, and initial reports and publications will be produced in 2020.

Project Procedures: If you consent to participation in this project, I would like to talk to you. This may include an interview of approximately 30-90 minutes, at a place and time that suits you. With your permission, this interview will be digitally recorded. Alternatively, we may send questions to you by email. If you choose to be involved in this research you will also select whether you wish to be referred to in any project outputs, or if you prefer that a descriptor is used (e.g. Physician, project manager). Any information you provide will only be available to direct project team members.

Data Management: The information you provide will be kept confidential and stored safely. All physical data, including interview notes and transcripts will be stored in a lockable cabinet or suitcase, and electronic copies of this data will be saved on the researcher's password-protected laptop and external hard drive. The data might be reanalysed in future studies and used in academic and associated conference presentations, book chapters and blog posts. Participants will be informed of findings through a summary report at the end of the research, along with access to project publications.

Participants Rights: You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study at any time;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded.
- ask for the recorder to be turned off at any time during the interview.

Ethics: This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher named in this document is responsible for the ethical conduct of this research. If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher, please contact Professor Craig Johnson, Director (Research Ethics), email humanethics@massey.ac.nz.

Project Contacts: If you have any questions about this research please contact the principal investigator: Cristine Werle. This project is funded by a Marsden Fund Grant, a contestable fund administered by the Royal Society of New Zealand on behalf of the Marsden Fund Council.

APPENDIX 2: Consent Form

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The gift of health:
Cuban medical cooperation in Kiribati
CONSENT FORM

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.
I agree/do not agree to the interview being sound recorded.

I would like to be referred to in this study in the following way (fill in your preference):

- My name and title i.e. ……..……

(e.g. .Jorge Cruz, Medical Director at ABC Clinic)

- My title or a descriptor i.e. ……..

(e.g. Medical Director at ABC Clinic)

I agree to participate in this study under the conditions set out in the Information Sheet.
I would/would not like a summary report of the findings sent to me on completion of this research.

Signature:……Date:……..

Full Name – printed:

……..

Email Address:

……..

APPENDIX 3: Interview guidelines: Cuban-trained doctors

The gift of health: Cuban cooperation in the Pacific
Interview Guidelines: Cuban-trained doctors

Interview format: Semi-structured

Interview time: Approx 45-60 minutes

Interviewer: Cristine Werle

Preliminary Questions/Information:

- Name
- Gender
- Civil Status
- Parents' education
- Position / role / specialty
- Years in Cuban training (when started / finished)
- Internship details (when started / finished)

Reflections on Cuban Training

- Strengths of Cuban health care / Cuban training
- Weaknesses of Cuban health care / Cuban training
- Key learnings

Reflections on return to Kiribati

- What helped your transition to practice?
- What hindered your transition to practice?
- What have you learned through the internship?
- How could the internship and /or transition to practice be improved?
- What are the key differences you have seen between the Cuban approach to health and health care in Kiribati?

Future Plans

- Where do you see yourself in 5/10 years
    - Specialisation? Location?

APPENDIX 4: Interview guidelines: Kiribati Internship Programme

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The gift of health: Cuban cooperation in the Pacific
Interview Guidelines: Kiribati Internship Programme

Interview format: Semi-structured

Interview time: Approx 45-60 minutes

Interviewer: Cristine Werle

Preliminary Questions/Information:

- Name
- Gender
- Position / role / title

Reflections on Cuban trained doctors

- Do you work directly with Cuban-trained doctors
    - In what capacity?
- What are your experiences of working with Cuban trained doctors?
- What differences in practice do you see, if any?
    - Strengths / weaknesses
- What challenges do they face?
- How can the internship / transition to practice be improved?

APPENDIX 5: Interview guidelines: I-Kiribati health workers

The gift of health: Cuban cooperation in the Pacific
Interview Guidelines: I-Kiribati health workers

Interview format: Semi-structured

Interview time: Approx 30-45 minutes

Interviewer: Cristine Werle

Preliminary Questions/Information:

- Name
- Gender
- Position / role / title

Reflections on Cuban trained doctors

- Do you work directly with Cuban-trained doctors
    - In what capacity?
- What are your experiences of working with Cuban trained doctors?
- What differences in practice do you see, if any?
    - Strengths / weaknesses
- What challenges do they face?
- How can the internship / transition to practice be improved?