Global AIDS Response Progress Kiribati Country Progress Report 2014

Submitted by Kiribati Country Coordination Mechanism

31 March 2014

Acronyms and Abbreviations

AG Attorney General
AIDS Acquired Immune Deficiency Syndrome
AMAK Aia Maea Ainen Kiribati (Kiribati Women's Federation)
AHD Adolescent Health Division, Ministry of Health and Medical Services
ARV Anti-retroviral
BBC Behaviour Change Communications
BTC Betio Town Council
BTS Blood Transfusion Service
CBO Community Based Organization
CCM Kiribati Country Coordination Mechanism for HIV, STIs and TB
CDO Community Development Organization
CEDAW Convention for the Elimination of Discrimination against Women
CRC Convention on the Rights of Children
CSO Civil Society Organization
DOTS Directly observed treatment short course
FTC Fisheries Training Centre
GARP Global AIDS Response Progress
GPA Global Program on AIDS
HDI Human Development Index
HIC Health Information Centre
HIV Human Immunodeficiency virus
HSV Herpes Simplex Virus
HW Health Worker
KFHA Kiribati Family Health Association
KPC Kiribati Protestant Church
KPS Kiribati Police Service
MDG Millennium Development Goals
M&E Monitoring and Evaluation
MISA Ministry of Environment and Social Development
MHARD Ministry of Home Affairs and Rural Development
MHMS Ministry of Health and Medical Service
MISA Ministry of Internal and Social Affairs
MICT Ministry of Information, Communication and Transport
MOU Memorandum of Understanding
MP Member of Parliament
MTC Marine Training Centre
NBTC National Blood Transfusion Centre
NGO Non-Governmental Organization

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I. Status at a glance

a. Inclusiveness of the stakeholders in the report writing process

This report was prepared through a consultative process involving key stakeholders from both Government and civil society. The Kiribati Country Coordinating Mechanism (CCM), as a GF-governing body at country level was involved every step of the way through consultative meetings and interviews. Four series of meeting took place in the process: 1) the first was a consultative and consolidation meeting that took place on Thursday 6 March to go over, refine and agree on the scope and relevance of core indicators that should be included in the report (See Annex 1 for list of participants); 2) the second meeting was held on Wednesday 19 March where participants were presented by the local TA, with progress on the reporting so far, highlighting areas, information and indicators that have been covered so far and those that still need to be sourced and researched, (see Annex 2 for list of participants); 3) the third meeting took place on Wednesday 19 March 2014 for completion of the National Commitments and Policy Instrument (NCPI), (see Annex 3 for list of participants). Over the period of two weeks between 10-21 March, a number interviews were conducted to various key informants to further validate data and get key informant's views on the national response, (See Annex 4 for list of key informants interviewed)

A literature search was undertaken to review recent development and research in this area. It must be noted that as far as recent data is concerned, little has taken place since the last mid-term review and the Kiribati GARP report of 2012. Whatever new information or data collected since then, have mainly come from HIV testing sites e.g. TCH National laboratory, Christmas Is hospital, Kieia Ataei Hospital in Tabiteuea North, KFHA, MTC and PPTCT. Because these initial rapid test kits are not confirmatory, the national laboratory would be the only place where HIV positive confirmed cases can be obtained. The other important sources of data are from interviews with key informants. For this, common and contrasting themes were used to build on existing and other sources of information to arrive at a consensus for the report.

b. Status of the epidemic;

Kiribati is experiencing a low level general HIV epidemic. To date Kiribati has an estimated 55 cumulative cases of HIV dating from 1991 to the end of December 2013[1]. The majority are males but there is increasing gender balance over the last decade. There are 23 confirmed AIDS related deaths four of which are children. Of the current estimated HIV positive cases (n=28), 6 are on antiretroviral treatment (ART).

c. The policy and programmatic responses

[1] National HIV/AIDS Program data

A number of policies and programs are in place to guide and spearhead the strategic response to HIV/AIDS in Kiribati. These are summarized in Table 1 below.

Table 1: Relevant Policy Documents and programs in the GARP report 2014

Name of policy and/or program	Year covered	HIV focus
Kiribati Development Plan	2012-2015	KPA 3: Health; Outcome 4: Reduced burden and incidence of communicable diseases (including TB, leprosy, lymphatic filariasis, STIs including spread HIV AIDS)
MHMS Strategic Plan	2012-2015	High burden & incidence of communicable diseases (TB, leprosy, lymphatic filariasis, STIs and HIV/AIDS) Strengthen DOTS services and existing diseases surveillance and outbreak response for TB, leprosy, lymphatic filariasis, STIs and HIV/AIDS
National HIV/AIDS and STI Strategic Plan	2013-2016	Response to HIV and STI
Kiribati HIV Testing and Counseling Policy Guidelines	Version 2, 2013	Response to HIV and STI
Guideline on prevention of parent to child transmission	2010	Prevention of child transmission and management of maternal HIV
OBG clinical guidelines for Medical Assistants and Nurses in health centers and clinics	2012	Treatment guideline for sexual and reproductive illnesses in health center settings
Flow chart for symptomatic management of STI	2011	Symptomatic management of STI

The Kiribati national response to HIV is centered around a number of national policy documents that address HIV in several different but contributing ways. Each is aligned to the national HIV Strategic Plan 2013-2016 which in turn supports the Kiribati Development Plan (KDP) 2012-2015. The KDP 2012–2015 has six Key Policy Areas (KPAs) and broad strategies to address each KPA[2]. The KPAs are aligned to international goals such as the Millennium Development Goals (MDG). KPA 3 on health sets out six core issues/outcomes for health: i) High population growth; ii) High maternal morbidity (including macro and micro nutrient deficiency); iii) High child morbidity (including malnutrition and childhood injuries); iv) High burden & incidence of communicable diseases (TB, leprosy, lymphatic filariasis, STIs an HIV/AIDS); v) High burden and incidence of other diseases (Non-communicable diseases), and vi) Apparent

[2] Kiribati Development Plan 2012-2015

gaps in health service delivery. These health priorities are also echoed in the Ministry of Health Strategic Plan 2012-2015[3] with outcome iv being most relevant to this report. More discussion of these linkages can be found in section on II, A. of this report.

d. Indicator data in an overview table

Table 2 below shows core indicators for Global AIDS response progress reporting. The 2012 GARP report data are included for comparison. The paucity of recent data is noted, with the majority of them coming from national laboratory database in addition to recent information obtained from key informant interviews and included in the comment column.

Table 2: Indicator data in an overview table

Target	Indicator		Value			Measurement tools and Comments
			2012 GARP report		This 2013 GARP report	
			Male	Female		
Target 1. Reduce sexual transmission of HIV by 50% by 2015 *General population*	1.1	Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	44%	48%	0	2012 figures obtained from Kiribati DHS 2009 No recent behavioral survey
	1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	1.6%	13.8%	0	2012 figures obtained from Kiribati DHS 2009 No recent behavioral survey data. Although the minimum legal age

[3] Kiribati MHMS Strategic Plan 2012-2015

						for a woman to get married is 18 in Kiribati, marriage among young girls is common. Among women aged 20–49, 5% are married by age 15, 26% are married by age 18, and 47% are married by age 20. The median age at first marriage is 20. However, the trend is shifting toward fewer women marrying at very young ages, as only 2% of women aged 15–19 are married before age 15 compared with 9% of women aged 45–49[4]. Similarly, the 2009 KDHS collected data on age at first sexual intercourse. By age 15, 6% of women aged 25–49 are sexually active, and 28% are active by age 18.
	1.3	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	1.8%	10.5%	0	2012 figures obtained from Kiribati DHS 2009. No recent behavioral survey data

[4] Kiribati Health and Demographic Survey 2009

	1.4	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse*	2.4%	33.2%	0	This figure is based on Age 15-24, from Kiribati DHS 2009. No recent behavioral survey data
	1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	-	-	-	National laboratory data shows a total of 4,193 people were tested for HIV in 2012 and 4,113 in 2013. No HIV positive case was found. There is no data on % who received results
	1.6	Percentage of young people aged 15-24 who are living with HIV*	-	-	-	No data available
Sex workers	1.7	Percentage of sex workers reached with HIV prevention programmes	-	-	-	No recent behavioral survey data on sex workers. KFHA data shows a total of about 30 sex workers reportedly working under an old woman's ("te unaine") supervision, and who have been receiving HIV prevention programs through KFHA outreach activities, including HIV and STI testing

						and condom use.
	1.8	Percentage of sex workers reporting the use of a condom with their most recent client	-	-	-	No recent behavioral survey data on sex workers
	1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	-	-	-	No recent behavioral survey data on sex workers. For KFHA 2013 records, HIV and STI testing were done on all 30 sex workers and all tested negative.
	1.10	Percentage of sex workers who are living with HIV	-	-	-	No recent behavioral survey data on sex workers.
Men who have sex with men	1.11	Percentage of men who have sex with men reached with HIV prevention programmes	-	-	-	No behavioral survey data on MSM. KFHA has also been able to identify and provide HIV prevention programs to 30 MSM especially on Betio area.
	1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	-	-	-	No behavioral survey data on MSM
	1.13	Percentage of men who have sex with men that	-	-	-	KFHA carried HIV and STI testing to 12 of the

		have received an HIV test in the past 12 months and know their results				30 MSM in 2013 and one tested positive for syphilis.
	1.14	Percentage of men who have sex with men who are living with HIV	-	-	-	No behavioral survey data on MSM
Target 2. Reduce transmission of HIV among people who inject drugs by 50% by 2015	2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	-	-	-	For Kiribati, IDU is considered irrelevant at this time of the reporting, i.e. there are no reported nor visible cases of IDU.
	2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	-	-	-	
	2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	-	-	-	
	2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	-	-	-	
	2.5	Percentage of people who inject drugs who are living with HIV	-	-	-	
Target 3.	3.1	Percentage of HIV-positive	-	-	-	There was only one

Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths**		pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission				HIV positive pregnant woman reported who delivered in 2010 (see indicator 3.1a below) and who has been receiving ART from only one preferred source/staff.
	3.1a	Percentage of women living with HIV receiving antiretroviral medicines for themselves or their infants during breastfeeding	-	-	-	There was one infant born to an HIV positive mother reported in 2010 (see indicator 3.1 above) but his/her HIV status was not known and did not receive ART. The mother is still on treatment however[5].
	3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	-	-	-	See above
	3.3	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	-	-	0	No PPTCT record of this case
Target 4. Reach 15	4.1	Percentage of adults and children currently	-	-	10.6%[6]	HIV/AIDS and STI program and

[5] This case prefers to be attended to by only one health staff (a clinical nurse and a counselor now working with KRCS), and from whom this information was obtained during key informant interview.
[6] Data based on SPC projection

million people living with HIV with lifesaving antiretroviral treatment by 2015		receiving antiretroviral therapy*				Pharmacy data shows there are 6 HIV cases on treatment.
	4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	-	-	-	2 HIV cases have been on treatment for more than 3 years.
Target 5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015	5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV				NTP data shows there were two HIV positive patients (a couple) on ART and TB treatment in December 2009 and completed treatment, "discharged as cured" in July 2010[7]. It has also been confirmed that both died one after the other over a course of several months in late 2010.
Target 6. Close the global AIDS resource gap by 2015 and reach annual global investment of US$ 22–24 billion in low- and middle-	6.1	Domestic and international AIDS spending by categories and financing sources				

[7] Data from Kiribati NTP TB Register

income countries						
Target 7. Eliminating gender inequalities	7.1	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months *All indicators with sex-disaggregated data can be used to measure progress towards target 7*	-	-	-	No recent data on this indicator. Kiribati Family Support and Health Study[8] found that 68% of women who had ever been in a relationship reported experiencing physical and/or sexual violence by an intimate partner.
Target 8. Eliminating stigma and discrimination	8.1	Discriminatory attitudes towards people living with HIV				There is no data on this indicator. However the following extract from Kiribati DHS 2009 is still relevant: "*Overall acceptance of PLHIV is limited, with 28% of women and 33% of men aged 15–49 expressing overall tolerance and acceptance. Negative attitudes mainly relate to concerns regarding hypothetical situations such as a female teacher with HIV being allowed to teach*

[8] Kiribati Family Support and Health Study: A study on violence against women and children 2010 SPC and Government of Kiribati

						(accepted by nearly 49% of women and 54%) and buying food from a shopkeeper with HIV (accepted by nearly 56% of women and 65% of men). A greater proportion of respondents would be prepared to care for a family member with HIV at home (79% of women and 91% of men), and most would not want hide the fact that a family member had HIV (85% of 212 women and 84% of men). Accepting attitudes increase with education level, but no clear trends are evident for other factors such as age, income or location (rural vs urban), except for rural male respondents who were somewhat more accepting overall (36%) than urban men (30%)". Key informant interview with one PLWHA shows that discrimination towards him and his spouse was intense during the initial stage

						of the epidemic. This has steadily waned over time and now he considers it “no longer an issue”.
Target 9. Eliminate travel restrictions		*Travel restriction data is collected directly by the Human Rights and Law Division at UNAIDS HQ, no reporting needed*				Not applicable
Target 10. Strengthening HIV integration	10.1	Current school attendance among orphans and non-orphans aged 10–14*				No recent data available, and the concept of orphan is not fully ingrained into Kiribati culture. Such cases usually end up with the widow ‘remarried’ into the diseased husband’s family to maintain family traditions, love, wealth, etc, or the children would simply be cared for by close or extended families.
	10.2	Proportion of the poorest households who received external economic support in the last 3 months				Government of Kiribati subsidizes secondary school fees for children with deceased or disabled fathers and there is an Elderly Fund for those over 67 years

Policy questions (relevant for all 10 targets)		National Commitments and Policy Instruments (NCPI)				NCPI

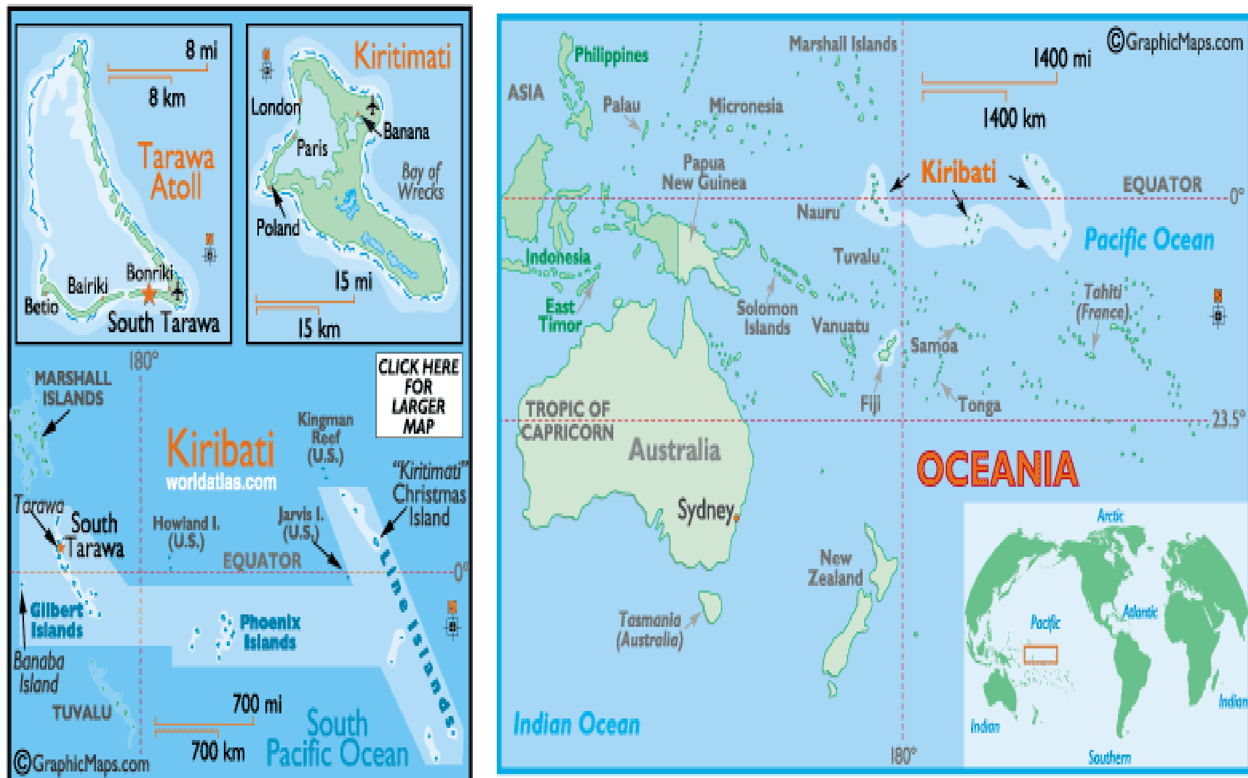
* Millennium Development Goals indicator

** The *Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive* defines this target as:

1. Reduce the number of new HIV infections among children by 90%
2. Reduce the number of AIDS-related maternal deaths by 50%

For further information see:
http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_JC2137_Global-Plan-Elimination-HIV-Children_en.pdf

II. Overview of the AIDS epidemic



a. Demographic overview

Kiribati is a small island republic located in the central Pacific consisting of 32 mostly low lying islands widely scattered across 3.4 million sq km of ocean. It has an estimated population of 103,371 .The capital is in South Tarawa. About half of the population lives on South Tarawa, the seat of government and centre of commercial industry. Overall, there are more women than men in Kiribati, with a sex ratio of 95 men to 100 women. Kiribati population is predominantly young, with 38% of the population under the age of 15, 50% aged 15-49 years and only 12% over the age of 50. A young population is a characteristic picture of many developing countries and this is usually coupled with easy spread of STIs including HIV. The average household size is 6 people (7 in urban areas, 5 in rural areas) and approximately 24% of households are headed by women. Though the islands are scattered migration between islands is high.

Kiribati's population is predominantly Micronesian with a small number of other ethnic groupings like Polynesian, Melanesian, Chinese and Europeans. Kiribati's population has almost doubled since independence in 1979, and population density has more than tripled since the first census in 1931. Increasing population density poses urgent challenges for Kiribati's resources as well as population health. In 2011 Kiribati was ranked 122 on the Human Development Index; in 2012 it rose only by one point to 121 , remaining one of the world's poorest and least developed countries.

b. MHMS Strategic Plan 2012-2015 and Health Service delivery

The six strategic objectives of the Kiribati Health Strategic Plan for the period 2012–2015 are:

i. 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.
ii. Improve maternal, newborn and child health.
iii. Prevent the introduction and spread of communicable diseases, strengthen existing control programmes and ensure Kiribati is prepared for any future outbreaks.
iv. Strengthen initiatives to reduce the prevalence of risk factors for NCDs, and to reduce morbidity, disability and mortality from NCDs.
v. Address gaps in health service delivery and strengthen the pillars of the health system.
vi. 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.

Note: The order of the objectives does not reflect their priority.

The first five of these objectives are aligned with core issues and strategies for health in the Kiribati Development Plan 2012–2015, while the sixth objective was identified by the Ministry of Health and Medical Services as a priority issue for the next four years.

Strategies relating to gender equality are included in the KDP under KPA 5 on governance, and gender based violence is considered in the results matrix for this KPA. The needs of youth are considered in various places in the KDP including in relation to health (STIs and HIV) and governance (empowerment, involvement and participation).

Kiribati's National Health Plan is based on a Primary Health Care model. There are 114 health facilities nationally, with one main national referral hospital (Tungaru Central Hospital) based on South Tarawa and two district hospitals one on Christmas Island and one on Tabiteuea North (Kieia Ataei). Healthcare is free at point of delivery and there are no private clinics or hospitals. Some clinics run by Kiribati Family Health Association (KFHA) also offer specific services like HIV and STI testing, cervical pap smears, male circumcision and vasectomy. Palliative care is limited and small numbers of patients receive specialist treatment in Fiji, New Zealand, India and Taiwan for conditions not treatable in the country, under the MHMS referral system funded under bilateral arrangement with New Zealand as the traditional donor and Taiwan as relatively recent source.

c. Status of epidemic

Kiribati is experiencing a low level general HIV epidemic. To date Kiribati has an estimated 55 cumulative cases of HIV dating from 1991 to the end of December 2013 , see Figure 1. The majority are males but there is increasing gender balance over the last decade, see Figure 2. There are 23 confirmed AIDS related deaths four of which are

children. Of the current estimated HIV positive cases (n=28), 6 are on antiretroviral treatment (ART). However apart from the two publicly known PLWHA, the high turn-over rate of HIV clinical core team coupled with poor handing over and recordings has made it increasingly difficult to fully document the progress of the remaining four patients in terms of their ART, CD4 counts, viral load results, and their general well-being. Moreover, with high migration both internally and abroad the whereabouts of the remaining 22 is unknown.

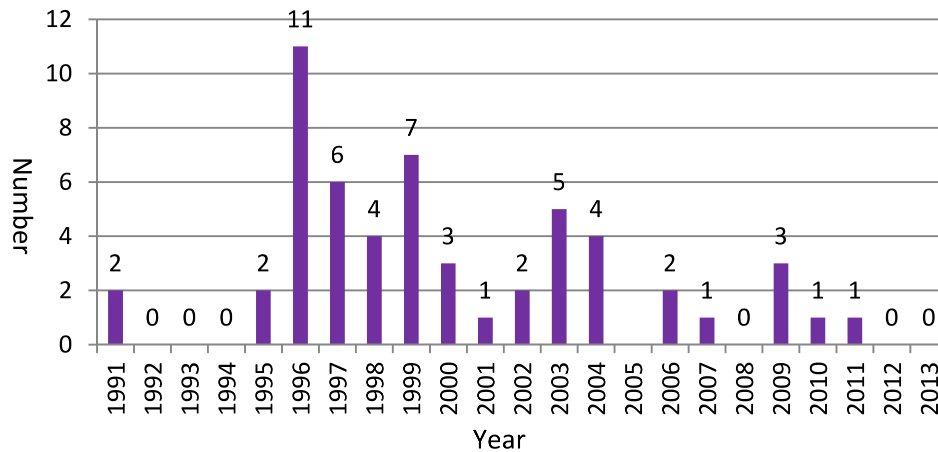


Figure 1: Number of HIV cases by year, 1991-2013

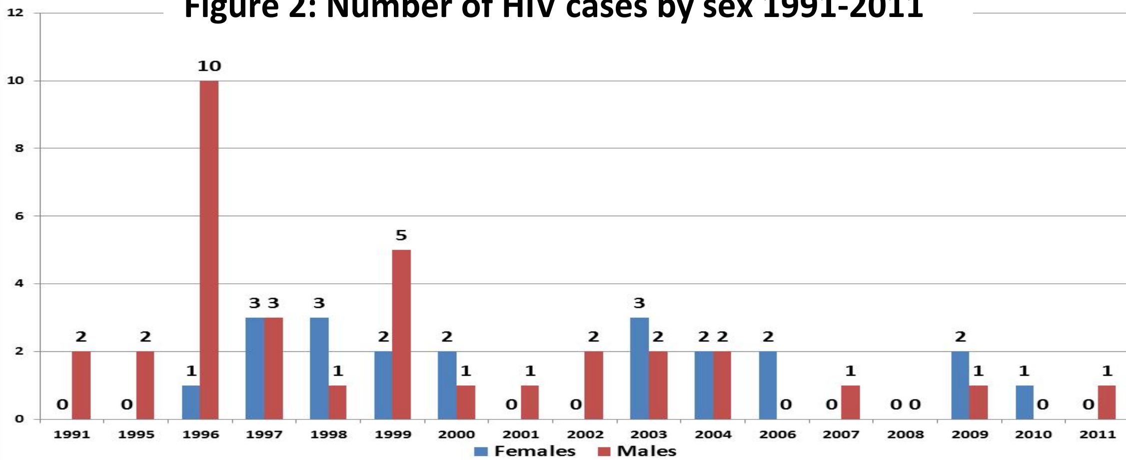


Figure 2: Number of HIV cases by sex 1991-2011

The main mode of transmission is understood to have been heterosexual sex, followed by perinatal transmission. Groups identified to be most at risk include seafarers, their spouses (and children), and those involved in commercial or transactional sex. There are 23 confirmed AIDS related deaths but this number is suspected to be higher. It should be noted that this total number of HIV positive cases does not always fully represent the real HIV epidemic situation in the country due to a number of reasons including accessibility to HIV testing facilities including availability of health care provider.

HIV and STI
Table 3 shows the total number of HBsAg, HIV and STI tests conducted in 2012 from the national laboratory from all sources (blood donations, VCCT, PPTCT, and STI clinics, KFHA, etc). While this is not a representative sample of the population the proportion of positive STIs, is a concern as this closely correlates with HIV transmission. Furthermore the lack of available disaggregated data does not allow for a clearer picture of exactly which ages within this group are most affected.

Table 3: Number of HBs Ag, HIV and STIs testing, 2012

Types of testing	Total	Positive	%
HBs Ag	5165	916	17.7
HIV	4193	0	0
Syphilis	4472	369	8.3
Bacterial vaginitis	619	61	9.8
Trichomona	619	27	4.4
Human papillomavirus	619	8	1.3
Genital Herpes	619	0	0
Gonorrhea	15	2	13.3

Source: National Laboratory

II. National response to the AIDS epidemic

a. Overview of the national response

Kiribati's national response to HIV and AIDS has always been governed by the availability of external funding sources. As such it relies heavily on international donor support for its programmatic response. The MHMS provides in-kinds contribution to the national response through the provision of housing, office space and transport to its HIV/AIDS and STI Program staff, who are paid by projects funds. It also provides staffing for the Prevention of Parent to Child Transmission (PPTCT) program, the Communication for Development (C4D) program, and Youth Friendly Health Services (YFHS). The HIV/AIDS and STI program receives significant support from the Global Fund, Response Funds and Continuum of Care (COC) Fund and UNICEF while the latter three programs are all UNICEF-funded. From civil society

perspectives, KFHA receives support through IPPF, NZFPI, AusAID and UNFPA, while a most recent contribution is coming from Kiribati Road Rehabilitation Contractor MacDow, targeting road workers as potential high risk groups. KRCS receives its funding directly from GF to assist in blood donation and condom distribution.

b. Prevention, care, treatment and support

Public awareness carried out by a variety of HIV related programs and services both at government and civil society levels, has been the key in the prevention of HIV spread. In addition to the general population awareness, targeted approach is also used so that high risk groups like youth, seafarers, sexual workers, MSM and entertainment spots are not missed.

Communication for Development (C4D)

Communications for development (C4D), a UNICEF funded program targeting youth has been active since 2010. For the years 2012 to 2013 C4D has, in close collaboration with Community Policing, been able to:

- conduct community and radio awareness during national sport completion (Te Runga 2013);
- village community groups awareness;
- truancy in schools;
- development and production of HIV DVD;
- HIV awareness and testing during National Youth Day 2013;
- public awareness during 2013 Independence Celebrations, and
- awareness to 40 Kava bars on South Tarawa and Betio.

Prevention of Parent to Child Transmission (PPTCT)

PPTCT is a UNICEF funded project with goal *'to promote HIV-free child survival in Kiribati through an integrated comprehensive approach to HIV and STI prevention and care for women and men at the reproductive stage of life and their children'*. It is coordinated by PNO in charge of Ante Natal Clinic. Through PPTCT all ANC mothers are given VCCT and tested for HIV in nine ANC clinics/centres on South Tarawa and Betio. All ANC clinics reports to ANC/TCH on monthly basis using MS1 and ANC/TCH then reports to HIU.

Voluntary Confidential Consent Testing (VCCT)

There are now approximately 40 professional counselors and eleven (11) accredited VCCT sites on South Tarawa and Betio: Betio clinics (3), Bairiki clinic, Teaoraereke, KIFHA, Banraeba clinic, Eita, Bikenibeu West clinic, Bikenibeu East clinic, TCH ANC Clinic. These sites however are not always fully manned by qualified counselors in view of staff retirements, movements and postings. A total of 1214 HIV counseling and testing (Determine = 1208 and 6 = Uni-Gold and Insti assay) were conducted in 2012 and all tested negative, see Table 4. There is a need to have data disaggregated into sex, age and special at-risk groups to give more insights into the extent of the

problem. According the *Report on comprehensive assessment of PPTCT*[9], 1238 women were tested in 2011 which represents about 43% of all ANC attendees. The majority of those that are missed would come from outer islands clinics due to the absence of counselor and non-availability of testing tools.

Table 4: HIV testing by category of request, 2012

	Tested	Positive
Blood donation	1566	0
Med Check-up	988	0
VCCT	1214	0
Outer island tours	425	0
Total	4,193	

Youth Friendly Health Services (YFHS)

YFHS is also a UNICEF-funded project aimed at addressing the developmental changes of young people (YP) to minimize risk behaviour and avoid problems encountered during adolescent . It is coordinated by the PNO who looks after Safe Motherhood Program. It was introduced in 2001 as the Adolescent Reproductive Health (ARH) program and in 2005 the name changed to Adolescent Health and Development (AHD) under UNICEF and UNFPA funding. Since 2010 Youth Friendly Health Services project has operated under the same mandate as AHD addressing the development changes of YP to minimize risk behaviour and avoid problems associated with adolescent. Since the closure of AHD centre at Betio when funds from UNFPA were exhausted, coupled with the departure of the former coordinator, there are now:

- No existing or operational youth centres on South Tarawa and Betio, and
- The change-over of coordinators with apparent lack of handing over has resulted in discontinuity and delay in implementation.

This may have some serious implications in addressing RSH needs of YP on South Tarawa. To partly address this, a Youth Centre at Abemama has been developed under UNICEF assistance as a pilot program for rolling out of YFHS to outer island, and another YC will be set up on Marakei. This has been a collaborative effort between MHMS, UNICEF and NGO such as KFHA and KRCS involving outer island peer education. Furthermore, PHN are being asked to include YFHS in their daily work or identify one day for YFHS. This would require some structural changes

[9] Report on Comprehensive assessment of PPTCT and syphilis management services in Kiribati, MHMS/UNICEF, 2012

including workload assessments, capacity buildings, a need for office space inside clinics for counselling etc. The Kiribati National Peer Educators Committee (KINPEC) has had two meetings in 2013, and YFHS provides narrative end of activity report to UNICEF only.

Blood donation HIV screening and Hepatitis B vaccination
All blood donors are screened for HBsAg, HIV, STIs, HCV. Out of 4,193 people tested for HIV in 2012, 1566 were done through blood donation and all were negative, see Table 2. Hepatitis B vaccination as part of the national vaccination program under EPI is an on-going vaccine preventable STIs, assisting in decreasing the risk of HIV transmission.

Condom distribution and MSM
KFHA and KRCS have been very active in conducting condom distribution. KFHA has in particular been working with MSM in this area and it is enlightening to note that MSM which in previous reports could not be fully accounted for, are now being dealt with as it should be. In this respect, KFHA has been able to identify and provide HIV prevention programs to 30 MSM especially on Betio area. KFHA also carried HIV and STI testing to 12 of the 30 MSM in 2013 and one tested positive for syphilis. Condom distribution has traditionally been done to public bars, night spots and hotels. The latest inclusion in now kava bars which are getting to be very popular in Kiribati.

Discrimination and stigma
Although there is no data with respect to discriminatory attitudes, the following extract from Kiribati DHS 2009 is still relevant:

> "Overall acceptance of PLHIV is limited, with 28% of women and 33% of men aged 15–49 expressing overall tolerance and acceptance. Negative attitudes mainly relate to concerns regarding hypothetical situations such as a female teacher with HIV being allowed to teach (accepted by nearly 49% of women and 54%) and buying food from a shopkeeper with HIV (accepted by nearly 56% of women and 65% of men). A greater proportion of respondents would be prepared to care for a family member with HIV at home (79% of women and 91% of men), and most would not want hide the fact that a family member had HIV (85% of 212 women and 84% of men). Accepting attitudes increase with education level, but no clear trends are evident for other factors such as age, income or location (rural vs urban), except for rural male respondents who were somewhat more accepting overall (36%) than urban men (30%).
>
> Page 211-212

Furthermore, key informant interview with one PLWHA shows that discrimination towards him and his spouse was intense during the initial stage of the epidemic. This has steadily waned over the years and now he considers it "no longer an issue". On his part he does not have any problem in traveling around and using public transports.

Ministry of Education (MoE) – HIV and curriculum development
The MoE has already included HIV in its curriculum starting from Class 3 (now called Year 3) onwards under the subject matter: *"Healthy Living".* Healthy living deals with a number of important health topics including communicable disease that includes TB, HIV and others.

The role of civil society
Kiribati Family Health Association (KFHA) is a very active partner in the fight against HIV, and is performing excellently in the following areas: Youth sexual and reproductive health (SRH), family planning including insertion of IUCD for referred case from MHMS clinics on South Tarawa and Betio, HIV counseling and testing, STI testing and condom distribution, and vasectomy. According to KFHA data there about 30 registered female sex workers supervised by elderly woman (te unaine). For 2013, HIV and STI testing were done on all of them and all were negative. KFHA has also been able to identify and work with about 30 MSM especially on Betio working under groups such as Miss July, also supervised an elderly MSM. HIV and STI testing were done to 12 MSM in 2013 and one was positive for syphilis.

Kiribati Red Cross Society (KRCS) is another NGO hat is working closely with MHMS in addressing the HIV epidemic in Kiribati. KRCS receives funding from GF. For 2013 a total of US$11,044.50 was used to carry out the following activities:

- Conduct cultural activities to educate key populations on HIV and other STIs including dramas, puppet show and candle light campaigns
- Employ M&E HIV officers
- Community mobilization campaigns and activities to recruit VNRBD in partnership with national ministry of health
- Initiate and develop the 'club 25' concept to target national community youth
- World Blood Donor Day celebrations/campaigns – 14 June (1 wk)
- HIV in workplace trainings for various organizations in the countries, following development and adoption of HIV work place policy in the national RC societies

Enabling environments
The Kiribati MHMS HIV/AIDS and STI Program is supported by GF while the MHMS provides support to other HIV-related programs through housing and staffing the Prevention of Parent to Child Transmission (PPTCT) clinic within the Antenatal Clinic (ANC), the UNICEF-supported Youth Friendly Health Services (YFHS), originally the UNFPA supported Adolescent Health Development (AHD) program, and some MHMS HIV & STI Unit staff. The MHMS also supports a HIV and AIDS Clinician. Funding support for Kiribati national response to HIV/AIDS and STI come mainly from GFATM fund, the Response fund, Continuity of care fund and UNICEF. However in view of high turn-over rate and small number of staff who needs appropriate training, this unit needs to be significantly strengthened.

The National HIV/AIDS Strategic Plan 2013-2016 has been endorsed by the MHMS as the working documents. The plan, with a vision to *"Reduce to bearest minimum all STIs and assure zero new HIV infections, zero preventable deaths HIV & AIDS, and zero discrimination associated with HIV"*; and the goal of: *"Achieving together a supportive environment to reduce the impact of HIV & other STIs on individuals, families and the community in Kiribati",* identifies five priority areas:

Priority 1: Prevention of HIV and other STIs, Prevention of Parent to Child Transmission, Safe Blood supply and assurance of Universal precautions.
Priority 2: Community leadership and an enabling environment to reduce stigma and discrimination
Priority 3: Diagnosis, treatment and support of people living with HIV
Priority 4: Quality diagnosis, management and control of STIs
Priority 5: Strengthening management and coordination of the national response

Kiribati NSP 2013-2016 M&E and GARP Report 2014 – a meaningful link. When creating data collection tools in Monitoring and Evaluation we will always relate them with indicators of the programme or project because that is really what we want to measure and report on. The NSP 2013-2016 has in place the M&E framework for monitoring a number of its key objectives under the five priority areas. Fifteen (15) of Kiribati NSP 2013-2016 M&E indicators were derived from either MDG or UNGASS and therefore are also captured in this Kiribati GARP 2014 report core indicators. This GARP report can therefore be seen as evaluation of the Kiribati National Strategic Plan 2013-2016.

National HIV/AIDS legislations. It was also noted that much of Kiribati's health-related legislations like *Public Health Ordinance* and *Offence against morality* under the Penal Code are over 30 years old (and based on United Kingdom legislation) and requires updating to meet new needs and international requirements. There are currently no national instruments specifically legislating HIV/AIDS. Some international conventions and national efforts in addressing (indirectly) the HIV epidemic in Kiribati includes[10]:

- Convention on the right of the Child (CRC, 1995);
- Convention on the elimination of all forms of violence against women (CEDAW, 2004);
- The Child Young People and Family Welfare Bill (2012)[11],
- The Family Peace Bill that aims to address all forms of violence against women.

At the policy level, Government has approved:

- Eliminating Sexual and Gender based violence (ESGBV) Policy;

[10] Statement by the Vice President Hon Ms Teima Onorio for the 57th Commission on the status of women, theme: Eliminating all forms of violence against women and girls, 2013.
[11] First Parliamentary reading in 2012, update is required.

- National Action Plan 2011-2021;
- The Child Young People and Family Welfare Policy, and
- The Gender Access and Equality Policy and Implementation Plan 2013-2016.

c. Knowledge and behavior change

Surveys to assess the level of awareness and knowledge to bring about positive behavioral change have not been conducted since the last behavioral surveys in 2008 and DHS in 2009 and. As such it would not be possible to compare trends between the 2013 and 2014 GARP reports. Public awareness campaigns are on-going however.

d. Treatment, support and impact alleviation

Currently there is no center designated to provide ART. TCH had trained doctor and Staff nurse to provide ART, however there are currently working at different centers. The high turn-over rate among HIV/AIDS Program staff is one of the major bottle-neck in this campaign. For example, the former HIV nurse (who is currently working with Red Cross) collects prescription drugs for the mother from the hospital pharmacy and delivers them to her at a place convenient. There is no documentation or reporting done on clients on treatment or follow up. Support to PLWHA is on-going as far as the two publicly known HIV positive cases are concerned in terms of regular follow-ups, conduct of CD4 count and viral load at regular intervals and other support services provided mostly by the HIV/AIDS and STI Program staff.

Identifying and enrolling all HIV positive cases on ART as well as do regular follow up and support for people with HIV is crucial in mitigating potential complications of advances AIDS disease. The onus is on the MHMS to provide a clinical core team that is fully functional, well equipped and appropriately trained to manage HIV cases. Care of people living with HIV is limited due to the limited number of people with known HIV status. There are only two in the country and although there are six HIV cases on ART, the quality and extent of care to the remaining four cases is not known.

IV. Best practices

KFHA track records and excellent role in prevention, diagnosis management of HIV has gone a long way in assisting Kiribati to deal with the HIV epidemic. With staff that are fully trained[12] in laboratory, clinical and program management, and a wide range of funding sources including GF, IPPF, NZFPI, AusAID, UNICEF/UNFPA and lately the Kiribati Road Rehabilitation Program, KFHA's role in assisting national efforts in the response against HIV should be recognized and strengthened. It should be well noted with sincere appreciation that the MHMS is currently referring cases for vasectomies to be done by KFHA. Table 5 shows KFHA range of activities and impressive record for 2013. And Figure

[12] Most KFHA technical staff are retired senior MHMS laboratory staff and nurses including Medical Assistants, who have worked with the MHMS for years. As such they have good work experience well suited for their roles at KFHA.

3 highlights the HIV services testing with pre and post counseling by age and sex, showing: i) more males are tested at younger age as opposed to females, and ii) a proportion of those pre-counselled and tested are not getting post-test counseling, mostly due to their negative their results.

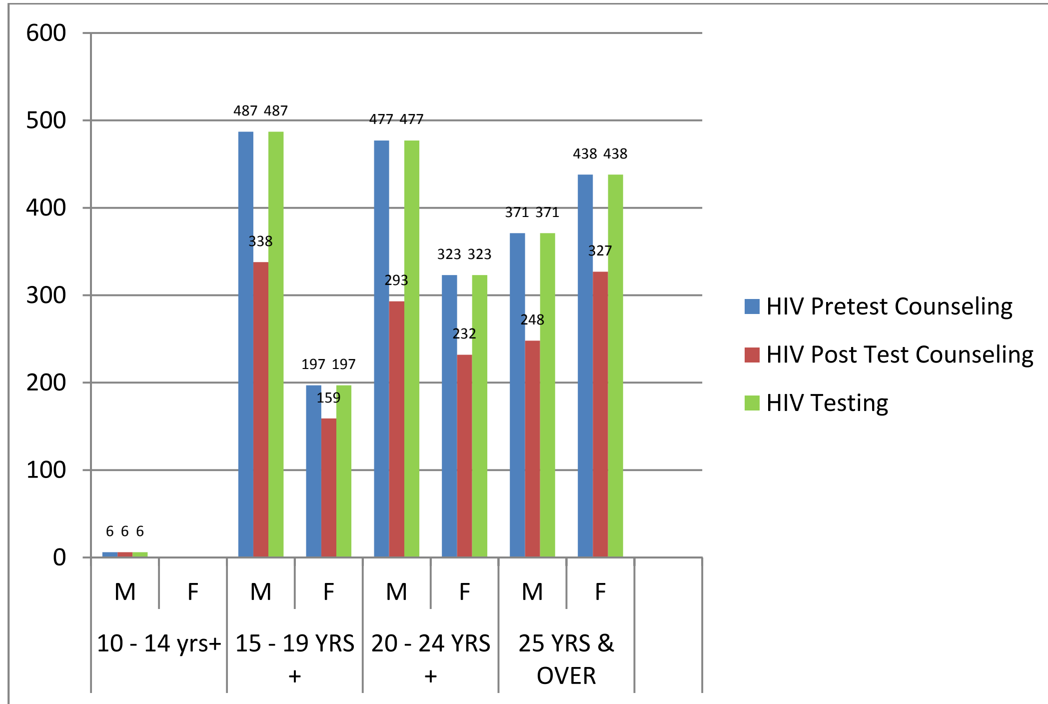
Table 5: KFHA activity report, 2013

ACTIVITY SUMMARY JANUARY - DECEMBER 2013.									
	10 - 14 Yrs		15 - 19 Yrs		20 - 24 Yrs		25 Yrs and over		TOTAL
	M	F	M	F	M	F	M	F	M/F
Total Obstetric Services									
Antenatal client				36		96		145	276
Pregnancy Test				28		117		239	384
HIV Services									
HIV Pretest Counseling	6		487	197	477	323	371	438	2293
HIV Post Test Counseling	6		338	159	293	232	248	327	1597
HIV Testing	6		487	197	477	323	371	438	2293
Total Clients & Serv ices	**18**		**0**	**33**	**0**	**95**	**0**	**675**	**6201**
Gynaecology Services									
Pap Smear Screening Test				6		44		504	554
Total clients treated				27		51		171	249
Referral									0
Total Gynae Services				**51**		**186**		**1718**	**1995**
RTI/STI SERVICES									
Pre Counseling Test	6		444	194	488	327	314	448	2221
Post Counseling Test	6		350	147	320	212	251	304	1590
Syphilis Test	6		444	194	488	327	314	448	2221
TOTAL SERVICES AND CLIENTS	**18**		**1238**	**535**	**1296**	**866**	**879**	**1200**	**6032**
MORBIDITY CASES									
RTI/STI Syndromic Mgt	1		30	4	25	53	39	177	329
RTI/STI Etiology Dx & Tx			27	11	46	54	38	157	333
Total RTI/STI Treated.	**1**		**57**	**15**	**71**	**107**	**77**	**334**	**662**
F/P Acceptors									
Combined Oral Contracept						18		24	42
Progestin Only Injectables				10		56		76	142
Implant - 5 years						42		128	170
Vasectomy							12		12
IUCD - 10 years								2	2
Condom Distributed									33,088
Outreach Program									
Mobile clinic									36
Outer Island visit									12

Number of Trainings done									7

Source: KFHA, 2013

Figure 3: No of Pre-tests, post-test and HIV tests by age and sex, KFHA, 2013



V. Major challenges and remedial actions

The major challenges encountered in the national response against HIV include the following:

- **Data management – the role of Health Information Unit**. This would probably be the most pressing problem of all. Coordination is information processing activity and closely related to communication and shared meaning. Several researchers have explained coordination requirements and use of different coordination mechanisms through the concept information[13]. Kiribati faces data management setbacks in monitoring and evaluating its national HIV and AIDS response. Currently, HIV, AIDS and STI data is collected, managed, stored and reported on by multiple parties involved in the national response (MHMS Health Information Unit, MHMS HIV & STI Unit, MHMS Safe Motherhood Program, Reproductive and Sexual Health Program, PPTCT, YFHS, C4D and NGOs e.g. KRCS and KIFHA). Moreover, the HIV/AIDS and STI Unit submits end of activity narrative and acquittal reports to GF/TTBEK Accountant. It also collects urine samples for STI[14] (chlamydia) from public health

[13] Strategies for coordination in complex multi-team development programs. Paper presented in 19th Nordic Academy of Management Conference, Bergen, Norway, August 9-11 2007

[14] The HIC of the MHMS MS1 reporting template only includes STI as a notifiable disease without specifying whether it is syphilis, chlamydia, gonorrhea etc. This needs to be addressed to improve data disaggregation.

clinics around South Tarawa and Betio including KIFHA to the National Laboratory at TCH where they are forwarded to Mataika Laboratoy in Fiji. Copy of results are forwarded to the DPHS and for positive results treatment is initiated. The Health Information Unit (HIU) does not receive any of these results. The last time the HIV/AIDS and STI Unit reported to HIU was in 2011[15].

- High turnover rate of staff of the HIV/AIDS and STI Program. At the time of the writing of this report:
    - The HIV/AIDS and STI Program staffs have been made redundant in view of lack of confirmation on continuation of GF support.
    - There was no HIV clinician after a duration of about a year when the last clinician, a third in line over a period of several years.
- The absence of a permanent HIV clinician
- For this particular reporting there is insufficient time for data collection in view of late appointment of a local TA, and
- Relative slow pace for submission of data from CCM participants for collation and validation
- The large membership of the CCM with unclear roles has made it rather difficult to efficiently manage the national HIV response

The following recommendations and remedial actions are put forward:

- Restructuring of HIV/AIDS and STI Program so that core posts like Coordinator, M&E Officer, Clinical nurse, Nurse Field officer, driver, including office equipment and computers
- Re-advertisement of HIV/AIDS and STI Program posts for more qualified staff in line with clear and approved terms of reference
- Training of HIV/AIDS and STI staff
- Training of **all HIV-related public health programs coordinators** including HIC in data management. This should cover evaluation of bidirectional links, communications and reporting between programs and especially with HIC as the national focal point in data management and information flow. The training also should include standardization (template) of all reporting forms including data disaggregation.
- New recruits of doctors to supplement staffing issues will go a long way in identifying the most appropriate clinician to go for further training in public health and HIV medicine and to occupy permanent posting as a HIV/AIDS and STI Program Coordinator.
- Evaluation of the coordination mechanism of HIV/AIDS and STI program under the governance of CCM needs to be conducted to streamline process, improve coordination and facilitate efficient implementation of the National HIV/AIDS and STI Strategy. This in fact has been done[16].

[15] Interview with Senior Health Information Officer

[16] Assessment of the Kiribati national HIV/AIDS and STI coordination mechanism: Recommendations for an expanded and a more sustainable mechanism. Supported by UNICEF Kiribati Office, November 2013

VI. Support from the country's development partners (if applicable)

See funding matrix

VII. Monitoring and evaluation environment

When creating data collection tools in Monitoring and Evaluation we will always be guided by indicators of the program or project on hand because that is really what we want to measure and report on. In this report we have the NSP 2013-2016 as our working documents. The NSP 2013-2016 has in place the M&E framework for monitoring a number of its key objectives under the five priority areas. A number of Kiribati NSP 2013-2016 M&E indicators[17] were derived from either MDG or UNGASS and therefore are also captured or similar to those in this Kiribati GARP 2014 report core indicators. This GARP report can therefore be seen as evaluation of the Kiribati HIV National Strategic Plan 2013-2016. But to make it a regular and meaningful undertaking to assist in policy decisions, improvement in data recording and reporting is most essential, see ***Section V: Major challenges and remedial actions*** **– recommendations and remedial actions.** Technical assistance will be required to review the current M&E framework. Of particular note is the importance of aligning and standardizing the NSP indicators more closely with the GARP indicators without losing sights of the NSP goals and objectives. This would prevent repetition of work and make reporting easy across programs.

ANNEXES

Annex 1: List of participants to the consultation/preparation meeting 6 March 2014

Annex 2: List of participant to the validation workshop Friday 14 March 2014

Annex 3: List of participants to the validation and NCPI meeting, 27 March 2014

Annex 4: List of key informants interviewed.

[17] These Kiribati NSP 2013-2016 indicators that also appear in GARP are: GARP 1.1-1.5; 1.7; 1.17.1-3; 1.17.6, 1.17.8-10; 3.1; 4.1-2; and 8.1

Annex 1: List of participants to the consultation/preparation meeting 6 March 2014

Name	Role	Organization
Kakiata Toanan	Fisheries Training Centre (FTC) instructor	FTC
Kamaua Bareua	HIV/AIDS Secretariat	MHMS
Bureti Williams	Project Management Accountant	MHMS
Baurina Kaburoro	HIV Nurse	MHMS
Moia Tetoa	President, AMAK	AMAK
Mareta Tito	HIV Officer	Kiribati Red Cross Society
Joy Uale	Ag SYDO	MWYSA
Buraua Itimwemwe	PLWHA	PLWHA
Emaima Tautebwa	HIV Field Officer	MHMS

Annex 2: List of participant to the validation workshop Friday 14 March 2014

Name	Role	Organization
Kakiata Toanan	Fisheries Training Centre (FTC) instructor	FTC
Ueraoi Taniera	HIV Officer	UNICEF Joint Presence Kiribati
Mweritonga Rubeiariki	Communication for Development (C4D), Health Promotion Section	MHMS
Baurina Kaburoro	HIV Nurse	MHMS
Takeieta Klenene		
Mareta Tito	HIV Officer	Kiribati Red Cross Society
Teiraoi Mote	TB research	MHMS
Buraua Itimwemwe	PLWHA	PLWHA
Emaima Tautebwa	HIV Field Officer	MHMS

Annex 3: List of participants to the validation and NCPI meeting, 27 March 2014

Name	Role	Organization
Terauango Beneteri	Coordinator, Youth Christian Living (YCL)	Kiribati Protestant Church
Tenea Atera	BTC Social officer	BTC
Teiraoi Mote	Nurse in research	MHMS
Salaamo Taing	NTP HIV Nurse Counselor	MHMS
Rosemary Tekoaua	Director National Laboratory	MHMS
Mweritonga Temariti	Communication for Development (C4D), Health Promotion Section	MHMS
Mareta Tito	HIV Officer, KRCS	Kiribati Red Cross Society
Luisa Kabong	ANC/PPTCT	MHMS
Losalin Tauaa	Curriculum Development Officer	CDRC/MOE
Kakaiata Ioana	Instructor, FTC	FTC
Joy Uale	Ag Senior Youth Development Officer	MWYSA
Ioteana Mouata	Police Community Officer	Police
Bureti Williams	Project Accountant	GF/TTBEK
Buraua Itimwemwe	PLWHA	PLWHA
Amota Tebao	Clinical Nurse, KFHA	KFHA

Annex 4: List of key informants interviewed

Name	Role	Organization
Teatao Tira	Director of Public Health Services and HIV clinician	MHMS
Rosemary Tekoaua	Director National Laboratory	MHMS
Mweritonga Temariti	Communication for Development (C4D), Health Promotion Section	MHMS
Biribo Hugill	Pharmacist in charge of HIV drugs	MHMS
Louisa Kabong	ANC/PPTCT	MHMS
Teanibuaka Tabunga	Senior Health Information Officer	MHMS
Buraua Itimwemwe	PLWHA	PLWHA
Amota Tebao	Clinical Nurse, KFHA	KFHA
	Coordinator, Youth Christian Living (YCL)	Kiribati Protestant Church
Mareta Tito	HIV Officer, KRCS	Kiribati Red Cross Society