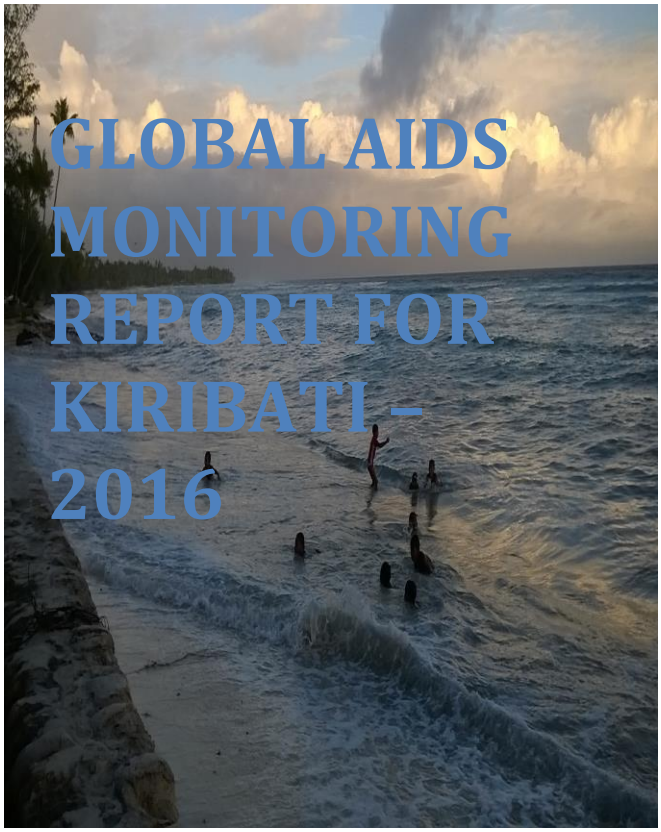

GLOBAL AIDS MONITORING REPORT FOR KIRIBATI – 2016

Ministry of Health and Medical Services

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Public health sources (National) and International sources (The Global Funds) are the main funding sources for (1) clinical services (HIV diagnosis and treatment) and (2) Drug Procurement (Refer to funding matrix). 23

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At the end of the reporting period, Kiribati has benefited from the followings: 25

- Capacity building of Medical Assistants and nurses on South Tarawa on strengthening HIV-TB diagnosis and management. 25
- Point of care training for antenatal Training for these nurses is point of care training, in an effort to decrease the waiting time of ANC mothers for HIV testing. 25
- A space at the HIV Program Unit for MSM use 25
- Drafting of the national HIV policy 25
- Election of the new CCM Chair 25
- Expanding routine HIV testing services to new sites (antenatal clinics) and reaching a broader array of at-risk populations. 25
- Linking most-at-risk populations to HIV/STI-related services..... **Error! Bookmark not defined.**
- Retention of the 7 PLHA in care. 25

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I. Status at a glance

Kiribati is one of the most remote and geographically-dispersed countries in the world consisting of 33 coral atolls that divided among three island groups: Gilbert, Phoenix, and Line islands (See Figure 1). With a total land area of 811 square kilometres, it sits astride the equator, and is widely scattered over five million square kilometres of ocean. The terrain of Kiribati consists almost exclusively of low-lying atolls with most islands less than two kilometres wide and about two meters above sea level, making it extremely vulnerable to climate change and natural hazards.

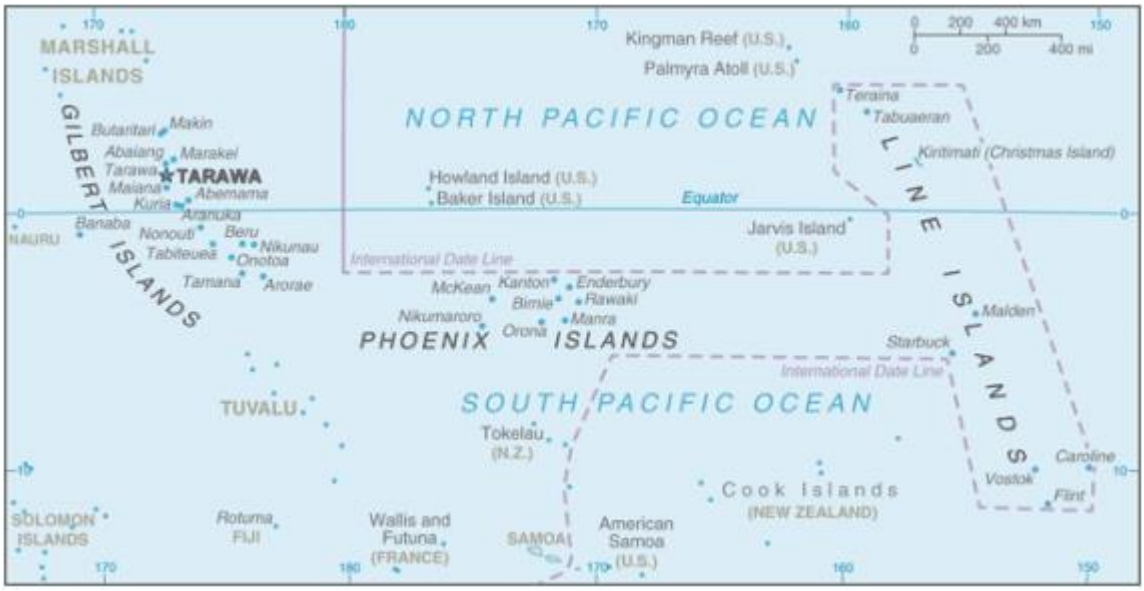


Figure 1

In 2015, Kiribati population was estimated at 110136 (latest official figure)[1]. Population distribution varies dramatically throughout Kiribati with more than half the population concentrated in the capital city, South Tarawa. Kiribati has a highly youthful population with young people aged 15 to 24 constituting approximately 20% of the population. There are limited health services, with only 3 hospitals in total (South Tarawa, Tabiteuea North, Kiritimati), limited laboratory and public health information capacity, and no doctors on the outer islands. There is a free national medical services. However, the increasing population coupled with the remoteness of Kiribati's coral atolls, provide an ongoing challenge for the Ministry of Health and Medical Services to provide universal access to sexual

1

2015 Population and Housing Census, (2015)

and reproductive health services. Kiribati youthful population combined with the spread of rural population across the widely scattered islandspose

high risk for pregnancies, unsafe abortions, and transmission of Sexually Transmitted Infections (STI) and Human Immunodeficiency Virus (HIV).

LIST OF REPORTED INDICATORS

Indicators for Commitment 6 and 7 will be reported starting with 2018

Indicator	Value 2017 (%)	Source	Comments
COMMITMENT 1: Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020			
1.1 Percentage of people living with HIV who know their HIV status at the end of the reporting period	45%	HIV Program record	
1.2 Percentage and number of adults and children on antiretroviral therapy among all adults and children living with HIV at the end of the reporting period	25.9	Antiretroviral therapy patient register	Of the 23 (1 has migrated) people living with HIV, only 7 are currently on treatment and the whereabouts of the remaining 15 is unknown despite effort to find them.
1.3 Percentage of adults and children living with HIV known to be on antiretroviral therapy 12 months after starting	87.5	Antiretroviral therapy patient register	
1.4 Percentage of people living with HIV who have suppressed viral loads at the end of the reporting period	3.7	Routine data	Out of 7 people living with HIV on ARV treatment, only 3 were able to have their viral test done. 3 were at outer islands (test is not

			available) and 1 is a child (uncooperative).
1.5 Percentages of people living with HIV with the initial CD4 cell count <200 cells/mm3 and <350 cells/mm3 during the reporting period	Data not available		No new case of HIV during the reporting period.
1.6 Percentage of treatment sites that had a stock-out of one or more required antiretroviral medicines during a defined period	Data not available		No stock out reported during the reporting period.
1.7 Total number of people who have died from AIDS-related causes per 100 000 population	0.9	Program record	
COMMITMENT 2: Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018			
2.1 Percentage of infants born to women living with HIV receiving a virological test for HIV within two months of birth	100	Program record	
2.2 Estimated percentage of children newly infected with HIV from mother-to-child transmission among women living with HIV delivering in the past 12 months	Data not available		No children newly infected with HIV during the reporting period.
2.3 Percentage of pregnant women living with HIV who received antiretroviral medicine to reduce the risk of mother-to-child transmission of HIV	100	Program record	
2.4 Percentage of women accessing antenatal care services who were tested for syphilis, tested positive and treated	100	Program record.	48 pregnant women tested positive and treated. Test for syphilis is routinely done every first ANC visit, however; the service is only accessible to pregnant women in the capital and few antenatal

			clinics in Kiritimati islands.
2.5 Percentage of reported congenital syphilis cases (live births and stillbirth)	Data not available		
COMMITMENT 3: Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations—gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners			
3.1 Number of people newly infected with HIV in the reporting period per 1000 uninfected population	Data not available		
3.2 Size estimations for key populations	Sex workers: 114; MSM: 358; Transgender: 358	Behavioural survey	Prisoners were not part of this study.
3.3a Percentage of sex workers living with HIV	Data not available		
3.3b Percentage of men who have sex with men who are living with HIV	Data not available		
3.3d HIV prevalence among transgender people	Data not available		
3.3e Percentage of prisoners/inmates/detainees who are living with HIV	Data not available		
3.4a Percentage of sex workers who know their HIV status	45.7	Behavioural study	
3.4b Percentage of men who have sex with men who know their HIV status	33.3	Behavioural study	

3.4d Percentage of transgender people who know their HIV status	47.4	Behavioural study	
3.5a Percentage of sex workers living with HIV receiving antiretroviral therapy in the past 12 months	Data not available		
3.5b Percentage of men who have sex with men living with HIV receiving antiretroviral therapy in the past 12 months	Data not available		
3.5d Percentage of transgender people living with HIV receiving antiretroviral therapy in the past 12 months	Data not available		
3.5e Percentage of prisoners living with HIV receiving antiretroviral therapy in the past 12 months	Data not available		
3.6a Percentage of sex workers reporting using a condom with their most recent client	28.6	Behavioural study	
3.6b Percentage of men reporting using a condom the last time they had anal sex with a male partner	33.3	Behavioural study	
3.6d Percentage of transgender people reporting using a condom during their most recent sexual intercourse or anal sex	15.8	Behavioural study	
3.7a Percentage of sex workers reporting having received a combined set of HIV prevention interventions	28.6	Behavioural study	
3.7b Percentage of men who have sex with men reporting having received a combined set of HIV prevention interventions	0	Behavioural study	
3.11 Percentage of sex workers with active syphilis	3.4	Program record	Out of the 29 sex workers screened for syphilis during outreach programs last year, only one was tested positive for syphilis.
3.12 Percentage of men who have sex with men with active syphilis	0	Program record	The syphilis test result was negative for all of the 17 MSM/TG tested

			during outreach programs last year.
3.13 HIV prevention and treatment programmes offered to prisoners while detained			40 prisoners were tested for HIV and syphilis during outer island visit last year, and all tested negative.
3.14 Prevalence of hepatitis and coinfection with HIV among key populations	Data not available		
3.15 Number of people who received PrEP for the first time during the calendar year	Data not available		
3.16 Percentage of men 15-49 that are circumcised	Data not available		
3.17 Annual number of males voluntarily circumcised	Data not available		Circumcision for young boys in Kiribati is almost universal – 99% of respondents reported being circumcised (Demographic Health Survey, 2009).
3.18 The percent of respondents who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months.	Data not available		
COMMITMENT 4: Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020			
4.1 Percentage of women and men aged 15-49 who report discriminatory attitudes towards people living with HIV	Data not available		
4.2a Percentage of sex workers who avoided seeking HIV testing because of fear of stigma, fear or experienced violence, and/or fear or experienced police harassment or arrest	Data not available		

4.2b Percentage of men who have sex with men who avoided seeking HIV testing because of fear of stigma, fear or experienced violence, and/or fear or experienced police harassment or arrest	Data not available		
4.2d Percentage of transgender people who avoided seeking HIV testing because of fear of stigma, fear or experienced violence, and/or fear or experienced police harassment or arrest	Data not available		
4.3 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	Data not available		
COMMITMENT 5: Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100 000 per year			
5.1 Percentage of women and men 15-24 years old who correctly identify both ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission	Data not available		
5.2 Percentage of women of reproductive age (15-49 years old) who have their demand for family planning satisfied with modern methods	48.5	Demographic Health Survey, 2009	
COMMITMENT 8: Ensure that HIV investments increase to US$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enable			
8.1 HIV expenditure - Annex			Refer to funding matrix
COMMITMENT 9: Empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services			

to prevent and challenge violations of human rights			
9. National Commitments and Policy Instrument – Annex			NCPI
COMMITMENT 10: Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C			
10.1 Percentage of estimated HIV-positive incident tuberculosis (TB) cases that received treatment for both TB and HIV	Data not available		No case that receive treatment for both HIV and TB during the reporting period.
10.2 Total number of people living with HIV with active TB expressed as a percentage of those who are newly enrolled in HIV care	Data not available		There was none living with HIV with active TB during the reporting period.
10.3 Number of patients started on treatment for latent TB infection, expressed as a percentage of the total number newly enrolled in HIV care during the reporting period	Data not available		No patient started on treatment for latent TB during the reporting period.
10.4 Number of men reporting urethral discharge in the past 12 months	0.1	Kiribati Family Health Association record	
10.5 Rate of laboratory-diagnosed gonorrhoea among men in countries with laboratory capacity for diagnosis	0	Kiribati Family Health Association (KFHA) record	4 cases of gonorrhoea were reported from KFHA & MHMS Laboratory (age range: 20-35)
10.6 Proportion of people starting antiretroviral therapy who were tested for hepatitis B	Data not available		
10.7 Proportion of people coinfected with HIV and HBV receiving combined treatment	Data not available		
10.8 Proportion of people starting antiretroviral therapy who were tested for hepatitis C virus (HCV)	Data not available		

10.9 Proportion of people coinfected with HIV and HCV starting HCV treatment	Data not available		
10.10 Proportion of women living with HIV 30–49 years old who report being screened for cervical cancer using any of the following methods: visual inspection withacetic acid or vinegar (VIA), Pap smear or human papillomavirus (HPV) test	Data not available		

II. Overview of the AIDS epidemic

Kiribati rate of incidence for HIV is among the highest in the Pacific with a cumulative total of 60 cases dating from 1991 to 2015 (See Figure 2& 3); of this number, 33 have died of AIDS-related illnesses (1 died in 2016, see figure 4). The most current cases were diagnosed in 2015. There are currently an estimated 23 people living with HIV in Kiribati (one has migrated). Of the 22 people living with HIV in the country, 7 are currently on ARV treatment and the whereabouts of the remaining 15 are unknown despite effort to find them (HIV Program record).

The main high risk groups and vulnerablepopulations affected by HIV (1991 - 2015) registered include:

- Seafarer – 5
- unemployed – 4
- Civil servant – 3
- Children – 2
- Unregistered – 46

The primary mode of spread is via heterosexual contact between men and women, with some subsequent associated mother-to-child transmission. Male-to-male sexual contact is another potential mode of transmission.

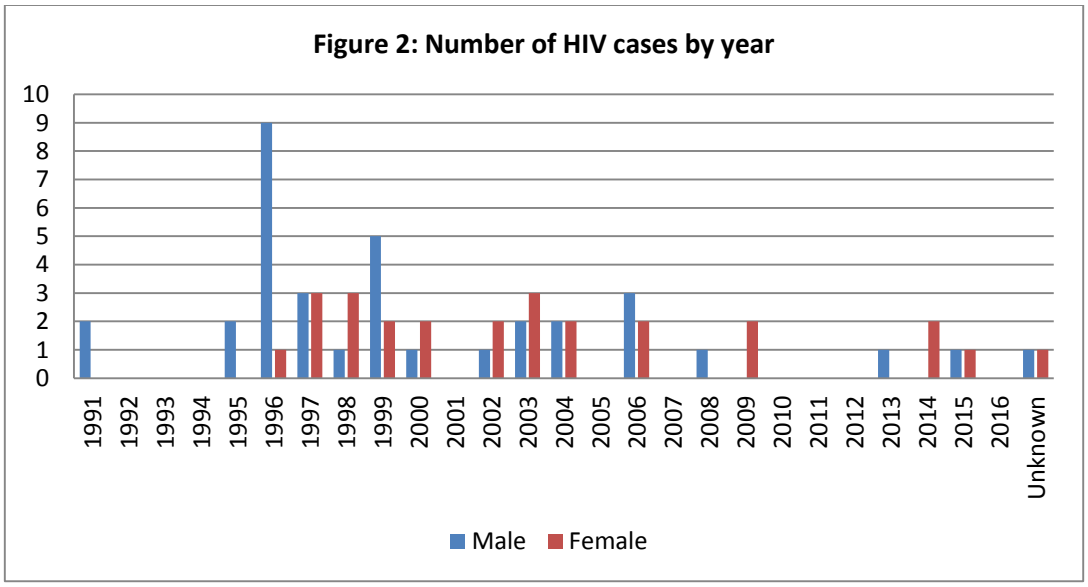
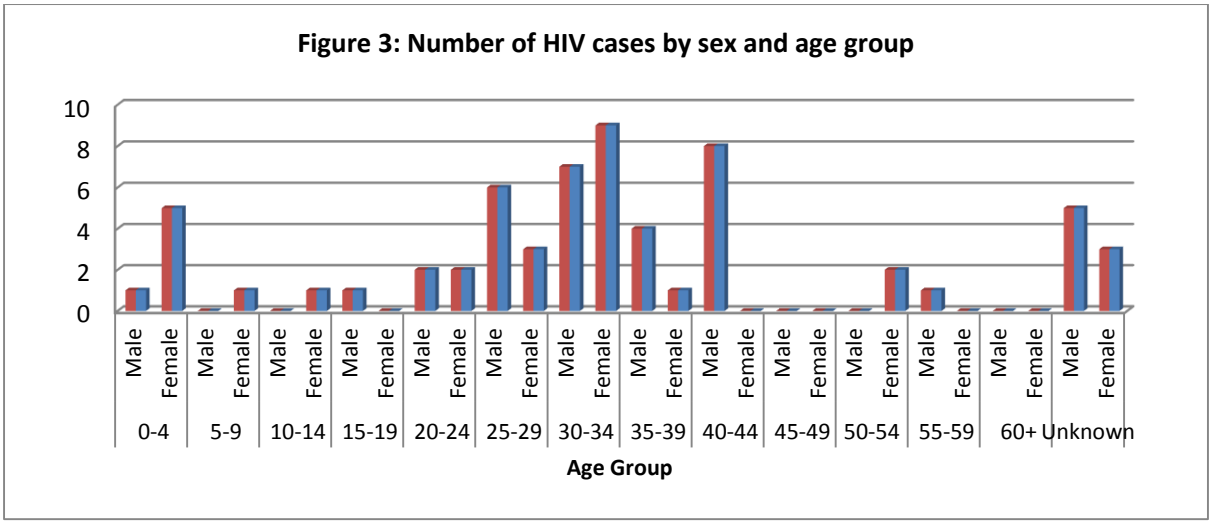
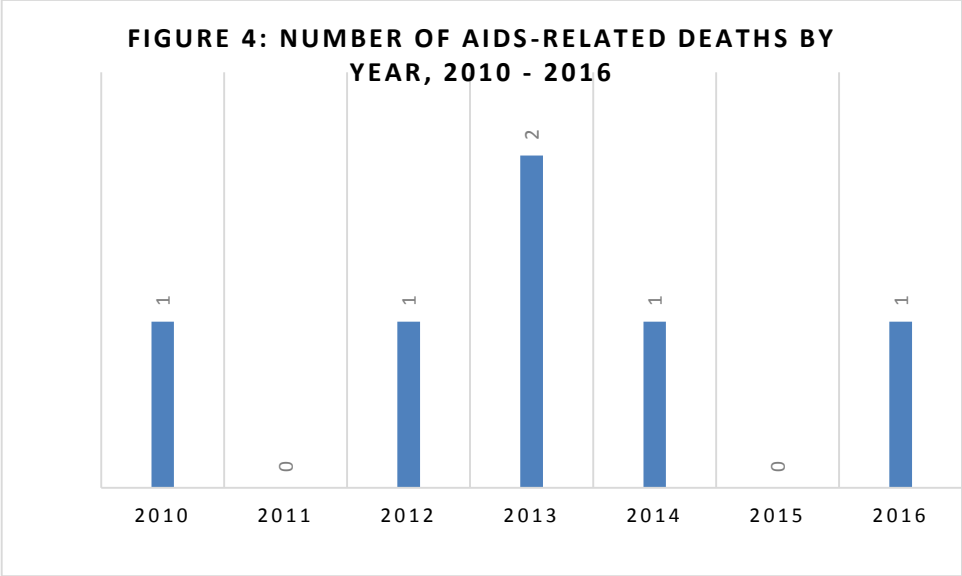


Figure 2





III. National response to the AIDS epidemic

Responding to HIV/AIDS and STIs is a strategic objective of the Kiribati Government Strategic Plan 2016-2019 (MHMS, 2016)[2].

1. Strengthen initiatives to reduce the prevalence of risk factors for NCDs, and to reduce morbidity, disability and mortality from NCDs.

[2] 2016 to 2019 Ministry strategic plan, (2015).

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. Improve maternal, newborn and child health.

3. Prevent the introduction and spread of communicable diseases, strengthen existing control programmes and ensure Kiribati is prepared for any future outbreaks. Address gaps in health service delivery and strengthen the pillars of the health system.

4. 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.

Within strategic objective 3, the relevant strategic action for HIV/AIDS is: *"Prevent the introduction and spread of communicable diseases, strengthen existing control programmes and ensure Kiribati is prepared for any future outbreaks. Address gaps in health service delivery and strengthen the pillars of the health system" (MHMS, 2016, p. 15.)*.[3]

The response to HIV in Kiribati has been guided by the Kiribati National HIV and STI Strategic Plan2013-2016 (expired in 2016). The National HIV and STI Strategic Plan for HIV 2013-2016 (expired in 2016) has been written but never officially endorsed. The with five priority areas of the Strategic Plan[4] include:

1. Prevention of HIV and other STIs, Prevention of Parent to Child Transmission, Safe Blood supply and assurance of Universal precautions;

2. Community leadership and an enabling environment to reduce stigma and discrimination;

3. Diagnosis, treatment and support of people living with HIV;

4. Quality diagnosis, management and control of STIs;

5. Strengthening management and coordination of the national response.

Progress toward achievement (by 2016) will be measured against four impact level outcomes:

- By 2016, there will be at least 50% reduction in the number of new cases of HIV in the general population and zero occurrence of parents to child transmission as measured by (1) percentage of women and men aged 10-24 who are HIV infected and (2) number and percentage of infants born to HIV infected mothers who are HIV-infected, respectively;
- By 2016, at least 80% of eligible individuals with HIV will be maintained on ARV asmeasured by (1) percentage of eligible adults and children currently receiving antiretroviral therapy, (2)

[3]2016 to 2019 Ministry strategic plan, (2015).
[4] Kiribati national HIV and STI strategic plan 2013-2016

number of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy;

- By 2016, a 30% reduction in the prevalence of STIs; By 2016, there will be a significant reduction in stigmaand discrimination associated with HIV or STIs as measured by STI prevalence amongst pregnant women who attend antenatal services;
- By 2016, there will be a significant reduction in stigmaand discrimination associated with HIV or STIs as measured by evidence of people surveyed expressing accepting and caring attitudes towards people living with HIV.

Measuring progress against the impact areas using the proposed indicators may prove difficult given the unavailability of baseline data, incompleteness, etc., stigmatization of men who engage in sex with other men, and lack of clarity on the extent and nature of commercial sex work and transactional sex with multiple cultural, social, and legal barriers to investigation.

National policies and guidelines that guide HIV/STI prevention, diagnosis, treatment, care, and support: include:

- Kiribati HIV Counselling and Testing Policy (2013)
- The National Policy Guideline on Prevention of Parent to Child Transmission (PPTCT) of HIV;
- Syndromic Approach Protocol for STIs; and
- Kiribati HIV Algorithm SOP (Aug, 2013)

At present, the national response involves participation by national and local-level entities, such as, government ministries (e.g. Health and Medical Services, Women, Youth, and Social Affairs, Labour, Education), Civil Society Organizations (CSO), non-government organizations (NGO), Faith-based Organizations (FBO), the private sector, including maritime services and seafarer trade unions. These entities coordinate their responses under the oversight of the Kiribati HIV Country Coordinating Mechanism, where matters related to HIV prevention, treatment and care are discussed.

i. Prevention:

Various efforts have been made to maintain the prevalence of HIV infection in Kiribati low with the focus on other STIs that are on the rise. Recently, there has been a gradual move towards the integration of services that are provided by related programs, particularly, of prevention activities related to HIV/AIDS, other sexually transmitted diseases, viral hepatitis, and tuberculosis. KFHA along with the Ministry of Health and other line ministries continued to provide awareness program to youths through peer education activities, informal training, and youth involvement in various national

activities which had exposed them to livelihood and sexual health-related information. The HIV Program Unit within the Ministry of Health reached the most at risk population (MSM and sex workers) with HIV/STI prevention programs including, HIV/STI awareness, condom promotion and distribution, and HIV testing services. The HIV Program has also developed positive work relationship with MSMs and sex workers. The Ministry of Health has provided a space at the HIV Program Office (MHMS) for use by the MSM to highlight the need for visibility of this group and for their leadership in the HIV response in the country. The general population (youth, in particular) were also reached with HIV/STI prevention programs. Effective use of media has also contributed to raise public awareness on HIV/STI-related information.

With the Global Funds support, 10 nurses from antenatal clinics had been trained on HIV rapid test in efforts to scale up and roll out HIV prevention programs. The training had somewhat contributed to an increase in number of pregnant women tested for HIV in 2016. However, with ongoing nurses reshuffle and workload, sustaining these trained nurses to provide such services is a challenge. Along with this training, a workshop was conducted by HIV/TB clinicians and Pharmacist to all Medical Assistants and nurses from all clinics on South Tarawa to ensure that an HIV-TB coinfection is promptly and properly addressed.

Currently, there are 5 HIV testing sites in Kiribati: 3are located in South Tarawa (MHMS laboratory, KFHA mini laboratory, & Marine Training Centre laboratory), 1 Tabiteuea North (hospital) and 1 in Kiritimati island (hospital). For screening purposes, HIV testing is routinely required for visa applicants, seafarers before each overseas contract, and for all Kiribati Marine Training Centre new entrants, although this mandatory testing violate their human rights. The MTC mini laboratory is used specifically for: visa applicants, seafarers, and MTC new entrants.

In South Tarawa (capital), routine HIV and syphilis tests are provided to pregnant women at first visit, to blood donors, and all suspected cases of tuberculosis. These tests are carried out at the MHMS laboratory.

A total of 9211 HIV and syphilis, 1285 HCV, and 6988 Hepatitis B tests were carried out at the MHMS laboratory in 2016. Of that number, none was newly diagnosed with HIV, 160 with syphilis with age range from 10 to 77 years, 1 with HCV, and 1125 with Hepatitis B (see Table 1). The MHMS Health Information Unit also reported 586 cases of STI, but unfortunately, the breakdown in terms of types of STI is not available to determine the incidence of classical STIs gonorrhoea, syphilis, and Chlamydia. However, by definition under the MS1 monthly report, the data should include gonorrhoea, Chlamydia and trichomonas but not HIV and syphilis. KFHA also reported cases of gonorrhoea (see Table 1).

Table 1: New STI, HIV, Hepatitis B and C diagnoses by gender – South Tarawa, 2016

Test done	Number of people tested	Male (positive)	Female (positive)
Gonorrhea	4	4	0
HCV	1285	1	0
Hep B	6988	440	685
HIV	9211	0	0
syphilis	9211	97	63
Grand Total	**27285**	**712**	**1164**

HIV/STI reporting in Kiribati is still limited by the laboratory and public health capacity. In outer islands, HIV/STIs tests are not available; the STIs diagnosis was generally made through syndromic management approach and referred to the main hospital (main island) for further testing and management. However, the data clearly showed the trend of STI in the country but most interestingly, the gradual increase of cases under the age of 15 years and over the age of 65 years that have been diagnosed with STIs and treated.

The Government recognized that the realistic picture of the level of STI in the country is greater than the data available (Figure 1 & Table 1). Understanding that STIs are independent risk factors for HIV transmission; the need to control them (STIs) has become more urgent. This urgency demands the support of all key stakeholders including government ministries and development partners to support the Government's effort to control and prevent STI/HIV in the country. The failure to control and prevent STIs, poses a serious risk that should HIV infection become established locally, major HIV epidemic is about to unfold there and that in Kiribati, and like in many other countries will disproportionately affect young people.

In terms of monitoring and evaluating HIV and AIDS response, Kiribati still faces challenges on data management resource, capacity challenges, and sharing and coordination. Generally, HIV/AIDS and STI data are collected, managed, stored and reported on by various parties involved in the response (MHMS: Health information Unit, HIV Program, Antenatal clinics, laboratories; KFHA; and MTC laboratory). Each party collects service data for various services and there is a lack of consistency in disaggregation and reporting. Within the MHMS, the National Health Information System collects

service data for a range of services, but these are not gender or age disaggregated, and do not provide sufficient detail to support programme reporting against strategic indictors and targets.

IV. COMMITMENT 1: Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020

Kiribati adopted the World Health Organization Guidelines on the use of antiretroviral drugs for treating and preventing infection (WHO, 2016) as its treatment guidelines.

There are no centres designated for provision of ARV treatments. Treatment services are only available at the Ministry of Health pharmacy in South Tarawa. The HIV Nurse (HIV Program Unit) is the key point of contact for ARV between the client and the HIV Core Care Team headed by the HIV Clinician.

On South Tarawa, the HIV nurse collects prescription drugs from the hospital pharmacy and delivers them to patients. No logistical barriers reported in the provision and supply of ART drugs. As with other patients on ART in outer islands, the HIV Clinician liaised with island based Medical Assistants to deliver treatment or treatment were sent directly to them or family members (patients decide). Drug delivery, along with accompanying support, has to be done with maximum care and discretion to prevent unintentional public disclosure of patient's HIV status. HIV nurse sees patients on ART on South Tarawa on a monthly basis; however, with outer island patients, this might take months – depends on availability of funding. Other services provided include, psychosocial support, adherence counselling and support, CD4 counts, viral load (new), and referral to hospital.

Currently, there are 7 people living with HIV receiving ART (3TC, AZT, EFV, & NVP) in 2016. All these 7 PLHIV reported good adherence to ARV treatments. However, with the unknown whereabouts of the 15 people living with HIV, achieving the 90-90-90 targets on treatment and viral suppression will be most likely impossible. All people living with HIV are eligible for initiation of ART regardless of CD4 counts. During the reporting period, 1 died of AIDS-related illnesses while being in treatment.

V. COMMITMENT 2: Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018

The National Policy Guideline on Prevention of Parent to Child Transmission (PPTCT) of HIV (2010) had been approved for PPTCT (require reviewing) with Consolidated Guidelines on HIV Testing Services (partially). Since the Consolidated Guidelines on HIV testing is new, a workshop to build capacity of all those who will be involved in providing HIV testing services is necessary.

Staffing for the Prevention of Parent to Child Transmission (PPTCT) program is provided by the MHMS. In South Tarawa (capital), routine HIV and syphilis tests are provided to pregnant women at first visit. Usually, blood samples are collected during antenatal visits and delivered to MHMS laboratory for analysis, however, lack of transport coupled with the overwhelming load of nurses at the clinics often cause interruption in service delivery.

During the reporting period, there were 1970 pregnant women (1 woman was a known case of HIV and on ARV treatment) tested for HIV/STI, of whom, 0 was newly diagnosed with HIV and 48 (2.7% aged 15-24 years; 2.3% aged > 25 years) were diagnosed with syphilis (see Table 2). There could be more pregnant women with HIV and syphilis out there but accessibility to these services (HIV/Syphilis tests) is the key issue – routine HIV/syphilis tests for pregnant are provided in few clinics on South Tarawa. Regarding HIV-vertical transmission, the initial DNA PCR test (not available in the country) of the HIV-exposed infant was done at birth and the result was negative. The test will be run again at six months (April 2017) and then confirmatory at 18 months – until the test is done, HIV status of the child can be confirmed. The HIV-exposed infant completed 6 weeks of daily Nevirapine prophylaxis.

Table 2: Percentage of pregnant women attending antenatal clinics with a positive (reactive) syphilis serology

Description	All	15-24 years	25+ years
% of pregnant women attending ANC with a reactive syphilis serology	2.4	2.7	2.3
Number of women attending ANC services who tested positive for syphilis	48	21	27
Denominator Number of ANC attendees who were tested for syphilis	1970	770	1200

VI. COMMITMENT 3: Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations—gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners.

The findings of a new joint study by the United Nations Development Programme (UNDP), the United Nations Children's Fund (UNICEF) and the University of New South Wales indicate the need for reforms in Pacific countries including Kiribati to adequately address HIV and sexually transmitted infections (STIs) among vulnerable populations: MSM/TG, sex workers, and seafarers[5]. Study findings are summarized below.

i. Men having sex with men (gay)

The study findings indicated low consistent use of condoms among the 22 MSMs participated in the study with 25% reported 'never', and none reported condom use 'most of the time' or 'always'and

[5]Pacific multi-country mapping and behavioural study: HIV and STI risk vulnerability among key populations, (2016).

45% were tested for HIV in the last 12 months. The majority reported feeling shame about their sexual identity. Over a third (36%) of participants reported forced sex in the past 12 month. The study also reported high level of knowledge about accessing HIV and STI testing, condoms and health-related information, but only half of all respondents knew how to access HIV and STI treatment and less (around a quarter) knew how to access support.

ii. Female sex workers

Condom use among female sex workers was also reported low with 31 % of sex workers used a condom for sex with their last client. In the last 12 months, 3% sex occurred on ships and 50 % tested for HIV. Female sex workers face threat of physical and sexual violence: local men, family members, clients' wives, and police officers with 64% assaulted in the last 12 months. Fifty percent were tested for HIV and 64% sexually assaulted in the last 12 months. Female sex workers are also stigmatized and marginalized and support each other to survive.

iii. Seafarers

Condom use was more likely with commercial partners (41.7%) and casual (22.2%) or regular partners (20%). There were 69% (high) of seafarers tested for HIV in the last 12 months.

Knowledge of HIV infection was relatively high, with 45.8% answering all knowledge questions correctly. Although a majority of seafarers knew where they could access health services, fewer knew where to access HIV/STI treatment and testing and more than 90% reported they would like to receive additional information about HIV and related services.

i. Prisoners

This group was not included in the study – the epidmiological situation of HIV and STIs in prisons is not clear. To date, none of the HIV reported cases in Kiribati have come from prisons.

VII. COMMITMENT 4: Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020

The study that was conducted on gender-based violence revealed that violence against women is prevalent in Kiribati with more than 2 in 3 (68%) ever-partnered women aged 15-49 reported experiencing physical or sexual violence, or both, by an intimate partner (2010). [6]

The MHMS Health Information Unit reports 482 cases of gender-based violence from across Kiribati in 2016 (age range: 0-70 years).

The study on gender-based violence has over recent years spurred policy action and resulted in the Government of Kiribati-led and donor-supported commitments to end violence against women and girls in Kiribati. A data base for Social Welfare and Gender Based Violence has been established to develop a systematic and comprehensive collection of disaggregated data. Social Welfare data base was financed by UNICEF.

A recent study on key populations also reported threat and physical violence faced by female sex workers and MSMs.

VIII. COMMITMENT 5: Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100 000 per year.

The following children-related legislations that have been passed: Juvenile Justice Act 2015 and the Children, Young People and Family Welfare Act 2013. Focuses of these legislations include: proceedings against juvenile offenders (a stepping stone in protecting children under 14 and 18 years of age from being treated as adults before the court of law); a reflection of the principles of the CRC (encompasses the support to parents and families to raise their children and protect children from acts of violence, sexual abuse, etc.), respectively. These legislations to some extent play a part in reducing the number of HIV infections among adolescent girls and young women.

With education, primary and junior secondary education for boys and girls is free and compulsory from six to 15 years of age. Sexual reproductive health (SRH) and HIV are already integrated (formally) into the primary school curriculum, yet, Kiribati was the furthest behind in terms of scope of quality and SRH education when compared with the other three countries studied. [7]

[6]Kiribati family health and support study: A study on violence against women and children, (2010).
[7] The Status of HIV prevention, sexuality and reproductive health education: Fiji, Kiribati, Solomon Islands and Vanuatu, (2013).

The KFHA on the other hand plays an important role in providing youth friendly health services both in Tarawa and some outer islands, along with the MHMS, cater specifically to the needs of youth for family planning, HIV and STI testing services.

The following were also highlighted during 2015 National Health Forum as HIV/STI and Gender-based achievements:

- An increase in the number of HIV and STIs public awareness campaigns conducted.
- An increase in the number of HIV tests done HIV tests on South Tarawa and in the outer islands as part of HIV outreach.
- Community advocacy and awareness with Ministry of Women Youth and Social Affairs and Ministry of Health and Medical Services.
- Funds availability for constructing a healthy family clinic.

IX. COMMITMENT 8: Ensure that HIV investments increase to US$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enable

Public health sources (National) and International sources (The Global Funds) are the main funding sources for (1) clinical services (HIV diagnosis and treatment) and (2) Drug Procurement (Refer to funding matrix).

X. COMMITMENT 10: Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C.

The following achievements have been reported for the following programs:

Hepatitis B:

- National Action Plan for Hepatitis 2016-2020 was endorsed last month by director of public health
- Treatment guideline has been drafted and awaiting incorporation to Kiribati National Antibiotic Guideline.
- Tenofovir as an antiviral drug for Hep B has just recently been included in the national essential drug list and approved through therapeutic committee.

Tuberculosis:

- Endorsement of (a) Guidelines for care and control of TB and HIV/AIDS in Kiribati: Recommended collaborative TB/HIV activities, and b) Guideline for care and control of TB and Diabetes in Kiribati: Recommended collaborative TB/Diabetes activities.

The objectives of the TB/HIV collaborative guideline are to:

- Conduct TB/HIV surveillance as appropriate in the epidemiological context
- Diagnose TB and HIV as early as possible through early HIV testing of TB patients and TB screening of people living with HIV;
- Ensure that people with both TB and HIV have early access to life saving treatment;
- Improve infection control at both TB and HIV care facilities/clinics, and
- Prevent new cases of TB and HIV

There was no patient diagnosed with HIV and TB during the reporting period.

XI. The situation with human rights in relation to HIV

With regard to human right, law prohibiting discrimination on the basis of disability, sexual orientation, gender identity, or social status does not exist. There is no specific legislative protection for the privacy and/or identity of HIV-positive people involved in legal proceedings as well as legislative prohibition on mandatory HIV testing, or discrimination on the ground of HIV. The terms of the Act are sufficiently broad to enable mandatory HIV screening for employment purposes.[8]To date, there are no reported societal discrimination or violence against persons with HIV/AIDS, although social stigma or intimidation were possible factors that might prevent such incidents from being reported.

[8] HIV, ethics and human rights: Review of legislation of Kiribati, (2009).

XII. Best practices

At the end of the reporting period, Kiribati has benefited from the followings:

- Capacity building of Medical Assistants and nurses on South Tarawa on strengthening HIV-TB diagnosis and management.
- Point of care training for antenatal Training for these nurses is point of care training, in an effort to decrease the waiting time of ANC mothers for HIV testing.
- Providing a space at the HIV Program Office (MHMS) for use by the MSM. This highlights the need for visibility of this group and for their leadership in the HIV response in the country.
- Draft of the national HIV policy is now awaiting finalization by the Country Coordination Mechanism and then endorsement by the MHMS.
- Election of the new CCM Chair
- Expanding routine HIV testing services to new sites (antenatal clinics) on South Tarawa.
- Retention of the 7 PLHA in care.
- Commemorating World AIDS Day with antenatal clinic nurses, Kiribati HV Champion, people with disabilities (Toamatoa), MSMs, Sex workers, and youth groups through awareness raising, drama, condom promotion and distribution, HIV/syphilis and Hepatitis B testing. The Kiribati President and government ministers also supported the day by wearing red ribbon during their cabinet meeting which happened to coincide with World AIDS Day. Marking of World AIDS Day highlights national efforts of raising awareness on HIV/AIDS and other STIs. The one-week campaign includes, outreach program to communities, story sharing by the HIV Champion through media programs and to youths meeting, working collaboratively with key partners to strengthen partnership which add volume to messages delivered throughout that week of campaign. The 2016 World AIDS Day was funded by UNDP.

XIII. Major challenges and remedial actions

- HIV Program team to work with Health Information Unit to improve HIV/STI-related services reporting.
- Annual meeting with Statistic Unit, DPNO, and remote hospitals and health centres to discuss data related issues and solutions.
- Basic training for all public health nurses on basic HIV awareness (HIV transmission and prevention) to ensure a standardized approach to providing current HIV information in Kiribati.

- POC training to expand access to HIV testing, particularly in outer islands where this service is not available.
- Incorporating HIV test into antenatal care.
- Strengthen coordination and linkages between SRH and HIV
- Work to address the essential intervention gaps in Tungaru, Kieia Ataei, and Kiritimati hospitals for all elements of national HIV response – particularly, HIV/syphilis tests for all pregnant women given the availability of MHMS laboratory in these islands.
- Identify and address the underlying factors that contribute to high incidence of STIs and poor referrals for treatment, low condom use.
- Review HIV/STI related policies and guidelines – outdated.
- Strengthen legislation, policy and political and social commitment to response to HIV.
- Allocating a specific transport for implementation of the National HIV/STI program activities.

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

XV. Monitoring and Evaluation Environment

Despite the existence of a Strategic Plan, the capacity to implement monitoring and evaluation system is weak because of lack resources and capacity. Strengthening of surveillance system together with capacity development of service providers to enhance surveillance, database management and quality reporting at all level should be the focus of the National Program.

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