Global AIDS Response Progress Kiribati Country Progress Report 2012

Submitted by Kiribati Country Coordination Mechanism

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Acronyms and abbreviations

AG	Attorney General
AIDS	Acquired Immune Deficiency Syndrome
AMAK	Aia Maea Ainen Kiribati (Kiribati Women's Federation)
APLF	Asia Pacific Leadership Forum
ARC	Atoll Research Committee
AHD	Adolescent Health Division, Ministry of Health and Medical Services
ARV	Anti-retroviral
BBC	Behaviour Change Communications
BI	Burnet Institute
BPA	Broadcasting and Publication Authority
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
CCJD	Council Commission for Justice and Development
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
FSP-K	Foundation of the South Pacific Kiribati
FTC	Fisheries Training Centre
GARP	Global AIDS Response Progress
GPA	Global Program on AIDS
HDI	Human Development Index
HIS	Health Information System
HIV	Human Immunodeficiency virus
HRD	Human Resource Development
HSV	Herpes Simplex Virus
HW	Health Worker
KANGO	Kiribati Association of Non-government Organisations
ILO	International Labour Organization
KFHA	Kiribati Family Health Association
KIOSU	Kiribati Overseas Seamen Union
KISWA	Kiribati Islands Seamen Wives Association
KNACC	Kiribati National Advisory Committee on Children
KNCC	Kiribati National Council of Churches
KPC	Kiribati Protestant Church
KPS	Kiribati Police Service
KSA	Kiribati Scout Association
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 Organisation

NSP	National Strategic Plan
OI	Opportunistic Infection
PEP	Post Exposure Prophylaxis
PLHIV	People living with HIV AND AIDS
PPMTCT	Preventing Parent to Mother to Child Transmission
PRHP	Pacific Regional HIV AND AIDS Project
PLA	Participatory Learning and Action
RC	Roman Catholic Church
RRRT	Regional Rights Resource Team
SPC	Secretariat of Pacific Communities
STI	Sexually transmitted infection
SW	Sex Worker
TB	Tuberculosis
TCH	Tungaru Central Hospital
TUC	Teinainano Urban Council
UNAIDS	Joint United Nations Programme on HIV AND AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV AND AIDS
UNICEF	United Nations Children Fund
UNIMANE	Elders or senior men
VCCT	Voluntary Confidential Counselling and Testing
WHO	World Health Organization
USP	University of the South Pacific
YP	Young People

I. Status at a glance

This report was compiled under the guidance of the Kiribati Country Coordination Mechanism for HIV, Sexually Transmitted Infections (STI) and Tuberculosis (TB) (CCM) and reporting was led by the Government of Kiribati Ministry of Health and Medical Services (MHMS) HIV & STI Unit. Data was collected and validated in a consultative and participative process involving government, non-government and civil society stakeholders. Litmus Ltd. provided technical support to the MHMS HIV & STI Unit throughout the reporting process, including data collection, analysis and validation, and drafting the narrative Country Progress Report.

A workshop was held to discuss and complete the National Commitments and Policy Instrument with CCM members and other key stakeholders (see Annex for a full attendance list). This workshop also confirmed the indicators that Kiribati would report on. A literature search was undertaken to review recent relevant research, and key informant interviews were conducted with stakeholders involved in the national response (see Annex for a list of stakeholders consulted). People living with HIV (PLHIV) were consulted in the compilation of this report.

Kiribati is experiencing a low level general HIV epidemic. Kiribati has an estimated 55 cumulative cases of HIV dating from 1991 to the end of December 2011. Of this cumulative number, most are male, but a more even gender balance emerges among new cases over the last decade. There are 23 confirmed AIDS related deaths but this number is suspected to be higher. Of the current estimated HIV positive cases (n=28), 6 are on antiretroviral treatment (ART). The whereabouts of the remaining 22 is unknown.

Kiribati's national response to HIV and AIDS has been shaped by its overall health resource and it currently relies heavily on international donor support for its programmatic response. The Kiribati MHMS provides support through housing and staffing the Prevention of Parent to Child Transmission (PPTCT) clinic, the MHMS Adolescent Health Division (AHD) and some MHMS HIV & STI Unit staff. The MHMS also supports a HIV and AIDS Clinician. To date there has been no endorsed National HIV/AIDS Strategy. There was a draft Strategy 2005-2008 and there is a new National HIV & STI Strategic Plan 2012-2015 currently in development.

The following table shows an overview of Global AIDS Response Progress (GARP) indicator data.

Table 1 Global AIDS Response Progress indicator data

Target	Female	Male	Data source/collection method/comments
Target 1. Halve sexual transmission of HIV by 2015			
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 (MDG indicator)	44%	48.6%	▪ Kiribati Demographic & Health Survey 2009
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%	▪ Kiribati Demographic & Health Survey 2009
1.3 Percentage of women and men aged 15-49 who have had sexual intercourse with more than one person in the past 12 months	1.8%	10.5%	▪ Kiribati Demographic & Health Survey 2009
1.4 Percentage of women and men aged 15-			▪ Kiribati

Target	Female	Male	Data source/collection method/comments
49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse	2.4%[1]	33.2%[2]	Demographic & Health Survey 2009
1.5 Percentage of young women and men aged 15-49 who received an HIV test in the past 12 months and know their results	-	-	▪ 1,714 people aged 15-49 tested and received results in 2010 (2011 Universal Access Health Sector Report for Kiribati). ▪ Testing data held by the National Laboratory, Tungaru Hospital indicate a total of 4,587 people received HIV tests in 2011. There is no data on % who received results
1.6 Percentage of young people who are living with HIV	-	-	▪ Based on 2011 ANC surveillance data[3], 1,238 ANC attendees were tested. Of these, one (aged 25-49) tested positive.
1.7 Percentage of sex workers reached with HIV prevention programmes	-	-	▪ No behavioural survey data on sex workers
1.8 Percentage of sex workers reporting the use of a condom with their most recent client	-	-	▪ No behavioural survey data on sex workers
1.9 Percentage of sex workers who received an HIV test in the past 12 months and know their results	-	-	▪ No behavioural survey data on sex workers
1.10 Percentage of sex workers who are living with HIV	-	-	▪ VCCT pre-test counselling form does not collect specific data on CSW
1.11 Percentage of men who have sex with men reached with HIV prevention programmes	-	-	▪ No behavioural survey data on MSM

[1] This figure is based on Age 15-24. Numbers for Age 25-49 were fewer than 25 cases and were suppressed in data calculations. (Kiribati Demographic and Health Survey 2009: 220)
[2] This figure is based on Age 15-24. Numbers for Age 25-49 were fewer than 25 cases and were suppressed in data calculations. (Kiribati Demographic and Health Survey 2009: 222)
[3] Prevention Parent To Child Transmission Programme data

Target	Female	Male	Data source/collection method/comments
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	-	-	▪ No behavioural survey data on MSM
1.13 Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results	-	-	▪ No behavioural survey data on MSM ▪ VCCT pre-test counselling form collects information on same sex partners but this information is not collated
1.14 Percentage of men who have sex with men who are living with HIV	-	-	▪ Current data on cumulative HIV cases do not record MSM ▪ VCCT pre-test collects information on same sex partners but this information is not collated
Target 2. Reduce transmission of HIV among people who inject drugs by 50% by 2015 Kiribati not reporting on Target 2 indicators as IDU are not currently considered relevant (no visible IDU) to Kiribati's epidemic and response			
Target 3. Eliminate Mother-to-child transmission of HIV by 2015 and substantially reduce AIDS related maternal deaths			
3.1 Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	*	*	▪ There was 1 HIV+ pregnant women recorded in 2010. This case received ART
3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	*	*	▪ There was 1 infant born to an HIV+ mother in 2010. This infant did not receive a virological test within 2 months of birth.
3.3 Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	-	-	▪ No HIV+ children infected through MTCT recorded 2010-2011
Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015			

Target	Female	Male	Data source/collection method/comments
4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy	-	-	▪ HIV surveillance data[4] and ART data[5] indicates 6 HIV cases currently on ART out of an estimated total 28 eligible adults and children: an indicative ART coverage of 21%
4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	-	-	▪ See commentary below for discussion of on-going ART data
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	-	-	▪ Data from TB Clinician indicates 2 HIV and TB cases in 2010, both of whom received treatment
Target 6. Reach a significant level of annual global expenditure (USD22-24 billion) in low and middle-income countries			
6.1 Domestic and international AIDS spending by categories and financing sources	2010-2011 USD682,994[6]		▪ Global Fund to fight AIDS, Tuberculosis and Malaria; Pacific Island HIV & STI Response Fund including Continuity of Care
Target 7. Critical enablers and synergies with development sectors			
7.1 National Commitments and Policy Instrument			▪ NCPI
7.2 Proportion of ever married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the last 12 months			▪ Kiribati Family Support and Health Study[7] found that 68% of women who had ever been in a relationship reported

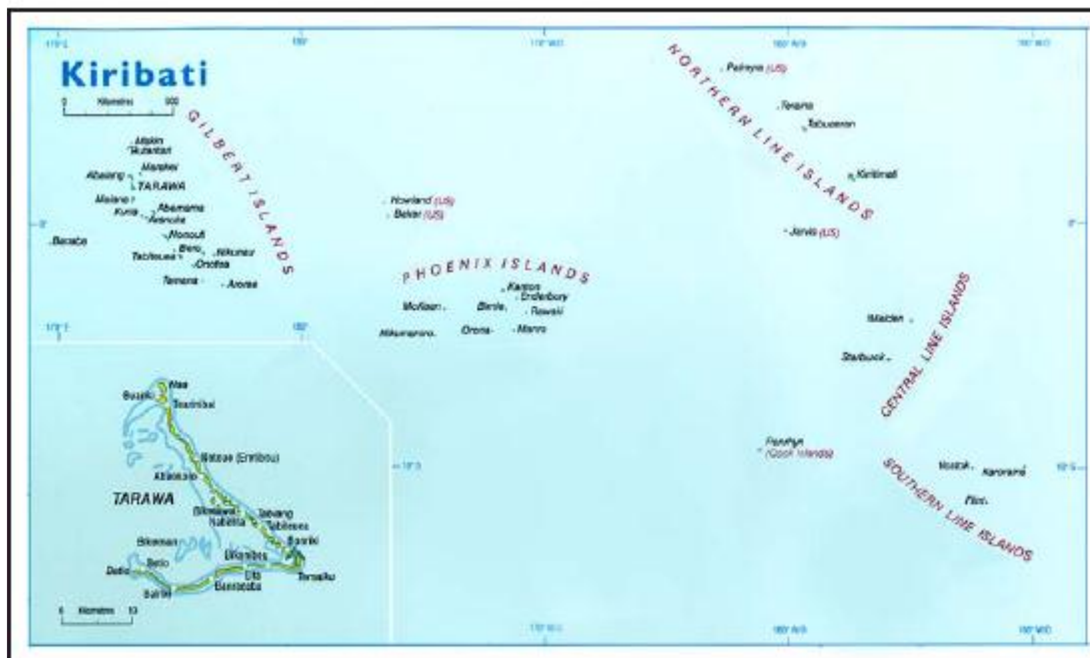
[4] Total HIV cases up to end December 2011 reported to SPC. Data received from Director of Public Health, Kiribati Ministry of Health and Medical Services.
[5] Data received from HIV Nurses administering ART February 2012.
[6] Total actual spend for Pacific Island HIV and STI Response Fund converted from AUD http://www.oanda.com/currency/converter/ accessed 10 April 2012
[7] *Kiribati Family Support and Health Study: A study on violence against women and children* 2010 SPC and Government of Kiribati

Target	Female	Male	Data source/collection method/comments
			experiencing physical and/or sexual violence by an intimate partner.
7.3 Current school attendance among orphans and non-orphans (10-14 years old, primary school age, secondary school age)	Kiribati not reporting on Indicator 7.3 -		▪ The concept of orphan is not readily applicable to Kiribati society. Such children are cared for by extended family. ▪ The Kiribati 2009 DHS notes 10% of households include orphans[8]
7.4 Proportion of the poorest households who received external economic support in the last 3 months			▪ Government of Kiribati subsidises secondary school fees for children with deceased or disabled fathers and there is an Elderly Fund for those over 67 years.

[8] There are more households (11%) with single orphans (one deceased parent, either mother or father), than double orphans (both parents deceased) (2%).

II. Overview of the AIDS epidemic

Country context



Source: "The Pacific Community" - The Pacific Islands Map, 1997

Kiribati is a small island republic located in the central Pacific. Formally part of a British protectorate, the Gilbert and Ellice Islands, Kiribati achieved independence in 1979 and is now a democratic nation with membership of the Commonwealth of Nations and the United Nations.

Kiribati consists of 32 mostly low lying islands widely scattered across 3,000 kilometres of ocean, with an estimated population of 103,371.[9] The islands are divided into three distinct groups: the Gilbert, Line and Phoenix Islands. The capital is in South Tarawa and there are two government administrative districts. A very large minority of the population (approximately 44% in 2005[10]) 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 ration of 95 men to 100 women. This sex ration is wider in South Tarawa[11]. The population profile is young, with 38% of the population under the age of 15, 50% aged 15-49 years and only 12% over the age of 50.[12] A significant proportion (22%) of children aged 0-18 years do not live with a biological parent, with this tendency more likely in rural areas.[13] The average household size is 6 people (7 in urban areas, 5 in rural areas) and approximately 24% (more in urban areas) of households are headed by women.[14]

Kiribati's population is predominantly Micronesian, with a small number of people of Polynesian, Melanesian and Chinese origin, and very few 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

[9] 2010 Population Census Preliminary Report July 27 2011.
[10] Kiribati 2005 Census Volume 2: Analytical Report (2007)
[11] Kiribati Demographic and Health Survey 2009: 8
[12] Ibid: 9
[13] ibid: 12
[14] Ibid:10

population health. In 2011 Kiribati was ranked 122 on the Human Development Index, one of the world's poorest and least developed countries, with life expectancy at birth 68 years, and under-five mortality at 46 deaths per 1,000 live births.[15]

Kiribati's socio-economic profile shares a number of features in common with other small island states in the Pacific: a low proportion of formal wage earners, a reliance on subsistence livelihoods and a narrow export and foreign revenue base. For most i-Kiribati people, subsistence means of livelihoods depend on indigenous agriculture and fishing, particularly coconut, pandanus, *bwabai* (giant taro), breadfruit, banana, fish and shellfish. Formal employment is dominated by the public sector with two thirds of wage paying jobs located in this sector.[16] Kiribati's exclusive economic zone (the largest in the Pacific) is a significant factor in revenue generation through fishing agreements with foreign countries (particularly Spain and Japan). Such fishing agreements, along with copra exports, foreign aid and overseas remittances, form the backbone of Kiribati's economy.

Kiribati's is experiencing a low level HIV epidemic. The first cases of HIV were diagnosed in 1991 and current cumulative cases stand at 55 (see Tables 1 and 2 below). This represents an HIV prevalence of 0.053 per 100,000. Of these cases, 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.

Over 2010-2011, 2 new cases of HIV were confirmed. HIV sentinel surveillance is carried out at the following points: antenatal first appointments, blood donation, employment and visa medicals, hospital in-patients and VCCT initiated. Tests are conducted at Public Health Clinics, the PPTCT Clinic at Tungaru Hospital, during community awareness outreach, and Tungaru Hospital laboratory. In 2010 a new mini-laboratory was established at Kiribati Family and Health Association Clinic. This mini-laboratory also conducts HIV testing. Apart from the community awareness outreach conducted by the MHMS's HIV & STI Unit, all HIV testing is restricted to South Tarawa.

Kiribati's National Health Plan is based on a Primary Health Care model (World Health Organisation)[17]. There are 114 health facilities nationally[18], with one main national referral hospital (Tungaru Central Hospital) based on South Tarawa. There are 2 other referral hospitals (based at Kiritimati and North Tabiteuea islands) and the remainder of health facilities are Public Health Clinics or Stations. Healthcare is free at point of delivery and there are no private clinics or hospitals. Some clinics run by NGOs also offer specific services for a fee (for example, cervical pap smears and male circumcision). The MHMS Strategic Plan 2008-2011 states that there is a wide range of secondary and surgical services available in the referral hospitals but utilization is variable. Palliative care is limited and only a small number of people receive Government funded tertiary services overseas.[19]

Sexual and reproductive health services and antenatal care are provided at almost all health facilities, but specialist obstetric care is only located at the national referral hospital. Normal pregnancy, childbirth and postpartum care is delivered at the Public Health Clinics and Hospitals. Higher risk pregnancies are referred to the PPTCT clinic in Tungaru Central Hospital.

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[15] Human Development Index accessed 21 March 2012 http://hdrstats.undp.org/en/countries/profiles/KIR.html
[16] ibid: 2
[17] *Kiribati Demographic & Health Survey* 2009: 3; Republic of Kiribati Ministry of Health and Medical Services Strategic Plan 2008-2011
[18] 2011 Universal Access Health Sector Report for Kiribati
[19] Republic of Kiribati Ministry of Health and Medical Services Strategic Plan 2008-2011

The MHMS Strategic Plan 2008-2011 identifies a number of specific challenges for Kiribati's health system: poor water and sanitation, crowded living conditions (particularly in South Tarawa), and less than optimum nutrition and health seeking behaviours in the population generally. The MHMS Strategic Plan 2008-2011 also reports on a number of critical issues highlighted by the 2005 census: a rise in infant mortality rates, lower life expectancy and higher infant mortality on South Tarawa compared to the outer islands, and an increase in the impact of lifestyle issues, particularly smoking, poor nutrition and alcohol, on population health. Communicable diseases, tuberculosis in particular, are a significant disease burden, and non-communicable diseases (diabetes, high blood pressure, heart disease, cancer and strokes) are reported to be increasing.[20] In the context of HIV, the increase in STIs is of particular concern. Overall, health system management is identified as requiring strengthening, particularly the quality of health data collection and use. Other key challenges facing Kiribati's health system include the wide geographic area for service delivery, the relatively small size of outer island communities, and restricted travel and communication systems. On a wider scale, Kiribati is also grappling with its vulnerability to climate change, most critically, rising sea levels.

National HIV/AIDS legislation and National Strategic Plan

The MHMS Strategic Plan 2008-2011 notes that much of Kiribati's health-related legislation is 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. The Secretariat of the Pacific Community (SPC) Regional Rights Resource Team conducted a 2009 review of the HIV and human rights legislative environment in Kiribati.[21] The review identified a need to review aspects of criminal law (e.g. those pertaining to homosexuality and prostitution), prisoners law, anti-discrimination law and legislation protecting the rights of vulnerable groups such as sex workers, people living with HIV (PLHIV) and MSM. The current mandatory requirement for HIV testing for seafarers' employment and visa applicants is also noted.

A draft National Strategic Plan for HIV 2005-2008[22] was written but never officially endorsed and the extent to which it shaped the national response over this period is unclear. In 2011, the Kiribati Country Coordination Mechanism for HIV, STIs & TB (CCM) undertook to develop a new National HIV & STI Strategic Plan 2012-2015 with the support of the National Strategic Frameworks Project.[23] This draft Plan is currently being reviewed by the CCM and a Monitoring and Evaluation Framework is yet to be developed with the support of SPC's Monitoring & Evaluation team.[24]

The Kiribati CCM is the national authority coordinating the response to HIV and AIDS. It was appointed in 2010 as a Global Fund requirement, and replaced the Kiribati Taskforce on HIV/AIDS & TB. There are 25 members of the CCM, with representatives from government, non-government, and civil society, including PLHIV. Over July – December 2011, the CCM met 7 times.

Current monitoring and evaluation of the national HIV and AIDS response primarily consists of data collection systems geared towards donor reporting (Global Fund and Response Fund including Continuity of Care fund). Routine health surveillance data is collected by the Health

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[20] Ibid: 9

[21] *HIV, Ethics and Human Rights Review of Legislation of Kiribati* 2009 UNDP Pacific Centre, Regional Rights Resource Team SPC and UNAIDS

[22] *Kiribati STI & HIV/AIDS Strategic Plan 2005-2008* Kiribati HIV/AIDS/TB Taskforce

[23] Strengthening Capacity to Develop National HIV & STI Strategic Frameworks in Pacific Island Countries Project (Implemented by the Burnet Institute in partnership with SPC and UNAIDS under Stream 5 of the Pacific HIV & STI Response Fund)

[24] *Kiribati: Navigating the way forward on HIV & STIs. Kiribati National HIV & STI Strategic Plan 2012-2015* DRAFT Kiribati Country Coordination Mechanism 2012: 12

Information Unit, Ministry of Health and Medical Services, but HIV and AIDS data is not collated (see Section III for further discussion of data collection and management).

National funding of HIV and AIDS prevention, treatment, care and support services over 2010-2011 comes from the following sources (see Table 2).

Table 2: Funding of Kiribati's HIV and AIDS response 2010-2011[25]

Funding source	Budget		Actual Spend	
	2010	2011	2010	2011
Global Fund (Round 7 Phase 2) USD$ **Service Delivery Area**				
People in PICTs have ready access to male and female condoms and lubricant, and the information and skills to use them, in order to prevent the transmission of HIV and other STIs	16,536	7,680	(12,351)	3,559
People in PICTs (including members of key populations) have the information, behaviours and skills to help prevent the transmission of HIV and other STIs	4,000	4,000	-	4,610
Transmission of blood-borne viruses in health care settings in PICTs is prevented	2,000	2,000	-	1,174
National and regional laboratory services in PICTs have improved capacity to provide testing and treatment monitoring in relation to HIV and other STIs	22,800	45,600	-	18,458
People in PICTs have access to evidence-based services for the detection and management of other STIs	134,293	-	215,752	5,130
PICTs have improved capacity to plan, fund, manage, implement and monitor their multisectoral response to the HIV epidemic and other STIs, in accordance with the "Three Ones" principles	101,020	77,000	8,187	51,028
Strengthened capacity in Pacific Island countries and territories to develop, implement, monitor and evaluate multisectoral national strategic plans in relation to HIV and other STIs	32,866		87,467	
Supportive environment for responses to HIV and other STIs improved and people living with HIV are effectively engaged according to the 'Greater Involvement of People with AIDS' principles	12,885		12,331	
People living with HIV in Pacific Island countries and territories have access to evidence-based treatment care and support	-		372	
People in Pacific Island countries and territories have access to effective counselling in relation to HIV and other STIs including voluntary and confidential counselling and	5,500		5,500	

[25] Financial data for Global Fund and Response Fund sourced from the Secretariat for the Pacific Community March 2012. Data was provided in different currencies (Global Fund in US dollars and Response Fund in Australian dollars.)

Funding source	Budget		Actual Spend	
	2010	2011	2010	2011
testing for HIV (VCCT)				
Health care services in Pacific Island countries and territories have access to the information and commodities required to prevent the transmission of blood-borne viruses in health care settings	3,392		3,546	
Pacific Island countries and territories have access to effective regional mechanisms for the procurement and supply of drugs and other commodities in relation to HIV and other STIs	671	-	671	-
Health care workers in Pacific Island countries and territories have access to effective national and regional laboratory services for essential testing in relation to HIV and other STIs	25,314	-	72,797	-
Project management	(1,279)	-	(5,132)	-
Total Global Fund USD$	**362,556**	**136,280**	**424,106**	**83,960**
Response Fund AUD$				
Stream 1 National Strategic Plan Support Grant (including Continuity of Care)	2,683	213,796	2,683	90,551
Stream 2 Capacity Development Organisation Grant	29,600	41,747	2,750	45,514
Stream 3 Community Actions Grant	-	-	-	-
Stream 4 Competitive Grant	39,438	-	98	33,853
Total Response Fund AUD$	**71,721**	**255,543**	**5,531**	**169,918**
Government of Kiribati (MHMS salaries)	No data available			
Parliamentarian HIV Budget	No data available			

National HIV and AIDS data

The most recent verified HIV and AIDS data for Kiribati is the Secretariat of the Pacific Community 2009 cumulative reported HIV and AIDS cases presented below (Table 3).

Table 3. Cumulative 2009 HIV, AIDS and AIDS related deaths cases and incidences[26]

Cumulative cases			HIV Cumulative incidence per 100,000	HIV		
HIV (including AIDS)	AIDS (including deaths)	AIDS related deaths		Male	Female	UK
52	28	23	52.5	33	19	0

There is further MHMS data for HIV incidence over 2010 and 2011 as indicated below (Table 4).

[26] 2009 HIV, AIDS and AIDS related deaths cases and incidences Updated June 2010 SPC http://www.spc.int/hiv/

Table 4. Updated HIV incidences by year, sex and age 1991-2011[27]

Year	Sex			Age group						Total
	M	F	U	<15	15-19	20-24	25-49	50>	U/K	
1991	2	0	0	0	0	0	2	0	0	2
1992	0	0	0	0	0	0	0	0	0	0
1993	0	0	0	0	0	0	0	0	0	0
1994	0	0	0	0	0	0	0	0	0	0
1995	2	0	0	0	0	0	2	0	0	2
1996	10	1	0	0	0	0	11	0	0	11
1997	3	3	0	0	1	1	4	0	0	6
1998	1	3	0	1	0	0	2	0	1	4
1999	5	2	0	1	0	0	3	0	3	7
2000	1	2	0	1	0	0	2	0	0	3
2001	0	0	0	0	0	0	0	0	0	0
2002	1	0	0	0	0	0	0	1	0	1
2003	2	3	0	3	0	0	2	0	0	5
2004	2	2	0	0	0	0	1	0	3	4
2005	0	0	0	0	0	0	0	0	0	0
2006	2	2	0	0	0	2	2	0	0	4
2007	1	0	0	0	0	0	0	0	0	1
2008	1	0	0	0	0	0	1	0	0	1
2009	0	2	0	0	0	0	2	0	0	2
2010	0	0	0	0	0	0	0	0	0	0
2011	1	1	0	0	0	0	0	0	2	2
Total	**34**	**21**	**0**	**6**	**1**	**3**	**33**	**1**	**9**	**55**

III. National response to the AIDS epidemic

Responding to HIV, AIDS and STIs is a strategic objective of the Government of Kiribati's Strategic Health Plan 2008-2011.[28] Five health 'highest priority areas' are identified:

1. Improving the child survival rate
2. Improving maternal health
3. Reducing the rate of active tuberculosis infection
4. Reducing prevalence of non-communicable diseases
5. Combating HIV/AIDS and STIs.

Within priority area 5, there are four key areas of the national HIV and AIDS response: strengthening a coordinated multi-sector response; developing and implementing policies and guidelines for the prevention, detection, care and treatment of HIV, AIDS and STIs; education and prevention; and blood safety and occupational safety.

A new MHMS Strategic Plan 2012-2015 is currently being drafted. Responding effectively to HIV, AIDS and STIs remains a priority and MHMS is committed to aligning HIV, AIDS and STI prevention and management within wider health operational plans.[29]

[27] Data sourced from Director of Public Health, Kiribati MHMS. Age disaggregation data sourced from Health Information Unit, Kiribati MHMS.
[28] Republic of Kiribati Ministry of Health and Medical Services Strategic Plan 2008-2011
[29] Interview with Director of Public Health 20 February 2012.

The following sections examine the national response to date, with a focus on January 2010-December 2011.

The Kiribati HIV response is led by the CCM and is implemented by the MHMS HIV & STI Unit, in partnership with Non-Government Organisations (Kiribati Red Cross and Kiribati Family Health Association) and the Adolescent Health Division (AHD), MHMS. Funding support for Kiribati's programmatic response comes primarily from the Global Fund to fight AIDS, Tuberculosis and Malaria (Round 7 Phase 1 and Phase 2) and the Pacific Island HIV and STI Response Fund 2009-2013, including the Continuity of Care Fund (all administered by the SPC).

The Pacific Island HIV and STI Response Fund supported the following programme areas in Kiribati over 2010-2011:

1. Strengthening and Coordination (capacity building for coordinating bodies; developing policies, guidelines and national strategic plans)
2. Prevention and Education (capacity building for Behaviour Community Change (BCC); community strengthening programmes e.g. Stepping Stones; peer education training and networks; STI campaign and community education)
3. Blood Safety (procurement of test kits for HIV, syphilis, Hepatitis B; technical training)
4. Monitoring and Evaluation (strengthening HIV and STI routine surveillance; capacity building in data collection and analysis).

The Continuity of Care Fund has supported the following programme areas in Kiribati over 2010-2011:

1. Strengthening monitoring and reporting
2. Youth peer education programmes
3. Integration of HIV & STI counselling and testing services into wider health services
4. Development and implementation of HIV workplace policies.

The Global Fund to fight AIDS, Tuberculosis and Malaria has supported the following programme areas in Kiribati over 2010-2011:

1. Technical and financial support to Government of Kiribati to implement national multi-sectoral HIV & STI strategic plan
2. Human resource development
3. Programme operation costs
4. Prevention programmes (HIV & STI education, condom promotion/social marketing campaigns; condom distribution to high-risk/vulnerable groups)
5. Laboratory strengthening
6. HIV & other STI diagnosis (referral of HIV and chlamydia specimens nationally and internationally)

During 2010-2011 a number of key personnel changes in the MHMS HIV & STI Unit affected implementation and delivery of the national response. In April 2011, a new HIV Coordinator, HIV Field Officer, and HIV Counsellor were appointed. Handover to new staff is reported to have been insufficient and there was little continuity between programme reporting over 2010 and 2011. There is a Global Fund supported Monitoring and Evaluation Officer but this post has not been consistently filled. The present HIV & STI Unit team is new to reporting and much of 2011 reporting has been 'learning-on-the-job' with the support of the SPC Monitoring and Evaluation team. There is also lack of clarity around data management (for example the location of 2010 programme reports). The narrative below draws upon 2011 programme reports, interviews with current HIV & STI Unit staff who have been in post from April 2011, and key informant interviews with other national response stakeholders.

KFHA, AHD and Kiribati Red Cross are key partner agencies implementing Kiribati's HIV response on South Tarawa. The island is divided into three target areas and each agency is responsible for carrying out the same activities in their area. These activities include: condom distribution, peer

education, and public awareness outreach to communities. AHD has a specific mandate to focus on young people, broadly defined as 10-24 years.

National Commitment and Programme Implementation

Prevention - Young people

Young people aged 15-24 years are a critical focus of Kiribati's HIV prevention activities. The overall population profile (38% under the age of 15), high levels of STIs and sexual risk behaviours indicate that this group has a heightened vulnerability to HIV transmission.

Youth services in Kiribati are provided by the Adolescent Health Division (AHD) of the MHMS, as well as a number of Non-government organisations (NGOs), primarily Kiribati Family and Health Association (KFHA) and Kiribati Red Cross, and international agencies (UNICEF). The two main churches (Roman Catholic and Protestant) in Kiribati also run youth programmes. There are 3 youth friendly services operating nationally; 2 in South Tarawa (services provided by AHD and KFHA) and 1 in the outer islands. In 2010 UNICEF piloted a youth friendly service on Abemama Island. Currently this is the only youth friendly service located outside South Tarawa. The Abemama Island site does not provide HIV testing and counselling however, and this is only available at the 2 youth friendly services based on South Tarawa. There is no data on the number of adolescents and youth utilizing youth friendly health services. Youth friendly service guidelines are reported to have been drafted in 2010, but are yet to be endorsed officially.[30]

During 2011 the MHMS HIV & STI Unit team coordinated with the wider MHMS and NGO partners to conduct community youth outreach. Outreach programmes include VCCT, peer to peer counselling, condom and pamphlet distribution as well as STI and HIV campaign youth drama.

Alcohol, drug, and substance abuse
The 2008 second generation surveillance of youth (15-24 years) identified Kiribati youth as more likely to be involved in alcohol, drug and substance use if they were male. Over half of males (56%) reported consuming alcohol two or more times per week compared with only one in five females (22%). Of those who do consume alcohol, consumption is high: 86% of males and 62% of females reported that they consumed 5 or more standard drinks in a usual drinking session.[31] Males were more likely to have used other drugs (kava and tobacco). Butane/gas/glue inhalation and use of Viagra/sex enhancers were rare. This data is broadly comparable to findings from UNICEF & Government of Kiribati 2010 research on Kiribati youth which found that especially vulnerable adolescents (EVA) were much more likely to consume alcohol three times or more per week.[32] This research also found that most-at-risk adolescents (15-19 year olds) and young people (20-24 year olds) were more likely to consume alcohol and *kaokioki* (toddy) and other substances (kava, betelnut, benzene/gas/glue, marijuana, datura) than mainstream adolescents and young people.

School enrolment
The 2005 Kiribati census reports that although overall, 91% of 6-15 year olds are enrolled in school, this proportion declines as children age: a quarter of 15 year olds have dropped out of school, and at 18, less than half are attending school.[33] There is little gender difference in school enrolment; however, attainment levels at secondary and tertiary education tend to be higher for

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[30] Interview, AHD, MHMS
[31] Government of Kiribati and Secretariat of the Pacific Community (2008) *Second Generation Surveillance of Antenatal Women, Seafarers, Policemen and Youth in Kiribati*
[32] UNICEF Pacific and Government of Kiribati (2010) *I feel I can never get infected. A Baseline Report on Understanding HIV and AIDS Risk Vulnerability Among Kiribati Youth*
[33] Kiribati 2005 Census Volume 2: Analytical Report: 41

males compared to females. The 2010 UNICEF research found that more vulnerable youth[34] were up to four times less likely to be enrolled in school, college or university full-time.

Peer education programmes

Peer educator programmes are well established in Kiribati, but over 2010-2011 these networks have been only operating on South Tarawa. There is a Kiribati National Peer Education Committee and peer educator groups are run by AHD, KFHA and Kiribati Red Cross. There are approximately 36 peer educators and the network includes MSM and those involved in commercial or transactional sex. There is no data on the number of young people reached by peer education programmes.

Sexual and reproductive health and life-skills based HIV & AIDS education in formal and non-formal education

Currently, sexual and reproductive health (SRH) and life-skills based HIV & AIDS education is not taught in formal education as part of the curriculum. The Adolescent Health Division Coordinator is reported to be working with the Ministry of Education Curriculum Development Division on plans to include SRH in the school curriculum.[35] Over 2010-2011, KFHA, Kiribati Red Cross, and AHD have delivered both SRH and HIV & AIDS education to schools and colleges. The MHMS HIV & STI Unit does not deliver SRH education, but delivers HIV & AIDS awareness during community outreach visits.

There is no age disaggregated data available for STIs cases among youth and adolescents.

The number of teenage pregnancies reported in Kiribati for 2010 was 155. This compares to 218 recorded teenage pregnancies in 2011.[36]The 2009 DHS found that 11% of 20-49 year old women had given birth before the age of 20[37] and that 10% of 15-19 year olds had begun childbearing (already had a child or were pregnant).[38]

Prevention – higher risk groups

As outlined in section 2, seafarers, their spouses and children, young people and those involved in commercial or transactional sex are considered to be at higher risk of HIV exposure.
The Kiribati MHMS Policy on HIV testing[39] guides clinical staff to especially encourage HIV testing and counselling for patients who are known to have behavioural or clinical factors suggesting high-risk of acquiring HIV. This includes: STI patients, male or female sex workers, MSM, police personnel, injecting drug users, TB patients, seafarers and their spouses.

There is no population based survey data estimating the numbers of sex workers or MSM. The second generation surveillance surveys conducted to date have specifically targeted pregnant women, seafarers, policemen and youth.[40] However, research conducted with female sex workers[41] and young MSM[42]provides some data on these groups.

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[34] Most-at-risk adolescents and young people and Especially-vulnerable adolescents and young people (UNICEF Pacific and Government of Kiribati (2010: 35)
[35] Interview, HIV Field Officer
[36] MHMS Health Information Unit
[37] *Kiribati Demographic and Health Survey* 2009: 64
[38] ibid: 68
[39] *Kiribati Ministry of Health Policy on Strengthening HIV Counselling and Testing to Promote Universal Access to HIV Care and Treatment* (undated. MHMS HIV Unit accessed a copy of the document from the former Director of Laboratory Services in 2011)
[40] *Second Generation Surveillance Surveys of HIV, other STIs and Risk Behaviours in 6 Pacific Island Countries* 2004-2005 (2006) WHO, SPC, UNSW; *Second Generation Surveillance of Antenatal Women, Seafarers, Policemen and Youth in Kiribati* (2008) Government of Kiribati and Secretariat of the Pacific Community
[41] *Risky Business Kiribati: HIV prevention amongst young women who board foreign fishing vessels to sell sex* K.MacMillan and H.Worth 2010 University of NSW

MSM is widely reported to be highly stigmatized in Kiribati society and culture.[43] Despite this, sexually active male youth on South Tarawa and Abemama Islands respectively reported 33.6% and 41.4% experience of MSM activity.[44] Of these, 85% had MSM sex in a hidden place and MSM condom use was very low at 17%.[45] Young men and women also reported incidences of forced sex and the risky influence of substance use on their sexual behavior.

In 2010, research was conducted with young i-Kiribati women (*ainen matawa*) who trade sex for money and goods.[46] The research investigated factors impacting on this group's higher risk of HIV exposure, including prevalence of condom use. The specific research context was the practice of boarding foreign fishing vessels. This practice is well established in parts of Kiribati and the research found that *ainen matawa* suffer from marginalization and discrimination and are more vulnerable to forced sex. The research also found that the sexual relationships *ainen matawa* form with their clients are often on-going in nature and that this feature must shape condom use promotion. There has been no other research conducted on sex work in Kiribati, and the extent of other local commercial and/or transactional sex work, including MSM sex work, is not known.

Over 2010-2011, the Kiribati Association of NGOs (KANGO) was the only organisation which specifically focused on HIV prevention activities with sex workers. No projects were targeted at MSM over 2010-2011. There are no health facilities which specifically deliver to sub-populations and marginalized groups with higher risk of HIV exposure, with the exception of the AHD centre which prioritises youth. The AHD centre does not offer clinical services but coordinates with near-by clinics to provide blood tests and family planning. There is no data on the number of MSM or sex workers who have tested for HIV.

Only two people living with HIV (PLHIV) in Kiribati have publicly disclosed their status. Both are actively involved in the national response, through HIV related employment with NGOs and government agencies. Both sit on the CCM.

Prevention – Sexually transmitted infections

The incidence of STIs is high in Kiribati.[47] A 2008 surveillance survey of antenatal women aged 15-46 years found an average prevalence of chlamydia at 11% and syphilis at 5%. Over one quarter of the women surveyed had experienced STI symptoms in the previous month. No cases of HIV or gonorrhea were detected in the sample of 206 women.[48] This compares to an earlier 2006 surveillance survey which detected a chlamydia prevalence of 13% and syphilis prevalence of 2.1% for antenatal attendees aged 18-44 years. Between 2006 and 2008, prevalence of chlamydia and syphilis had decreased for women 25 years and younger, but remained either unchanged (chlamydia) or increased (syphilis) for women 25 years and older. In the 2008 survey, 27% of seafarers and 17% of policemen were found to have the Hepatitis B antigen, but

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[42] *I feel I can never get infected. A Baseline Report on Understanding HIV and AIDS Risk Vulnerability Among Kiribati Youth* (2010) UNICEF Pacific and Government of Kiribati
[43] Ibid; key informant interviews
[44] ibid
[45] ibid: 99
[46] *Risky Business Kiribati: HIV prevention amongst young women who board foreign fishing vessels to sell sex* K.MacMillan and H.Worth 2010 University of NSW
[47] *Second Generation Surveillance Surveys of HIV, other STIs and Risk Behaviours in 6 Pacific Island Countries* 2004-2005 (WHO, SPC, UNSW); *Second Generation Surveillance of Antenatal Women, Seafarers, Policemen and Youth in Kiribati* 2008 (Government of Kiribati and SPC); Kiribati Demographic and Health Survey 2009
[48] *Second Generation Surveillance of Antenatal Women, Seafarers, Policemen and Youth in Kiribati* (Government of Kiribati and SPC 2008)

no HIV or gonorrhea cases were detected amongst these groups.[49] STI prevalence in the general population may also be negatively impacted by poor self-referral for treatment. The Kiribati DHS 2009 found that a significant proportion (one third) of those with self-reported STI symptoms in the previous 12 months had not sought treatment.

STI management in Kiribati follows a syndromic approach overall, particularly in the outer islands where there are no laboratory services. On South Tarawa, Tungaru Central Hospital Laboratory conducts tests for the following STIs: syphilis, HIV, gonorrhea (swab test). Chlamydia and urine tests for gonorrhea are sent to Fiji for testing. The MHMS HIV & STI Unit team includes STI data in their monitoring and evaluation activities. In the first half of 2011, the team reports that 1,753 tests were conducted for chlamydia and gonorrhea.[50]In July-December 2011, 83 cases of chlamydia were reported by the HIV & STI Unit team.[51]

Kiribati's primary health data collection tool, the MHMS Monthly Consolidated Statistical Report (MS-1) does not collect disaggregated STI data. Overall numbers of STI cases are reported on the MS-1 but these are not disaggregated by disease. There is no data on repeated STI cases or re-infections. Data on syphilis cases (and other STIs such as gonorrhea and chlamydia) are collected by the MHMS HIV & STI Unit Coordinator and reporting is directed at donor requirements (Global Fund and Response Fund).

Prevention - HIV testing and counselling services

Kiribati has a national HIV testing policy[52] which has four principle strategies:

1. Client-initiated voluntary counselling and testing (VCCT): people who present themselves to health facilities;
2. Provider-encouraged counselling and testing (PECT): health care staff will encourage people suspected to be at high-risk to voluntarily consent to HIV testing;
3. Medically-indicated counselling and testing (MICT): health care staff will encourage people to voluntarily consent to be tested for HIV where they exhibit clinical signs and symptoms suggesting HIV infection and need for HIV care;
4. Compulsory counselling and testing (CCT): HIV counselling and testing will be provided to individuals where it may be required by law or policy. This includes individuals voluntarily presenting themselves for blood donations, employment physicals or applicants for visas.

The policy is founded on rights-based principles of confidentiality, voluntary consent and post-test follow up services, and includes flow charts for HIV testing and counselling and the management of results. Virological testing of exposed infants and children are covered by a separate policy (see section on PMTCT services below). The national HIV policy does not cover CD4 or viral load testing guidelines.

There are approximately 46 VCCT trained counsellors in Kiribati, including medical, nursing and laboratory staff, MHMS HIV & STI Unit personnel, government staff (e.g. in the MHMS Adolescent Health Division) and NGO staff. VCCT counsellor training was been conducted in 2011 with health providers and counselors,[53] increasing the overall national number of accredited VCCT counsellors. However, nearly all VCCT counsellors are based on South Tarawa, with the exception of one on Kiritimati Island. Counsellors have individual codes which are used to code blood samples confidentially (along with a patient code) and to track test results for post-test

[49] ibid
[50] Continuity of Care Report Jan-June 2011
[51] Global Fund Six-Monthly Report July – Dec 2011
[52] *Kiribati Ministry of Health Policy on Strengthening HIV Counselling and Testing to Promote Universal Access to HIV Care and Treatment* (undated. MHMS HIV Unit accessed a copy of the document from the former Director of Laboratory Services in 2011)
[53] Pacific Islands HIV & STI Response Fund Six Monthly Report Jan-June 2011

counselling. Counsellors report that achieving a 100% post-test counselling rate is challenging due to contact and follow-up difficulties.

HIV testing and counselling is carried out in 9 permanent sites and various mobile outreach sites. The 9 permanent sites are all based on South Tarawa. All 9 sites are VCCT accredited (3 accredited in 2010, 6 in 2011). There have been physical improvements (fencing, gates, lighting, curtains) to VCCT clinics over 2011. All HIV tests are carried out at 2 South Tarawa sites: Tungaru Central Hospital Laboratory and Kiribati Family Health Association mini-laboratory. The latter is a mini-laboratory which sends any positive results to Tungaru Hospital for confirmation. The HIV testing algorithm used in Kiribati is a simple/rapid assay test using Determine HIV 1/2 with reactive specimens re-tested using Unigold and INSTI tests in parallel. This algorithm was piloted in Kiribati with SPC support in 2010. The testing algorithm is recommended by the National Research Laboratory, Australia. The first HIV positive cases in Kiribati were recorded in 1991. As outlined in the previous section, there is some uncertainty about the exact numbers of HIV positive cases as MHMS does not hold data on all cases (some of whom may have subsequently died). In addition, a few HIV cases were diagnosed overseas and may have been double counted. The following table outlines data where it exists for HIV testing in 2010-2011.

Table 5. Number of women and men aged 15 and older who received HIV testing in 2010-2011[54]

Year	Male	Female	Unknown	Total tests
2010				4,594
2011				4,587
Total 2010-2011				**9,181**

Partially disaggregated data is only available for 2011, as shown below.

Table 6. Available disaggregated HIV testing data 2011

Type	Male	Female	U/K	Total	<15			15-19			20-24			25-49			50>		
					M	F	U	M	F	U	M	F	U	M	F	U	M	F	U
ANC[55]		1,238		**1,238**															
Blood donors																			
TB[56]	154	155	8	**317**	23	26	0	25	25	0	19	26	0	66	60	8	21	18	0
VCCT[57]	112	121	17	**250**	14	22	0	14	19	3	13	13	0	45	29	9	18	25	0
Outpatient (visa, employment)																			
Inpatient																			

The Tungaru Hospital Laboratory does not routinely collate disaggregated HIV testing data. Every quarter the Laboratory reports total HIV testing figures to the MHMS Health Information Unit. Entry points typically recorded by the Laboratory are 'Medical Check-up' (outpatients requiring HIV testing for visa or employment), 'Blood donors' and 'VCCT' (presumed to be all others).

HIV testing data collection is fragmented across differing testing sites, reporting purposes and personnel responsible for different areas. Hospital based testing is coordinated by the Laboratory for blood donors, TB patients, in-patients and out-patients. Antenatal HIV testing is coordinated

[54] Tungaru Central Hospital Laboratory HIV testing data
[55] Pre-test data from PPTCT Programme, Tungaru Central Hospital
[56] Data from MHMS HIV & STI Unit
[57] Ibid

by clinic staff in the 8 different Public Health Clinics offering antenatal VCCT testing in South Tarawa. Additionally antenatal data coordination is done by the PPTCT Programme Coordinator and the MHMS HIV & STI Unit. Client initiated HIV testing is coordinated by VCCT counsellors and collated by the MHMS HIV & STI Unit.

There was one recorded case of an infant born to an HIV positive mother over in 2010. This infant has not yet received virological testing.

Prevention - PMTCT services

The 2009 Kiribati Demographic and Health Survey indicates that 88% of expectant mothers access health professionals (doctor, nurse, midwife and auxillary nurses/midwifes) during pregnancy. However, the number of births attended by health professionals or skilled birth attendants (excluding traditional birth attendants), is lower than this, with only 66% of mothers delivering at health facilities.[58] Data from the Health Information Unit, MHMS indicates that of 1,778 registered births in 2010[59], 1,292 were attended by skilled birth attendants (a coverage rate of 72%). However, mothers who have not accessed antenatal health care at all will not be included in these figures, indicating that coverage may actually be lower.

The 2009 Kiribati Demographic and Health Survey indicates that 3% of women (typically older and already mothers) do not receive any antenatal care. Additionally, Kiribati women, and rural women in particular, are more likely to have their first antenatal bookings quite late in pregnancy (fourth, fifth or subsequent month) and to deliver at home.[60] Services routinely offered (but not universally)[61] to pregnant women include: weighing, blood pressure measurement, urine testing, blood testing to detect syphilis and severe anemia. VCCT counselling and testing services at first antenatal bookings are only available at 8 antenatal clinics in South Tarawa. Almost all health facilities nationally (108[62] out of 114) offer antenatal services, with specialist obstetric care only available at Tungaru Central Hospital.

As part of its Safe Motherhood Programme, Kiribati's MHMS has a Prevention of Parent to Child Transmission of HIV (PPTCT) national policy.[63] This was adopted in late 2010 and replaces an earlier policy.[64] The new 2010 PPTCT policy regulates all aspects of prevention of vertical HIV transmission, including primary prevention of HIV among women of reproductive age and their male partners; provision of VCCT services; access to reproductive health advice and family planning services; and provision of ART for pregnant women and infants. The policy incorporates WHO and UNICEF 2010 guidelines on ART for pregnant women, preventing HIV infection in infants and infant feeding guidelines. The policy includes STIs in its overarching 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…and their children"[65] Antenatal syphilis testing (as well as Hepatitis B) is routinely offered and if detected, pregnant women are referred to an STI clinic.

One HIV positive mother is reported to have delivered in 2010. This HIV case was not newly diagnosed during pregnancy. It is not yet known if the child has been infected with HIV. The infant received ART after birth and will be tested for HIV infection at 18 months. There are

[58] *Kiribati Demographic & Health Survey* 2009: 139
[59] National collated figure for births in 2011 are not yet available
[60] *Kiribati Demographic & Health Survey* 2009: 140, 148
[61] Ibid: 143-144
[62] MHMS Health Information Unit
[63] *National Policy Guideline on Prevention of Parent to Child Transmission (PPTCT) of HIV* Ministry of Health and Medical Services, Kiribati October 2010
[64] *National Policy Guidelines on Prevention of Mother to Child (PMTCT)* Ministry of Health and Medical Services, Kiribati 2009
[65] *National Policy Guideline on Prevention of Parent to Child Transmission (PPTCT) of HIV* Ministry of Health and Medical Services, Kiribati October 2010: 15

therefore no reported cases of vertical transmission of HIV over the 2010 and 2011 period. Infant feeding policy for HIV positive mothers is in line with the national breastfeeding policy for the first 6 months (exclusive breastfeeding), followed by an abrupt weaning.

5 treatment and prophylaxis drug regimens are detailed for differing patient (mother and infant) scenarios.[66] Co-trimoxazole is recommended for exposed children from 4 or 6 weeks of age and continued for 5 years until the child is either HIV negative or asymptomatic. Currently only one site offers ART (Tungaru Central Hospital). No logistical problems were reported in the provision and supply of ART drugs. Significant efforts, however, have to be made to maintain patient confidentiality in delivering ART and on-going care (please see below for further discussion of confidentiality issues).

Table 6. HIV testing and counselling of ANC attendees

Year	Number of ANC attendees	Number of ANC attendees tested for		Percentage of ANC attendees tested for		Number of new cases among pregnant women		Percentage of new cases among pregnant women	
		Syphilis	HIV	Syphilis	HIV	Syphilis	HIV	Syphilis	HIV
2010[67]	3,063	1,100				92	1	8.3%	
2011	Data not available								

Care - ART treatment (prophylaxis), care and support

Following an HIV positive diagnosis, individuals are assigned to the care of a multi-disciplinary HIV Care Team, headed by the HIV Clinician based at Tungaru Central Hospital. Kiribati has one HIV Clinician who is responsible for all ART treatment and follow-up care nationally. There is one ART site (Tungaru Central Hospital).

There are currently 6 individuals on ART treatment in Kiribati. 5 are based in South Tarawa, 1 on an outer island. [68] These cases are reported to be 3 female and 3 male, all aged between 25-49 years. All 6 cases have been on ART for more than two years, although some ART patients are reported to have stopped and started treatment. Reasons for this are unclear, but anecdotal reports suggest some patients have declined ART because they feel healthy.[69] As noted earlier in the report, Kiribati is estimated to have 28 HIV positive cases. The whereabouts and status of the estimated 22 HIV positive cases who are not receiving ART is not known.

On-going ART treatment and support is led by the HIV Clinician with two HIV nurses. HIV nurses are a critical liaison point between patients and treatment as the responsibility for maintaining patient confidentiality lies primarily with them. On South Tarawa HIV nurses collect prescription drugs from the hospital pharmacy and deliver them to patients. The outer island ART patient is overseen by the HIV Clinician. Drug delivery, along with accompanying support, has to be done with maximum care and discretion in order to avoid inadvertent public disclosure. HIV nurses see ART patients on South Tarawa monthly; the HIV clinician sees the outer island patient bi-monthly. This outer island travel has been supported during the 2010-2011 period by the Continuity of Care fund (part of the Pacific Island HIV and STI Response Fund).

Over 2010 – 2011 ART and STI treatment drugs have been financed through the Global Fund to fight AIDS, Tuberculosis and Malaria. The national ART guidelines were last updated in 2009.[70]

[66] ibid: 20-22
[67] 2011 Universal Access Health Sector Report for Kiribati (UNAIDS). The report notes however that there is difficulty disaggregating data for syphilis due to coding system on counsellors' forms.
[68] Interview, HIV nurse
[69] Ibid
[70] 2011 Universal Access Health Sector Report for Kiribati (UNAIDS)

CD4 tests are conducted on the request of the HIV clinician. Laboratory data shows 7 CD4 tests were done in 2011. The Tungaru Central Hospital Laboratory does not carry out viral load tests (these are sent to Mataika Laboratory in Fiji). The Tuberculosis Clinician reports that all new TB patients are recommended to receive VCCT HIV testing. There have been 2 cases of TB and HIV co-infection. There is a national TB/HIV co-infection policy. These guidelines were adopted in 2006 and last updated in 2010.[71]

Knowledge and behaviour change activities among general population

Knowledge and behavior change activities among the general population form a substantial part of Kiribati's national programmatic response to HIV and AIDS over 2010-2011.

Knowledge and behavior change activities are implemented by the MHMS HIV & STI Unit, KFHA, AHD, and Kiribati Red Cross who conduct peer educator networks and community awareness events. 6 community awareness visits are reported for January-June 2011. Most of these activities are concentrated in South Tarawa, although outreach visits to the outer islands are also regularly scheduled. There were four outer island visits conducted in 2011. Public awareness and clinic outreach are delivered to the general population at community meeting houses.

Over the 2010-2011 period there have been media campaigns (radio, TV, newspaper) to raise public awareness of HIV & AIDS prevention. Detail of the number and types of campaign, including estimation of people reached, is unclear due to reporting gaps.

HIV & STI prevention and awareness raising campaigns have been run on World AIDS Day 2010 and Independence Day 2011.

NGOs (KFHA, Kiribati Red Cross and AHD) implement condom promotion and distribution in South Tarawa bars, clubs and shops. Spot checks are conducted by the MHMS HIV & STI Unit to ensure condoms are being distributed, are available and to replenish supplies if necessary.

IV. Conclusions

Kiribati has made significant progress in developing its national response to HIV, AIDS and STIs over 2010-2011. International funds, the Global and Response Funds in particular, have been of critical importance in the progress made. It is very unlikely that Kiribati could support the same level of programme activities within national budgets. Data challenges mean that evidencing programme impact is difficult however. It has not been possible to report fully disaggregated or complete data for the 2010-2011 period.

Underlying social and structural factors within the Kiribati epidemic include deeply rooted challenges such as low educational attainment, restricted employment opportunity and economic choices, gender inequality and stigma and discrimination. Tackling these underlying factors requires high-level multi-agency coordination.

The risks and vulnerabilities that make Kiribati's general and sub-populations vulnerable to HIV exposure are on-going. These include difficult socio-economic circumstances (particularly over-crowding and poverty), risky sexual behaviours (multiple partners, early male sexual debut and low condom use), i-Kiribati seafarers' global travel, the presence of foreign seafarers, and established practices of commercial and/or transactional sex. On-going high levels of stigma and fear of may also be discouraging HIV positive people from accessing ART or publically disclosing their status. Kiribati's high incidence of STIs, poor self-referral for treatment, low condom use and the fact that many STIs are asymptomatic, represents a worrying combination of factors for potential HIV transmission. This is particularly so for adolescents and young people who are at increased risk. Research shows that Kiribati youth are particularly vulnerable to HIV exposure

[7171] Email correspondence TB Clinician March 2012

through a variety of social, economic and cultural factors. There is an urgent need to strengthen the programmatic response to these multiple vulnerabilities.

Church leadership was identified by stakeholders as a strong driver of change in Kiribati. Although the Roman Catholic and Protestant Churches are represented on the CCM, the extent to which the mainstream Churches are actively involved in the national HIV response is unclear. This lack of active coordinated involvement may represent a missed opportunity during 2010-2011.

Rigorous test surveillance data, along with further demographic and health surveys and second generation surveillance, will indicate whether the national response over 2010-2011 has had a positive impact upon HIV transmission, knowledge, attitudes and practice. This analysis is necessary for Kiribati is to direct resource most effectively at combating the spread of HIV.

There have been a number of achievements in Kiribati's national HIV and AIDS response over 2010-2011. These include:

- Human resource for HIV & STI prevention, care and treatment increased significantly during 2010-2011
- A new CCM for HIV, STI & TB was appointed and is well-established
- A new National Strategic Plan for HIV/AIDS 2012-2015 has been drafted
- The number of VCCT accredited sites has increased from zero to 9 (3 accredited in 2010, 6 in 2011)
- There are 46 trained VCCT counsellors, covering a number of government and NGO agencies
- A new National Blood Policy has been drafted (2011) and is close to finalization.

A number of examples of effective practice emerged:

- The MHMS HIV & STI Unit is coordinating well with KFHA, Kiribati Red Cross, and AHD to conduct advocacy and public awareness activities
- The Tungaru Central Hospital Pharmacy coordinates effectively with SPC regarding ART drug supply
- Civil society organisations (CSOs) are endeavouring to engage with key drivers of social change in Kiribati: the parents of young people and mainstream churches. CSOs have advocated the need for HIV awareness with some success; for example, in 2011 KFHA successfully lobbied the Catholic Church leadership to agree to KFHA addressing delegates on HIV at the 2011 Catholic women's conference.

However, implementation of some programme activities was slow to start, resulting in undisbursed funds over the reporting period 2010-2011.[72] Some activities (for example, International Air Transport Association training in shipping infectious substances for Laboratory and Programme staff) have not yet happened. Factors that have constrained the national response are outlined below.

V. Major challenges and gaps

A number of challenges and gaps are evident in Kiribati's response to HIV and AIDS over 2010-2011:

- High staff turnover and poor handover has limited the effectiveness and efficiency of the MHMS HIV & STI Unit.

[72] Interview MHMS Accountant for Global Fund and Response Fund (including Continuity of Care)

- Data management and reporting skills were new to the current MHMS HIV & STI Unit recruited in 2011. This adversely affected programme reporting in 2011 and limited lessons learned from 2010 (and previous).

- HIV prevention and testing services are concentrated on South Tarawa; the 9 VCCT accredited sites are all located on this main island, and antenatal first booking screening is currently restricted to South Tarawa. HIV public awareness, testing and counselling currently only happens on the outer islands when the MHMS HIV & STI Unit conduct community outreach visits. There is thus a service gap for outer island communities, particularly for those at higher risk of HIV exposure.

- Kiritimati Island is the second largest commercial hub in Kiribati. No VCCT or HIV outreach activities were undertaken on Kiritimati Island over 2010-2011, and there is currently only one VCCT counsellor based there.

- Geographical distances and limited transport availability represent a logistical challenge for a national response based in South Tarawa. The difficulty of transport logistics particularly impact on the scheduling of pre and post-test visits to outer islands. The gap between visits can be up to one year, leaving people who have received HIV tests waiting a long time to hear the results and receive post-test counselling.

- Following the closure of the Kiribati Association of NGOs in 2011, there are no agencies specifically engaging those involved in sex work. This is a concern as this group is at higher risk of HIV exposure.

- There is currently no population based data on MSM and those involved in sex work. Numbers of these groups are unclear and there is no representative information on sex worker and MSM HIV knowledge, attitudes and practices.

- Although condom distribution appears to be well implemented, this is largely restricted to South Tarawa and the impact of social marketing of condoms is unclear. Low condom use is reported in the 2009 DHS and research with youth.

- Strong consensus emerged across stakeholders that public knowledge of HIV transmission, public sensitization of issues around HIV and AIDS, and public trust in the confidentiality of testing, counselling and care all require further strengthening. Fear of public disclosure was identified as a contributing factor to HIV positive cases refusing ART treatment and participating in PLHIV support networks. This fear has a highly negative impact on Kiribati effectively responding to the impact of HIV and AIDS.

- The lack of coordinated HIV & STI data management (data collection, analysis and reporting) between different national response partners has hindered effective analysis of the national picture, and national achievement and impact over 2010-2011.

VI. Recommendations

A number of recommendations are made to improve Kiribati's national HIV and AIDS response 2012-2013. Some of these will be addressed in the new National HIV & STI Strategic Plan 2012-2015.

Recommendations fall into a number of areas:

Policy and Programming

- Complete and endorse the new National HIV & STI Strategic Plan 2012-2015, including a comprehensive monitoring and evaluation framework.

- Re/establish programmes that will engage with MSM and commercial/transactional sex workers. Following the closure of KANGO there are no organisations specifically seeking to engage these groups.

- Strengthen the links between building young peoples' HIV knowledge and actual behaviour change by incorporating age appropriate life skills based HIV education in school curriculums and by increasing access to youth friendly testing and treatment services.

- Increase access to prevention, testing and treatment programmes and services in the outer islands, most particularly, Kiritimati Island.

Technical support & capacity building

- Support on-going high quality training in HIV, AIDS and STI prevention, care and treatment for those involved in implementing the national response.

- Provide on-going technical support to the MHMS HIV & STI Unit in data collection, analysis and reporting

Monitoring and evaluation

- Priority should be given to recruiting a strong MHMS HIV & STI Unit monitoring and evaluation officer who can lead a coordinated HIV & STI data approach by different national response partners (MHMS HIV & STI Unit; PPTCT programme; MHMS Health Information Unit; NGOs; Hospital Laboratory)

- Improve data disaggregation by collecting consistent information on MSM and sex work on VCCT forms.

- Conduct population based behavioural surveys of sex workers and MSM in order to inform programme interventions.

Advocacy

- Step up advocacy and training on HIV and Human Rights to address fear and stigma surrounding HIV and AIDS.

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

Kiribati's national response to HIV and AIDS has received considerable support from development partners. Most response activities were resourced by the Global Fund and Response Fund, including Continuity of Care. These grants are due to end in 2013 and 2012 respectively. In-country stakeholders expressed concern about the sustainability of the national response following cessation of Global Fund and Response Fund support.

Kiribati requires on-going financial and technical assistance to ensure that progress made over 2010-2011 is continued and that the National HIV & STI Strategic Plan 2012-2015 is fully implemented.

VIII. Monitoring and evaluation environment

Kiribati faces data management resource and capacity challenges in monitoring and evaluating its HIV and AIDS response. Currently, HIV, AIDS and STI data is collected, managed, stored and reported on by multiple parties involved in the response (MHMS Health Information Unit, MHMS HIV & STI Unit, MHMS Safe Motherhood Programme and NGOs). Each party carries out its data activities for varying purposes and there is a lack of consistency in disaggregation and reporting.

Kiribati does not currently have a nationally coordinated multi-year HIV and AIDS monitoring and evaluation framework. A monitoring and evaluation framework is planned for inclusion in the draft National Strategic Plan for HIV, AIDS and STIs 2012-2015. Technical assistance is required to draft this framework. Additional capacity building support is also required to train relevant parties to implement and manage the framework. It is recommended that a "users' manual" be developed to assist staff and to improve handover.

ANNEXES

ANNEX 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the 2011 Declaration of Commitment on HIV/AIDS

This report was compiled under the guidance of the Kiribati Country Coordination Mechanism for HIV, STIs and TB (CCM) and reporting was led by the Government of Kiribati Ministry of Health and Medical Services (MHMS) HIV & STI Unit. Data was collected and validated in a consultative and participative process involving government, non-government and civil society stakeholders. Litmus Ltd. provided technical support to the MHMS HIV & STI Unit throughout the reporting process, including data collection, analysis and validation, and drafting the narrative Country Progress Report.

A workshop was held to discuss and complete the National Commitments and Policy Instrument with CCM members and other key stakeholders. The following stakeholders attended the data validation workshop:

Name	Role	Organisation
Emaima Iotebwa	HIV Field Officer	MHMS
Mareta Tito	HIV Nurse	MHMS
Baurina Kaburoro	HIV Coordinator	MHMS
Teriao Koria	Coordinator Community Policing	Kiribati Police
Meaua Tooki	Secretary General	Red Cross
Ueraoi Taniera	HIV/AIDS Programme Officer	UNICEF
Moia Tetoa	President AMAK/Chair CCM	Aia Maea Ainen Kiribati (Kiribati Women's Federation)
Ioana Taakau	Director	Tungaru Central Hospital Pharmacy
Tiero Tetabea	Acting Director	MHMS Laboratory Services
Taboneao Bataroma	Deputy Director	Kiribati Health & Family Association
Harry Langley	Youth and Sport Officer	Kiribati Trade Union Congress
Dr Kenneth Reuee	National TB Clinician/NTP Manager	MHMS

Maoto Uriam	Coordinator	Adolescent Health & Development
Bureti Williams	Accountant, Global Fund and Response Fund	MHMS
Mweritonga Rubeiariki	Health Promotion Officer	Health Promotion Unit, MHMS
Teanibuaka Tabunga	Senior Health Information Officer	Health Information Unit, MHMS

This workshop also confirmed the indicators that Kiribati would report on. A literature search was undertaken to review recent relevant research, and key informant interviews were undertaken with key stakeholders involved in the national response.

The following stakeholders were interviewed in the preparation of this report:

Meeting with	Role	Organisation
HIV Unit Baurina Kaburoro Emaima Iotebwa Taniobeia Terubea Mareta Tito	 HIV Coordinator HIV Field Officer HIV Nurse HIV Nurse	MHMS
Teriao Koria	Coordinator Community Policing	Kiribati Police
Meaua Tooki	Secretary General	Red Cross
Tiero Tetabea	Acting Director	MHMS Laboratory Services
Luisa Cati	Senior Nursing Officer, Acting Safe Motherhood Programme Coordinator	Main referral hospital
Abitari Tekeke	Youth Officer	Kiribati Health & Family Association
Taboneao Bataroma	Deputy Director	Kiribati Health & Family Association
Baibuki Teikake	Laboratory Technician	Kiribati Health & Family Association
Buraua	PLHIV Advocate	MHMS
Takamwe Ioata	Assistant Project Officer	Adolescent Health & Development
Bureti Williams	Accountant, Global Fund and Response Fund	MHMS
Mweritonga Rubeiariki	Health Promotion Officer	Health Promotion Unit, MHMS
Teanibuaka Tabunga	Senior Health Information Officer	Health Information Unit, MHMS

One person (of two public PLHIV) living with HIV was consulted in the compilation of this report.

ANNEX 2: National Commitments and Policy Instrument (NCPI) 2012

COUNTRY: KIRIBATI

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:

Mrs Emaima Iotebwa, HIV Field Officer, Ministry of Health and Medical Services, Kiribati

Postal address:

Ministry of Health and Medical Services, HIV Unit, P.O Box 268 Bikenibeu, Tarawa, Republic of Kiribati

Tel: _+686 28414

E-mail: ema.iotebwa@gmail.com

Date of submission: 31 March 2012

NATIONAL COMMITMENTS AND POLICY INSTRUMENT (NCPI)

DATA GATHERING AND VALIDATION PROCESS

Describe the process used for NCPI data gathering and validation:
The NCPI was completed in a data gathering and validation workshop held in Tarawa, Kiribati 17 February 2012. Government and Civil Society participants considered Parts A and Part B respectively. The process was facilitated by an external consultant.
Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:
Answers to each question were discussed in each group (Government and Civil Society) and consensus was reached. There were no unresolved disagreements.
Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):
The NCPI is the first undertaken in Kiribati. Stakeholders were unable to answer some questions. Answers are highlighted in yellow.

NCPI Respondents

[Indicate information for** all **whose responses were compiled to fill out (parts of) the NCPI in the below table; add as many rows as needed]

NCPI - PART A [to be administered to government officials]

Organization	Names/Positions	Respondents to Part A [indicate which parts each respondent was queried on]					
		A.I	A.II	A.III	A.IV	A.V	A.VI
MHMS	Emaima Iotebwa HIV Field Officer	√	√	√	√	√	√
MHMS	Mareta Tito, HIV Nurse	√	√	√	√	√	√
MHMS	Baurina Kaburoro, HIV & STI Coordinator	√	√	√	√	√	√
Kiribati Police	Teriao Koria	√	√	√	√	√	√
Tungaru Central Hospital Pharmacy	Ioana Taakau	√	√	√	√	√	√
MHMS Laboratory Services	Tiero Tetabea	√	√	√	√	√	√
MHMS	Dr Kenneth Reuee National TB Clinician/NTP Manager	√	√	√	√	√	√
Adolescent Health Division, MHMS	Maoto Uriam Coordinator	√	√	√	√	√	√
MHMS	Bureti Williams, Accountant, Global Fund and Response Fund						
Health Promotion Unit, MHMS	Mweritonga Rubeiariki, Health Promotion Officer	√	√	√	√	√	√
Health Information Unit, MHMS	Teanibuaka Tabunga, Senior Health Information Officer	√	√	√	√	√	√

Add details for all respondents.

NCPI - PART B [to be administered to civil society organizations, bilateral agencies, and UN

organizations]

Organization	Names/Positions	Respondents to Part B [indicate which parts each respondent was queried on]				
		B.I	B.II	B.III	B.IV	B.V
Red Cross	Meaua Tooki, Secretary General	√	√	√	√	√
UNICEF	Ueraoi Taniera, HIV/AIDS Programme Officer	√	√	√	√	√
Aia Maea Ainen Kiribati (Kiribati Women's Federation)	Moia Tetoa, President AMAK/Chair CCM	√	√	√	√	√
Kiribati Health & Family Association	Taboneao Bataroma, Deputy Director	√	√	√	√	√
Kiribati Trade Union Congress	Harry Langley, Youth and Sport Officer	√	√	√	√	√

Add details for all respondents.

NATIONAL COMMITMENTS AND POLICY INSTRUMENT (NCPI)

PART A

[to be administered to government officials]

I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?

(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as Agriculture, Finance, Human Resources, Justice, Minerals and Energy, Planning, Public Works, Tourism, Trade and Industry)

Yes	No

IF YES, what was the period covered *[write in]*:

IF YES, briefly describe key developments/modifications between the current national strategy and the prior one. ***IF NO or NOT APPLICABLE***, briefly explain why.
There is a draft National HIV & STI Strategic Plan 2012-2015.

IF YES, complete questions 1.1 through 1.10; ***IF NO***, go to question 2.

1.1. Which government ministries or agencies have overall responsibility for the development and implementation of the national multi-sectoral strategy to respond to HIV?

Name of government ministries or agencies *[write in]*:

MHMS	Police	MOE
MISA	Marine Training Centre	

1.2. Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

SECTORS	Included in Strategy		Earmarked Budget	
Education	Yes	No	Yes	No
Health	Yes	No	Yes	No
Labour	Yes	No	Yes	No
Military/Police	Yes	No	Yes	No
Transportation	Yes	No	Yes	No
Women	Yes	No	Yes	No
Young People	Yes	No	Yes	No
Other [write in]:	Yes	No	Yes	No
Marine Training Centre (MTC)	Yes	No	Yes	No

	Yes	No	Yes	No

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?
International donor funding

1.3. ***Does the multisectoral strategy address the following key populations/other vulnerable populations, settings and cross-cutting issues?*** **The Draft National HIV & STI Strategic Plan 2012-2015**

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations[73] **Seafarers**	Yes	No
SETTINGS		
Prisons	Yes	No
Schools	Yes	No
Workplace	Yes	No
CROSS-CUTTING ISSUES		
Addressing stigma and discrimination	Yes	No
Gender empowerment and/or gender equality	Yes	No
HIV and poverty	Yes	No
Human rights protection	Yes	No
Involvement of people living with HIV	Yes	No

IF NO, **explain how key populations were identified?**

[73] Other specific vulnerable populations other than those listed above, that have been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people, internally displaced people, prisoners and refugees)

***1.5. What are the identified key populations and vulnerable groups for HIV programmes in the country** [write in]?*

KEY POPULATIONS
• Antenatal attendees • Infants in utero • Sex workers • Seafarers • Youth • MSM • Health workers • TB patients

1.6. Does the multisectoral strategy include an operational plan? **The Draft National HIV & STI Strategic Plan 2012-2015**

Yes	No

1.7. Does the multisectoral strategy or operational plan include:

A monitoring and evaluation framework? goals?	Yes	No
An indication of funding sources to support programme implementation?	Yes	No
Clear targets or milestones?	Yes	No
Detailed costs for each programmatic area?	Yes	No
Formal programme	Yes	No

1.8. Has the country ensured "full involvement and participation" of civil society [*] ***in the development of the multisectoral strategy?***

Active involvement	Moderate involvement	No involvement

IF ACTIVE INVOLVEMENT, briefly explain how this was organised:

[*] Civil society includes among others: networks and organisations of people living with HIV,women, young people, key affected groups (including men who have sex with men, transgendered people, sex workers, people who inject drugs, migrants, refugees/displaced populations, prisoners); faith-based organizations; AIDS service organizations; community-based organizations; ; workers organizations, human rights organizations; etc. Note: The private sector is considered separately.

Through the Kiribati Country Coordination Mechanism for HIV, STIs and TB (CCM) which includes representatives from CSOs.

IF NO or MODERATE INVOLVEMENT, briefly explain why this was the case:

1.9. ***Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?***

Yes	No	N/A

1.10. ***Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?***

Yes, all partners	Yes, some partners	No	N/A

IF SOME PARTNERS or NO, briefly explain for which areas there is no alignment/harmonization and why:
The Draft National HIV & STI Strategic Plan 2012-2015 is not yet endorsed or rolled out.

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?

Yes	No	N/A

2.1. ***IF YES, is support for HIV integrated in the following specific development plans?***

SPECIFIC DEVELOPMENT PLANS			
Common Country Assessment/UN Development Assistance Framework	Yes	No	N/A

National Development Plan	Yes	No	N/A
Poverty Reduction Strategy	Yes	No	N/A
Sector-wide approach	Yes	No	N/A
Other [write in]:	Yes	No	N/A
	Yes	No	N/A

2.2. *IF YES, are the following specific HIV-related areas included in one or more of the development plans?*

HIV-RELATED AREA INCLUDED IN PLAN(S)		
HIV impact alleviation	Yes	No
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	Yes	No
Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support	Yes	No
Reduction of stigma and discrimination	Yes	No
Treatment, care, and support (including social security or other schemes)	Yes	No
Women's economic empowerment (e.g. access to credit, access to land, training)	Yes	No
Other[write in below]:	Yes	No

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

Yes	No	N/A

3.1. *IF YES, on a scale of 0 to 5 (where 0 is "Low" and 5 is "High"), to what extent has the evaluation informed resource allocation decisions?*

LOW					HIGH
0	1	2	3	4	5

4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?

Yes	No

5. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2011?

Yes	No

5.1. *Have the national strategy and national HIV budget been revised accordingly?*

Yes	No

5.2. *Have the estimates of the size of the main key populations been updated?*

Yes	No

5.3. ***Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?***

Estimates of Current and Future Needs	Estimates of Current Needs Only	No

5.4. ***Is HIV programme coverage being monitored?***

Yes	No

(a) ***IF YES*, *is coverage monitored by sex (male, female)?***

Yes	No

(b) ***IF YES*, *is coverage monitored by population groups?***

Yes	No

IF YES, **for which population groups?**
Key populations as set out in section 1.5
Briefly explain how this information is used:
Budget Deciding next direction activities Forecasting need

(c) Is coverage monitored by geographical area?

Yes	No

IF YES, **at which geographical levels (provincial, district, other)?**
Briefly explain how this information is used:

5.5. ***Has the country developed a plan to strengthen health systems?***

Yes	No

Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications:
• Laboratory capacity building • Monitoring and evaluation • Information and Database • HIV counselling activities • Continuity of Care • Strengthening of MHMS HIV Unit (increased human resources)

6. ***Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy planning efforts in the HIV programmes in 2011?***

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, **what have been key achievements in this area:**
• Active engagement and participation of civil society and government agencies in strategy development • More collaborative and transparent processes
What challenges remain in this area:

- National HIV & STI Strategic Plan 2012-2015 behind schedule
- High staff turnover and poor handing over
- Lack of monitoring by MHMS

II. POLITICAL SUPPORT AND LEADERSHIP

Strong political support includes: government and political leaders who regularly speak out about HIV/AIDS and demonstrate leadership in different ways: allocation of national budgets to support HIV programmes; and, effective use of government and civil society organizations to support HIV programmes.

1. Do the following high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?

	Yes	No
A. Government ministers	Yes	No (highlighted)
B. Other high officials at sub-national level	Yes (highlighted)	No

1.1. In the last 12 months, have the head of government or other high officials taken action that demonstrated leadership in the response to HIV?

	Yes	No
(For example, promised more resources to rectify identified weaknesses in the HIV response, spoke of HIV as a human rights issue in a major domestic/international forum, and such activities as visiting an HIV clinic, etc.)	Yes (highlighted)	No

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:

President of Kiribati attended the 2011 World AIDS Day as guest speaker.

2. **Does the country have an officially recognized national multisectoral HIV coordination body (i.e., a National HIV Council or equivalent)?**

Yes	No

IF NO, **briefly explain why not and how HIV programmes are being managed:**

2.1. ***IF YES, does the national multisectoral HIV coordination body:***

IF YES, **does the national multisectoral HIV coordination body:**		
Have terms of reference?	Yes	No
Have active government leadership and participation?	Yes	No
Have an official chair person?	Yes	No
IF YES, *what is his/her name and position title?* Mrs Moia Tetoa, President of Aia Maea Ainen Kiribati (Kiribati Women's Federation)		
Have a defined membership?	Yes	No
IF YES, *how many members?* 25		
Include civil society representatives?	Yes	No
IF YES, *how many?* 7		
Include people living with HIV?	Yes	No
IF YES, *how many?* 1		
Include the private sector?	Yes	No
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes	No

3. **Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?**

Yes	No	N/A

***IF YES*, briefly describe the main achievements:**
2010 Establishment of the CCM
What challenges remain in this area:
• CCM decisions approved but action not as effective. • CCM has authority to mobilise funds (Global Fund) as set out in its Terms of Reference but members are not familiar with this authority.

4. **What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?**

Don't know %

5. **What kind of support does the National HIV Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?**

Capacity-building	Yes	No
Coordination with other implementing partners	Yes	No
Information on priority needs	Yes	No
Procurement and distribution of medications or other supplies	Yes	No
Technical guidance	Yes	No
Other [write in below]:	Yes	No

Yes	No

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National HIV Control policies?

6.1. *IF YES, were policies and laws amended to be consistent with the National HIV Control policies?*

Yes	No

IF YES, name and describe how the policies / laws were amended
Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:
Legal situation vis-à-vis prostitution laws and i-Kiribati young women boarding foreign vessels is unclear.

7. ***Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the political support for the HIV programme in 2011?***

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:
Delegates noted that there is a difference in the political leadership coming from different Ministries. Also noted was that the true level of political support for the HIV programme would emerge post July 2013, following cessation of Global Fund and Response Fund support.
What challenges remain in this area:

III. HUMAN RIGHTS

1.1. ***Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups? Circle yes if the policy specifies any of the following key populations and vulnerable groups:***

KEY POPULATIONS and VULNERABLE GROUPS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations [write in]:	Yes	No

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?

Yes	No

IF YES to Question 1.1. or 1.2., **briefly describe the content of the/laws:**
The Kiribati Constitution protects the rights of individuals.

Briefly explain what mechanisms are in place to ensure these laws are implemented:

Legal and judicial system

Briefly comment on the degree to which they are currently implemented:
Not known

2. **Does the country have laws, regulations or policies that present obstacles[74] to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?**

Yes	No

IF YES, for which key populations and vulnerable groups?		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No

[74] These are not necessarily HIV-specific policies or laws. They include policies, laws or regulations which may deter people from or make it difficult for them to access prevention, treatment, care and support services. Examples cited in country reports in the past have include: "laws that criminalize same sex relationships", "laws that criminalize possession of condoms or drug paraphernalia"; "loitering laws"; "laws that preclude importation of generic medicines"; "policies that preclude distribution or possession of condoms in prisons"; "policies that preclude non-citizens from accessing ART"; "criminalization of HIV transmission and exposure", "inheritance laws/rights for women", "laws that prohibit provision of sexual and reproductive health information and services to young people", etc.

Young women/young men	Yes	No
Other specific vulnerable populations[75] [write in below]:	Yes	No

Briefly describe the content of these laws, regulations or policies:
Homosexuality is illegal. Sex work is illegal.
Briefly comment on how they pose barriers:
Homosexuality is illegal; there have been no cases of prosecution within memory, however, illegality acts as a barrier to effective HIV prevention, treatment, care and support for MSM. Illegality of sex work contributes to the vulnerability of this group and increases the obstacles to effective programme interventions.

IV. PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?

Yes	No

The Draft National HIV and STI Strategic Plan 2012-2015 includes IEC

***IF YES*, what key messages are explicitly promoted?**		
Abstain from injecting drugs	Yes	No
Avoid commercial sex	Yes	No
Avoid inter-generational sex	Yes	No
Be faithful	Yes	No
Be sexually abstinent	Yes	No
Delay sexual debut	Yes	No

[75] Other specific vulnerable populations other than above, may be defined as having been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people , internally displaced people, prisoners, and refugees)

Engage in safe(r) sex	Yes	No
Fight against violence against women	Yes	No
Greater acceptance and involvement of people living with HIV	Yes	No
Greater involvement of men in reproductive health programmes	Yes	No
Know your HIV status	Yes	No
Males to get circumcised under medical supervision	Yes	No
Prevent mother-to-child transmission of HIV	Yes	No
Promote greater equality between men and women	Yes	No
Reduce the number of sexual partners	Yes	No
Use clean needles and syringes	Yes	No
Use condoms consistently	Yes	No
Other [write in below]:	Yes	No

1.2. ***In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?***

Yes	No

2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?

Yes	No

The current HIV programme implemented by the MHMS HIV Unit and key NGO stakeholders is not guided by an overall national HIV policy/strategy. There are a number of separate policies for different aspects of the HIV response, such as the HIV Testing policy. See narrative report for further detail.

Current HIV programme promotes life-skills based education for young people.

2.1. ***Is HIV education part of the curriculum in:***

Primary schools?	Yes	No
Secondary schools?	Yes	No
Teacher training?	Yes	No

2.2. ***Does the strategy include age-appropriate, gender-sensitive sexual and reproductive health elements?***

Yes	No

2.3. ***Does the country have an HIV education strategy for out-of-school young people?***

Yes	No

3. Does the country have a policy

Yes	No

or strategy to promote information, education and communication and other preventive health interventions for key or other vulnerable sub-populations?

Briefly explain what mechanisms are in place to ensure these laws are implemented:

3.1. ***IF YES, which populations and what elements of HIV prevention does the policy/strategy address?***

The current HIV programme implemented by the MHMS HIV Unit and key NGO stakeholders is not guided by an overall national HIV policy/strategy.

✓ Check which specific populations and elements are included in the current HIV programme

	IDU[76]	MSM[77]	Sex workers	Customers of Sex Workers	Prison inmates	Other populations[78] *[write in]*
Condom promotion		√	√	√		***Young people***
Drug substitution therapy						
HIV testing and counselling						
Needle & syringe exchange						
Reproductive health, including sexually						***Pregnant women***

76 IDU = People who inject drugs

77 MSM=men who have sex with men

78 Other vulnerable population other than those listed above, that have been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order)
bisexual people, clients of sex workers, indigenous people , internally displaced people, prisoners, and refugees)

transmitted infections prevention and treatment						
Stigma and discrimination reduction						
Targeted information on risk reduction and HIV education						
Vulnerability reduction (e.g. income generation)						

3.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate policy efforts in support of HIV prevention in 2011?

Very Poor										**Excellent**
0	1	2	3	4	5	6	7	8	9	10

***Since 2009,* what have been key achievements in this area:**
Delegates noted that there is a big difference between policy efforts and implementation efforts. It was felt that Ministry of Health and Medical Services management support is lacking for the HIV Unit. It was further felt that within health strategic planning, HIV takes second place to family planning in terms of priorities.
What challenges remain in this area:

4. Has the country identified specific needs for HIV prevention programmes?

Yes	No

***IF YES,* how were these specific needs determined?**

The Draft National HIV and STI Strategic Plan 2012-2015 is based on situational analyses conducted by all stakeholders involved in the HIV response to date.

IF NO, **how are HIV prevention programmes being scaled-up?**

4.1. To what extent has HIV prevention been implemented?

The majority of people in need have access to…						
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A
Blood safety	1	2	3	4	5	N/A
Condom promotion	1	2	3	4	5	N/A
Harm reduction for people who inject drugs	1	2	3	4	5	N/A
HIV prevention for out-of-school young people	1	2	3	4	5	N/A
HIV prevention in the workplace	1	2	3	4	5	N/A
HIV testing and counselling	1	2	3	4	5	N/A
IEC[79] on risk reduction	1	2	3	4	5	N/A
IEC on stigma and discrimination reduction	1	2	3	4	5	N/A
Prevention of mother-to-child transmission of HIV	1	2	3	4	5	N/A
Prevention for people living with HIV	1	2	3	4	5	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2	3	4	5	N/A
Risk reduction for intimate partners of any of	1	2	3	4	5	N/A

79 IEC = information, education, communication

the above three key populations						
Risk reduction for men who have sex with men	1	2	3	4	5	N/A
Risk reduction for sex workers	1	2	3	4	5	N/A
School-based HIV education for young people	1	2	3	4	5	N/A
Universal precautions in health care settings	1	2	3	4	5	N/A
Other[write in]:	1	2	3	4	5	N/A

5. ***Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in implementation of HIV prevention programmes in 2011?***

Very Poor										**Excellent**
0	1	2	3	4	5	6	7	8	9	10

Since 2009, **what have been key achievements in this area:**
What challenges remain in this area:
• Laboratory Human Resource is stretched • On-going problems of poor coordination, availability of funds on time, and lack of clarity around fund allocation were also reported.

V. TREATMENT, CARE AND SUPPORT

1. **Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?**

Yes	No

If YES, **Briefly identify the elements and what has been prioritized:**

ART treatment 2 HIV nurses providing treatment and support

Briefly identify how HIV treatment, care and support services are being scaled-up?

1.1. To what extent have the following HIV treatment, care and support services been implemented?

The majority of people in need have access to…						
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A
Antiretroviral therapy	1	2	3	4	5	N/A
ART for TB patients	1	2	3	4	5	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	3	4	5	N/A
Early infant diagnosis	1	2	3	4	5	N/A
HIV care and support in the workplace (including alternative working arrangements)	1	2	3	4	5	N/A
HIV testing and counselling for people with TB	1	2	3	4	5	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	1	2	3	4	5	N/A
Nutritional care	1	2	3	4	5	N/A
Paediatric AIDS treatment	1	2	3	4	5	N/A
Post-delivery ART provision to women	1	2	3	4	5	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)	1	2	3	4	5	N/A
Post-exposure prophylaxis for occupational exposures to HIV	1	2	3	4	5	N/A

Psychosocial support for people living with HIV and their families	1	2	3	4	5	N/A
Sexually transmitted infection management	1	2	3	4	5	N/A
TB infection control in HIV treatment and care facilities	1	2	3	4	5	N/A
TB preventive therapy for people living with HIV	1	2	3	4	5	N/A
TB screening for people living with HIV	1	2	3	4	5	N/A
Treatment of common HIV-related infections	1	2	3	4	5	N/A
Other[write in]:	1	2	3	4	5	N/A

2. **Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?**

Yes	No

Please clarify which social and economic support[80] is provided:

3. **Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV?**

Yes	No

4. **Does the country have access to regional procurement and**

Yes	No

80 These can include, for example, non-contributory state pensions/old age grants, Free primary health care and ART for the poor, Free and/or subsidized educational support (primary and secondary school) for the poor, Disability grants, Child grants, Micro-finance/credit, Start-up kits for income generation, and the care and support needs of carers.

supply management mechanisms for critical commodities, such as antiretroviral therapy medications, condoms, and substitution medications?

IF YES, **for which commodities?**
• ARV drugs • Condoms • STI drugs • Family planning commodities

5. ***Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2011?***

Very Poor										**Excellent**
0	1	2	3	4	5	6	7	8	9	10

Since 2009, **what have been key achievements in this area:**
What challenges remain in this area:
Monitoring of treatment needs to be reinforced. There are many factors involved which increases the challenge.

5. **Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?**

Yes	No	N/A

IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes	No

IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No

IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes	No

IF YES, what percentage of orphans and vulnerable children is being reached?

%

6. ***Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?***

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, **what have been key achievements in this area:**
What challenges remain in this area:

VI. MONITORING AND EVALUATION

1. Does the country have one national Monitoring and Evaluation (M&E) plan for HIV?

Yes	No	N/A

Briefly describe any challenges in development or implementation:

1.1. IF YES, years covered [write in]:

1.2 IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners	Yes, some partners	No	N/A

Briefly describe what the issues are:

2. ***Does the national Monitoring and Evaluation plan include?***

IF YES, **what key messages are explicitly promoted?**		
A data collection strategy	Yes	No
IF YES, does it address:		
Behavioural surveys	Yes	No
Evaluation / research studies	Yes	No
HIV Drug resistance surveillance	Yes	No
HIV surveillance	Yes	No
Routine programme monitoring	Yes	No
A data analysis strategy	Yes	No
A data dissemination and use strategy	Yes	No
A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate)	Yes	No
Guidelines on tools for data collection	Yes	No

3. Is there a budget for implementation of the M&E plan?

Yes	In Progress	No

3.1. ***IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?***

%

4. Is there a functional national M&E Unit?

Yes	In Progress	No

Briefly describe any obstacles:

There is currently no national unit responsible for coordinated monitoring and evaluation of HIV activities against agreed performance targets. Different parties (MHMS, other government agencies and NGOs) conduct HIV related M&E.

4.1. ***Where is the national M&E Unit based?***

In the Ministry of Health?	Yes	No
In the National HIV Commission (or equivalent)?	Yes	No
Elsewhere [write in]?	Yes	No

4.2. ***How many and what type of professional staff are working in the national M&E Unit?***

POSITION [write in position titles in spaces below]	**Fulltime**	**Part time**	**Since when?**
Permanent Staff *[Add as many as needed]*			
	Fulltime	**Part time**	**Since when?**
Temporary Staff *[Add as many as needed]*			

4.3. ***Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?***

Yes	No

Briefly describe the data-sharing mechanisms:
What are the major challenges in this area:

6. **Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?**

Yes	No

7. **Is there a central national database with HIV- related data?**

Yes	No

***IF YES,* briefly describe the national database and who manages it.**

7.2. ***IF YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?***

Yes, all of the above	Yes, but only some of the above	No, none of the above

IF YES, but only some of the above, **which aspects does it include?**

7.3. Is there a functional Health Information System[81]?

At national level	Yes	No
At subnational level	Yes	No
IF YES, at what level(s)? [write in] Public Health Nurses send health data on a monthly basis to the Health Information Unit, MHMS. This data is collected on the Monthly Consolidated Statistical Report form (MS-1). Not all information (none on HIV and STI data not disaggregated) is collected however.		

8. Does the country publish an M&E report on HIV , including HIV surveillance data at least once a year?

Yes	No

9. How are M&E data used?

For programme improvement?	Yes	No
In developing / revising the national HIV response?	Yes	No
For resource allocation?	Yes	No
Other [write in]: For reporting to donors	Yes	No

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:

[81] *Such as regularly reporting data from health facilities which are aggregated at district level and sent to national level; data are analysed and used at different levels)?*

As above, M&E data is principally collected and reported following donor requirements. Overall, there is low M&E capacity in Kiribati.

10. In the last year, was training in M&E conducted

At national level?	Yes	No
IF YES, what was the number trained:		
At subnational level?	Yes	No
IF YES, what was the number trained		
At service delivery level including civil society?	Yes	No
IF YES, how many?		

10.1. Were other M&E capacity-building activities conducted ` other than training?

Yes	No

IF YES, **describe what types of activities**

11. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluation (M&E) in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, **what have been key achievements in this area:**

Current MHMS HIV Unit staff have M&E activities against their different workplans (Global Fund and Response Fund have different workplans).
What challenges remain in this area:

NATIONAL COMMITMENTS AND POLICY INSTRUMENT (NCPI)

PART B

[to be administered to representatives from civil society organizations, bilateral agencies, and UN organizations]

I. CIVIL SOCIETY* INVOLVEMENT

1. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:
Overall, civil society is felt to contribute to political commitment. Examples include the existence of a Parliamentarian HIV Budget and the President's attendance at official the 2011 World AIDS Day event organized by civil society. Civil Society is strongly represented on the Country Coordination Mechanism which is leading the development of the National Strategic Plan for HIV/AIDS and STI 2012-2015.

* Civil society includes among others: networks and organisations of people living with HIV, women, young people, key affected groups (including men who have sex with men, transgendered people, sex workers, people who inject drugs, migrants, refugees/displaced populations, prisoners); faith-based organizations; AIDS service organizations; community-based organizations; ; workers organizations, human rights organizations; etc. Note: The private sector is considered separately.

2. **To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?**

LOW					HIGH
0	1	2	3	4	5

Comments and examples:
Civil Society representatives felt that they were involved in the development of the National Strategic Plan for HIV/AIDS and STI 2012-2015 and in particular were trying to seek funding to support gaps in the development process. Civil Society was consulted in the situational analysis conducted in preparing the National Strategic Plan 2012-2015.

3. **To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:**

a. The national HIV strategy?

LOW					HIGH
0	1	2	3	4	5

b. The national HIV budget?

LOW					HIGH
0	1	2	3	4	5

c. The national HIV reports?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:

It is important to note that different Civil Society Organisations (CSOs) have different levels of involvement.

Civil Society delivered a significant level of services within the national HIV strategy, with NGOs (Kiribati Family Health Association and Red Cross) delivering most education, awareness and condom promotion activities. Some CSOs reported resource constraints however, for example Aia Maea Ainen Kiribati (Kiribati Women's Federation) Strategic Plan aimed to support caregivers for PLHIV but were unable to implement due to lack of resource.

CSOs apply to the Country Coordination Mechanism for funding of proposed activities.

There have been no nationally coordinated HIV reports to date. HIV reporting has been directed to donor reporting requirements.

4. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. Developing the national M&E plan?

LOW					HIGH
0	1	2	3	4	5

b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?

LOW					HIGH
0	1	2	3	4	5

c. Participate in using data for decision-making?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:

There is no national HIV M&E plan.

Civil society is well represented on Country Coordination Mechanism (CCM) which is leading the development of the new National Strategic Plan for HIV/AIDS and STIs 2012-2015 which should include a Monitoring and Evaluation Framework.

There is no formally established and active national M&E committee.

The CCM is developing its capacity to use data for decision making.

5. **To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. organisations and networks of people living with HIV, of sex workers, and faith-based organizations)?**

LOW					HIGH
0	1	2	3	4	5

Comments and examples:
There is mainstream (Roman Catholic and Protestant) church representation on the CCM. Commercial or transactional sex workers and MSM are not represented on the CCM.

6. **To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society able to access:**

a. Adequate financial support to implement its HIV activities?

LOW					HIGH
0	1	2	3	4	5

b. Adequate technical support to implement its HIV activities?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:
Delegates felt that Churches probably lack access to funding to support HIV activities.

7. **What percentage of the following HIV programmes/services is estimated to be provided by civil society?**

Prevention for key-populations				
People living with HIV	<25%	25-50%	51–75%	>75%
Men who have sex with men	<25%	25-50%	51–75%	>75%

People who inject drugs	<25%	25-50%	51–75%	>75%
Sex workers	<25%	25-50%	51–75%	>75%
Transgendered people	<25%	25-50%	51–75%	>75%
Testing and Counselling	<25%	25-50%	51–75%	>75%
Reduction of Stigma and Discrimination	<25%	25-50%	51–75%	>75%
Clinical services (ART/OI)*	<25%	25-50%	51–75%	>75%
Home-based care	<25%	25-50%	51–75%	>75%
Programmes for OVC**	<25%	25-50%	51–75%	>75%

**ART = Antiretroviral Therapy; OI=Opportunistic infections*
***OVC = Orphans and other vulnerable children*

8. ***Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to increase civil society participation in 2011?***

Very Poor										**Excellent**
0	1	2	3	4	5	6	7	8	9	10

***Since 2009,* what have been key achievements in this area:**
What challenges remain in this area:
The Government of Kiribati does not provide direct funding to CSO participation, this is only supported by donor funding. Without this Government budget support, it is felt there is no priority given to CSO participation.

II. POLITICAL SUPPORT AND LEADERSHIP

1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design

Yes	No

and programme implementation?

***IF YES*, describe some examples of when and how this has happened:**
Examples include: Two new Divisions were created in the Ministry of Internal and Social Affairs in 2010. (Women's Development Division and Youth Division).This has increased the focus on these groups that are have a higher risk of HIV exposure.

III. HUMAN RIGHTS

1a. ***Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations? Circle yes if the policy specifies any of the following key populations:***

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations[82] [write in]:	Yes	No

1b. ***Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?***

Yes	No

***IF YES to Question 1a or 1b*, briefly describe the contents of these laws:**

[82] Other vulnerable population other than those listed above, that have been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people , internally displaced people, prisoners, and refugees)

Kiribati has signed the Convention for the Elimination of Discrimination against Women in 2004 but has not submitted any reports on progress towards meeting its treaty obligations. The constitution of Kiribati protects fundamental rights and freedoms of individuals but does not include provision against discrimination on the grounds of gender, HIV status or sexual orientation.
Briefly explain what mechanisms are in place to ensure that these laws are implemented:
Legal and judicial system.
Briefly comment on the degree to which they are currently implemented:

Yes	No

2. Does the country have laws, regulations or policies that present obstacles[83] to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?

2.1. *IF YES, for which sub-populations?*

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People who inject drugs	Yes	No
People with disabilities	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable populations[84][write in]:	Yes	No

Briefly describe the content of these laws, regulations or policies:
Homosexuality is illegal in Kiribati. The SPC Regional Rights Resource Team conducted a 2009 review of the HIV and human rights legislative environment in Kiribati. The review identified a need to review aspects of criminal law (e.g. those pertaining to homosexuality and prostitution), prisoners law, anti-discrimination law and legislation protecting the rights of vulnerable groups such as sex workers, PLHIV and MSM. The current mandatory requirement for HIV testing for seafarers' employment and visa applicants is also noted.
Briefly comment on how they pose barriers:

83 These are not necessarily HIV-specific policies or laws. They include policies, laws, or regulations which may deter people from or make it difficult for them to access prevention, treatment, care and support services. Examples cited in country reports in the past have include: "laws that criminalize same sex relationships", "laws that criminalize possession of condoms or drug paraphernalia"; "loitering laws"; "laws that preclude importation of generic medicines"; "policies that preclude distribution or possession of condoms in prisons"; "policies that preclude non-citizens from accessing ART"; "criminalization of HIV transmission and exposure", "inheritance laws/rights for women", "laws that prohibit provision of sexual and reproductive health information and services to young people", etc.

84 Sub-population other than those listed above, that have been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people , internally displaced people, lesbians, prisoners, and refugees) ditto above changes if you agree.

The illegality of same sex relationships contributes to an overall lack of cultural acceptance for MSM in particular. MSM activities and identity are largely hidden within i-Kiribati society.

3. **Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?**

Yes	No

Briefly describe the content of the policy, law or regulation and the populations included.
See comments on Kiribati ratification of CEDAW above. There is no legislation specific to violence against women. Under the Penal Code of Kiribati, such offenses are prosecuted under the same principles as other offenses.

4. **Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?**

Yes	No

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:
The new draft National Strategic Plan for HIV/AIDS and STIs includes the human rights of PLHIV.

5. **Is there a mechanism to record, document and address cases of discrimination experienced by**

Yes	No

people living with HIV, key populations and other vulnerable populations?

IF YES, briefly describe this mechanism:
The CCM delegates agreed that documenting and addressing cases of discrimination against PLHIV was within the CCM remit, but reported that there are currently no systems to implement this duty.

6. **Does the country have a policy or strategy of free services for the following? Indicate if these services are provided free-of-charge to all people, to some people or not at all (circle "yes" or "no" as applicable).**

	Provided free-of-charge to all people in the country		Provided free-of-charge to some people in the country		Provided, but only at a cost	
Antiretroviral treatment	Yes	No	Yes	No	Yes	No
HIV prevention services[85]	Yes	No	Yes	No	Yes	No
HIV-related care and support interventions	Yes	No	Yes	No	Yes	No

If applicable, which populations have been identified as priority, and for which services?

7. **Does the country have a policy**

Yes	No

[85] Such as blood safety, condom promotion, harm reduction for people who inject drugs, HIV prevention for out-of-school young people, HIV prevention in the workplace, HIV testing and counselling, IEC[85] on risk reduction, IEC on stigma and discrimination reduction, prevention of mother-to-child transmission of HIV, prevention for people living with HIV, reproductive health services including sexually transmitted infections prevention and treatment, risk reduction for intimate partners of any of the above three key populations, risk reduction for men who have sex with men, risk reduction for sex workers, school-based HIV education for young people, universal precautions in health care settings.

or strategy to ensure equal access for women and men to HIV prevention, treatment, care and support?

7.1. ***In particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?***

Yes	No

8. Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?

Yes	No

IF YES, **Briefly describe the content of this policy/strategy and the populations included:**
There is a *Policy on Strengthening HIV Counselling and Testing to Promote Universal Access to HIV Care and Treatment*. This states that access to HIV prevention services be equal for men and women. Other than the above Policy, there is no policy or strategy to ensure access to HIV services to women outside the context of pregnancy and childbirth. The draft *National Strategic Plan for HIV/AIDS and STIs 2012-2015* will address equal access for vulnerable groups.

8.1. ***IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?***

Yes	No

IF YES, **briefly explain the different types of approaches to ensure equal access for different populations:**
The draft *National Strategic Plan for HIV/AIDS and STIs 2012-2015* identifies Youth Friendly Clinics as an important venue to increase youth access to prevention, treatment, care and support.

9. Does the country have a policy or law prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

Yes	No

IF YES **briefly describe the content of the policy or law:**

There is an employer requirement for seafarers to be tested for HIV.

Applicants for overseas scholarships are also required to undergo HIV testing.

The Kiribati Police have an endorsed Workplace HIV Policy and the Marine Training Centre (South Pacific Marine Services) have a draft Workplace HIV Policy which address HIV Human Rights issues in the workplace.

10. Does the country have the following human rights monitoring and enforcement mechanisms?

a. ***Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work***

Yes	No

b. ***Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts***

Yes	No

IF YES **on any of the above questions, describe some examples:**
No independent national institutions actively promoting HIV and human rights were identified by delegates.

11. In the last 2 years, have there been the following training and/or capacity-building activities:

a. ***Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)[86]?***

Yes	No

b. ***Programmes for members of the judiciary and law enforcement[87] on HIV and human rights issues that may come up in the context of their work?***

Yes	No

86 Including, for example, Know-your-rights campaigns – campaigns that empower those affected by HIV to know their rights and the laws in context of the epidemic (see UNAIDS Guidance Note: Addressing HIV-related law at National Level, Working Paper, 30 April 2008)

87 Including, for example, judges, magistrates, prosecutors, police, human rights commissioners and employment tribunal/ labour court judges or commissioners

12. Are the following legal support services available in the country?

	Yes	No
a. Legal aid systems for HIV casework	Yes	No
b. Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV	Yes	No

13. Are there programmes in place to reduce HIV-related stigma and discrimination?

Yes	No

IF YES, what types of programmes?		
Programmes for health care workers	Yes	No
Programmes for the media	Yes	No
Programmes in the work place	Yes	No
Other [write in]:	Yes	No

- The 2010 Aia Maea Ainen Kiribati (Kiribati Women's Federation) conference guest speaker was the Human Rights Officer from the Attorney General's Office.
- 2010 UNICEF workshop on Information, Education and Communication materials addressing HIV-related stigma and discrimination.
- 2011 Pacific Islands AIDS Foundation workshop on HIV and Human Rights

12. ***Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2011?***

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, **what have been key achievements in this area:**
2010 Kiribati Police endorsed a Workplace HIV Policy 2011 There is a draft bill addressing HIV in the workplace.
What challenges remain in this area:
Draft bill currently waiting for presentation by the Ministry of Health and Medical Services to Parliament.

13. ***Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the effort to implement human rights related policies, laws and regulations in 2011?***

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, **what have been key achievements in this area:**
The 2011 HIV and Human Rights workshop was delivered to a small number of key stakeholders.
What challenges remain in this area:
HIV and Human Rights a new and challenging area for Kiribati communities. Increased public awareness needs to happen.

III. PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?

Yes	No

IF YES, **how were these specific needs determined?**
Situational analysis and monitoring and evaluation from CSOs and other organisations involved in the national response.
IF NO, **how are HIV prevention programmes being scaled-up?**

1.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access to…					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A
Blood safety	1	2	3	4	5	N/A
Condom promotion	1	2	3	4	5	N/A
Harm reduction for people who inject drugs	1	2	3	4	5	N/A
HIV prevention for out-of-school young people	1	2	3	4	5	N/A
HIV prevention in the workplace	1	2	3	4	5	N/A
HIV testing and counselling	1	2	3	4	5	N/A
IEC[88] on risk reduction	1	2	3	4	5	N/A
IEC on stigma and discrimination reduction	1	2	3	4	5	N/A
Prevention of mother-to-child transmission of HIV	1	2	3	4	5	N/A
Prevention for people living with HIV	1	2	3	4	5	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2	3	4	5	N/A
Risk reduction for intimate partners of any of the above three key populations	1	2	3	4	5	N/A
Risk reduction for men who have sex with men	1	2	3	4	5	N/A
Risk reduction for sex workers	1	2	3	4	5	N/A
School-based HIV education for young people	1	2	3	4	5	N/A
Universal precautions in health care settings	1	2	3	4	5	N/A
Other[write in]:	1	2	3	4	5	N/A

2. ***Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV prevention programmes in 2011??***

88 IEC = information, education, communication

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

***Since 2009,* what have been key achievements in this area:**
VCCT sites have been established and the number of trained counsellors has increased. The Kiribati Country Coordination Mechanism for HIV, STIs and TB established Data collection has been carried out on people using prevention services, including Prevention of Parent to Child Transmission Clinic attendees.
What challenges remain in this area:
Data collection and HIV reporting systems require strengthening Most prevention programmes are concentrated on South Tarawa and Betion. Religious beliefs leading to the rejection of prevention messages e.g. condom use Insufficient funding Faith based organisations represented on the CCM are not involved in workplans

IV. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV and AIDS treatment, care and support services?

Yes	No

***IF YES*, Briefly identify the elements and what has been prioritized:**

ART treatment
Briefly identify how HIV treatment, care and support services are being scaled-up?
Increased availability of ART treatment. Home visits (treatment delivery)

1.1. ***To what extent have the following HIV treatment, care and support services been implemented?***

HIV treatment, care and support service	**The majority of people in need have access to…**					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A
Antiretroviral therapy	1	2	3	4	5	N/A
ART for TB patients	1	2	3	4	5	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	3	4	5	N/A
Early infant diagnosis	1	2	3	4	5	N/A
HIV care and support in the workplace (including alternative working arrangements)	1	2	3	4	5	N/A
HIV testing and counselling for people with TB	1	2	3	4	5	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	1	2	3	4	5	N/A
Nutritional care	1	2	3	4	5	N/A
Paediatric AIDS treatment	1	2	3	4	5	N/A
Post-delivery ART provision to women	1	2	3	4	5	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)	1	2	3	4	5	N/A
Post-exposure prophylaxis for occupational exposures to HIV	1	2	3	4	5	N/A
Psychosocial support for people living with HIV and their families	1	2	3	4	5	N/A
Sexually transmitted infection management	1	2	3	4	5	N/A
TB infection control in HIV treatment and	1	2	3	4	5	N/A

care facilities						
TB preventive therapy for people living with HIV	1	2	3	4	5	N/A
TB screening for people living with HIV	1	2	3	4	5	N/A
Treatment of common HIV-related infections	1	2	3	4	5	N/A
Other[write in]:	1	2	3	4	5	N/A

1.2. ***Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011??***

Very Poor										**Excellent**
0	1	2	3	4	5	6	7	8	9	10

***Since 2009,* what have been key achievements in this area:**
Availability of free ART treatment
What challenges remain in this area:
Follow up care and treatment for eligible HIV positive cases (only 6 people on ART out of an estimated 28 eligible cases). Challenges include: identifying and locating the other HIV positive cases (current whereabouts unknown), and overcoming patients' fear of inadvertent public disclosure as a result of accessing treatment.

2. **Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?**

Yes	No

2.1. ***IF YES, is there an operational definition for orphans and vulnerable children in the country?***

Yes	No

2.2. ***IF YES, does the country have a national action plan specifically for orphans and vulnerable children?***

Yes	No

2.3 . ***IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?***

Yes	No

2.4. ***IF YES, what percentage of orphans and vulnerable children is being reached?***

%

3. ***Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011??***

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, **what have been key achievements in this area:**
See answers to 1.2 above
What challenges remain in this area: