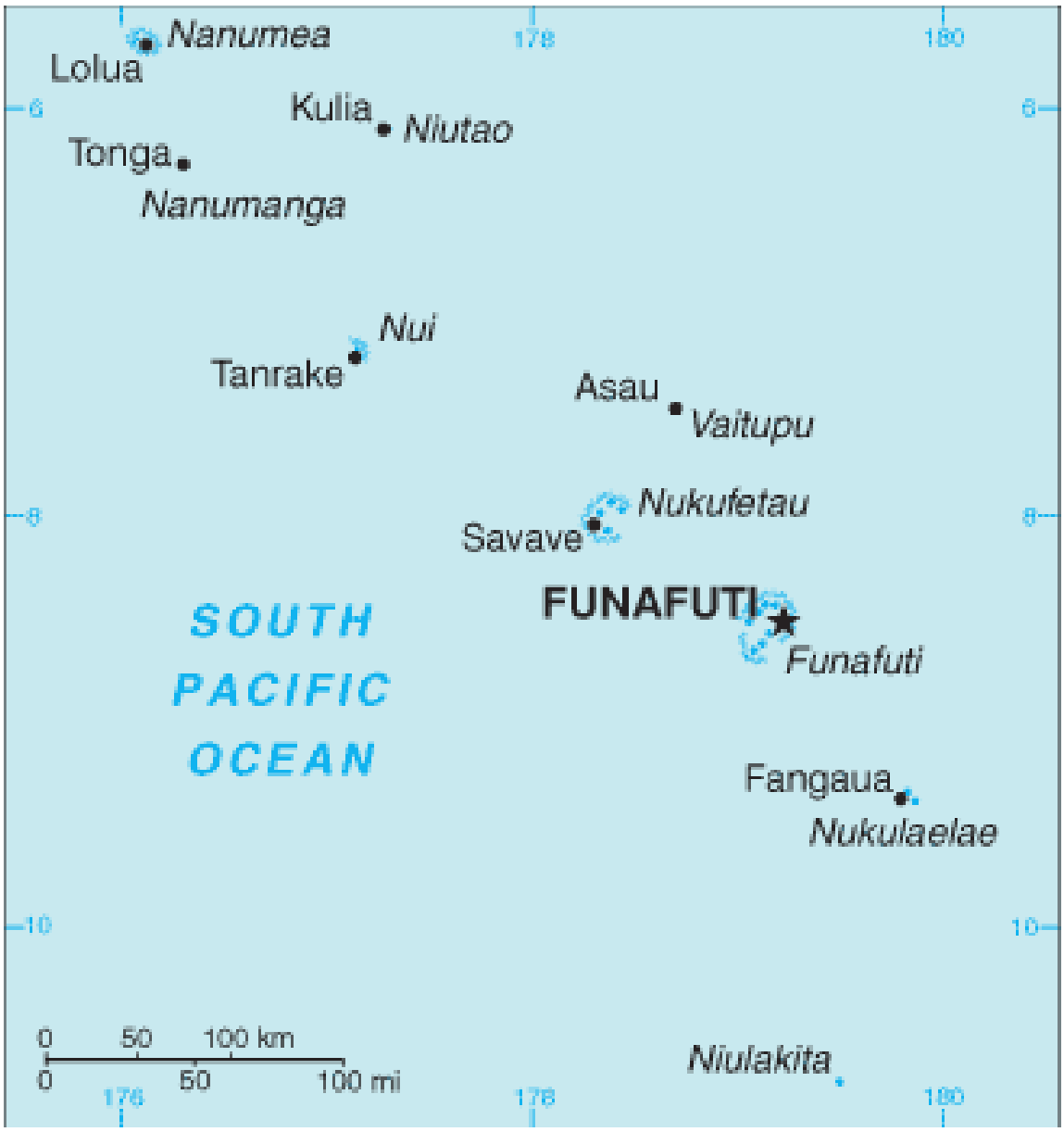
UNGASS COUNTRY PROGRESS REPORT

Tuvalu

Reporting period: January 2008–December 2009



Prepared by: **Tuvalu National Aids Committee**

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Acronyms and Abbreviations

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal clinic
ARV/ART	Antiretroviral Drugs/ Antiretroviral treatment
AusAID	Australia Agency for International Development
BSS	Behavioural surveillance survey
CRGA	Committee of Representatives of Governments and Administrations
DHS	Demographic Health Survey
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
EKT	Ekalesia Kelisiano Tuvalu
HIV	Human immunodeficiency virus
IDU	Injecting drug user
IPPF	International Planned Parenthood Federation
KAP	Knowledge, attitude and practices
M&E	Monitoring and evaluation
MDG	Millennium Development Goal
MSM	Men who have sex with men
NASA	National AIDS spending assessment
NCPI	National composite policy index
NCM	National coordinating mechanism
NGO	Non-governmental organisation
NSP	National Strategic Plan for HIV/ AIDS and STI
NZAID	New Zealand Agency for International Development
PIC	Pacific Island countries
PIF	Pacific Islands Forum
PLWH	People living with HIV
PMH	Princess Margaret Hospital (Funafuti)
PMTCT	Prevention of mother-to-child transmission
OSSHM	Oceania Society of Sexual Health Medicine
SGS	Second-generation surveillance
STI	Sexually transmitted infection
SPC	Secretariat of the Pacific Community
TANG0	Tuvalu Association of Non-governmental Organisations
TNCW	Tuvalu National Council of Women
TOSU	Tuvalu Overseas Seaman's Union
TuFHA	Tuvalu Family Health Association
TuNAC	Tuvalu National Aids Committee
TRCS	Tuvalu Red Cross Society
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children's Fund
VCCT	Voluntary confidential counselling and testing
WHO	World Health Organization

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Status at a Glance

Report preparation

This report was compiled by the Tuvalu National AIDS Committee (TuNAC), a body which comprises representatives of government agencies and non-governmental organisations (NGOs) that are actively involved in reducing the vulnerability of people in Tuvalu to HIV and AIDS, as well as other health and community risks. All members of TuNAC were actively involved in preparing and reviewing the report.

The data and commentary presented in this report was drawn from a diverse range of sources including (but not limited to): Ministry of Health and other contributing agencies' administrative, financial and reporting data; Tuvalu's Demographic Health Survey (DHS) 2007, Tuvalu Family Health Association's (TuFHA) second Knowledge Attitude and Practice (KAP) survey in 2007; key informant interviews and published evaluation reports.

The following organisations were consulted and contributed to the preparation and validation of the report:

- Clark to Parliament
- Economic, Planning and Budget (MDG Officer)
- Ministry of Education
- Ministry of Health
- Tuvalu Association of Non-Governmental Organisations (TANGO)
- Tuvalu Family Health Association (TUFHA)
- Tuvalu National Council of Women (TNCW)
- Tuvalu National Youth Council (TNYC)
- Tuvalu Overseas Seaman's Union (TOSU)
- Tuvalu Red Cross Society (TRCS)
- Tuvalu Media Department
- Tuvalu Seven Day Adventist Church.

At the outset, we wish to thank and acknowledge all those who offered their wisdom and insight when preparing this report. As intended, the preparation of the report offered the opportunity to review what has been achieved and to continue to plan and implement Tuvalu's National Strategic Plan for HIV/ AIDS and STI (NSP).

Tuvalu mo te Atua

Status of the epidemic

The Pacific region began to respond to HIV/ AIDS when the first case of HIV was diagnosed in the Marshall Islands in 1984. What started in the 1980s as national general population awareness activities became more co-ordinated in the mid-1990s. Following a meeting of health directors and ministers, the Secretariat of the Pacific Community (SPC) was strongly urged to secure funding for a regional meeting of national AIDS managers and NGOs to develop a multi-sectoral strategy for HIV/AIDS and STI education and prevention initiative for the 22 Pacific Island countries and territories. This meeting provided the basis for the first Pacific regional strategy to address HIV and AIDS, 1997–2000.[1]

Work towards preventing the spread of HIV/AIDS and STIs gained momentum in this region after 2003, when the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) provided 11 Pacific Island countries with a grant of US$3 million for the period 2003-2005.

In 2004, the Council of Regional Government Administrations (CRGA) and Pacific Islands Forum (PIF) mandated the SPC's HIV and STI team to give effect to the Strategy, and develop an overarching coordination Framework to guide its implementation. Endorsed in 2005 by the PIF, this coordination Framework became known as the Pacific Regional Strategic Implementation Plan Phase 1 2004-2008. In 2006, NZAID, followed by ADB, each committed funds of US$5 and $8m respectively to support implementation of the PRSIP I Framework. This complemented existing resources allocated to the region in 2003-04, consisting of approximately A$14.5m channelled through AusAID's Pacific Regional HIV/AIDS Project (PRHP) Project. The PRHP assisted Pacific Island countries and territories to develop a regional strategy and national strategies to strengthen HIV/STI surveillance. An allocation of US$5.1m under the GFATM's Round 2 was managed by SPC as the principal recipient on behalf of 11 countries.

Between mid-2007-2008, SPC led the development of the second Pacific Regional HIV Strategy and accompanying Implementation Plan, covering the years 2009-2013. The second Strategy and Implementation Plan were finalised and endorsed by the PIF and CRGA leaders in August 2008. AusAID and NZAID renewed their commitment to jointly pool funds of approximately A$37m under the Pacific Island HIV and STI Response Fund. This fund is complemented by the successful multi-country Round 7 GFATM allocation of US$25m (over 5 years) announced in late 2008. The Response Fund aims to contribute to the Pacific Regional HIV and STI Strategy goal, which is to reduce the spread and impact of HIV and other STIs, while supporting people infected by HIV in Pacific communities[2].

UNAIDS and other UN agencies in the Pacific region are also engaged in various regional and national projects ranging from prevention, treatment, diagnostics, surveillance and research[3].

The national and regional HIV response over the past decade has helped keep the epidemic at low levels in most Pacific Island countries, with Papua New Guinea being the notable exception. The response to HIV has brought some wider benefits to the Pacific. Improved testing and laboratory services have brought benefits to broader health systems. More openness about human, particularly sexual, behaviour has forced recognition of social issues that mainstream society had previously shunned. Multi-sectoral approaches to HIV have also demonstrated the importance of involving the

[1] SPC (2005).
[2] Pacific AIDS Commission (2009).
[3] Buchanan-Aruwafu (2007).

whole community and not just the health sector. However, significant challenges remain to prevent new infections and mitigate the impacts of HIV.

It is estimated that in 2008, there are 29,629 reported cases of people living with HIV in the Pacific – with 5,162 new HIV diagnoses reported. It is also speculated that the numbers of cases are under-reported. Cases from Papua New Guinea make up an ever-increasing proportion of the total cases detected in the Pacific - from 21 per cent in 1984-1989 to over 99 per cent in 2008.[4]

Different types of epidemics are unfolding in various ways across the region that require separate responses. These can be categorised as[5]:

- Papua New Guinea - the overwhelming locus of the Pacific epidemic;
- Fiji, French Polynesia, New Caledonia and Guam - with significant HIV cases ;
- Other countries - with lower-level epidemics, including Tuvalu.

Countries that have reported the largest number of infections also have the most widespread voluntary counselling and testing facilities. So it is not clear whether low HIV prevalence in other countries is a result of low levels of testing, their relative isolation and the late introduction of HIV, the presence of protective factors, or the absence of specific vulnerability and risk factors[6].

The predominant means of reported HIV transmission in the Pacific is unprotected sex. Sexually transmitted infections (STIs) which enhance HIV transmission are endemic in the region. A significant proportion of infections in New Caledonia, French Polynesia and Guam, especially, are due to unprotected male-to-male sex (MSM) and injecting drug use. The numbers of HIV-positive young people are steadily increasing (the majority of people diagnosed with HIV are young people and young adults aged between 15 and 34) and young women are infected earlier than young men.

Despite its remoteness, Tuvalu has not been spared from the effects of HIV. In 1995, the islands recorded their first case of HIV, and since then there have been 11 cases to date. In this small population of approximately 9,100 people, this translates into one of the highest per capita rates of HIV in the Pacific (refer table 1). Out of the 11 cases, 8 people are still alive and 3 people have died of HIV-related illnesses[7].

Seafarers account for eight of all cases of HIV; the others are one housewife, one student and one child. The seafarers contracted HIV while working on overseas ships. The student appears to have caught the disease while studying in Fiji. The woman contracted the disease from her seafarer husband. She then transmitted the virus to her infant who became the first case of mother-to-child transmission (MTCT) in Tuvalu[8].

Table 1 Distribution of confirmed HIV cases by year, sex and mode of transmission in Tuvalu from December 2006 - 2009

	Dec 2006	Dec 2007	Dec 2008	Dec 2009
Gender				
Male	9	9	10	10
Female	1	1	1	1
Mode of transmissions				
Heterosexual	9	9	10	10
Mother-to-child	1	1	1	1
Homo/bisexual	0	0	0	0
IDU	0	0	0	0
Blood products	0	0	0	0
Other/unknown	0	0	0	0
Total	**10**	**10**	**11**	**11**

Source: Ministry of Health, Tuvalu, Feb 2010

[4] SPC (2009a).

[5] SPC (2009a).

[6] SPC (2009a).

[7] Three males died in 2004, 2007, and 2008 respectively.

[8] Tuvalu 2002 Population and Housing Census vol 1- Analytical report, 2002.

In 2005/06, the Second-Generation Surveillance (SGS) Survey indicated increasing incidence of STIs in Tuvalu. In 2009, results from testing across a range of sites confirms chlamydia as the most commonly reported STIs based on syndromic case reporting. Results from testing also suggest an increase in the number of positive tests for syphilis and gonorrhoea.[9]

Seafarers, youths and women are among those most vulnerable in the community. Many young men in Tuvalu seek employment on overseas ships as seafarers which allows them to travel extensively around the world. The nature of their work and their long periods of time away from their wives and families puts them at increased risk of contracting HIV and STI. The average period of absence from Tuvalu for seafarers is 12 months and ranges from seven months to 15 months. There have been reports of seafarers contracting gonorrhoea in Fiji, a stop-over destination before they return home.[10] These were traced based on the incubation period of gonorrhoea linked with their sexual history. However, there is no more firm evidence to support this claim.

Many women in Tuvalu are married to seafarers and are at an increased risk of contracting HIV and STI when their husbands return from overseas. The only screening available to these women is during pregnancy when they will undergo routine serology for treponemal antibodies, hepatitis B surface antigen and HIV. In 2009, a national cervical screening pilot program to include STIs commenced. Following a review by the Ministry of Health and UNFPA, the programme is moving to full implementation.

Tuvalu's population is relatively young. Just over one third of the population (36.4%) is aged less than15 years.[11] Youths (aged 15 to 24 years) make up a large proportion of the national population. Social changes in Tuvalu have seen an increase in alcohol abuse among youths, teenage pregnancies, and the number of young people engaged in risky sexual behaviours, particularly on the main island of Funafuti. Urban drift and increased international travel all contribute to the growing risk of transmission of HIV and STI in Tuvalu. Young people are quite knowledgeable about HIV and STI prevention in general; although risky sexual behaviour continues. [12]

[9] Ministry of Health, STI Surveillance Data 01/01/09-31/12/09.

[10] Annual Report. Ministry of Health, Tuvalu Government, 2003.

[11] Department of Statistics, 2002,Tuvalu National Census.

[12] Tuvalu DHS 2007.

Policy and programmatic response

To respond to these challenges the Ministry of Health in partnership with NGOs formed the national coordinating body now known as the Tuvalu National AIDS Committee (TUNAC). Taking a multi-sectoral approach, TuNAC combines the efforts of key government departments, NGOs, community-based organisations and civil society to work towards halting the spread of HIV/ AIDS and STIs in Tuvalu. This committee, under the guidance of Tuvalu's National Strategic Plan (NSP) coordinates all HIV/ AIDS and STI related activities in the country.

Tuvalu's Ministry of Health Strategic Health Plan 2009-2019 lists effective and integrated programmes to combat the spread of HIV/ AIDS and other STIs as a key health priority under primary and preventative health services. In December 2008, Tuvalu's Ministry of Health and TuNAC launched the second National HIV/ AIDS and STI Strategic Plan (NSP) which operates from 2008–2012[13]. The Plan focuses on achieving an enabling environment, prevention, treatment, care and support, and improving programme management.

The current policy on HIV testing advocates for voluntary confidential counselling and testing (VCCT). The laboratory is capable of doing HIV Determine and Serodia but confirmatory tests are still being sent to Fiji. Apart from voluntary testing, the laboratory also performs screening of all blood products for HIV and other common STIs.

Diagnostic facilities for any STI remain a challenge in Tuvalu. The only laboratory in Tuvalu is capable of doing a serology for syphilis, hepatitis B surface antigen, a gram stain for gonorrhoea, wet mount for trichomoniasis and candida infections. There are no facilities to test for chlamydia infection in Tuvalu; all specimens are sent to Fiji.[14]

Free antiretroviral treatment paid for by the Global Fund commenced in December 2007 for those who needed it. A clinical team of two medical officers, a clinical nurse, laboratory technician and pharmacist is trained to fully implement the national anti-retroviral therapy guideline endorsed by the Ministry of Health, 2004.[15]

In 2009, two HIV programme officers were employed under Global Fund and an HIV Unit was established. The HIV Unit, working collaboratively with NGOs, provide assistance and service to implement activities in the NSP.

[13] A copy of Tuvalu's NSP for HIV/ AIDS and STIs is appended in the 2008 UNGASS report

[14] Annual Report. Ministry of Health, Tuvalu Government, 2003; Strategic Plan to respond to HIV/AIDS and STI, 2001-2005, Ministry of Health Tuvalu.

[15] Strategic Plan to respond to HIV/AIDS and STI, 2001-2005, Ministry of Health Tuvalu.

Overview of UNGASS indicator data

Table 2: Overview of UNGASS Indicator Data

Indicators	Data	Data Collection Method/ Comments
National Commitment and Action		
Expenditures		
1. Domestic and international AIDS spending	Total funding of US$161,426 for 2008-2009	National AIDS Spending Assessment Financial resource flows
Policy Development and Implementation Status		
2. National Composite Policy Index	Completed by government agencies and civil society. Highlights Tuvalu's ongoing multi-sectoral commitment and incremental progress in delivering their HIV/ AIDS response	
National Programmes		
3. Percentage of donated blood units screened for HIV in a quality assured manner	Data not available	No blood bank. Blood donors are recruited, screened annually for HIV and other infections, when required to donate, screened again. In 2009, no potential blood donors tested had HIV
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy*	100%	1 person with advanced HIV infection who is receiving ART
5. Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	No mothers with HIV detected	-
6. Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV	No known HIV-positive people with TB	-
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results	3% women 13% men	Tuvalu's DHS 2007
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results	No data available	• Payment for sexual intercourse is low (1% of men between 15 and 49). • No known injecting drug users (IDU) • Low incidence of MSM • No repeat of 2006 SGS survey for seafarers
9. Percentage of most-at-risk populations reached with HIV/AIDS prevention programmes	No data is available for sex workers, IDU, MSM and seafarers	-
10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	No children have been orphaned by AIDS	Concept of orphans is not relevant to the Tuvalu society
11. Percentage of schools that provided life-skills based HIV/AIDS education within the last academic year	Coverage for primary schools: 100% Coverage for secondary schools: 100%	-

Indicators	Data	Data Collection Method/ Comments
Knowledge and Behaviour		
12. Current school attendance among orphans and among non-orphans aged 10–14*	No relevant	No children have been orphaned by AIDS in Tuvalu
13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	UNGASS: Comprehensive knowledge — Women 39%, Men 61% Reduce risk by sex with one — Women 89%, Men 87% Reduce risk by using condom — Women 79%, Men 88% Healthy-looking person — Women 69%, Men 90% Transmitted by mosquito bites — Women 26%, Men 22% Get HIV by sharing food — Women 16%, Men 13%	Tuvalu DHS 2007
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	No data available	• Payment for sexual intercourse is low (1% of men between 15 and 49) • No known IDU • Low incidence MSM • No repeat of 2006 SGS survey for seafarers
15. Percentage of young women and men who have had sexual intercourse before the age of 15	2% of young women and 15% of young men first had sex before they were age 15	Tuvalu DHS 2007
16. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	Only 1% of women aged 15-49 years had more than two partners and 4% had higher-risk sex 5% of men aged 15-49 years had more than one partner and 21% had higher-risk sex	Tuvalu DHS 2007
17. Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse*	Of the 58 men aged 15 to 49 years who had higher-risk sex, 45% used reported using a condom	Tuvalu DHS 2007
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	No robust data available	Payment for sexual intercourse is low (1% of men between 15 and 49)
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	No robust data exists about the percentage of men reporting the use of a condom the last time they had anal sex with a male partner	-
20. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected	Not relevant	No known IDU
21. Percentage of injecting drug users who report the use of a condom at last sexual intercourse	Not relevant	No known IDU

Indicators	Data	Data Collection Method/ Comments
Impact		
22. Percentage of young women and men aged 15–24 who are HIV infected*	None. In 2009, 135 women were tested for HIV at antenatal clinic; none tested positive	Highly likely that the 135 include women older than 24 years
23. Percentage of most-at-risk populations who are HIV infected	No data available for the most at risk population groups	No repeat of 2006 SGS survey for seafarers
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	100%	One (male, aged 30-39 yrs) of the nine people living with HIV started ART in December 2007
25. Percentage of infants born to HIV infected mothers who are infected	Subject matter is relevant, but indicator not relevant	Between 1 January 2008 and 31 December 2009, no infants were born to HIV infected mothers. The latter reflects there were no detected HIV infected mothers during this period

*Millennium Development Goal

Overview of the AIDS epidemic

During the period January 2008 to December 2009, out of 689 people tested no one tested positive for HIV (Ministry of Health, 2010). However, of the three people noted in the 2008 UNGASS report as waiting for their HIV test confirmation, one tested positive. One person living with HIV has died.

Between January and December 2009, 638 people were tested for HIV with no confirmed cases. This was not the case for other STIs: chlamydia was detected in 10%, of those tested, syphilis 5% and gonorrhoea 1% (refer tables 3 and 4)[16]. A comparison between the 2009 test results and the findings of the 2005/06 SGS[17] for pregnant women attending the Princess Margaret Hospital, Funafuti suggests that detection rates have[18]:

- Increased for gonorrhoea with 3.8% in 2010 compared to 0.9% in 2006
- Increased for syphilis with 3.7% in 2010 compared to 1.7% in 2006
- Remained fairly constant for chlamydia with 17.0% in 2010 and 17.5% in 2006.

Table 3: Female HIV and STI surveillance data between 1 January and 31 December 2009

HIV and STI assessed	HIV Test	Confirmed no.	Gono-rrhoea	Detected no.	Syphilis	Detected no.	Chlamydia	Detected no.
ANC	**135**	**0**	**53**	**2**	**135**	**5**	**53**	**9**
PMH	121	0	56	0	121	4	56	2
Blood donors	10	0	na	na	na	na	na	na
TUFHA clinic	0	0	17	0	0	0	17	3
Under 15	3	0	0	0	3	0	0	0
15-19	12	0	11	2	12	0	11	3
20-24	55	0	26	0	55	0	26	3
25 plus	145	0	89	0	145	4	89	7
Unknown	51	0	0	0	51	1[19]	0	0[20]
Total	**266**	**0**	**126**	**2**	**266**	**9**	**126**	**14**

Table 4: Male HIV and STI surveillance data between 1 January and 31 December 2009

HIV and STI assessed	HIV Test	Confirmed no.	Gono-rrhoea	Detected no.	Syphilis	Detected no.	Chlamydia	Detected no.
PMH	360	0	268	1	360	14	268	24
Blood donors	58	0	na	na	58	5	na	na
TUFHA clinic	5	0	6	1	5	4	6	2
Under 15	2	0	1	0	2	0	1	0
15-19	31	0	59	0	31	0	59	7
20-24	58	0	79	1	58	3	79	11
25 plus	222	0	135	1	222	10	135	8
Unknown	110	0	0	0	110	10	0	0
Total	**423**	**0**	**274**	**2**	**423**	**23**	**274**	**26**

Tuvalu is a country of low prevalence of HIV infection. However, the detection of other bacterial STIs, endemicity of hepatitis B[21], high risk behaviours, and low condom use provides a path for the introduction and spread of HIV. Being a small country, with a population of less than 10,000, even a single case of HIV would raise the per capita incidence quite alarmingly. In 2004, the number of known infections in Tuvalu jumped precipitously, from three to nine cases, underlining the high vulnerability of this small country and its very mobile work-force. There is no room for complacency.

[16] Ministry of Health, STI surveillance data January to December 2010.

[17] Caution is advised with these comparisons, given the relatively small number of women tested.

[18] Increases noted may be reflective of increased testing for STIs in Tuvalu.

[19] Data provided inconsistent.

[20] Data provided inconsistent.

[21] 9.8% of antenatal women in the 2005/06 SGS.

National Response to the AIDS Epidemic

Tuvalu has been an active participant in all regional programmes and strategies to reduce the risk of HIV transmission in Pacific Island countries. In 2001, the Tuvalu Minister of Health presented the Pacific Islands situation report to the UNGASS in New York on behalf of other countries in the region.

A strong, effective and engaged multi-sectoral approach, lead by TuNAC, has steered the ongoing implementation of the NSP. Between January 2008 and December 2009, key implementation activities undertaken related to the priority areas of the NSP include:

Achieving an enabling environment

- Maintenance of strong and effective multi-sectoral approach
- Ongoing funding commitment from Government for the treatment of HIV/ AIDS and STIs.

Prevention of HIV and other STIs

- In 2007, TuFHA reported on the KAP II on sexual reproductive health of young people aged 14 to 25. The findings of KAP II were used to develop their programmatic response
- Continuance of World AIDS Day across the nation with high levels of community participation
- In 2009, TRC commenced the life skills training programme. Funding to continue this programme is currently being sought
- Workshop with church leaders from the main denomination Tuvalu Church which secured their ongoing support to the national response to HIV/AIDS and STIs
- More material developed and targeted specifically for Tuvalu (i.e. language and images used)
- New materials developed for radio
- Peer education programmes expanded to TRC and 20 trainers completed formal training on peer education
- A drop-in centre was established at TOSU's main headquarters which provides education and computer/ communication services for seafarers and wives
- More test requirements were added for all blood donations including Hepatitis C and chlamydia
- A nurse trainer officer was recruited to train nurses in infection control including those on the outer islands
- Training of counsellors specifically on HIV and STIs was completed. Two counsellors are currently enrolled in Diploma of Counselling Course distance learning to further enhance their knowledge
- The Ministry of Health conducted training and provided information to the Tuvalu Police Force on VCCT and the availability of treatment services. As a result, the Police Force has developed their strategies to address HIV prevention and alleviating Violence against Women.

Treatment care and support

- The OSSHM treatment guidelines are used for the treatment and care of PLWH and STIs
- Voluntary testing is conducted at the laboratory. This service is only available at Funafuti
- PLWH are now accessing treatment
- There is a six months supply of ARVs and drugs for other STIs with a three month buffer. Drug therapy is funded by Global Fund
- Confirmatory testing for HIV is being sent to Fiji. In 2010, Tuvalu's laboratory achieved a 100% accuracy rate in a quality assurance assessment
- Ongoing voluntary testing of pregnant mothers

- An advocacy group was established to offer support to PLWH
- HIV testing referral systems in place between NGOs and the Government's national laboratory.

Programme management

- Funding from Response Fund for the implementation activities of NSP is expected in 2010
- The Ministry of Health and NGOs have a better understanding of funding sources available which will enable activity implementation
- Two HIV programme officers were employed under Global Fund and an HIV Unit was established. The HIV Unit is working collaboratively with NGOs to provide assistance and service to implement activities detailed in the NSP
- A draft Monitoring and Evaluation (M&E) framework has been developed. It is expected that the M&E framework will be endorsed by TuNAC in March 2010
- In 2007, Tuvalu's Demographic Health Survey (DHS) was designed to include questions to inform policy direction and reporting to UNGASS.

National Commitment and Action Indicators

Indicators 1: National AIDS Spending Assessment

The Ministry of Health continues to receive allocations of US$6,369 for HIV treatment from the national recurrent budget. Tuvalu also receives funds from the Global Fund and UNFPA for specific national HIV activities. Between January 2008 and December 2009, the total national AIDS spending was US$161,426 across all funding sources.

NGOs like TUFHA, TANGO and TRCS received specific financial support in the area of HIV (detailed in tables 5 and 6):

- TUFHA, as the leading NGO in the area of sexual and reproductive health, receives funding from developmental partners to assist with in-country HIV activities
- TRCS program for HIV peer education among seafarers received financial support from UNICEF for the period 2008-2009
- TANGO the umbrella body for NGOs in Tuvalu, received direct funding from the Pacific Regional HIV Project in 2008 focusing on capacity building and empowerment of NGOs nationwide.

Table 5: AIDS Spending for 2008

Agency	Government/ NGO	Project Name	Donor	Provision US$	Expenditure US$
Ministry of Health	Government	Global Fund HIV Program	GFATM	47,750	47,750
		National HIV Program	Tuvalu Government	6,369	6,369
TUFHA	NGO	IPPF HIV Program	IPPF	4,710	4,710
		PRHP HIV Program	PRHP	34,556	34,556
TRCS	NGO	Peer Education Program on HIV	UNICEF	4,424	4,424
		World AIDS Day	ARC (Australia)	2,323	2,323
Total				$100,132	$100,132

Table 6: AIDS Spending for 2009

Agency	Government/ NGO	Project Name	Donor	Provision US$	Expenditure US$
Ministry of Health	Government	Global Fund HIV Program	GFATM	64,166	32,000[22]
		National HIV Program	Tuvalu Government	6,369	6,369
TUFHA	NGO	IPPF HIV Program	IPPF	10,127	10,127
TRCS TRCS	NGO	Peer Education Program on HIV	UNICEF	10,528	10,528
		World AIDS Day 2009	ARC (Fiji)	2,270	2,270
Totals				$93,460	$61,294

[22] The funding provision is to March 2010, the figure presented is expenditure to December 2009.

Indicator 2 National Composite Policy Index (NCPI)

The analysis of the NCPI focused on trend analysis and potential differing perspectives of government and civil society about Tuvalu's in the HIV/ AIDS response. Overall, the results from the NCPI, across both government and civil society, highlight Tuvalu's ongoing and strengthening multi-sectoral commitment and incremental progress in delivering their HIV/ AIDS response.

Key points of note are:

- Compared to 2007, there is now full participation of civil society in the development of Tuvalu's multi-sectoral strategy. NGOs are members of TuNAC and the Ministry of Health ensures civil society participation in all health programmes at a national level. Efforts are being made to ensure there is co-ordination and harmonisation of programmes to avoid duplication between government and NGOs
    - This strengthening was demonstrated by civil society's increased ratings of their participation in the development of the national HIV/ AIDS strategy and budget.
- There is consistency of response between government and civil society in the NCPI.
- Since 2007, there has been a strengthening of high officials and church leaders speaking publicly about HIV efforts in domestic forums, (e.g. the Governor General, island and church leaders speaking at the 2008 World AIDS Day).
- An increase in government and civil society ratings of the efforts in the implementation of HIV prevention programmes.
- Development of the draft M&E framework awaiting sign-off by TuNAC in early 2010. The implementation of the M&E plan will be the responsibility of the HIV programme officers as part of their work to implement the NSP. One noted implementation challenge is the lack of local capacity for epidemiology work.
- An increase in civil society rating of Tuvalu's policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009 and their enforcement. This reflects:
    - The continuing support for a RRRT program responsible for all legal rights training in country including HIV
    - Extensive legal rights training in 2008-2009 generating interest from the Government Legal Department and civil society to revise laws related to HIV.

National Programme Indicators

Indicator 3. Percentage of donated blood units screened for HIV in a quality assured manner

There is no blood bank in Tuvalu and people are recruited on the spot as the need arises. Donors are recruited by the Tuvalu Red Cross and screened annually for HIV and all other infections. When they are required to donate, they are again screened, but that may not detect all HIV.

A register is kept in the Princess Margaret Hospital (the main national hospital in Funafuti) of all blood donations and the donors' test results. However, this does not meet the quality assurance standards required by UNGASS. Table 7 details the number of donors tested between January and December 2009 and their results. It shows that no blood donors tested positive for HIV.

Table 7: Number of blood donors tested for HIV between January and December 2009, and their results.

Gender	Total tests	Confirmed
Female	10	0
Male	58	0
Total	**68**	**0**

Since the 2008 UNGASS report, the laboratory technician has had further quality assurance training. The last report from the quality assurance laboratory in Wellington, New Zealand showed 100% accuracy in testing.

Indicator 4. Percentage of adults and children with advanced infection receiving antiretroviral therapy

100%. One (male, aged 30-39 yrs) of the nine people living with HIV started ART in December 2007. He is the only person currently requiring this treatment. The patient and the family receive counselling and general support as needed.

From December 2007, free ART has been available in Tuvalu. The arrival of treatment in-country reflects funding by the Global Fund, and the patient's agreement to commence treatment. All people living with advanced HIV infection in Tuvalu are entitled to receive free ART (as costs are covered by the Global Fund).

No significant change compared to 2008 UNGASS reporting.

Indicator 5. Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission

Between January 2008 and December 2009, there were no known HIV-positive pregnant women in Tuvalu. No treatment was required to reduce the risk of mother-to-child transmission.

Since 2005, pregnant women in Tuvalu are invited to be tested for HIV and STI, while attending antenatal clinics. In the three years (preceding the 2007 DHS), 67% of pregnant women[23] had at least four antenatal care visits for their last birth (Tuvalu DHS, 2007).

Tuvalu's DHS 2007 states that 22% out of 170 pregnant women received HIV counselling during their antenatal care, of which 10% received their results and very few (3%) did not receive their test results. Women in Funafuti were more likely to receive counselling, testing and receive test results than women in the outer islands.

No significant change compared to 2008 UNGASS reporting.

[23] Women aged 15-49 who gave birth in the two years preceding the survey.

Indicator 6. Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV

Between January 2008 and December 2009, there were no known HIV-positive people with TB in Tuvalu. No treatment was therefore required.

No significant change compared to 2008 UNGASS reporting.

Indicator 7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results

In order to protect themselves and to prevent infecting others, it is important individuals know their HIV status. Knowledge of one's status is also critical factor in the decision to seek treatment.

Tuvalu's DHS survey (2007: chap12-14: 22) reports:

- High awareness of where to go to get HIV testing by women (89%) and men (93%) aged 15-49 years.
- Low levels of HIV testing with 88% of women and men (71%) aged 15-49 years having never been tested.
- Low prevalence of current HIV testing for both women (3%) and men (13%) who received their results in the 12 months preceding the survey.

Further details of the coverage of HIV testing in Tuvalu can be found in section 12.8.4 of Tuvalu's 2007 DHS.

Table 8: People tested for HIV in Tuvalu in last 12 months preceding the DHS survey and know results (base those answered question as per report)

Age	Female Base	Female %	Male Base	Male No.	Male %
15-19	111	2.7	91	3	3.3
20-24 yrs	145	4.1	74	11	14.9
25-49 yrs	594	3.2	262	42	16.0
Total	850	3.3	427	56	13.1

Source: Tuvalu DHS, 2007

In 2007, 240 men and 120 women were tested for HIV, all were aware of their results. The decline in people being aware of their results may reflect the significant increase in testing levels or the ongoing fear and stigma about HIV/ AIDS.

Indicator 8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results

In order to protect themselves and to prevent infecting others, it is important the most-at-risk know their HIV status. Knowledge of one's status is also critical factor in the decision to seek treatment. UNGASS seeks that this indicator is calculated separately for each population that is considered most-at-risk in a given country: sex workers, IDU and MSM.

Sex workers

In Tuvalu, there are no recognised sex workers, (although there are anecdotal reports of informal kinds of transactional sex). Payment for sexual intercourse is low. Tuvalu's DHS (2007) reported 1% of men between 15 and 49 had paid for sexual intercourse in the 12 months preceding the survey. However, it is more common among men in the 20-24 age group (4.1%).

There is no data available about HIV testing for sex workers in Tuvalu.

Injecting drug users

There are no known injecting drug users in Tuvalu. This subject matter is therefore not relevant to Tuvalu.

Men who have sex with men
In 2007, TUFHA's KAP II survey reported 5.9% of youth aged 14-25 years had a male sex partner (i.e. 13 men). The youth BSS survey (2005) reported that 13.9% of males aged 15 to 24 years ever having sex with a male. While both surveys highlight the existence of MSM in Tuvalu, neither provide robust data on whether they had been tested for HIV.

Seafarers
As noted in the Status of the Epidemic section, seafarers are a recognised group of people at particular risk in Tuvalu. Sea-farers are men who work away from Tuvalu for months or years at a time on foreign-registered ships. Tuvalu's 2008 UNGASS report noted seafarers has had tight surveillance and account for 73% of known HIV cases. Note: this does not necessarily reflect their higher prevalence but possibly their closer monitoring.

There is no current data available about HIV testing for this group. However, all seafarers have up to 2009 been required by the German recruitment company to have a yearly HIV test. This may explain the significantly higher level of testing of men than women in 2009 (refer table 4). It is unknown whether seafarers tested know their test results.

Indicator 9. Percentage of most-at-risk populations reached with HIV/AIDS prevention programmes

No data is available for sex workers, IDU, MSM and seafarers (for reasons refer indicator 8).

Between 2005 and 2009, seafarers and their wives have been provided with specially-designed education programmes by the TRC, funded by UNICEF. These education programs include awareness about HIV and STIs, information about protection, and life-skills training to counter family problems associated with long absences of men, problems that have included family breakdowns and other social problems. Most of these programs operated on the main island of Funafuti because of limited financial resources to conduct them on the other eight 'outer' islands. This programme has now stopped due lack of funding. A new programme is now being developed with UNICEF due for commencement in 2010.

Indicator 10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child

No children have been orphaned by AIDS in Tuvalu.

This indicator is not relevant to Tuvalu as the concept of 'orphans' is not recognised in Tuvalu society. Children move freely between the households of their extended families and children who lose one or more parents are readily taken into care by their other relatives. Tuvalu's DHS (2007) notes about one in four Tuvaluan households included one or more children who were staying with neither their natural father nor their natural mother. Around one in ten households have orphans (not due to AIDS): 8% with single orphans[24] and 1% with double orphans.

No significant change compared to 2008 UNGASS reporting.

Indicator 11. Percentage of schools that provided life-skills based HIV/AIDS education within the last academic year

Coverage for primary schools: 100%

Coverage for secondary schools: 100%

[24] A single orphan is a child who has only one parent, which could be a mother or a father.

Basic education from the age of 6 to 15 years is compulsory in Tuvalu. There are schools on all islands, and enrolment in primary education in Tuvalu is very close to 100%. Preschool and primary school curricula include lessons on health science, with language and content appropriate to the children's ages.

The senior primary classes (ages 12-14) have full education on STIs and HIV included in the curricular. These classes are monitored by the Ministries of Education and Health.

At the two secondary schools in Tuvalu, all students participate in science classes including human biology. Dependent on teachers, human biology may include life-skills based HIV/ AIDS education. A review of the secondary school curricular with a focus on HIV/ AIDS education is pending.

No significant change compared to 2008 UNGASS reporting.

Indicator 12. Current school attendance among orphans and among non-orphans aged 10–14*

As noted in indicator 10, no children have been orphaned by AIDS in Tuvalu, and the concept of orphans is not relevant to the Tuvalu society.

The official ranges for primary and secondary schools in Tuvalu are 6-13 years and 14-17 years. Tuvalu's DHS (2007) reports that 98% of the primary school aged population attend a primary school. For secondary school attendance is lower at 40% of those who are secondary school age attending secondary school.

While this indicator is not relevant, it is worth noting that the Ministry of Education maintains a database on all children attending school in Tuvalu. However, no data is collected on whether these children have living parents or not.

Indicator 13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*

HIV epidemics are perpetuated through primarily sexual transmission of infection of successive generations of young people. Sound knowledge about HIV is an essential pre-requisite for adoption of behaviours that reduce the risk of HIV transmission. Table 9 below details the knowledge levels of young people aged 15 to 25 years for the UNGASS indicators and wider knowledge areas.

Tuvalu's DHS (2007) found amongst those aged 15 to 25 years:

- Awareness of HIV is high amongst both women (98%) and men (98%).
- Men (61 %) have a more comprehensive knowledge of HVI and STIs than women (39%). There is an especially marked difference in knowledge about:
    - Healthy-looking people having HIV
    - Reducing the risk by using a condom every time they have sex
    - HIV not being transmitted by supernatural means
    - Abstaining from sex.
- More women were aware that HIV can be transmitted by breastfeeding than men (79% and 66% respectively).
- Compared to the 2008 Tuvalu UNGASS report, levels of awareness and knowledge about HIV and STI remains mostly unchanged. The only statistically significant changes in knowledge are:
    - A decline in the proportion of women aware that abstaining from sex can prevent HIV (93% in 2008 UNGASS report)
    - A decline in the proportion of women aware that a healthy person can have HIV (83% in 2008 UNGASS report)
    - An increase in the proportion of men aware that a healthy person can have HIV (81% in 2008 UNGASS report).

Table 9: Knowledge about HIV and AIDS amongst people aged 15-24 (Tuvalu DHS 2007)

Gender	Women			Men		
Age	**15-24 n=257 %**	**15-19 n=111 %**	**20-24 n=145 %**	**15-24 n=164 %**	**15-19 n=94 %**	**20-24 n=74 %**
Core UNGASS indicators						
Comprehensive knowledge of HIV and STIs	**39.4**	31.1	45.7	**60.7**↑	57.2	65.0
Reduce risk by having sex with one uninfected partner who has no other partners	89.0	82.6	93.9	87.0	84.7	89.9
Reduce risk by using condom every time have sex	**79.0**	70.4	85.6	**88.4**↑	86.6	90.6
A healthy-looking person can have HIV	**69.4**	63.8	73.6	**89.9**↑	90.7	88.9
HIV cannot be transmitted by mosquito bites[25]	73.7	67.2	78.7	77.7	75.3	80.7
A person cannot become infected by sharing food with a person who has HIV	83.9	76.5	89.6	87.1	84.4	90.5
Other knowledge measures						
Have heard of HIV	98.1	96.5	99.3	97.6	98.1	96.9
Know a condom source	90.6	85.9	94.2	92.9	92.2	93.8
Know where to get an HIV test	89.8	83.7	94.5	86.5	87.2	85.7
HIV can be transmitted by breastfeeding	**78.8**	71.3	84.5	**66.1**↓	64.2	68.5
HIV cannot be transmitted by supernatural means	**78.3**	78.2	78.4	**90.6**↑	91.7	89.2
Abstaining from sex	**83.9**	77.2	89.0	**92.2**↑	89.7	95.3

Indicator 14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

No indicator data exists for UNGASS' most-at-risk populations in Tuvalu:

- No recognised sex workers, (although there are anecdotal reports of informal kinds of transactional sex).
- No known IDU in Tuvalu therefore the subject matter is not relevant
- No data on knowledge levels of MSM in Tuvalu about HIV and AIDS.

Seafarers

As noted in indicator 8, seafarers are a recognised group of people at particular risk in Tuvalu. No new data has been collected on seafarers, since Tuvalu completed its 2008 UNGASS report. TuRC undertake pre and post-testing of knowledge as part of their education programmes and life-skills training for seafarers and their wives, which offers an indicative measure prevention knowledge and rejection of misconceptions amongst seafarers attending.

The data presented in the 2008 UNGASS report has been repeated below for ease of reference. Out of 209 seafarers covered by the SGS survey (2006), only 28% had correct knowledge of HIV/AIDS prevention methods, and only 17% reported both correct knowledge of HIV/AIDS prevention and no incorrect beliefs about HIV/AIDS transmission (refer table 10 below).

Of the seafarers surveyed, none were found to be HIV positive. However, other STI rates were high: chlamydia 8.1%; hepatitis B surface antigen 13.4%; syphilis 5.2%. The

[25] The table lists the two indicators on food sharing and mosquito transfer of HIV as specified in Tuvalu's DHS (2007). UNGASS require the indicators to be reported in the reverse (i.e. can a person get HIV from mosquito bites? and can a person get HIV by sharing food with someone who is infected?). Reporting here reflects the DHS findings to allow comparison to Tuvalu's 2008 UNGASS report. However, the indicator table and electronic reporting meets UNGASS' precise reporting requirements.

overall prevalence for any STI (excluding Hepatitis B) among seafarer was 27.3%. None of the seafarers diagnosed with any of the STIs reported any symptoms of infection. These high rates suggest that these seafarers either did not understand about transmission of STIs or did not practice safe sex.

Consistent condom use between seafarers and all their partners was low. Among those infected with any STI, 57% were using condoms when having sex with a commercial partner and 17% with casual partner. On their return to Tuvalu these men engage in unprotected sexual contact with their regular partners, increasing the risk of transmission of any STIs three fold in this population.

Seafarers are therefore important bridges for the spread of STIs and potentially HIV into Tuvalu. They have unprotected sex with partners overseas and also with regular partners in Tuvalu. Seafarers are therefore an important population for targeted interventions. The development of targeted behavioural interventions for seafarers may eventually exert positive attitudes towards behavioural change leading to safer sexual behaviours and practices.

Table 10 Selected indicators of HIV and sexual behaviour among 209 seafarers attending Princess Margaret Hospital from August 2005 to February 2006

Indicators	Seafarers n=209
HIV prevalence (%)	0
Median age at first sex (years)	18 (9-30)
Median number of female sex partners in last 12 months (number)	1 (0-10)
Proportion having sex with female casual partners in last 12 months (%)	14.4
Median number of female casual partners in last 12 months (number)	0 (0-10)
Proportion of adult male using condoms at last sex with female casual partner in last 12 months (%)	5.7
Consistent condom use of adult male with female casual partners in last 12 months (%)	2.4
Proportion of adult male reporting having sex with female commercial partners in last 12 months (%)	3.3
Median number of female commercial partners in last 12 months (number)	1 (0-5)
Proportion of adult male using condoms at last female commercial sex (%)	85.7
Consistent condom use of adult male with female commercial partner in last 12 months (%)	57.1
Proportion of adult males reporting sex with men in the last 12 months (%)	0.0
Proportion of adult males reporting use of condoms with last anal sex with male partner (%)	0.0
Proportion who have ever received HIV testing and know the result	93.7
Correct knowledge of HIV/AIDS prevention methods (%) 1	27.8
No incorrect beliefs about HIV/AIDS transmission (%)	63.6
Proportion who both report correct knowledge of HIV/AIDS prevention and no incorrect beliefs about HIV/AIDS transmission (%)	14.8

Source: Homasi, 2007

Indicator 15. Percentage of young women and men aged 15-24 who have had sex before the age of 15

Age at first intercourse marks the time at which most individuals first risk exposure to HIV and other STIs as well as unplanned pregnancy leading to early childbirth.

Table 11 shows the percentage of women and men (aged 15-24 years) who had sexual intercourse before reaching the age of 15 and 18.

- 2% of young women and 15% of young men first had sex before they were age 15.
- 13% of young women and 52% of young men first had sex before they were age 18.

Table 11: Age first had sex amongst those aged 15 to 24 years

Gender	Women			Men		
Age	**15-24 n=257 n=196 %**	**15-19 n=111 %**	**20-24 n=145 %**	**15-24 n=164 n=124 %**	**15-19 n=91 %**	**20-24 n=74 %**
Percentage who had sex before 15	**1.7%**	2.1%	1.4%	**14.7%**	18.9%	9.6%
Percentage who had sex before 18	13.2	na	12.9%	51.7%	na	45.7%

Source: Tuvalu's DHS 2007

This data is not in a form comparable to that in the 2008 UNGASS report.

Indicator 16. Percentage of adults aged 15–49 who have had sex with more than one partner in the last 12 months

Sexual behaviour that places people at greater risk of acquiring HIV and other STIs includes unprotected sex with one or more partners. Higher risk sex involves having sex with a person who is neither a spouse nor a co-habiting partner. Tuvalu's DHS (2007) highlights the strong social mores against premarital and extramarital sexual activity in Tuvalu. As shown in table 12:

- Only 1% of women aged 15-49 years had more than two partners and 4% had higher-risk sex
- 5% of men aged 15-49 years had more than one partner and 21% had higher-risk sex.

Table 12: Multiple sexual partners and higher risk intercourse in 12 months preceding the survey

In 12 months preceding the survey…	Women				Men			
	15-19 n=12 %	**20-24 n=80 %**	**25-49 n=486 %**	**Total n=578 %**	**15-19 n=38 %**	**20-24 n=44 %**	**25-49 n=199 %**	**Total n=281 %**
Had more than 2+ partners	*	1.4	0.5	1.1	14.1	17.6	1.0	5.3
Had higher-risk sex	*	10.9	2.1	3.9	55.4	43.4	9.0	20.5

Source: Tuvalu DHS 2007

This data is not in a form comparable to that in the 2008 UNGASS report.

Indicator 17. Percentage of adults aged 15–49 who have had more than one sexual partner in the past 12 months reporting the use of a condom during their last intercourse*

Due to the low incidence of women aged 15 to 49 years having more than one sexual partner (1% or 6 women), there is no data reported in the Tuvalu DHS 2007 on condom use during their last intercourse.

Of the 58 men aged 15 to 49 years who had higher-risk sex, 45% used reported using a condom (Tuvalu DHS 2007).

This data is not in a form comparable to that in the 2008 UNGASS report.

Indicator 18. Percentage of female and male sex workers reporting the use of a condom with their most recent client

While some transactional sex occurs in Tuvalu in an informal, disorganised way, no people are identifiable as sex workers. No robust data therefore exists for this indicator.

Indicator 19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

No robust data exists about the percentage of men reporting the use of a condom the last time they had anal sex with a male partner. However, the TUFHA KAP II survey (2007)

offers some insight with 2 out of 13 men who had sex with a male had used a condom last time they had sex.

The youth BSS (2007), reported in Tuvalu's 2008 UNGASS report, offers further insight. Among 187 male youths, 26 (13.9%) reported ever having sex with another male and 15 (8.0%) in the last 12 months. Anal sex was reported by 16 (8.6%) with 10 (62.5) reporting the use of a condom.

Indicator 20. Percentage of injecting drug users reporting using sterile injecting equipment the last time they injected

There are no known IDU in Tuvalu. Subject matter is therefore not relevant.

Indicator 21. Percentage of injecting drug users reporting the use of a condom at last sexual intercourse

There are no known IDU in Tuvalu. Subject matter is therefore not relevant.

Impact indicators

Indicator 22. Percentage of young women and men aged 15–24 who are HIV infected*

Between January and December 2009, 135 women were tested for HIV at Princess Margaret Hospital's antenatal clinic in Funafuti; none tested positive. Note: It is highly likely that the 135 include women older than 24 years.

Table 13 below summaries the number of HIV tests conducted between January and Decembers 2009. It highlights that more tests where done for men than women and people aged over 20 years. This is likely to be due to mandatory testing required by seafarers' overseas employers. Of the tests conducted none where positive.

Table 13: The number of HIV tests and their results between January and December 2009 by location, gender and age.

Indicators		Total HIV tests	Confirmed
Location	ANC	135	0
	PMH	481	0
	Blood donors	68	0
	TUFHA clinic	5	0
Gender	Male	423	0
	Female	266	0
Age – female	Under 15	3	0
	15-19	12	0
	20-24	55	0
	25 plus	145	0
	Unknown	51	0
Age – male	Under 15	2	0
	15-19	31	0
	20-24	58	0
	25 plus	222	0
	Unknown	110	0

Source: Ministry of Health 2009

Indicator 23. Percentage of most-at-risk populations who are HIV infected

There are no data available for the population groups that are conventionally considered to be most at risk, namely sex workers, IDU and MSM. Refer indicator 8 for explanation of no existing data.

As noted for Tuvalu, seafarers are considered the most-at-risk population group. Between January 2008 and December 2009, no new data is available on the percentage of seafarers who are infected with HIV.

The most recent data available is the 2006 sero-surveillance study of seafarers reported in Tuvalu's 2008 UNGASS report[26]. For ease of reference, key points noted from the survey of 209 seafarers include:

- Most (94%) had been tested for HIV and know the result.
- Of the 209 seafarers tested for HIV, none were found to be HIV positive.
- Most seafarers (94%) had sex in the previous 12 months.
- The median age at first sex was 18 (range 9-30).
- Approximately 83% of seafarers with any STI reported having sex with a regular female partner in Tuvalu in the last 12 months. About 3% reported having sex with a commercial female partner and 14% with casual female partner in the last 12 months.
- Amongst those seafarers infected with any STI, a condom was never used or rarely used when having sex with a regular partner(s) in Tuvalu (100%) and overseas on ships (96%).
- Those who had sex with a commercial female partner 86% reported using condoms, but only 57% were using consistently. Among those who had sex with a casual partner in the last 12 months 33% reported using condoms at last sexual encounter but very few 17% used condoms consistently.
- None of the seafarers reported having sex with a male partner in the last 12 months or in their lifetime.
- Among the different levels of seafarers, ordinary seaman accounted for 28% of all STIs in this population. Ordinary seafarers are usually new to seafaring and most have just completed one contract of work overseas.
- Knowledge of HIV prevention methods was poor among seafarers. Only 58 (28%) had all correct knowledge of HIV protection patterns of condom protection (62%), faithful partner (50%) and abstinence from sex (55%).
- Only 15% seafarers had both correct HIV protection knowledge and belief of HIV transmission.
- Most (97%) of seafarers reported the possibility of a confidential HIV test in their community.

Indicator 24. Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy

100%. One (male, aged 30-39 yrs) of the nine people living with HIV started ART in December 2007. Over time, he has consistently followed the prescribed treatment and receives one-to-one counselling with senior medical staff with specific expertise in antiretroviral therapy.

Indicator 25. Percentage of infants born to HIV infected mothers who are infected

Subject matter is relevant, but indicator not relevant. Between 1 January 2008 and 31 December 2009, no infants were born to HIV infected mothers. There were no HIV infected mothers during this period.

To date, only one child has ever been born to an HIV infected mother in early 2000s.

[26] World Health Organization in the Western Pacific Regional Office in 2005 and 2006 provided support for the implementation of the first round of Second Generation Surveillance in Tuvalu.

Best Practices

Tuvalu is a small and fairly conservative Polynesian society where open discussion of sexual matters is still inhibited by custom. Sexual behaviour, especially of young people, is constrained by social expectations, although this is changing. Sexual intercourse is the main mode of HIV transmission in Tuvalu. Public education has been primarily used to address the threat of HIV. These programmes have had to work around the strong traditional constraints on discussing sexual issues and be focused on changing public attitudes, both towards increasing use of safe sex methods and away from prejudices against people with HIV and other STIs.

Public education programmes have been implemented mainly by NGOs:

- TANGO has been working to strengthen the capacity of communities to address HIV issues, particularly in the design of public education materials to more effectively communicate in the Tuvaluan cultural context and in Tuvaluan language. TANGO has received funding from AusAID and SPC.
- TUFHA has conducted a variety of programs to raise awareness and improve understanding about family issues and sexual and reproductive health, including HIV and STIs, including group discussions, workshops, drama group productions, school programmes, and other presentations. TUFHA is funded principally by IPPF.
- TRC has focussed on education programmes and life-skills training for seafarers and their wives. These types of behavioural and attitudinal changes can be difficult to monitor. This initiative was funded mainly by UNICEF. Funding is currently being sought to continue this programme.

The following were identified by government and civil society as examples of best practices occurring in Tuvalu over the last two years:

- Effective and collaborative working relationship between government and NGOs in their response to HIV/ AIDS and STIs. Demonstrated by:
    - The collaborative implementation of the NSP
    - Regular well attended TuNAC meetings to share progress, challenges and discuss and agree future directions
    - Open access and effective communication across agencies
    - Flexible and transparent funding arrangements to minimise duplication of effort
    - Sharing of resources including people and money
    - A targeted programmatic approach based on the NSP.
- Growing political commitment as demonstrated by:
    - Ongoing Government agreement to allocate funds for the treatment of HIV/ AIDS
    - A Clark to Parliament being is a member of TuNAC. Their role is to remain informed about the national response and ensure Parliamentarians remain up-to-date on activities and progress.
- Capacity building across NGOs through TANGO assisting in the preparation of proposals across the nine islands. This capacity building has enabled NGOs to remain connected and engaged and able to access Government funding streams.
- TuNAC has secured the support of the Ekalesia Kelisiano Tuvalu (EKT)[27] for the NSP. This is a significant achievement given the previous resistance to the national programme, in particular the marketing and promotion of condoms. Through the EKT General Assembly, members of the church are now actively involved in the implementation of the NSP through their membership of TANGO, TuFHA and TuNAC.

[27] Main denomination church of which over 90% of the population are followers.

Major Challenges and Remedial Actions

Discussions with government and civil society and wider analysis identified the following challenges arising between 2008 and 2009, and their remedial actions.

Challenge 1: Outer island access

- Ensuring reach of prevention programmes and access to testing, counselling and treatment to the outer islands, (around 50% of people live in the outer islands).

Action 1

- Expand education programmes to outer island and develop testing protocols for the islands.

Challenge 2: Ongoing stigma towards PLWH

- In Tuvalu, PLWH do not want their HIV status to be disclosed in their communities. As a result, there are PLWH who are not registering for treatment for fear others may learn of their status. Only one person is currently receiving ARV treatment, and they only agreed to treatment when significantly ill with HIV related illnesses.

Action 2

- Ensure PLWH feel secure and reassured about the confidentiality of VCCT processes
- Support for PLWH to ensure they feel both confident and protected to act as positive ambassadors to encourage greater uptake of testing and treatment.

Challenge 3: Ongoing stigma and fear of HIV/ AIDS within the community

- Tuvalu's DHS 2007 highlighted the ongoing stigma about HIV/ AIDs
    - Only 30% of women and men expressed acceptance attitudes on all four indicators.
- Ministry of Health and civil society comment that testing levels are low due to the ongoing stigma and fear about HIV/ AIDS and STIs.

Action 3

- Strengthening the stigma and discrimination of the HIV training for peer educators
- Inclusion of other population groups in education programmes, in particular parents and grandparents, as their messages need resonate with wider education and prevention programmes for youth
- Expansion of stigma and discrimination education about HIV/ AIDS to the outer islands
- Ensuring VCCT is perceived by population as offering a confidential service.
- Revising the secondary school curriculum and training teachers to deliver the HIV/ AIDS and STI curriculum.

Challenge 4: Seafarers

- Mandatory testing for HIV/ AIDS has been for a long time a requirement for seafarers wanting to work on overseas ships. From 2010, mandatory testing will no longer be required. From a human rights perspective, this is a positive change for seafarers with HIV as it enables them to continue their work. This has significant wider family and community benefits as seafarers tend to be the main income earner for their wider family. From an epidemiology perspective, this is likely to decrease the number of people seeking an HIV test, particularly amongst Tuvalu's most-at-risk population.

Action 4

- Ministry of Health is exploring the possibility of testing and not linking for the most at risk population, and is given careful consideration of the legal and ethical implications of this approach.

Challenge 5: Other most-at-risk populations

- Tuvalu's 2007 DHS identified a low incidence of sex workers and MSM. Currently, there are no programmes targeting these populations.

Action 5

- TuNAC will continue to monitor these groups and will target as appropriate.

Challenge 6: High knowledge levels but continuing high risk behaviour

- Knowledge of prevention strategies for HIV/ AIDS is high across the population. However, high risk sex continues.
- In 2008, the Burnett Institute noted that awareness raising of HIV/ AIDS is reaching saturation and that efforts need to be targeted towards high-risk groups[28]

Action 6

- Developing a behavioural change strategy for Tuvalu.
- Devising a condom distribution strategy and a national monitoring system to track promotion and distribution.
- Developing tailored prevention plans to meet the specific needs of high-risk groups especially: seafarers and their wives/ partners, men who have sex with men; frequent travellers, students studying aboard, and youth.

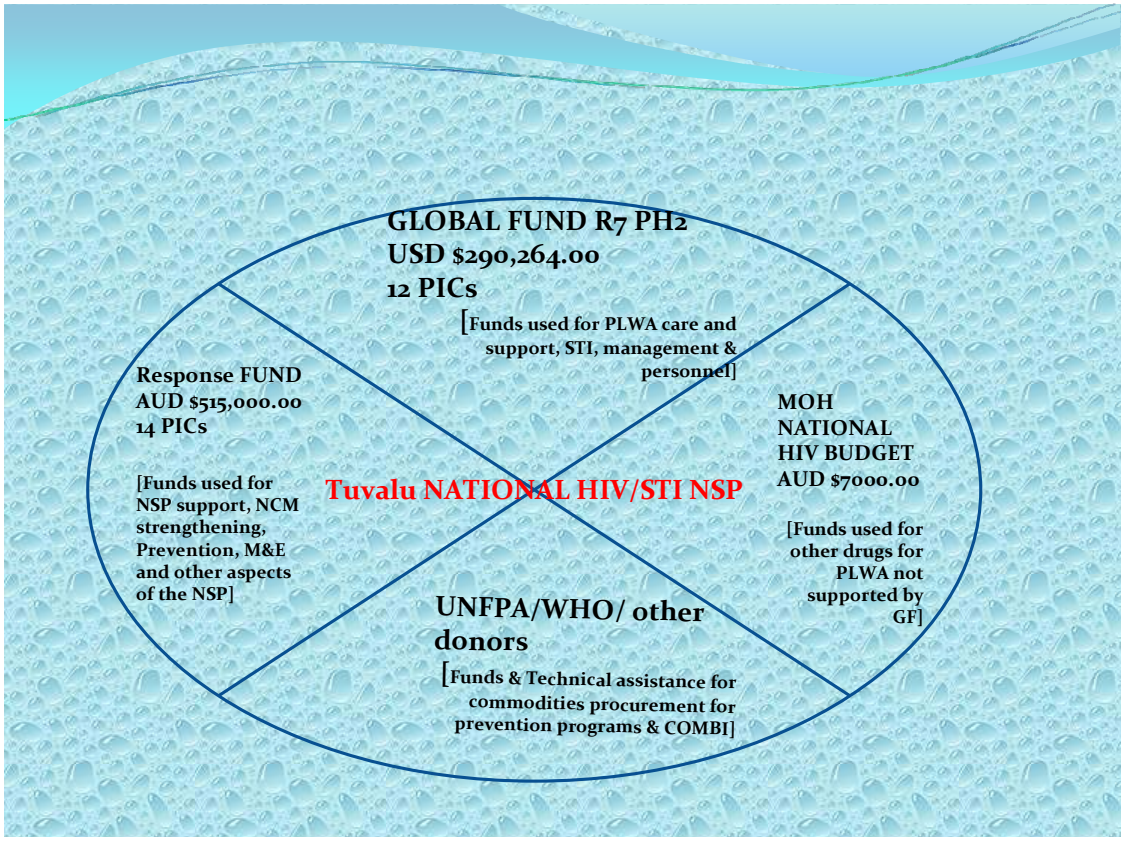
[28] In 2008, the Burnett Institute undertook the Tuvalu Cluster Evaluation of the Pacific Regional HIV/AIDS Project Grants Program.

Support from Tuvalu's Development Partners

The Tuvalu Government provides only a small annual allocation (AU$7,000) to the Ministry of Health for HIV treatment. All other funds for activities specific to HIV and AIDS come from development partners. These principally are:

- GFATM, this funding is channelled through TANGO for community empowerment and education activities.
- AusAID, through the Australian Government's bilateral aid programme to Tuvalu. This funding similarly is channelled through TANGO for community empowerment and education activities.
- IPPF which is channelled through TuFHA for community education activities
- WHO, which assists the Ministry of Health.
- UNICEF, which provides funding through the TRC for education programmes and lifeskills training.
- The Response Fund which is used for NSP support, NCM strengthening, prevention, M&E and other NSP aspects.

The following chart summarises the four key funding streams:



Monitoring and Evaluation Environment

TuNAC is responsible for the overall monitoring and evaluation of the national response to HIV. The NSP details the various monitoring and evaluation tools that will monitor the various activities for different Government agencies and NGOs. The NSP 2008 – 2012 will be reviewed at the end of every year for the next four years to allow for evaluation and planning.

- In 2005, the first SGS was undertaken which included STI surveillance to monitor the spread of STI in populations at risk of HIV and behavioural surveillance to monitor trends in risk behaviours over time.
- In 2007, Tuvalu undertook the DHS which included questions on HIV/ AIDS related knowledge, attitude and behaviours. The final report was released in early 2010 and was a key data source for the 2010 UNGASS indicator reporting[29].

A draft M&E framework has been collaboratively developed and is currently waiting endorsement from TuNAC. This is expected to occur in March 2010. A review was undertaken in 2008, using an M&E Systems Strengthening Tool, which focused on Assessing the M&E Plan and the Data Management Capabilities of the Program/Projects Management Units. A copy of the 2008 assessment of the M&E systems is in Annex 1. The following strengthening measures were identified in 2008:

- Devise monitoring and evaluation framework for the NSP with clear indicators and develop simplified/standardised reporting tools. *Awaiting TuNAC endorsement.*
- Provide M&E training for NAC secretariat, Ministry of Health staff, NGOs, and other focal personnel on utilisation of tools developed. *Not known if occurred/ occurring.*
- Train all health workers (including outer island) and lab staff in STI case recording and reporting procedures. *Not known if occurred/ occurring.*
- Review the NSP annually to assess progress against targets. *To be implemented.*
- Undertake a review and implement recommendations of HIV and STI laboratory testing policy and procedures in Tuvalu (including review of stock and inventory system - especially financial aspects). *Not known if occurred/ occurring.*
- Establish sero-surveillance sites and develop a national database for sero and behavioural surveillance enabling regular review and analysis of trends in the epidemic, reporting and aggregation of data. *Not known if occurred/ occurring.*
- Develop and implement tools for routine monitoring of CSM activities, particularly: condom availability; lube availability; condom / lube quality; condom/ lube cost; community attitudes to condoms; condom use; and lubricant use. *Not known if occurred/ occurring.*

Monitoring of disease trend is currently the work of the Ministry of Health who reports directly to the TuNAC. M&E of disease was previously based entirely on biological surveillance with the use of case reporting of HIV and AIDS in a national register, death registration and STI surveillance are among the other surveillance systems still in use.

Going forward AUSAID is assisting Tuvalu to utilise the health information system. This will assist in improving the ability to collate and synthesis data currently being collected to inform policy and implementation of NSP. Tuvalu has requested short-term capability building for epidemiology to develop and to train local personnel. This will ensure in-country continuity and that data collected has meaning and relevance, and can be used to effectively inform programme development.

[29] http://www.spc.int/sdp/index.php?option=com_content&task=blogsection&id=13&Itemid=43

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ANNEXES

ANNEX 1: Findings from 2008 assessment of data reporting systems per program area

D.1- CHECKLIST - DATA REPORTING SYSTEMS PER PROGRAM AREA - Health Facilities			
		ANSWER Yes - completely Mostly Partly No - not at all	**COMMENTS** (compulsory if the answer is not "Yes - completely")
I- Systems for Reporting on Numbers of People Reached			
I.1. Data collection and aggregation at all Service Points			
1	There is a list of operational definitions of what is being counted for each indicator (e.g. what constitutes a person on treatment, a person counseled, a person tested).	Partly	The National Strategic Plan 2009-1013 has been endorsed and implementation begun. A need exists to create an M&E framework with operational definitions. Mandatory testing (required by recruiting agencies) conducted with seafarers, and overseas workers and students (although Government are apparently working to overturn both these policies) . OSSHHM guidelines are being used for treatment and care. There are also indications that testing practices do not adhere to international standards which has resulted in discrepancies in the number of confirmed HIV cases in Tuvalu. VCT is embryonic and implemented in an ad hoc manner. Clear definitions exist within health policy of what constitutes a health centre and the number of health centres in the outer islands.
These operational definitions meet ...			
2	… national standards.	Partly	Age groups are defined by MOH Statistics as >1, 1-4, 5-14, 15-25, 25+.

3	… international standards.	Partly	OSSHHM treatment and care guidelines were based upon international standards and have been endorsed by TUNAC and MoH. However, HIV testing practice appears to be inconsistent and deviate from international standards affecting the integrity and consistency of data collected.
4	The same operational definitions of indicators are systematically followed by all service points included in the Program/Project(s).	Partly	Two service points for HIV and STI care: MOH and TUFHA, all testing is done by Government lab, so uniform in definitions. However, VCCT is sporadic, no NSP M & E framework, making further developments necessary.
The reporting system avoids double counting …			
5	*…within* each point of service (e.g., when an individual receiving the same service multiple times at the same service point is improperly counted more than once).	Mostly	Small PLHA numbers managed by one clinician, and usage of patient identification numbers largely limits the double counting issue.
6	*…across* service points (e.g., when an individual receiving the same service from different service points is improperly counted more than once).	Mostly	There are two service points at the national level. Service provision in the outer islands is limited to basic primary health care although it seems that symptomatic treatment of STIs provided and reported on. Counting appears to occur at point of service delivery which, when coupled with limited sites and limited populations makes double counting unlikely
7	The reporting system enables the clear identification of a "drop out" or a person "lost to follow-up".	Yes - completely	Follow-up is conducted for all clients, the small population (one treating clinician, one lab technician, one health promotion officer) contributes to this.

8	At each point of service, the responsibility for data-collection is clearly assigned to the relevant staff (i.e., it is in their job description).	Mostly	Government are working on institutionalising a reporting form for treatment provided in outer islands. Presumably, responsibility for collecting data will be allocated as part of this process. Currently, however there appears to be sporadic reporting, and no formal allocation of responsibilities. While there is a STI/HIV register for patients symptomatically diagnosed, there is little to indicate that it is being consistently updated.
9	All service points use standardized or compatible data-collection forms (e.g., medical records, registers).	Mostly	See above
10	Clear instructions are available on how to fill-out the data-collection forms.	No - not at all	See above, no instructions are on the lab requisition form. It generally appears that ability to use these forms are assumed or will be gained through on-the-job experience rather than through a formal, national procedure - so there is some potential for error here, especially with absence of operational definitions.
11	When available, the relevant national forms are used for data-collection. *[Not applicable to the National Program]*	Yes - completely	Lab requisition forms are used by all departments at Princess Margaret Hospital to request HIV and STI testing. And, as mentioned, HIV/STI data collection forms exist and are utilised.
12	For reporting on aggregated numbers of people reached/served, all service points use standardized or compatible reporting tools/forms.	Partly	One service point for testing enables aggregation. Consolidated Monthly returns from each of the islands requires the Officer in-charge to report any STI cases treated for that particular month. These data are recorded on the centralised Health Information System Unit at PMH. However, need to develop and ensure that data collected consistently, and responsibility for data collection is clear.

13	Clear instructions are available on how to use the reporting tools/forms.	Mostly	Outer islands have a form for HIV/STI reporting that they are required to fill in, and Ministry of Health are now working to ensure that they are trained and information consistently reported. As such, need to ensure that MoH institutionalisation of reporting includes instructions on how reporting forms should be filled in, and responsibility for this formally recognised henceforth.
14	At all service points, there are designated staff responsible for the review and validation of aggregated numbers prior to submission to the next level (i.e., it is in their job description).	Partly	Consistent review of validation of data continues to be a challenge. Public Health Director is responsible for reviewing data and reports. A Ministry of Health annual report has not been produced since 2002. However, as mentioned, there do appear to be moves to improve this.
15	All source documents (e.g., medical records, registers) are available for auditing purposes.	Mostly	All documents are available for review if the appropriate person is there to locate the documentation. Computer system is not backed up.
I.2. Further data aggregation and processing (related to people reached at service points)			
16	Data on aggregated numbers of people reached/served are reported through a single channel of the national information systems.	Partly	To date, data generally remains within its relevant domain (e.g. lab, public health, OPD) and is not aggregated into one report. However. As mentioned, there are moves to aggregate treatment data and to promote inclusion of data from NGO site in national figures - although no indication if this will be reported upon
17	At all intermediate levels at which data are aggregated (e.g., Districts, Regions), there are designated staff responsible for reviewing the quality of reports submitted by lower levels (e.g. from service points)	Partly	Responsibility is designated to the Public Health Director for reviewing all data.
18	At all intermediate levels at which data are aggregated, reports received from lower levels are systematically verified for completeness and obvious mistakes.	Mostly	There is currently slow reporting from outer islands and human resource capacity to review and verify information is limited. However, as mentioned, there are moves to improve this system
19	At all intermediate levels at which data are aggregated, mechanisms/procedures are in place to reconcile discrepancies in reports.	No - not at all	At present this does not appear to be the case, as there is little/no evidence that data is being systematically reviewed, nor reports collated.

20	There are quality controls in place for when data from paper-based forms are entered into a computer (e.g., double entry, post-data entry verification).	No - not at all	Data entry is occurring on national health information system, but not indication of how this data is checked, as above.
21	There is a written back-up procedure for when data-entry or data-processing is computerized.	No - not at all	No indication of this.
22	All reporting forms used for aggregating or analysis are available for auditing purposes at all levels at which data is being reported.	Partly	As there is only one level of aggregation, and original data is kept - although sometimes difficult to access, this appears to be partially fulfilled.

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23	Distributors systematically use log sheets to record the number of commodities distributed.	Mostly	Pharmacy and lab have log sheets for supplies, not updated on a regular basis. Reproductive health record the number of condoms distributed in an ad hoc manner.
24	Distribution log sheets received from distributors are systematically verified for completeness and obvious mistakes.	Partly	As above, record of distribution not consistently kept
25	Mechanisms/Procedures are in place to reconcile discrepancies in distribution log sheets.	Partly	As above, record of distribution not consistently kept
26	Distribution numbers (from aggregated log sheets) are reconciled with the numbers from the inventory control systems (i.e., the numbers of commodities retrieved from warehouses for distribution purposes).	Partly	As above, record of distribution not consistently kept
27	There are quality controls in place for when data from distribution log sheets are entered into a computer (e.g., double entry, post-data entry verification).	N/A	Data is not entered into a computer. Log books are used. Data entered at the Pharmacy does not have a quality control procedures; the paper based log book is the primary source of data. Laboratory does not have its own computer; the computer is on loan from a local internet cafe. The lab is using a paper based log book.
28	All data source documents (e.g., distribution log sheets) are available for auditing purposes.	Mostly	

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29	There is a clear definition of what constitutes training for health facility-based interventions (e.g., specific learning objectives based on needs assessment, course outline, expected knowledge to be gained).	Mostly	Health master plan development in progress, conducted by MOH and WHO. This should be completed early 2009 and will include a human resource component. Government has pre-service and in-service training plan for government staff. Yearly development plans are submitted which highlight training needs.
This definition meets…			
30	…national standards.	Partly	In the process of developing the above stated plan with the assistance of WHO
31	…international standards (e.g., technical agency or donor standards, if any).	Partly	In the process of developing the above stated plan with the assistance of WHO
32	There is a mechanism/procedure in place to ensure that people counted as trained have completed the whole training.	Yes - completely	
33	There is a mechanism/procedure in place to verify that the learning objectives have been reached (e.g., pre-post test, on the job observation of acquired skills).	Partly	Not all trainings have follow-up on learning objectives or evaluations.
34	The reporting system avoids double counting (e.g., when an individual receiving multiple trainings in the same program area is improperly counted more than once).	Mostly	Small population limits potential for double-up in training, and training records are kept and ostensibly aggregated. However, unclear as to whether this information is used for the purposes of avoiding duplication.
35	At all levels at which training data are aggregated, training reports received from lower levels are systematically verified for completeness and obvious mistakes.	Partly	There is a centralised database with Personnel and Training and reports are reviewed by public health staff. How consistently data are aggregated at this central point, however, is not clear
36	At all levels at which training data are aggregated, mechanism/procedures are in place to reconcile discrepancies in training reports.	Partly	One focal point receives the data, however, data is reviewed and aggregated on an ad hoc basis.
37	All source documents (e.g., attendance sheets, course outline with learning objectives) are available for auditing purposes.	Yes - completely	

38	There is a complete list of service points that is systematically updated (i.e., the name, location/address and characteristics of service points are periodically checked).	Yes - completely	
39	The service points are identified using ID numbers that follow a national system.	Yes - completely	Atolls are identified by name, one service point per atoll.
40	There is a mechanism/procedure in place to avoid double counting of service points/sites (e.g., two organization supporting the same site in the same program area in the same reporting period)	Yes - completely	
41	There is a mechanism/procedure in place to track inventory levels and stock-outs at the service points.	Mostly	Issues with financial system. Orders are placed, but invoices are not paid in a timely manner. This can interfere with service provision.

I- Systems for Reporting on Numbers of People Reached			
I.1. Data collection and aggregation in Community-based Entities			
1	There is a list of operational definitions of what is being counted for each indicator (e.g., what constitutes a person receiving a service).	No - not at all	National Strategic Plan 2009-1013 has yet to be finalised. A need exists to create and M&E framework with operational definitions. Clearer definitions are needed for VCT, peer education, community education.
These operational definitions meet ...			
2	… national standards.	N/A	No national standards exist
3	… international standards.	Partly	Striving to meet the UNICEF, UNFPA, ATFF and SPC standards.
4	The same operational definitions of indicators are systematically followed by all groups delivering the services through the Program/Project(s).	Partly	There exists some confusion around how data is to be collected, for what purpose and the process of ongoing data collection.
The reporting system avoids double counting…			

5	....*within* each group delivering services (e.g., when an individual receiving identical or related services from the same group is improperly counted more than once. For example, an OVC receiving school-related expenses and/or nutritional support from the same group).	No - not at all	Data collection is not systematic, nor is the data that is collected analysed. Log books are kept by TUFHA on condom distribution and training, but this information is not always routinely collected. Red Cross has a condom distribution log and a training log, however, the consistency of this data collection should be reviewed.
6	...*across* groups delivering similar services (e.g. ,when an individual receiving identical or related services from different groups is improperly counted more than once. For example, an OVC receiving school-related expenses and/or nutritional support from different groups).	No - not at all	Common data collection tools should be developed and civil society trained in methods of data collection, analysis and reporting. Limited or inconsistent data collection is particularly evident in peer education outreach and condom distribution.
7	Within each group delivering the services, the responsibility for data-collection is clearly assigned to the relevant staff (i.e., it is in their job description).	Partly	Head of agency collects information, however, data is not systematically or routinely collected.
8	All groups delivering the same services use standardized or compatible data-collection forms.	No - not at all	Common data collection tools need to be developed.
9	Clear instructions are available on how to fill-out the data-collection forms.	No - not at all	See above
10	When available, the relevant national forms are used for data-collection. *[Not applicable to the National Program]*	Partly	National Lab requisition forms are used by TUFHA. No current indication that national STI/HIV reporting forms are being used, however there are moves from Government to promote utilisation of such forms and aggregation at national level.
11	For reporting on aggregated numbers of people reached/served, all groups delivering the services use standardized or compatible reporting tools/forms.	No - not at all	As above
12	Clear instructions are available on how to use the reporting tools/forms.	No - not at all	As above
13	Within all groups delivering the services, there are designated staff responsible for the review and validation of aggregated numbers prior to submission to the next level (i.e., it is in their job description).	Partly	Data is not always aggregated or analysed.

14	All source documents (e.g., forms) are available for auditing purposes.	Partly	Condom distribution log and some training data is available
15	At all intermediate levels at which data are aggregated (e.g., Districts, Regions), there are designated staff responsible for reviewing the quality of reports submitted by lower levels (e.g. from service points)	N/A	No inter-organisational levels of aggregation - national only
16	At all intermediate levels at which data are aggregated, reports received from lower levels are systematically verified for completeness and obvious mistakes.	N/A	
17	At all intermediate levels at which data are aggregated, mechanisms/procedures are in place to reconcile discrepancies in reports.	N/A	
18	There are quality controls in place for when data from paper-based forms are entered into a computer (e.g., double entry, post-data entry verification).	N/A	Systems are not computerized.
19	There is a written back-up procedure for when data-entry or data-processing is computerized.	N/A	
20	All reporting forms used for aggregating or analysis are available for auditing purposes at all levels at which data is being reported.	Partly	As per 14

21	Distributors systematically use log sheets to record the number of commodities distributed (i.e., to commercial and community sites).	Partly	TUFHA has distribution log, not continued when the staff member travels, peer educators distribute in night clubs and Fusi, but no consistency in data collection
22	Distribution log sheets received from distributors are systematically verified for completeness and obvious mistakes.	Partly	MSI condoms are monitored by MSI project officer at TUFHA - but again not always routinely collected. Some confusion around the availability of UNFPA condoms and how these condoms are tracked and how distribution is monitored. IPPF condoms are also distributed, however, there is no aggregated number of condoms distributed.
23	Mechanisms/Procedures are in place to reconcile discrepancies in distribution log sheets.	Partly	MSI condoms are monitored by MSI project officer at TUFHA.

24	Distribution numbers (from aggregated log sheets) are reconciled with the numbers from the inventory control systems (i.e., the numbers of commodities retrieved from warehouses for distribution purposes).	Partly	MSI condoms are monitored by MSI project officer at TUFHA.
25	There are quality controls in place for when data from distribution log sheets are entered into a computer (e.g., double entry, post-data entry verification).	N/A	Paper based system is in use throughout civil society.
26	All data source documents (e.g., distribution log sheets) are available for auditing purposes.	Mostly	Access to information is limited when key staff are travelling (which is frequent) or out of office.
27	There is a complete list of points of distribution/sale that is systematically updated (i.e., the name, location/address and characteristics of points are periodically checked).	Partly	Condom research being conducted by TUFPA: questionnaire on youth and their use of condoms, accessibility. Intend to develop an evidence based social marketing campaign with 8 island youth groups.
28	Stock-outs at points of distribution/sale are regularly monitored and reported.	Mostly	MSI condoms are monitored and maintained by MSI project officer at TUFHA. Unclear for other partners

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29	There is a clear definition of what constitutes training for community-based interventions (e.g., specific learning objectives based on needs assessment, course outline, expected knowledge to be gained).	Partly	Peer educators are trained using SPC/UNFPA or ATFF training manuals. Concerning external training provision, it is dependent upon the training and which technical agency facilitates it making this difficult to assess
This definition meets…			
30	…national standards.	N/A	No national standard
31	…international standards (e.g., technical agency or donor standards, if any).	Partly	As per 29
32	There is a mechanism/procedure in place to ensure that people counted as trained have completed the whole training.	Partly	Data remains with selected key focal points at each agency. Unclear as to whether participants must have completed entire training to be counted
33	There is a mechanism/procedure in place to verify that the learning objectives have been reached (e.g., pre-post test, on the job observation of acquired skills).	Partly	Dependent upon the training and who facilitates it.

34	The reporting system avoids double counting (e.g., when an individual receiving multiple trainings in the same program area is improperly counted more than once).	No - not at all	Double counting is evident in training records and/or lack of training records
35	At all levels at which training data are aggregated, training reports received from lower levels are systematically verified for completeness and obvious mistakes.	N/A	Training data not aggregated within organisations
36	At all levels at which training data are aggregated, mechanisms/procedures are in place to reconcile discrepancies in training reports.	N/A	Training data not aggregated within organisations
37	All data source documents (e.g., attendance sheets, course outline with learning objectives) are available for auditing purposes.	Partly	Data is fragmented and incomplete

I- Systems for Reporting on Numbers of Individuals Trained related to Systems Strengthening			
1	There is a clear definition of what constitutes training related to systems strengthening (e.g., specific learning objectives based on needs assessment, course outline, expected knowledge to be gained).	Partly	Draft National Strategic Plan and Pacific Regional Strategy Implementation Plan incorporate training needs for system strengthening.
This definition meets …			
2	…national standards.	N/A	No national standards
3	…international standards (e.g., technical agency or donor standards, if any).	Mostly	Based on the Regional Strategy Implementation Plan
4	There is a mechanism/procedure in place to ensure that people counted as trained have completed the whole training.	Yes - completely	Attendance records are kept
5	There is a mechanism/procedure in place to verify that the learning objectives have been reached (e.g., pre-post test, on the job observation of acquired skills).	Partly	Dependent upon who conducts the training and their method of evaluation or follow-up
6	The reporting system avoids double counting (e.g., when an individual receiving multiple trainings in the same program area is improperly counted more than once).	Partly	This data is not aggregated; small numbers of staff and a small community limit double counting. E.g. One lab in the country with one lab staff member
7	At all levels at which training data are aggregated, training reports received from lower levels are systematically verified for completeness and obvious mistakes.	No - not at all	Data is not aggregated

8	At all levels at which training data are aggregated, mechanism/procedures are in place to reconcile discrepancies in training reports.	N/A	Data is not aggregated
9	All source documents (e.g., attendance sheets, course outline with learning objectives) are available for auditing purposes.	Partly	Dependent upon whether or not the person who has the records is available

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10	There is a complete list of supported facilities/organizations that is systematically updated (i.e., name, location/address and characteristics of facilities/organizations).	Yes - completely	
11	The supported facilities/organizations are identified using ID numbers that follow a national system.	N/A	There is one lab in Tuvalu
12	There is a mechanism/procedure in place to avoid double counting of supported facilities/organizations (e.g., two organization supporting the same site in the same program area)	N/A	There is one lab in Tuvalu
13	There is a mechanism in place to track inventory levels and stock-outs at the service points.	Yes - completely	