



GLOBAL AIDS  
MONITORING  
REPORT FOR TUVALU



Ministry of Health of Tuvalu  
2017



We are pleased to introduce the Global AIDS Progress report of Tuvalu for 2017.

With this report you will find evidence of better use of data to guide national planning processes, and greater focus on reflecting the contribution of all stakeholders in the national response to AIDS. This reporting cycle has reiterated the willingness of the government not only to honor the commitment to the High Level Declaration of Commitment of 2016, but also to ensure that the interventions set out to reach the commitments are successful, constructive and accountable.

The reporting process has established a framework for strengthened collaboration and partnerships across organizations, regions and sectors going beyond health.

The common objectives, such as reaching 90-90-90 goals, reinforced the message that HIV is one of the world's challenges that is too intersectorial and complex for any sector to proceed alone.

Common objectives – such as to save people's lives, to ensure social inclusion of People Living with HIV/AIDS and to mitigate the impact AIDS has on community and household levels have finally paved the way for enhanced collaboration between the government, civil society, and People Living with HIV/AIDS.

We are strong in our intention to support further GAM reporting, and to ensure its quality improves along with the increased quality of strategic planning, coordination and transparency of decision making and with improved monitoring and evaluation.

A handwritten signature in blue ink, reading "Nese Ituaso-Conway". The signature is written in a cursive style and is set against a light blue background.

Dr. Nese Ituaso-Conway  
Director of Health

This report was prepared by the Ministry of Health of Tuvalu on March 31, 2017 with technical support from UNAIDS Office in the Pacific.

This report was coordinated by the Tuvalu Department of Public Health which is leading the HIV/AIDS program response in Tuvalu. The data and analyses presented in this report was drawn from a diverse range of sources including (but not limited to): Department of Public Health and the Tuvalu Princess Margaret Hospital, Laboratory and STI Clinic administrative and reporting data; Pacific Multi-Country Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations, Tuvalu 2016 and key informant interviews.

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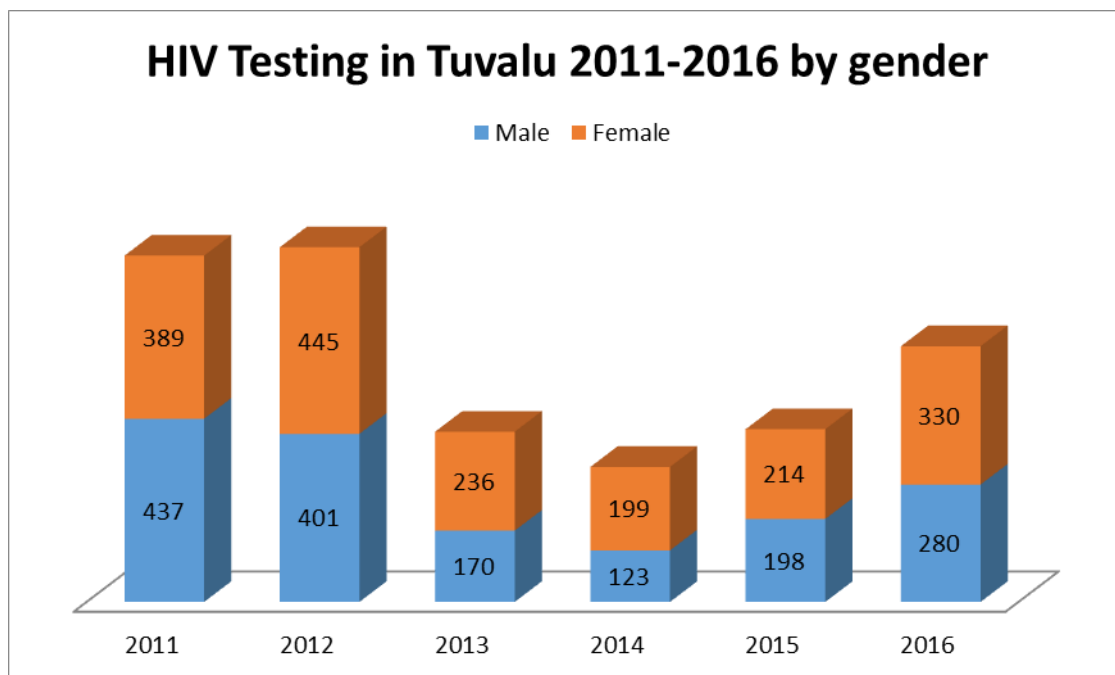
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## I. Status at a glance

### HIV Status

In terms of land area, Tuvalu is the fourth smallest country in the world. The land is very low-lying, with five narrow coral atolls and four islands. The highest elevation is five metres (16 ft) above sea level. Because of the low elevation, the islands that make up the nation may be threatened by any future rise in sea level due to global warming. Under such circumstances, the population may evacuate to New Zealand, Niue or the Fijian island of Kioa. The land is very poor and the soil is hardly usable for agriculture. This is why the majority of male population of Tuvalu are working as seafarers. There is almost no reliable supply of drinking water. Westerly gales and heavy rain affect the country from November to March and tropical temperatures moderated by easterly winds from March to November.

The first HIV case in Tuvalu was found in 1995. The cumulative number of HIV cases by the end of 2017 was 15, four of whom have died. Two patients died in 2016. Of the 11 people with HIV still alive, none are currently enrolled in ART. In 2016, a total of 610 persons were tested for HIV, which represents 5,5% of the total population compared to 7.5% tested in 2015. The most recent HIV positive people in Tuvalu were registered in 2016 totalling 4, all males, two seafarers and 2 MSM/TG. For a population of approximately 11,000 people, this represents the highest rate of confirmed HIV cases of all 11 countries.



Voluntary counselling and testing (VCT) is current practice in Tuvalu for all HIV testing. The country's only laboratory, at Princess Margaret Hospital in Funafuti, is capable of doing HIV Determine and Serodia diagnostic tests. There is no testing available in outer islands. VCCT is performed by certified HIV Counsellors following an HIV Testing Policy for confidential counselling services. Upon consent, a HIV test is performed at PMH. HIV testing rates in Tuvalu dropped by 50% in 2014 but now it is slowly picking up.

	Male	Female	Total	
2011		437	389	826
2012		401	445	846
2013		170	236	406
2014		123	199	322
2015		198	214	412
2016		280	330	610
<b>Total</b>		1609	1813	3422

Table 1. HIV Testing in Tuvalu, 2011-2016

Seafarers account for most of Tuvalu's HIV cases (8 out of 11), while 2 other cases are an infected wife of a seafarer and her child. Thus nearly all HIV cases are linked to the seafarer community. In Tuvalu, there are no known people who inject drugs, nor known sex workers; however, there is anecdotal evidence of informal transactional sex.

Confirmatory tests, however, are still being sent to Fiji and/or Melbourne, Australia. This process can take weeks (Fiji) and months (Australia) and causes difficulties in the return of results, which can have a significant effect on the management of a case. Apart from voluntary testing, the laboratory also performs screening of all blood products for HIV and other common STIs.

Many young men in Tuvalu seek employment on overseas ships as it enables them to visit other countries. The nature of their work and the long periods of time away from their wives and families puts them at increased risk of contracting HIV and STIs. The period of absence from Tuvalu for seafarers ranges from seven months to 15 months and averages 12 months. Many women in Tuvalu are married to seafarers and are therefore at increased risk of contracting HIV and STIs when their husbands return from overseas (MOH Tuvalu, 2012). Behavioural surveys in the past few years among seafarers and young people have highlighted risk behaviours. Of the 209 seafarers covered by the a bio-behavioural (IBBS) survey in 2005, only 28% had correct knowledge of HIV prevention methods, while only 17% had both correct knowledge of HIV prevention and no incorrect beliefs about HIV transmission. While none of the seafarers in the study were HIV-positive, other STI rates were high: Chlamydia 8%; Hepatitis B 13%; and Syphilis 5% (MOH Tuvalu, 2012). Consistent condom use was reported as low between seafarers and all of their partners. Among seafarers with any STI, 57% reported using condoms during sex with a sex worker and 16.6% with a casual partner. Seafarers may play a key role in the spread of HIV and other STIs in Tuvalu as they have unprotected sex with partners overseas and also with regular partners in Tuvalu (MOH Tuvalu, 2012)..

In the same 2005 IBBS study, young people aged 15-24 had better knowledge of HIV and AIDS than seafarers: 84% had correct knowledge of HIV prevention and no incorrect beliefs about HIV transmission. The study also found that 43% of young people (14% of girls) were sexually active before the age of 18. While few youth reported sexual contacts with sex workers, nearly 14% of male respondents acknowledged having had sex with a male partner at some time in their life, and 8% said they had sex with a male partner during the previous 12 months. In addition, social change in Tuvalu has 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. (MOH Tuvalu, 2012)

Tuvalu Maritime Training Institute (TMTI) trains the young men who become seafarers in Tuvalu. The school runs an 18 months intensive course on seafaring which includes a comprehensive health subject specifically designed modules to educate them on HIV and STIs. The curriculum has been in place since 1999 and is taught by the clinical nurse based at TMTI. Seafarers who missed out on this

opportunity were given refresher courses on HIV and STI organized by the Tuvalu Overseas Seaman Union (TOSU), Tuvalu Red Cross (TRC) with support from the Ministry of Health.

Tuvalu Family Health Association (TUFHA) is a member of TUNAC and has been associated with HIV activities since the late 1980s and has been most active in the area of education and awareness and IEC development targeting young people in the country. Initially mandated for the provision of family planning services in its early days, TUFHA has since expanded its services to providing sexual and reproductive health services, including youth friendly services, counseling and clinical services which include HIV and STI referrals<sup>i</sup>.

Other stakeholders include the faith-based organizations, Tuvalu National Council of Women, Tuvalu Association for Non-governmental Organizations, Tuvalu Media Corporation, Ministry of Finance, Ministry of Education and Tuvalu National Youth Council.

### STI Status

Overall, the number of STI cases is low, with on average 16 cases among males per year, 10 cases among women overall, and three cases among ANC women per year (on average). In total, 155 Syphilis cases were found in the 2011-2016 period: 112 cases among males; 79 among females, of whom 37 among ANC women. There is a remarkable increase in the number of Syphilis cases detected in 2015, which cannot be attributed to increased testing: the number of tests in 2015 (n=461) was almost the same as in 2013 (n=413), but while only one case was detected in 2013, 77 cases were found in 2015, the majority among males (n=46) and 31 among females. All 46 male cases were found among OPD patients, while 24 out of 31 female cases were also found among OPD patients. There is no clear explanation for the disproportionately large number of cases among OPD patients in 2015. 604 syphilis tests were performed in 2017 with 24 positive cases detected.

	2010			2011			2012			2013			2014			2015			2016		
	F	All	M	F	All	M	F	All	M	F	All	M	F	All	M	F	All	M	F	All	
M	0	0	424	386	810	382	383	779	173	240	413	95	80	175	216	245	461			610	

Table 2. Syphilis Testing in Tuvalu, 2011-2016

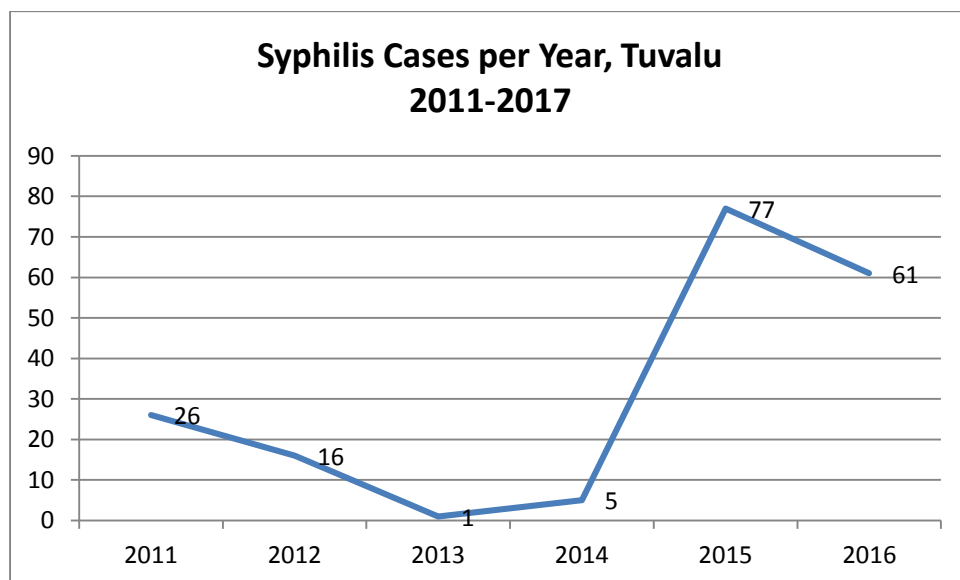
As we may see from the table syphilis testing increased from the last year, however when we look at the number of positive cases the number has also increased.

Most Syphilis cases among males were detected at outpatient departments, with the remaining cases found at the TuFHA clinic, among inpatients or seafarers. Almost two thirds of female cases are detected at outpatient departments, while most other cases are found among pregnant women at ANC facilities.

	Male	Female	Total
2011	18	8	26
2012	13	3	16
2013	0	1	1
2014	1	4	5
2015	46	31	77
2016	34	27	61

Table 3. Gender distribution of syphilis cases, 2011-2016

As you may see the number of males tested positive with syphilis is higher than in women, given that the proportion of women tested for syphilis is higher it indicates to a hidden men having sex with men transmission.



In 2016 212 pregnant women were tested for syphilis with 22 being diagnosed positive thus the percentage with a positive (reactive) syphilis serology in pregnant women is 10,4%. All of them received treatment. Tuvalu has subscribed to the regional Elimination of Congenital Syphilis (ECS) in the Pacific Strategy developed by SPC in 2014.<sup>ii</sup>

There have been ad hoc reports on an increasing incidence of sexually transmitted infections (STIs) in Tuvalu but no surveillance systems are in place to properly report and monitor the trends in the country. Information gathered from various clinics, found urethral discharge and genital ulcers to be the most commonly reported STIs based on syndromic case reporting. Diagnostic facilities for any STI remain a challenge in Tuvalu. The only laboratory in Tuvalu is capable of doing serology for syphilis, hepatitis B surface antigen, Gram stain for gonorrhoea, wet mount for trichomonal and candida infections. There are no facilities to test for chlamydia infection in Tuvalu.<sup>iii</sup>



## LIST OF REPORTED INDICATORS

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

Indicator	Value 2017	Source	Comments
<b>COMMITMENT 1: Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020</b>			
1.1 Percentage of people living with HIV who know their HIV status at the end of the reporting period			
1.2 Percentage and number of adults and children on antiretroviral therapy among all adults and children living with HIV at the end of the reporting period	0	MOH	
1.3 Percentage of adults and children living with HIV known to be on antiretroviral therapy 12 months after starting	Not relevant. No patients started treatment 12 months back		
1.4 Percentage of people living with HIV who have suppressed viral loads at the end of the reporting period	0	MOH	
1.5 Percentages of people living with HIV with the initial CD4 cell count <200 cells/mm <sup>3</sup> and <350 cells/mm <sup>3</sup> during the reporting period		MOH	No data
1.6 Percentage of treatment sites that had a stock-out of one or more required antiretroviral medicines during a defined period	0	MOH	No stock out
1.7 Total number of people who have died from AIDS-related causes per 100 000 population	19.9	MOH	2 died in 2016 to a population of 10058
<b>COMMITMENT 2: Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018</b>			
2.1 Percentage of infants born to women living with HIV receiving a virological test for HIV within two months of birth	Not relevant no HIV+ pregnant		
2.2 Estimated percentage of children newly infected with HIV from mother-to-child transmission among women living with HIV delivering in the past 12 months	Not relevant no HIV+ pregnant		
2.3 Percentage of pregnant women living with HIV who received antiretroviral medicine to reduce the risk of mother-to-child transmission of HIV	Not relevant no HIV+ pregnant		
2.4 Percentage of women accessing antenatal care services who were tested for syphilis, tested positive and treated	100		212 tested for syphilis, 22 positive and in treatment
2.5 Percentage of reported congenital syphilis cases (live births and stillbirth)			Data not available
<b>COMMITMENT 3: Ensure access to combination prevention options, including pre-exposure prophylaxis,</b>			

<b>voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations—gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners</b>			
3.1 Number of people newly infected with HIV in the reporting period per 1000 uninfected population			
3.2 Size estimations for key populations	10 – SWs, 300 – MSM, 40-TG		
3.3a Percentage of sex workers living with HIV			No data
3.3b Percentage of men who have sex with men who are living with HIV			No data
3.3d HIV prevalence among transgender people			No data
3.3e Percentage of prisoners/inmates/detainees who are living with HIV			No data
3.4a Percentage of sex workers who know their HIV status	25%		KAP Study
3.4b Percentage of men who have sex with men who know their HIV status	28.6%		KAP Study
3.4d Percentage of transgender people who know their HIV status	0%		Not available
3.5a Percentage of sex workers living with HIV receiving antiretroviral therapy in the past 12 months			No data
3.5b Percentage of men who have sex with men living with HIV receiving antiretroviral therapy in the past 12 months			No data
3.5d Percentage of transgender people living with HIV receiving antiretroviral therapy in the past 12 months			No data
3.5e Percentage of prisoners living with HIV receiving antiretroviral therapy in the past 12 months			No data
3.6a Percentage of sex workers reporting using a condom with their most recent client	25%		KAP Study
3.6b Percentage of men reporting using a condom the last time they had anal sex with a male partner	14,3%		KAP Study
3.6d Percentage of transgender people reporting using a condom during their most recent sexual intercourse or anal sex	60%		No data
3.7a Percentage of sex workers reporting having received a combined set of HIV prevention interventions	25%		KAP Study
3.7b Percentage of men who have sex with men reporting having received a combined set of HIV prevention interventions	14,3%		KAP Study
3.7d Percentage of transgender reporting having received a combined set of HIV prevention interventions	20%		KAP Study
3.11 Percentage of sex workers with active syphilis			No data
3.12 Percentage of men who have sex with men with active syphilis			No data
3.13 HIV prevention and treatment programmes offered to prisoners while detained			No data
3.14 Prevalence of hepatitis and coinfection with HIV among key populations			No data
3.15 Number of people who received PrEP for the first time during the calendar year			No data
3.18 The percent of respondents who say they used a condom the last time they had sex with a non-marital,			No new data

non-cohabiting partner, of those who have had sex with such a partner in the last 12 months.			reported previously
<b>COMMITMENT 4: Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020</b>			
4.1 Percentage of women and men aged 15-49 who report discriminatory attitudes towards people living with HIV			No new data reported previously
4.2a Percentage of sex workers who avoided seeking HIV testing because of fear of stigma, fear or experienced violence, and/or fear or experienced police harassment or arrest			No data
4.2b Percentage of men who have sex with men who avoided seeking HIV testing because of fear of stigma, fear or experienced violence, and/or fear or experienced police harassment or arrest			No data
4.2d Percentage of transgender people who avoided seeking HIV testing because of fear of stigma, fear or experienced violence, and/or fear or experienced police harassment or arrest			No data
4.3 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	37%		Gender Affairs Dept
<b>COMMITMENT 5: Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100 000 per year</b>			
5.1 Percentage of women and men 15-24 years old who correctly identify both ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission			No new data reported previously
5.2 Percentage of women of reproductive age (15-49 years old) who have their demand for family planning satisfied with modern methods	24,2%		DHS 2007
<b>COMMITMENT 8: Ensure that HIV investments increase to US\$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enable</b>			
8.1 HIV expenditure - Annex			
<b>COMMITMENT 9: Empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violations of human rights</b>			
9. National Commitments and Policy Instrument – Annex			
<b>COMMITMENT 10: Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C</b>			
10.1 Percentage of estimated HIV-positive incident tuberculosis (TB) cases that received treatment for both TB and HIV			No data
10.2 Total number of people living with HIV with active TB expressed as a percentage of those who are newly enrolled in HIV care			No data

10.3 Number of patients started on treatment for latent TB infection, expressed as a percentage of the total number newly enrolled in HIV care during the reporting period			No data
10.4 Number of men reporting urethral discharge in the past 12 months			No data
10.5 Rate of laboratory-diagnosed gonorrhoea among men in countries with laboratory capacity for diagnosis			No data
10.6 Proportion of people starting antiretroviral therapy who were tested for hepatitis B			No data
10.7 Proportion of people coinfectd with HIV and HBV receiving combined treatment			No data
10.8 Proportion of people starting antiretroviral therapy who were tested for hepatitis C virus (HCV)			No data
10.9 Proportion of people coinfectd with HIV and HCV starting HCV treatment			No data
10.10 Proportion of women living with HIV 30–49 years old who report being screened for cervical cancer using any of the following methods: visual inspection with acetic acid or vinegar (VIA), Pap smear or human papillomavirus (HPV) test			No data

## II. Overview of the AIDS epidemic

Tuvalu is having a low prevalence epidemic, however, the last four cases in 2016 with 2 seafarers and 2 TG/MSM indicates that there is a hidden MSM/TG transmission pattern. There are 15 cases of HIV registered in Tuvalu with 4 cases being registered in 2016 all males, none of the patients is currently in ART treatment. ART treatment has been initiated in only one male in 2007 but the patient died in 2010 due to non-adherence. There are 4 patients in total that died of AIDS of which two died in 2016 and 3 of them refused treatment. Among all patients there is also a child born from an HIV positive mother.

HIV and STI testing, counselling and treatment are provided by the MoH at the Princess Margaret Hospital on Funafuti. Until 2014, TuFHA was also providing testing services; however, at the request of the MoH, clients are now referred to the hospital for testing. It is unclear why the MoH requested that TuFHA cease testing activities. Given that key informants indicated a high degree of recognition and trust of TuFHA's services (including testing), re-establishing this service is advisable.

The Red Cross refers blood donors to the hospital for HIV testing when a blood donation is required. All seafarers are required to undertake an HIV test before signing a work contract. No clarification was provided as to whether people who test positive for HIV would be ineligible to undertake a seafaring job. Testing is not available on the outer islands, although testing on outer islands has taken place during TuFHA mobile outreach visits when a MoH laboratory technician has been available to undertake the visit.

HIV prevalence in Tuvalu is relatively low, but there are significant risk factors for HIV transmission. The high levels of STIs and teenage pregnancy are indications of high prevalence of risk-taking behaviours and low condom use. The significant amount of traveling out of and within the region increases the risk for exposure to and bridging infections. Traditional practices of tattooing, cultural taboos preventing open discussion of sexual matters and customary practices that encourage multiple sex partners and polygamy are not uncommon in the Pacific. Inequalities faced by women are still felt across in Tuvalu. The high proportion of rural populations makes it difficult to access and provide services needed especially in remote settings. Limited economic opportunities and high levels of unemployment sometimes force people into sex work as a means of generating an income. Religious beliefs that discourage condom use are very common in Tuvalu. In areas of conflict and social unrest, there is an increase incidence of forced sex and rape.

## III. National response to the AIDS epidemic

The mission of the Ministry of Health is "to ensure the highest attainable standard of health for all people of Tuvalu".

The Ministry's vision is "that all people of Tuvalu should enjoy the highest attainable standard of health, regardless of race, religion, political belief, or economic or social condition".

The year 2008 marked the beginning of the health reform process, with the development of a new health master plan to guide the work of the Ministry of Health over a 10-year period stretching from 2009 to 2019. The Strategic Health Plan 2009-2019, completed in early 2009, provides the Ministry of Health with the renewed aim to focus on primary health care and disease prevention.

In 2011, a review of several pieces of health legislation has been undertaken, including the Nurses Act, the Medical and Dental Act, the Public Health Act and the Pharmacy and Poison Act. The options

for development of an umbrella Act for Health Professionals in Tuvalu are also currently being reviewed. Development of the health infrastructure in the outer islands was another successful project that the Ministry of Health started to execute in 2008. The Ministry secured funding through the Government of Japan's Grant Assistance for Grassroots Human Security Projects to build a new medical centre for Vaitupu Island, followed by Niutao Island Medical Centre and Nui Medical Centre.

The same project will also cover new medical centres for the remaining outer islands. The new centres will improve the delivery of health services to the outer islands, with better facilities for inpatient care. In Funafuti, the renovation of the Reproductive Health Clinic to house the integrated programmes for Reproductive Health, Maternal Child Health, HIV and STI, TB and Adolescent Health Development was completed in early 2009.

Tuvalu does not have a standalone HIV Programme, the last one ended in 2013, however, the Tuvalu Ministry of Health Strategic Health plan 2009-2018 does provide for HIV through Outcome 4.2 Effective and integrated programs to combat spread of: HIV/AIDS and other STIs through strengthening health education and awareness programs to address communicable diseases and provides for Community awareness of risk factors and knowledge of preventive behaviours.

Tuvalu is also making use of the Regional Pacific Sexual Health & Well-Being SHARED AGENDA 2015-2019 as a guiding document for all HIV programs. TUNAC is the National HIV coordination mechanism and meets every two months.

The Tuvalu MoH, TuFHA and the Tuvalu Red Cross are the main organisations in Tuvalu working in HIV/STI prevention. The Tuvalu Pina Association, Tuvalu Maritime Training Institute, Tuvalu Overseas Seamen's Union, National Council of Women and National Youth Council have undertaken some activities in HIV/STI prevention over the past few years as well.

Prevention activities include education, condom distribution, and HIV/STI testing, predominantly taking place on the main island of Funafuti on which approximately half of Tuvalu's population resides.

In recent years, the focus of development activities in the country has broadly shifted to climate change, with a reduction in funding for HIV prevention. This shift is reflected in the work of many of the organisations, which are now focusing on climate change-related activities.

All organisations are based on the island of Funafuti; however, the Red Cross has representatives on the outer islands and the MoH has outer island clinics. No organisation currently specifically targets men who have sex with men or sex workers, though some engage directly with pina. In 2015, TuFHA attempted to engage with females thought to be undertaking sex work. This was unsuccessful, as the group of women denied being involved in sex work. The women were subsequently reached through broader community outreach activities.

The recently formed Tuvalu Pina Association, as well as the Red Cross and TuFHA, engage with transgender or pina in HIV-prevention activities. The Tuvalu Pina Association was established in 2015 following the Pacific Sexual Diversity Network (PSDN) Conference in Tonga. The organisation is currently in the process of gaining legal recognition as an association. The main mandate of the organisation is to advocate for the rights of pina. The association is comprised of 15 members who are members of two informal pina groups.

In addition to the Tuvalu Pina Association, PSDN currently has a Tuvalu representative who is a board member of PSDN and is responsible for executing the Board's objective and activities at the national and community level in Tuvalu.

There are two seafarer organisations: the Tuvalu Maritime Training Institute and the Tuvalu Overseas Seamen's Union (TOSU). The former carries out HIV/STI-related education and condom distribution as part of its seafarer training program. The MoH, TuFHA and the Red Cross also conduct HIV and STI prevention workshops at the Maritime Training Institute, and with other seafarers on an ad hoc basis. In 2011, a workshop was held by TOSU to develop an HIV Workplace Policy for Seafarers, the details of which could not be located at the time of the visit.

The National Council of Women is an umbrella organisation for 17 women's community groups. The National Youth Council undertakes the same role for youth and comprises 15 youth groups from Funafuti and outer islands. Both organisations have conducted HIV and sexual and reproductive health education workshops integrated into larger activities on an ad hoc basis when funding is available.

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

ART treatment for people living with HIV is available in Tuvalu for free, however none of the people living with HIV is currently in treatment due to high level of stigma and discrimination. ART treatment has been initiated in only one male in 2007 but the patient died in 2010 due to non-adherence.

Oceania Society for Sexual Health and HIV Medicine (OSSHM) Guidelines 2010- 2011 revised version is used for ART treatment. There are no cases of HIV- TB co-infection but OSSHM guidelines are in place for patient management, should a case is diagnosed. Only the Director for Ministry of Health provides treatment for HIV positive persons.

A HIV Clinical Team has been set up at Princess Margaret Hospital to look after people living with HIV and AIDS. This clinical team, consisting of three senior doctors, two senior nurses, a nurse from TUFHA, and a pharmacist, has been trained to fully implement the national anti-retroviral therapy (ART) guidelines endorsed by the Ministry of Health in 2004. The HIV clinical team is in the process of developing broader care and support systems for people living with HIV and AIDS in Tuvalu that are expected to be finalized in 2017. Also the guidelines will be aligned to WHO recommendations for treatment in patients with HIV with support from WHO.

Syndromic management of STIs is currently used for the treatment of all STIs in Tuvalu. The protocols are available at all medical centres on the outer islands. Syphilis cases that are detected at PMH are treated according to WHO standard protocols.

Legislation in Tuvalu prevents the operation of private medical practices and pharmacies, and all facilities available on the islands are public, with 99% of total health funding being provided by the government. The country's one hospital, Princess Margaret Hospital, is located in Funafuti and is capable of providing basic primary healthcare, dental and pharmaceutical services. There are also eight medical centres, located on the outer islands, which are staffed by nurses. Tuvalu's main

pharmacy is located in the Princess Margaret Hospital, and is responsible for the procurement of drugs and reproductive health commodities from suppliers. The Department of Pharmacy, which is a branch of the Ministry of Health, is responsible for organising training for nurses working in Tuvalu's medical centres, such that they are proficient in the ordering and management of medicines and drugs.

Human resources are the main challenge to health services in Tuvalu. There needs to be an on-going effort to strengthen the knowledge and expertise of existing staff.

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

There are 8 ANC facilities in Tuvalu, one for each island except for the island of Niulakita. There is 100% ANC and skilled delivery coverage in Tuvalu. All standard routine tests are done for mothers on their first booking. They are then referred for VCCT which is offered by a group of certified counsellors. HIV screening services for pregnant women is offered by TUFHA and PMH. However ART is provided by PMH only. Zero cases of HIV positive pregnant women have been reported in 2016. Tuvalu does not have a PMTCT/ PPTCT policy at this stage, but work has begun on drafting this. PMH is a baby friendly hospital and implements the Breastfeeding policy.

A total number of **286** pregnant women have been registered in Tuvalu with **286** having an HIV test in 2016. This is a routine check for all pregnant mothers.

From among HIV patients there is a child born from an HIV+ mother.

PMH is the main centre for child birth. Due to the geography of Tuvalu and shipping being the main mode of transport (which takes between 4 hours – 22 hours of travel each way from Funafuti), each island has a trained mid- wife. First time mothers as well as women with history of previous complicated deliveries or suspected complex cases are always referred to PMH at about 32 weeks of gestation. Around 99% - 100% of births take place in the hospital and are attended by skilled health personnel. In addition, TUFHA and PMH also provide family planning services. VCCT is offered to all pregnant mothers only in Funafuti, HIV testing is not available in outer islands. Counselling is done by a group of certified HIV counsellors.

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



While Tuvalu has only a small number of people living with HIV, three groups are vulnerable to infection: seafarers, transgender/men who have sex with men, and female sex workers. Health service capacity is limited and it is unknown how well these services meet the needs of these groups. In the 2016 the Pacific Multi-Country Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populationsiv for Tuvalu Study it is estimated that there are between 20 and 40 transgender in Tuvalu; however, due to the hidden nature of the population, the team was unable to provide an accurate estimation of the number of men who have sex with men. The same study estimated that there are at present up to 10 women involved in transactional sex.

### **Seafarers**

The behavioural survey of 41 Tuvalu seafarers was undertaken. Half of the seafarers had a regular sexual partner in the last 12 months. Only 15% had casual sexual partners and 12% had commercial sexual partners in that time.

Condom use was low on the occasion of last sex with all types of partners (27% with regular partners, 12% with casual partners, and 20% with commercial partners).

Knowledge of HIV transmission was poor, with only 10% answering all knowledge questions correctly. While a majority of seafarers knew where they could access health services, fewer knew where to access HIV and STI testing and condoms. Nearly 50% had accessed a health service and the majority were satisfied with the service and would use it again. 31.7% of the seafarers had been tested for HIV in the last 12 months. Two of the men in the survey had tested positive for HIV.

### **MSM/Transgender**

Twelve transgender/men who have sex with men took part in a behavioural survey and five in in-depth interviews. There was a spread of sexual identity across gay/homosexual, bisexual, heterosexual and transgender. Transgender having sex with men is culturally unacceptable, but even more proscribed is men having sex with transgender, and sex between men. A minority of participants reported feeling ashamed and guilty of their sexual identity. 83% of men in the survey had had sexual intercourse. Of these, 44% had anal intercourse (either insertive or receptive) in the last 12 months. Four of the 11 men reported sex with a female partner in the last 12 months.

Overall knowledge about HIV was good in this group, and the participants knew that condoms are a barrier to HIV infection. Even so, condom use was inconsistent and the barriers to condom use were stigma and shyness. Three of six men reported condom use for anal sex with a regular male partner on the last occasion; only one in five did so at the last occasion with a casual partner. Forced sex was common, and five of 11 participants who responded to this question reported forced sex in the past 12 months.

Although a majority of participants knew how to access health services for HIV and STI testing and condoms, most did not know that they could access treatment and support. Six of the 12 men had been tested for HIV in the past 12 months. Two people reported being HIV positive.

### **Female sex workers**

Four women took part in the survey and were interviewed in-depth. Sex work in Tuvalu is opportunistic and casual, and is often not for money but rather for alcohol, motorcycle rides and other goods. Many women meet men at nightclubs. Sexual partners are Tuvaluan and mostly married.

Sex had begun at an early age (between 14 and 17). The median number of paying partners in the last 12 months was 4.5. All four women surveyed had regular partners, and three of the four had casual partners.

Condom use is sporadic at best. On the last occasion of sex with a paying partner, only one of the four reported condom use. Three women never used condoms with regular partners and three occasionally used condoms with casual partners – although all the women knew where to obtain condoms, but for various reasons did not use them.

Alcohol use was heavy, with two of the four women drinking 15 or more alcoholic drinks on the last drinking occasion. Two women had sex in the last 4 weeks where they did not feel in control after drinking.

All the women are scared that someone might find out about their transactional sex and that they would be beaten if someone did. Three of the four women had been sexually assaulted in the last 12 months – all of whom indicated that the perpetrator was a husband or boyfriend. Those who used the health services were generally satisfied with them. However, only one in four had been tested for HIV in the past 12 months.

The Tuvalu Ministry of Health (MoH), the Tuvalu Family Health Association (TuFHA) and the Tuvalu Red Cross are the main organisations working in HIV. No organisations specifically target men who have sex with men or sex workers, although some engage with transgender and there is a newly formed transgender association. There are two seafarer organisations. HIV and STI testing is provided by the MoH. The testing services provided by TuFHA (the most trusted organisation) have ceased.

The major strengths of the organisations are that there is a national coordinating body (the Tuvalu National AIDS Council), there is wide membership, and condom distribution and peer workshops are carried out in an integrated way. The major needs are finalisation of the National Strategic Plan; strengthening the coordination of HIV activities, peer networks and information, education and communication (IEC) materials; human rights training and legislation; and funding to carry these out.

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

The indigenous cultures of the South Pacific were at one time and in many cases still are, among the most isolated in the world. Prior to their discovery by Europeans from the sixteenth to the eighteenth century, these societies had little if any contact with outside civilizations, including Tuvalu. The vast regions include Australia, New Guinea, New Zealand and all of the various Polynesian islands of the Pacific Ocean.

When the Europeans first explored the South Seas they found large, thriving settlements along many of the islands coastlines. Some of the more inhabited islands such as Tahiti and Hawaii, had populations of up to two hundred thousand and were comparable in size with many European and American towns of the same period. Within these communities, homosexual and transgender natives were well documented by early French and British explorers such as Louis de Bougainville, James Cook, William Bligh and others.

Third gender natives were evident in all major Polynesian islands including Tonga, Tahiti, Fiji, New Zealand, Hawaii, Tonga, Samoa, Tuvalu, and Vanuatu and to a lesser degree among dark-skinned aborigines that formed smaller tribes along the coasts of Australia and New Guinea. In Polynesia, European Explorers were surprised to encounter societies that had long regarded bisexual, homosexual and transgender conduct as normative. Third-gender natives were common on all of the islands and known by different names. In Tahiti, for instance, male-to-male transgenders that lived and behaved as women were called mahu. In Hawaii Islands, whose inhabitants are believed to have originated from Tahiti, the mahu were also present along with the aikane – sexually related or “friendly” men that were essentially masculine-type homosexuals and bisexuals.

In Tuvalu, the word pina substitutes for mahu, as does the word fa’afafine (like a woman) in Samoa and fakafefine in Tonga. All these various terms referred to the different types of transgender and homosexual men found among the South Sea natives. Polynesian mahu lived and worked alongside the women and excelled in traditionally female tasks such as basket weaving. They did not perform castration but instead tied their genitals up tightly against the groin. Both mahu and aikane were known for their talent in the elaborate dance ceremonies performed throughout the islands. Bisexuality was quite common in Polynesia and many islands kings kept both male and female partners in their royal huts for intimate relations. Lesbians were less reported in the South Sea although early British ethnographers observed such women in several of the western islands such as Vanuatu.

In 2016 a size mapping for key populations was conducted in Tuvalu identifying risks and behaviours.

The constitution of Tuvalu provides for gender equality in education. Correspondingly there are no significant differences between females and males in the education system, and females are perceived to perform better than males. A literacy rate of 99% has been achieved for both boys and girls in primary and secondary education. However, there are social pressures that discourage women from obtaining education and training at post-secondary levels. Only a third of post-secondary scholarships are awarded to women. There is a widespread belief within the Tuvalu society that women studying and working abroad are likely to find their partners abroad and thus, would not return.

Gender disparities exist in participation in the labour force, land tenure, and inheritance practices. Although formal policies and laws provide for gender equality, women in Tuvalu in general cannot inherit land. According to the “Beijing+10” the Department of Women’s Affairs reports that the banking system offers equal financial services to men and women. Between 2004-2005 the number of women that obtained a credit from the Development Bank of Tuvalu increased from 16 to 30% compared to the number of credit given to men, which increased from 31 to 41%. However, the total loan approval rate is still lower for women at 37% compared to men at 63%, and the total loan value for men accounts for 74% of the total credit given.

Significant gender disparities exist in political participation at the national level. Although one woman was elected to the Parliament in 1990s, none of the 15 parliamentary seats today is held by a woman.

Tuvalu ratified the Convention on Elimination of All Forms of Discrimination against Women in 1999, and is a signatory to the Beijing Platform for Action and the Pacific Platform for Action. In addition, the Department of Women’s Affairs within the Ministry of Health and the Tuvalu National Council of Women strongly advocates for equality and empowerment of women in decision making levels. The majority of women in Tuvalu are married to seafarers. These women are thereby at an increased risk of contracting HIV and STIs. Most are not aware of the need to screen their husbands on their

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, none for chlamydia. There is a current plan for a national cervical screening program to include STIs but this is still in the pipeline.

The majority of pregnant women in the 2007 SGGs have partners working as seafarers (38.5%) and Government workers (18.4%), the two most mobile populations in terms of travelling within and out of the country compared to other types of partners in Tuvalu. Among pregnant women infected with chlamydia nearly half (45%) were married to or partnered to a seafarer. There is the likelihood that these women were reinfected from their seafarer husbands. Miller JM (1998) identified maternal age below 20 years as the only risk factor associated with the likelihood of recurrent chlamydial infection, a possibility in this cohort. There is also the possibility that women left behind at home may infect their husbands upon their return home. Lurie et al (2003) concluded that the direction of spread of the epidemic is not only from returning migrant men to their rural partners, but also from women to their migrant partners, and therefore their recommendations for prevention efforts to target both migrant men and women who remain at home.

Only 57% of currently married women and almost 93% of currently married men were employed at some time in the year prior to the 2007 TDHS<sup>v</sup>. More women than men in the 25–34 age group are employed. The low employment rate at young ages is expected because part of the labour force in those ages are students at secondary and higher learning institutions who are therefore not available for work. For those who are working, most women and men are likely to be paid in cash (85% women, 71% men). Men are more likely to do any type of work without any payment (23%) than women (4%). In contrast, women are more likely to be paid in cash and in-kind (9%) than men (1%).

The 2007 TDHS included questions that addressed women's control over their own earnings and also those of their husbands. This information may help provide further insight into women's direct empowerment within the family and their indirect empowerment within the community. Over two in five women (44%) are more likely to decide mainly for themselves how their cash earnings are used if their husband or partner has no earnings or did not work in the preceding 12 months (see Table 13.4). The same proportion of women (44%) also reported to make joint decisions with husband or partner. Women are more likely to make joint decisions with their husband or partner about the use of their earnings if they earn more than their husband or partner. Meanwhile, almost the same proportion of women and men make joint decisions about the use of wife's and husband's cash earnings regardless of who earns more than the other. About 50% of women who did not work in the 12 months preceding the survey reported that they jointly decided with their husband or partner on how to use his cash earnings.

Violence against women has serious consequences for their mental and physical well-being, including their reproductive and sexual health (WHO 1999). One of the most common forms of violence against women worldwide is physical abuse by a husband or partner (Heise et al. 1999). The 2007 TDHS gathered information on women's attitudes toward wife beating, which is a proxy for women's perception of their status. Women who believe that a husband is justified in hitting or beating his wife for any specified reason may believe themselves to have a low status, both absolutely and relative to men. Such a perception acts as a barrier to accessing health care for themselves and their children, affects their attitude toward contraceptive use, and impacts their general well-being. Women were asked whether a husband is justified in beating his wife under a series of circumstances: 1) if the wife burns the food; 2) argues with him; 3) goes out without telling him; 4) neglects the children; and 5) refuses sexual relations. Table 13.9 summarises women's attitudes toward wife beating in these five specific circumstances.

Most women find wife beating justified in certain circumstances. For example, 70% of women agree that at least one of the five reasons is sufficient justification for wife beating. This indicates that Tuvaluan women generally accept violence as part of male–female relationships, which is not surprising because traditional norms teach women to accept, tolerate and even rationalise battery. The most widely accepted reasons for wife beating are: neglecting the children (66%), going out without informing the husband or partner (42%), and arguing with the husband or partner (28%). About 21% of women feel that burning the food is also a justification for wife beating, as is denying a husband sex (18%).

Acceptance of wife beating for at least one of the specified reasons is generally lower among: 1) women in the outer islands; 2) women with more than a secondary education; 3) women who are not married and women who are married; and 4) women who have more than five children. Men were also asked about their opinions on the justification of wife beating under certain circumstances. More than seven in ten men (73%) agree that wife beating is justified for at least one of the specified reasons. It is interesting to note that this is about the same as the percentage of women who agreed with at least one of the reasons. The results also show similar proportions of men and women justifying reasons for wife beating.

The most likely groups of men to agree with at least one of the specified reasons for wife beating include: 1) younger men, those who are employed but not for cash; 2) men who are not married; 3) men with one and two children; 4) men living in Funafuti; 5) men who have no education or only a primary level education; and 6) men in the lowest wealth quintile households. Men with more than a secondary education (35%) are the least likely to accept wife beating. A higher educational attainment tends to decrease the chances that a man will agree with any of the reasons for wife beating.

The 2007 TDHS included questions about whether a woman is justified in refusing to have sexual relations with her husband if she: 1) knows the husband has an STI; 2) knows the husband has intercourse with other women; and 3) is tired or not in the mood. These three issues have been addressed because they are related to women's rights and health. About 81% of women agree that a wife is justified in refusing to have sex with her husband for all of the specified reasons. Of these, 94% believe that a wife is justified in refusing to have sex if she is tired and 91% believe that a wife is justified in refusing to have sex if she knows her husband has sexual relations with other women. An estimated 88% of women believe that a wife is justified in refusing to have sex if her husband has an STI. Very few women disagree with any of the specified reasons. Young women, women who are unemployed, single women and women with no children are the least likely to agree that a wife is justified in refusing to have sex with her husband for any reason.

The percentage of men who believe that a wife is justified in refusing to have sex with her husband under these same specific circumstances. The same proportions of men and women agree on all specific circumstances, except that men are more likely to agree that a wife is justified in refusing to have sex with the husband when she knows that he has an STI. The least likely group of men to agree with all of the reasons for a wife refusing to have sex with her husband include single men, men with no children, men who live in Funafuti, men with a higher education and men living in the highest wealth quintile households.

About 52% of men aged 15–49 believe that a husband has the right to get angry and reprimand his wife if she refuses to have sex with him. Nearly equal proportions of men (less than 16%) believe they have the right to: 1) force their wife to have sex; 2) refuse their wife financial support; and 3) have sex with another women if their wife refuses to have sex.. Single men and men living in Funafuti are the least likely to agree that a husband has a right to certain behaviours when his wife

refuses to have sex with him. However, education and wealth quintile show a negative correlation against all of the specified behaviours.

Out of the total 501 women interviewed, about 37% have ever experienced physical violence any time since the age of 15, while nearly 25% reported having experienced physical violence in the 12 months preceding the survey. About 1% of women have frequently experienced physical violence, while 23% have experienced violence sometime in the 12 months preceding the survey. The proportion of women who have experienced physical violence is highest among women aged 20–29. Moreover, women aged 25–29 are most likely to report having experienced physical violence often or sometimes in the 12 months preceding the survey (35%). Although there is very little difference between employed and unemployed women with regard to their experience of physical violence, women who are unemployed are slightly more likely to report having experienced physical violence since age 15.

Employed women are more likely to experience physical violence (25%) often in the 12 months preceding the survey than women who are unemployed compared to (23%). Women who are married or in a living together arrangement are slightly less likely to have ever experienced physical violence (37%) than women who are currently divorced, widowed or separated (38%). The pattern for recent violence suggests that women with partners are more likely to experience violence currently (22%) than women who are currently divorced, widowed or separated in the past 12 months (25%). The number of children that women have is also related to their experience of physical violence. Women with no or few children are more likely to experience physical violence since age 15 and in the past 12 months than women with more children.

Physical violence is higher among women in Funafuti (38%) than among women in the outer islands (36%). Women in Funafuti are also more likely to have experienced physical violence in the 12 months preceding the survey, and are more likely to have experienced it often during that time. Women with less than a secondary education are slightly more likely to have experienced physical violence than women with a secondary education or more than a secondary education. Although women with a secondary education and those with more than a secondary education are equally likely to have ever experienced physical violence, women with a secondary education are much more likely to have experienced physical violence (29%) in the 12 months preceding the survey than women with more than a secondary education (24%). Women with more than a secondary education and women with less than a secondary education are also less likely to have experienced physical violence in the 12 months preceding the 2007 TDHS (24% and 19%, respectively). There is no clear pattern by wealth quintile of women ever experiencing physical violence; however, Table 14.1 indicates that women in the highest and fourth highest wealth quintiles are less likely to experience physical violence in the 12 months preceding the survey than women in other wealth quintiles. Among women who have ever experienced physical violence and among women who have experienced sexual violence. Among women who have experienced physical violence since age 15, 90% reported that a current husband or partner committed physical violence against them, while 8% reported that they experienced violence by a sister or brother. Other perpetrators commonly reported by women are other relatives (5%), former husbands/partners and 'others' (4.5% each).

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

Youths (15 to 24 years) make up a significantly large proportion of the national population. Tuvalu 2002 Population and Housing Census reported 38.6% of the total population were below the age of 15 years and 52.8% from 16 to 59 years<sup>vi</sup> It has been reported that knowledge on HIV and STI prevention in general is poor in this population [36]. Social changes in Tuvalu have seen an increase in alcohol use among youths, teenage pregnancy and increasing numbers of young people engaged in risky sexual behaviours predominantly in the urban settings. Urban drift and increasing international travel all contribute to the risk of increased transmission of HIV and STIs in the country<sup>vii</sup>

The only study in Tuvalu among youth was conducted back in 2004 but the data show that youths were sexually active (43.6%) but only 20.3% used a condom at first sex. Many male youths (13.9%) reported having sex with another male, but only 3 reported having sex with a commercial partner<sup>viii</sup>. HIV knowledge was generally good but didn't translate into healthy behaviours in this study. Alcohol use was high (41.6%) but none was injecting drugs.

Tuvalu is well on track towards achieving the EFA goal 2 of 100% of eligible students attend school which is compulsory in Tuvalu up to 15 years of age.<sup>ix</sup> While there was no national policy or plan of action for children, a National Youth Policy (for youth between 15 and 34 years) was developed for the period 2005 to 2010 and was mentioned in both Te Kakeega II (NSSD 2005-2015) and the TESP I (2006-2010). Still, other national policies have been developed to cater for the interests of children and youth, and are consistent with the Convention on the Rights of the Child. Recent examples include the MDGs, National Policy on Early Childhood Care Education 2007, and Ministry of Health Strategic Plan 2008-2018. At the same time, several priorities and strategies were proposed to improve the welfare and opportunities available to young people, for example, the NSSD proposed the following: implement a National Youth Policy (which was developed in 2007), increase training opportunities, create more job opportunities, educate youth on the value of healthy lifestyles and the threat of HIV/AIDS, educate youth on traditional knowledge/skills, expand youth facilities on outer islands, increase the availability of credit, provide a greater role for youth in the Falekaupule decision-making process, and increase the role of NGOs and churches in addressing youth-related issues.

The literacy rate among youth is very high and estimated to be 97.7%. The division of gender roles in employment and education is very clear, reflecting the gender division in society and culture in Tuvalu. The overall majority of men received training in the Maritime sector while women generally went into teaching and nursing. Community training centres cater for the less academic students. Tuvalu has high adult literacy rates and approximately 60% of adults have completed secondary education or higher. This figure is higher in Funafuti than that recorded for the outer islands and the proportion of males and females receiving higher education is similar. Limited opportunities are available for further training.

### **Peer Education**

The Red Cross and TuFHA have an extensive network of peer motivators both in Funafuti and the outer islands; however, both organisations reported that many are now inactive. The peer motivators are volunteers who assist with condom distribution and sexual and reproductive health education among their peers. A small number of peer motivators are transgender or *pina*. There are no MSM, sex worker and seafarer peer motivators. The last peer motivator training in Funafuti was held by the International Planned Parenthood Foundation (IPPF) in 2013. A previous peer educator training was held by the Secretariat of the Pacific Community (SPC) in 2009. Currently, peer education and strategic health communication activities and workshops carried out by the Red Cross and TuFHA take place on an ad hoc basis and are not coordinated between the two organisations.

### **Condoms**

Condoms and lubricants are provided to the MoH by the United Nations Population Fund (UNFPA). The MoH works with TuFHA, the Red Cross and the Maritime Training Institute to distribute condoms. TuFHA and the Red Cross distribute condoms through condom distribution boxes, which are placed outside each building, and through their peer education networks during public events and outreach activities to nightclubs and communities. The Tuvalu Pina Association has also recently started distributing condoms (which it accesses through TuFHA) at the nightclubs and among their peers. The Maritime Training Institute reported that condoms are accessible through its clinic (upon request) and also on its training Pacific Multi-Country Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations – Tuvalu 60 boats. It was reported that condoms can be purchased occasionally from the petrol stations. Other than at these outlets, condoms and lubricants are not widely available. TuFHA reported that condoms are generally well received by the public during outreach activities; however, female condoms are not popular and lubricant is not usually available. Condoms are unlikely to be accessible on outer islands. Key informant interviews indicated that condom use is rare among key population groups.

### **Strategic health communication**

While workshops to develop HIV/STI information, education and communication (IEC) materials were reported, there are no printed IEC materials available, with organisations indicating a lack of funding for printing existing materials as well as a need to develop new materials.

Awareness workshops are targeted at seafarers, young people and communities and are predominantly conducted by TuFHA and the Red Cross. TuFHA carries out HIV prevention education as part of the sexual and reproductive health workshops that it conducts with communities.

The target group is predominantly youth. The Red Cross carries out basic HIV prevention education as part of its first-aid training with communities. In 2014, a Pina Beauty Pageant was held by the *Waka Waka* to promote the rights of *pina*. During this time, TuFHA carried out an HIV prevention workshop with *pina*. This is the only reported HIV-related activity to have taken place with *pina*. No HIV prevention activities have been targeted at MSM or sex workers due to their hidden nature and social taboos. TuFHA and the Red Cross deliver HIV prevention workshops to seafarers at the Maritime Training Institute. The Institute also includes one day's training on HIV prevention as part of its training curriculum. This is administered by the Institute's in-house Medical Officer.



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

Tuvalu's public spending on health was 10% of GDP in 2010, equivalent to US\$534 per capita. The Ministry of Health started work on development of a national health account system in 2009 to track all health financial resources and spending within the Government core budgetary system and those outside the Government jurisdiction. The system, which is expected to be ready for implementation in 2011, will allow better monitoring, evaluation and planning for the Ministry of Health in developing its own financial plans. The Ministry of Health receives financial support from WHO, the United Nations Population Fund (UNFPA) and the Global Fund.

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

Tuvalu is one of the high TB burden countries with an approximate population of 11,000. The estimated incidence rate is 223 and the mortality at 19 per 100,000 population as per the Global TB report 2015<sup>x</sup> data are very high. The case notification rates is about 80 % of the estimates incidence. The program is notifying high rate of TB among children and almost 43 % retreatment cases as per the 2015 data. The treatment outcomes have been fluctuating from low of 65 % to satisfactory of 87% in 2015 report. The contact investigation and prophylaxis for children below 5 years is very poor.

The Global Fund grant supports TB program and one Gene xpert for TB diagnosis is in place while one portable digital xray machine is in process under GF. WHO supports for FLD procurement.

The TB Programme fails to test people living with HIV for TB as due to high level of stigma the patients refuse to take contact with health authorities.

Tuvalu has a population of 3,950 women ages 15 years and older who are at risk of developing cervical cancer. Data is not yet available on the HPV burden in the general population of Tuvalu. However, in Oceania about 8.3% of women in the general population are estimated to harbour cervical HPV-16/18 infection at a given time, and 76.6% of invasive cervical cancers are attributed to HPVs 16 or 18.<sup>xi</sup>

In the prevalence study of 2007 the prevalence of Hepatitis B among ANC attendees, mainly women was 9.6% while among seafarers it was 13,4%.

## **XI. The situation with human rights in relation to HIV**

Tuvalu becomes the first Pacific country as well as one of the few in the world, to launch a national action plan on human rights.

Tuvalu is a sovereign democratic State, governed in accordance with the Constitution and in particular in accordance with the Principles set out in the Preamble.<sup>xii</sup>

Sources of law consist of —

- the Constitution and Acts of the Parliament;
- English common law and equity;
- pre-Independence British Acts continued after Independence and not replaced;
- customary laws, to determine title to land and for the determination of civil and criminal proceedings in Magistrates' Courts, provided the custom was not repugnant to natural justice, equity and conscience or inconsistent with any Ordinance or other law for the time being in force in the country, for all civil or criminal proceedings in all courts except to the extent that it is inconsistent with the Constitution or legislation.

The Public Health Ordinance and Quarantine Act are inappropriate for the management of HIV and STIs.

Priority actions to build a human rights framework for addressing HIV include:

- (i) amending the Public Health Ordinance to remove AIDS from the list of infectious diseases, and to introduce provisions for confidential notification, voluntary and confidential testing and counselling, contact tracing with consent, and right to access information about sexual and reproductive health and means of prevention of HIV and STIs;
- (ii) enacting anti-discrimination legislation that covers discrimination on the grounds of HIV status, disability, sex, sexuality, and transgender status; and
- (iii) decriminalizing homosexuality, sex work and abortion.

The offences related to prostitution and homosexuality involving consenting adults in private contravene the human right to privacy and undermine HIV and STI prevention and care efforts.

The offence of abortion (miscarriage) contravenes the rights of women and girls to make their own reproductive choices.

Legislation should guarantee that custom does not have precedence over rights to equality between men and women. This would remedy the inequality experienced by women under the Lands Act, customary laws relating to property and inheritance, and the law of bigamy.

De facto relationships including same sex relationships should be recognised by law.

The provision of the Native Lands Act that provides that an unmarried mother automatically loses custody of her child at the age of two years to the father should be repealed.

Section 156 (5) of the Penal Code, which criminalises underage girls involved in incest, should be repealed.

Blood safety legislation is required.

Legislation is required to ensure that condoms comply with international quality standards.

Male and female condoms should not be subject to the prohibition on publishing any statement, by advertisement or otherwise, to promote the sale of articles for preventing conception (Pharmacy and Poisons Act Section 27).

Legislation that requires the teaching of sex education in schools within the context of learning life skills and promoting health would help prevention efforts.

Exceptions should be introduced in censorship legislation for HIV information that contains sexually explicit information or images for bona fide educational or health promotion purposes.

Patents legislation should include powers to issue compulsory licences for government use of generic medicines in the public health system and for parallel importing of medicines that are marketed more cheaply in other countries.

## **XII. Best practices**

1. Tuvalu National AIDS Council – Tuvalu has a national HIV coordinating body with a wide breadth of stakeholders. The organisation currently does not have a representative from the transgender/pina community.
2. Peer and NGO member networks – TuFHA and the Red Cross currently have a wide membership and established peer networks, which should continue to be strengthened to include greater involvement of key populations.
3. Seafarer workshops – the MoH, TuFHA and the Red Cross all carry out HIV prevention workshops and HIV prevention is part of the Maritime Training Institute’s seafarer training curriculum. The quality of the workshops, however, is unknown.
4. Integration of services – HIV prevention activities are integrated into sexual and reproductive health education (TuFHA) and first-aid training (Red Cross). Currently, the MoH routinely tests all ANC patients for HIV and other STIs.
5. Condom distribution – Condoms are currently provided by UNFPA to the MoH. Condoms are distributed by TuFHA, the Red Cross and the Tuvalu Pina Association. Condoms are available from a number of different locations in Funafuti, including the nightclubs, TuFHA and Red Cross offices, petrol stations and the Maritime Training Institute. Condoms are distributed at national events. This should be maintained and condoms also should be placed in other accessible and discreet outlets, such as the hotel and guesthouses.

## **XIII. Major challenges and remedial actions**

### **Challenges:**

1. Finalisation of the National Strategic Plan (NSP) – technical assistance is required to finalise the NSP. Consider an integrated sexual and reproductive health strategic plan.
2. Strengthening the coordination of HIV/STI activities – a joint work plan between organisations based on an up-to-date national strategic plan would prevent overlap of activities and improve efficiency.
3. Capacity building in monitoring and evaluation (M&E) and reporting – a need for further training in developing skills in M&E, reporting and utilisation of data in policy and programming. Training is requested in the use of Global Fund reporting requirements and templates.
4. Peer motivator network strengthening – many peer educators are currently inactive or have left for paid employment. The last peer motivator training took place in 2013. Therefore, motivators would benefit from refresher training and greater levels of on-going support.

5. Review of legislation and policy to promote human rights – it is currently unclear whether legislation exists that supports the rights of people living with HIV/AIDS
6. (PLWH) and other key affected populations, particularly those of diverse sexual orientation and gender identify. Further investigation is recommended.
7. Sexual and reproductive rights training – training for decision-makers such as parliamentarians and program managers on sexual and reproductive rights and engaging with key populations.
8. Development and dissemination of context-appropriate IEC materials – develop and disseminate context-appropriate IEC materials that can be used in clinics and outreach activities to ensure accurate and clear messaging.
9. Reach outer islands – expand HIV and STI testing and counselling and strategic health communication activities to the outer islands through the use of rapid tests during outreach and/or at local clinical services.
10. Funding – following the end of the Pacific Response Fund, there is currently a gap in the funding of HIV activities. The primary donor is the Global Fund, plus an A\$5,000 annual contribution from the government. TuFHA and the Red Cross currently receive some funding from international affiliates.

### **Remedial Action**

1. Up-date national ART, HTC and PMTCT country clinical guidelines to align to the last WHO recommendations
2. Institutionalize HIV rapid testing and scaling up to outer islands
3. Build health staff capacity in ART/OI treatment and adherence
4. TG/MSM - Support the Tuvalu Pina Association to become an established and registered organisation with the structures and resources in place to carry out peer activities including condom distribution. Undertake sensitisation training/workshops with health workers and community members to reduce stigma toward Pina and MSM.
5. Seafarers – Update the HIV training manual used at the Maritime Training College and provide the clinician/educator at the college with refresher training. Strengthen HIV and other STI testing opportunities for seafarers upon return from overseas. 3. FSW - It would not be appropriate to have a sex worker program given the small number and hidden nature of FSW. The method TuFHA used to reach FSW, which was to carry out community workshops for the whole community in communities which they suspected sex workers to exist is the best approach. However, TuFHA could look at recruiting one or two young women they suspect engage in sex work as peer educators, though they would need to be discrete about this.
6. TuFHA is a very good resource with a wide pool of peer educators, provider of clinical services and the main health educators of communities. Interviewees from KAPs reported they have or would go to TuFHA for clinical support and condoms and many stated they had learnt about HIV from TuFHA community workshops. Both TuFHA and Red Cross expressed a need for further training of peer educators, funding to reach outer islands and funding to develop IEC materials (at present there are no IEC materials available in the country). In addition, TuFHA reported their supply of condoms has recently stopped (they used to get them from the UNFPA via the MoH) and that the MoH no longer allows them to test for HIV. These appear to be wasted opportunities. We would recommend UNDP look more closely at how it could work with TuFHA to reach all three key populations particularly in terms of condom distribution and testing.
7. Review current STI and HIV prevention strategies for young people.

- Consider the introduction of Life Skills program to the education system
  - Monitor and evaluate the current Health Science curriculum at primary schools which includes modules in Sexual Health similar to Family Life Education programs.
  - Support the implementation of Adolescent Health and Development (AHD) program focusing on reproductive and sexual health in young people aged 9 to 19 years.
8. Improve syndromic case management reporting (especially in rural settings). Improve methods of etiological reporting at Princess Margaret Hospital Laboratory.

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

The introduction of the Cuban Medical Programme in 2008 was a result of the agreement between the Government of Tuvalu and the Government of Cuba to assist Tuvalu with its shortages in medical specialists working at the main hospital, Princess Margaret Hospital.

Mobile medical teams from Taiwan (China) visit Tuvalu to offer services in general surgery, urology, obstetrics and gynaecology, ENT, cardiology, anaesthesiology, dermatology, and orthopaedics. The Australian Pacific Islands Project (PIP) also provides eye surgery, ENT, diabetes, cardiology, and biomedical services in the country.

In the field of HIV the majority of support comes from the Global Fund with technical assistance provided by UNAIDS, WHO, UNICEF and UNFPA.

#### **XV. Monitoring and evaluation environment**

Consolidated monthly reports (CMR) are sent by the nurses based in the health centres in the islands to PMH. The only health statistician based in Funafuti, compiles all the data. Since the CMR, is sent via ships, it takes a long time to arrive thus generating timely reports becomes a challenge. Sometimes discrepancies or incomplete CMR causes further delays. To address this, the health statistician travels to the island and collaboratively works with the staff stationed there to correct any inconsistencies. HIV data is regarded as "highly confidential" and is kept with the Director of Ministry of Health.

Bi-annual trainings are conducted for junior and senior nurses at PMH to give them feedback about the CMR and as an incentive for improving the reporting process. Special sessions are delivered by field experts on gaps that were highlighted in the CMR.

Tuvalu is basing its research and evaluation on the Population Based Approaches under the responsibility of the Tuvalu Central Statistics Department, which is under the authority of the Ministry of Finance and is responsible with censuses, civil registration and population surveys. Health Data are usually collected from outer-islands Health Clinics using CMR forms. The Health Managers: SOH, DOH, MS, CPH, Statistician & the help of his Assistant are responsible for:

- \* Data handling & collection
- \* Data Storage
- \* Data Processing
- \* Compiling & data analysis

The Health Information Products later are transformed into a Health Annual Report. For prevention programmes data are being collected focusing on specific problems. The value of the health data are considered to be reliable and will be used by decision-makers. The data will be disseminated within the Ministry of Health, Department heads and to outer island health clinics and other interested organizations.

Currently the Health information System strategy is underway of improving the way of communications by replacing the paper based reporting from outer islands with electronic information. An upgrade the existing HIS is foreseen by means of installation of ICT at their respective Health Clinics so that they can access through the internet.<sup>1</sup>

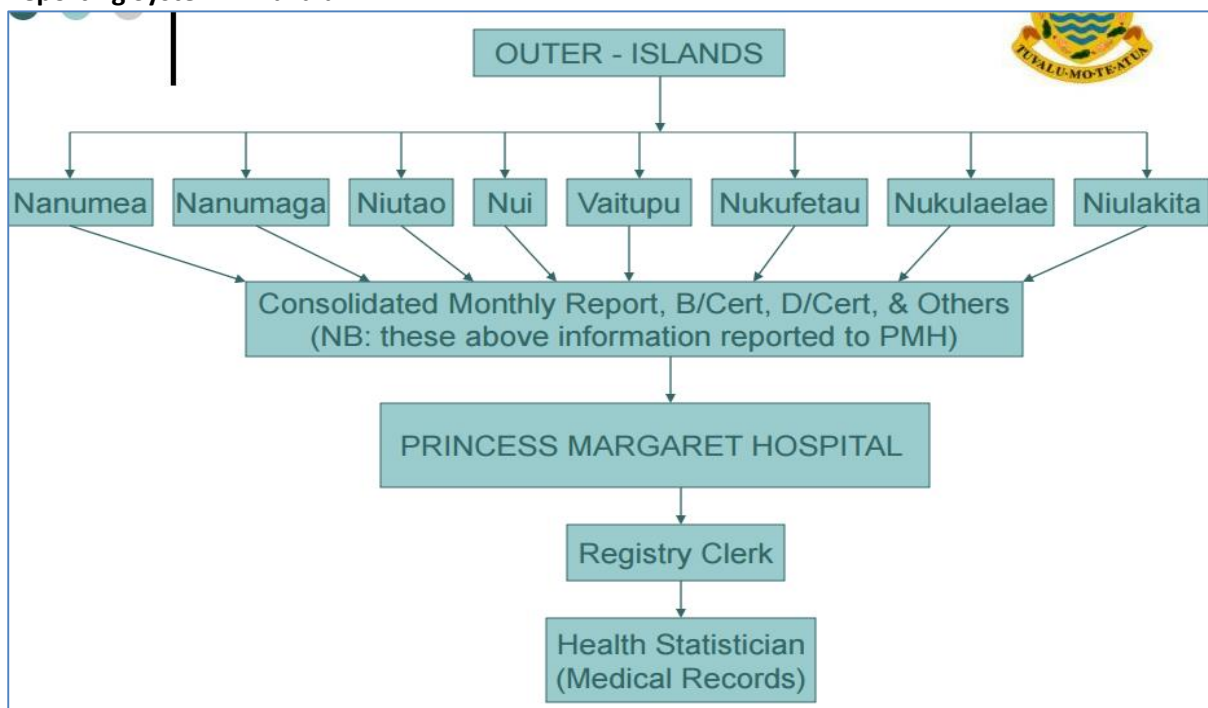
Based on previous experience the data follow 3 ways of reporting:

- \* Facsimile Transmission
- \* Surface Mail Delivery
- \* Hand Safe Delivery (not recommended)

Internet connection was established in outer islands very recently and it is not fully functional yet.

There is no specific M&E Plan developed for the NSP of Tuvalu.

### Reporting System in Tuvalu



The year 2008 marked the beginning of the health reform process, with the development of a new health master plan to guide the work of the Ministry of Health over a 10-year period stretching from 2009 to 2019. The Strategic Health Plan 2009-2019, completed in early 2009, provides the Ministry of Health with the renewed aim to focus on primary health care and disease prevention.

<sup>1</sup> <http://www.uq.edu.au/hishub/docs/Tuvalu.pdf>

## **ANNEXES**

NCPI

Indicator 8.1 expenditures

## BIBLIOGRAPHY (SOURCES)

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- <sup>i</sup> Strategic Plan to respond to HIV/AIDS and STI, 2001-2005, Ministry of Health, Funafuti, Tuvalu 2001
- <sup>ii</sup> Elimination of Congenital Syphilis (ECS) in the Pacific, 2014, Policy and Technical Guidance from the Pacific STI Working Group
- <sup>iii</sup>  
[http://www.spc.int/hiv/index2.php?option=com\\_docman&task=doc\\_view&gid=204&Itemid=1](http://www.spc.int/hiv/index2.php?option=com_docman&task=doc_view&gid=204&Itemid=1)
- <sup>iv</sup> Pacific Multi-Country Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations  
Tuvalu 2016, Heather Worth, Patrick Rawstorne, Michelle O'Connor, Scott McGill
- <sup>v</sup> Tuvalu Demographic and Health Survey 2007 by Central Statistics Division, the Secretariat of the Pacific Community, and Macro International Inc.
- <sup>vi</sup> Tuvalu 2002 Population and Housing Census vol 1- Analytical report, Department of Statistics, Tuvalu Government, Funafuti, Tuvalu 2002
- <sup>vii</sup> HIV/AIDS AND OTHER STIs IN TUVALU SOUTH PACIFIC, Dr Stephen Mafoa Kaimoko Homasi, 2007
- <sup>viii</sup> WHO: Second Generation Surveillance Surveys of HIV, other STIs and Risk Behaviours in 6 Pacific Island Countries, 2004-2005
- <sup>ix</sup> Education for All 2015 National Review, 2015, Ministry of Education, Youth and Sports Education Department
- <sup>x</sup> Global TB Report 2015, WHO, 20<sup>th</sup> edition,  
[http://apps.who.int/iris/bitstream/10665/191102/1/9789241565059\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/191102/1/9789241565059_eng.pdf)
- <sup>xi</sup> Human Papillomavirus and Related Cancers, Fact Sheet 2016, Tuvalu, ICO Information Centre on HPV and Cancer at [http://www.hpvcentre.net/statistics/reports/TUV\\_FS.pdf](http://www.hpvcentre.net/statistics/reports/TUV_FS.pdf)
- <sup>xii</sup> Tuvalu HIV and Human Rights Legislative Compliance Review: March 2009