Global AIDS Response Progress Kiribati Country Progress Report 2015

Submitted by Kiribati Country Coordination Mechanism

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Acronyms and Abbreviations

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

MWYSA Ministry of Women Youth and Social Affairs
NBTC National Blood Transfusion Centre
NGO Non-Governmental Organization
PCC Pacific Council of Churches
WCC World Council of Churches

Statement by the Ministry of Health on official submission

This report was prepared through a consultative process involving key stakeholders from both Government and civil society. This 2015 Global AIDS Response Progress (GARP)report presents Kiribati national HIV response for the year 2014 in line with a number of international commitments to which Kiribati is a party to. In addition to the 2000 Millennium Declaration, the 2011 UN Political Declaration on HIV and AIDS builds on two previous political declarations: the 2001 Declaration of commitments on HIV/AIDS, and the 2006 Political Declaration on HIV/AIDS. Now by 2015, we have reached the deadline, and it is timely that we now take stock of all our efforts in combating HIV/AIDS in Kiribati.

I would like to take this opportunity to thank all our development partners (UNAIDS, GF, UNICEF, UNFPA, WHO, IPPF, DFAT, NZAID Program, etc) who have in one way or another contributed to our struggle to control the spread of HIV in Kiribati.

This 2015 GARP report will give us the full picture of our national response, where we are, and set the stage for our "next steps" in addressing the HIV epidemic in Kiribati.

Dr Alfred Tonganibeia
Medical Officer, TB, HIV and Leprosy

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Status at a glance

Inclusiveness of the stakeholders in the report writing process

This report was prepared through a consultative process involving key stakeholders from both Government and civil society. The Kiribati Country Coordinating Mechanism (CCM), as a GF-governing body at country level was involved every step of the way through consultative meetings and interviews. Two series of meeting took place in the process: 1) the first was a consultative and consolidation meeting that took place on Monday 16 March 2015 to go over, refine and agree on the scope and relevance of core indicators that should be included in the report, and how participants can communicate their data to the local TA for initial collection and compilation, see Annex 1 for list of participants; 2) the second meeting was held on Friday 27 March 2015. In this second meeting participants were presented by the local TA, with progress on the reporting so far, highlighting areas, information and indicators that have been covered so far and those that still need to be sourced and researched. There was also interview with key informants to elicit relevant information on HIV based on their experience and after having worked with the community and HIV-related programs. Annex 3 provides the list of key informants interviewed.

Status of the epidemic

Kiribati is experiencing a low level general HIV epidemic. To date Kiribati has an estimated 57 cumulative cases of HIV dating from 1991 to the end of December 2014, see Figure 1. The majority are males but there is increasing gender balance over the last decade, see Figure 2. There are 23 confirmed AIDS related deaths four of which are children. Of the current estimated HIV positive cases (n=28), and out the 6 who received treatment in 2013, one who had both HIV and TB, died in 2014 thus leaving 5 on antiretroviral treatment (ART).

Indicator data in an overview table

Table 1 below shows core indicators for Global AIDS response progress reporting. For the purpose of comparison and to see the trends over time in addition to identifying areas and gaps where recent true surveillance data or behavioral surveys are lacking, the 2012 and 2014 GARP report data are included. Comments from previous reports in the last column are retained and/or updated if they are considered still relevant. The paucity of recent data is noted, with the majority of them coming from national laboratory database in addition to recent information obtained from key informant interviews and included in the comment column.

Table 1: Indicator Overview Table

			Value				
Target		***Indicators***	***2012 GARP report***		***2014***	***2015***	***Sources of data and comments***
			Male	***Female***			
Target 1. Reduce sexual transmission of HIV by 50 per cent by 2015		1.1 Young People: Knowledge about HIV Prevention*	44%	48%	0	0	2012 figures obtained from Kiribati DHS 2009 No recent behavioral survey
	Indicators for the general population	1.2 Sex Before the Age of 15					2012 figures obtained from Kiribati DHS 2009 No recent behavioral survey data. Although the minimum legal age for a woman to get married is 18 in Kiribati, marriage among young girls is common. The issue of forced sex including rape also cannot be excluded. Among women aged 20–49, 5% are married by age 15, 26% are married by age 18, and 47% are married by age 20. The median age at first marriage is 20. However, the trend is shifting toward fewer women marrying at very young

			1.6%	13.8%	0	0	ages, as only 2% of women aged 15–19 are married before age 15 compared with 9% of women aged 45–49[1]. Similarly, the 2009 KDHS collected data on age at first sexual intercourse. By age 15, 6% of women aged 25–49 are sexually active, and 28% are active by age 18.
		1.3 Multiple sexual partners	1.8%	10.5%	0	0	2012 figures obtained from Kiribati DHS 2009. No recent behavioral survey data
		1.4 Condom Use During Higher Risk-Sex*	2.4%	33.2%	0	0	This figure is based on age group 15-24 years, from Kiribati DHS 2009. No recent behavioral survey data
		1.5 HIV Testing in the General Population	-	-	-	-	The national laboratory data from all sources shows that out of 4,577 HIV tests conducted in 2014, only two were positive.
		1.6 HIV prevalence in young people	-	-	-	-	No data
	Indicators for sex workers	1.7 Sex Workers: Prevention programmes	-	-	-	-	No data. KFHA data and HIV Program data shows a total of about 50 sex workers reportedly working under an old woman's ("te unaine") supervision, and who

[1] Kiribati Health and Demographic Survey 2009

							received in 2013 HIV prevention programs through KFHA outreach activities, including HIV and STI testing and condom use. No HIV testing was done in 2014
		1.8 Sex Workers: Condom Use	-	-	-	-	No data
		1.9 Sex Workers: HIV Testing	-	-	-	-	No data. For KFHA 2013 records, HIV and STI testing were done on all 50 sex workers and all tested negative.
		1.10 Sex Workers: HIV Prevalence	-	-	-	-	No data
	Indicators for men who have sex with men	1.11 Men who have sex with men: Prevention programmes	-	-	-	-	No behavioral survey data on MSM. KFHA has also been able in 2013 to identify and provided HIV prevention programs to 30 MSM especially on Betio area. No prevention program was done in 2014
		1.12 Men who have sex with men: Condom Use	-	-	-	-	No data
		1.13 Men who have sex with men: HIV Testing	-	-	-	-	KFHA carried out in 2013 HIV and STI testing to 12 of then reported 30 MSM and one tested positive for syphilis and treated.
		1.14. Men who have sex with men: HIV Prevalence	-	-	-	-	No data
	Testing and Counselling	1.15 Number of Health facilities that provide HIV testing and counselling services			9	9	HIV Program data. These facilities are situated only in South Tarawa, with none on outer islands.
		1.16 HIV Testing in 15+ (from programme records)				M= 2186 F=2391 Tot=4577	Laboratory data shows that 2,186 men and 2,391 females were tested for HIV in 2014 with a total of 4577, and one male and

							one female were tested positive
	Sexually Transmitted Infections	1.17 Sexually Transmitted Infections (STIs)					
		1.17.1 Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit				100 %	HIV Program and PPTCT data. This is only for Central Hospital data, does not include outlying clinics and outer islands
		1.17.2 Percentage of antenatal care attendees who were positive for syphilis				6.4%	HIV Program and PPTCT data. This is only for Central Hospital data, does not include outlying clinics and outer islands
		1.17.3 Percentage of antenatal care attendees positive for syphilis who received treatment	-	-	-	100 %	HIV Program and PPTCT data. This is only for Central Hospital data, does not include outlying clinics and outer islands
		1.17.4 Percentage of sex workers with active syphilis					No data
		1.17.5 Percentage of men who have sex with men (MSM) with active syphilis	-	-	-	-	No data
		1.17.6 Number of adults reported with syphilis (primary/secondary and latent) during the reporting period	-	-	-	-	No data
		1.17.7 Number of reported congenital syphilis cases (live births and stillbirth) during the reporting period	-	-	-	-	No data
		1.17.8 Number of men reported with gonorrhoea during the reporting period				2	National laboratory data
		1.17.9 Number of men reported with urethral discharge during the reporting period				45	National laboratory data
		1.17.10 Number of adults reported with genital ulcer disease during the reporting period				0	National laboratory data
Target 2. Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015		2.1 People who inject drugs: Number of needles/IDU					Not relevant
		2.2. People who inject drugs: Condom Use					Not relevant
		2.3 People who inject drugs: Safe Injecting Practices					Not relevant
		2.4 People who inject drugs: HIV Testing					Not relevant
		2.5 People who inject drugs: HIV Prevalence					Not relevant
		2.6 People on opioid substitution therapy					Not relevant

	2.7 NSP and OST sites					Not relevant
Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths	3.1 Prevention of Mother-to-Child Transmission				0	No HIV positive pregnant woman reported in 2014
	3.1 a Prevention of mother-to-child transmission during breastfeeding				0	No HIV positive lactating woman reported in 2014
	3.2 Early Infant Diagnosis				0	No infant born of HIV positive mothers reported in 2014. Refer to 4-6 yr old positive HIV female children, in section 3.2 in narrative report
	3.3 Mother-to-Child transmission rate (modelled)				0	No data
	3.3 a Mother-to-child transmission of HIV (based on programme data)				0	No data
	3.4 Pregnant women who were tested for HIV and received their results				100 %	The reported number of ANC attendant of 252 is only from Central Hospital data and all were tested for HIV
	3.5 Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months				-	No data
	3.6 Percentage of HIV-infected pregnant women who had a CD4 test				-	Not relevant, no HIV positive pregnant women in 2014
	3.7 Infants born to HIV-infected women receiving ARV prophylaxis for prevention of Mother-to-child-transmission				-	No HIV positive pregnant woman reported in 2014
	3.9 Percentage of infants born to HIV-infected women started on cotrimoxazole (CTX) prophylaxis within two months of birth				-	No HIV positive pregnant woman reported in 2014
	3.10 Distribution of feeding practices for infants born to HIV-infected women at DTP3 visit				-	No data
	3.11 Number of pregnant women attending ANC at least once during the reporting period				252	The reported number of ANC attendant of 252 is only from Central Hospital data
Target 4. Have 15 million people living with HIV on	4.1 ART coverage (adults and children)* , including Number of eligible adults and children who newly				18%	HIV Program data. Out of the total eligible person

antiretroviral treatment by 2015	enrolled on antiretroviral therapy during the reporting period					for ART of 27 only 5 are on treatment. The whereabouts of the others is unknown
	4.2 HIV Treatment: 12 months retention				0	HIV Program data
	4.2b HIV Treatment: 24 months retention				3	HIV Program data
	4.2c HIV Treatment: 60 months retention				2	HIV Program data. Only Buraua and Tabeta have been on treatment this long
	4.3 Health facilities that offer antiretroviral therapy				1	HIV Program data
	4.4 ART stock-outs				0	There was no reported stock-outs of ART in 2014
	4.5 Late HIV diagnoses				-	No data
	4.6 HIV Care				0	HIV Program data. Out of the total eligible person for ART of 27 only 5 are on ART. The whereabouts of the others is unknown There are no newly enrolled HIV case for 2014
	4.7 Viral load suppression					This has never been done locally
Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015	5.1. Co-Management of Tuberculosis and HIV Treatment					One new HIV positive female case in 2014 was also diagnosed with TB and died not long after initiation of treatment for both HIV and TB
	5.2 Health care facilities providing ART for PLHIV with demonstrable infection control practices that include TB control				1	The HIV Core Team within the MHMS HIV Program is the only site that provides ART to PLHIV
	5.3 Percentage of adults and children newly enrolled in HIV care (starting isoniazid preventive therapy (IPT))				0	For some reason all the 5 people on ARV are not on IPT

	5.4 Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit				40%	a) Out of 5 HIV patients on ARV treatment, 2 were screened for TB in 2014 b) One new HIV positive case in 2014 was also diagnosed with TB and died not long after initiation of treatment
Target 6. Close the resource gap	6.1 AIDS Spending - Domestic and international AIDS spending by categories and financing sources					See funding matrix and narrative report.
Target 7. Eliminating gender inequalities	7.1 Prevalence of Recent Intimate Partner Violence (IPV)	-	-	-	-	No recent survey data. a) Kiribati Family Support and Health Study[2] found that 68% of women who had ever been in a relationship reported experiencing physical and/or sexual violence by an intimate partner b) Health information unit reports that there were 221 cases of IPV in 2014
Target 8. Eliminating stigma and discrimination	8.1 Discriminatory attitudes towards person living with HIV					No new data since last GARP report
Target 9. Eliminate Travel restrictions	Travel restriction data collected by Human Rights and Law Division at UNAIDS HQ, no data collected needed					Not applicable
Target 10. Strengthening HIV integration	10.1 Orphans and non-orphans school attendance*					No recent data available, and the concept of orphan is not fully

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

						ingrained into Kiribati culture. Such cases usually end up with the widow 'remarried' into the diseased husband's family to maintain family traditions, love, wealth, etc, or the children would simply be cared for by close or extended families.
	10.2 Economic support for eligible households					Government of Kiribati subsidizes secondary school fees for children with deceased or disabled fathers and there is an Elderly Fund for those over 67 years. Economic support in this indicator refers to "*Proportion of the poorest households who received external economic support",* but the concept of Elderly Fund is inclusive of everyone 67 years and over.

II. Overview of the AIDS epidemic

Demographic overview

Kiribati is a small island republic located in the central Pacific consisting of 32 mostly low lying islands widely scattered across 3.4 million sq km of ocean. It has an estimated population of 104,448[3]., see Table 2. The capital is in South Tarawa. About half of the population lives on South Tarawa, the seat of government and centre of commercial industry. Overall, there are slightly more women than men in Kiribati, with women making up 51% of the population. Kiribati population is predominantly young, with 32% of the population under the age of 15, 59% aged 15-54 years and only 4% over the age of 65. The average household size is 6 people (7 in urban areas, 5 in rural areas) and approximately 24% of households are headed by women. Though the islands are scattered migration between islands is high. A young population is a characteristic picture of many developing countries and this is usually coupled with easy spread of STIs including HIV.

[3] Kiribati demographic profile July 2014 estimates

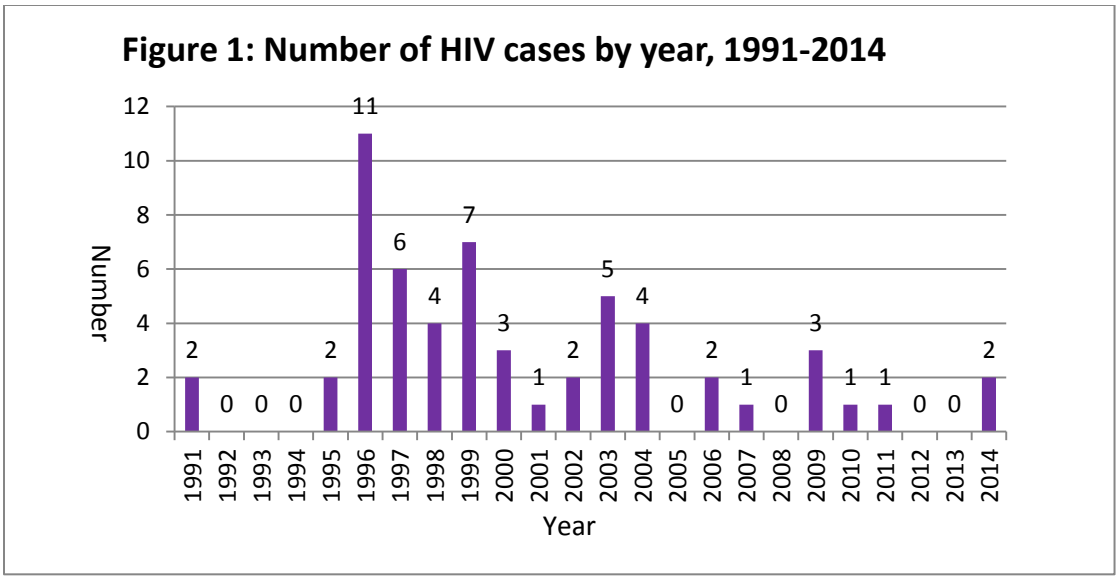
Table 2: Kiribati demographic profiles, 2014

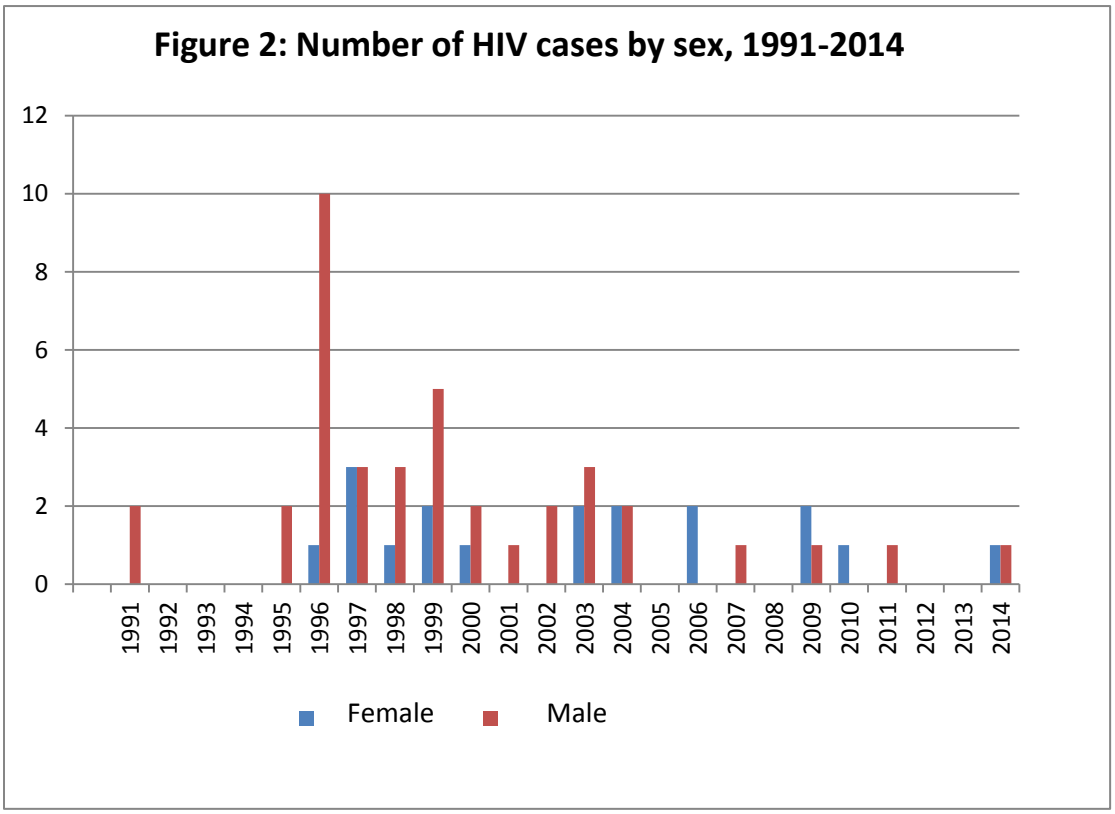
Age	%	male	female	
0-14	31.5	16779	16151	
15-24	21.3	11099	11122	
25-54	37.8	18978	20477	
55-64	5.5	2605	3137	
65	4	1630	2510	
Totals		51091	53397	104488

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

Status of epidemic

Kiribati is experiencing a low level general HIV epidemic. To date Kiribati has an estimated 57 cumulative cases of HIV dating from 1991 to the end of December 2014, see Figure 1. The majority are males but there is increasing gender balance over the last decade, see Figure 2. There are 23 confirmed AIDS related deaths four of which are children. Of the current estimated HIV positive cases (n=28), and out the 6 who received treatment in 2013, one died in 2014 thus leaving five on antiretroviral treatment (ART). Moreover, apart from the two publicly known PLWHA, the high turn-over rate of HIV clinical core team coupled with poor handing over and recordings has made it increasingly difficult to fully document the progress of the remaining three patients in terms of their ART, CD4 counts, viral load results, and their general well-being. Moreover, with high migration both internally and abroad the whereabouts of the remaining 22 is unknown.





The main mode of transmission is understood to have been heterosexual sex, followed by perinatal transmission. Groups identified to be most at risk include seafarers, their spouses (and children), and those involved in commercial or transactional sex. There

are 23 confirmed AIDS related deaths but this number is suspected to be higher. It should be noted that this total number of HIV positive cases does not always fully represent the real HIV epidemic situation in the country due to a number of reasons including accessibility to HIV testing facilities including availability of health care provider.

HIV and STI

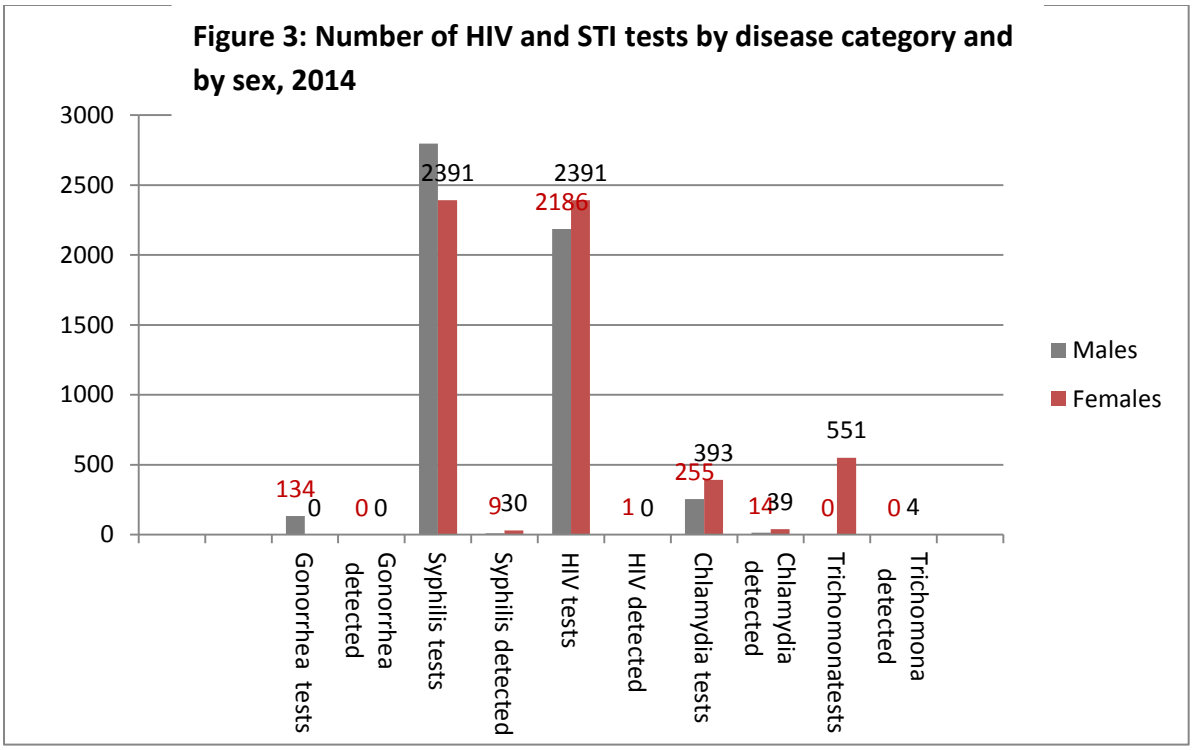
Due to the extremely poor data management especially in terms of storage, coordination and sharing of data nation-wide, it remains very difficult to come up with good quality data. For the purpose of this report stakeholders have agreed, based on validation, on what data is appropriate for reporting. Table 3 shows the total number of HIV and STI tests (syphilis, gonorrhea, chlamydia and trichomona) conducted in 2014 and gathered and complied from a number of sources (laboratory, blood donations, VCCT, PPTCT, STI clinics, Gynecological clinic, outer islands outreach activities and KFHA). Part of this data was also obtained and validated using data from the recent HIV/AIDS and STI Workshop conducted by SPC in Kiribati from Friday 27 March to Wednesday 1 April 2015[4]. While this is not a representative sample of the population the proportion of positive STIs, is a concern as this closely correlates with HIV transmission. The prevalence of chlamydia ranging from 5-10% in this population especially in women, confirms earlier findings of the high prevalence of this condition in the population.[5] Out of 4577 HIV tests conducted in 2014 only two were positive.

Table 3: Number of HIV and STI testing, 2014

Sex	Gonorrhea			Chlamydia			Syphilis			HIV			Trichomonas		
	Total tests	Detected	%	Total tests	Detected	%	Total tests	Detected	%	Total tests	Confirmed	%	Total tests	Detected	%
Male	134	0	0	255	14	5.49	2845	9	0.7	2186	1	5%	0	0	0
Female	0	0		393	39	9.92	2391	30	1.25	2391	1	0%	551	4	0.73
Total	134	0	0	648	53	8.18	5236	39	1.95	4577	2	5%	551	4	0.73

Figure 3 projects data on Table 3 graphically to appreciate male and female contribution to the HIV and STI situation.

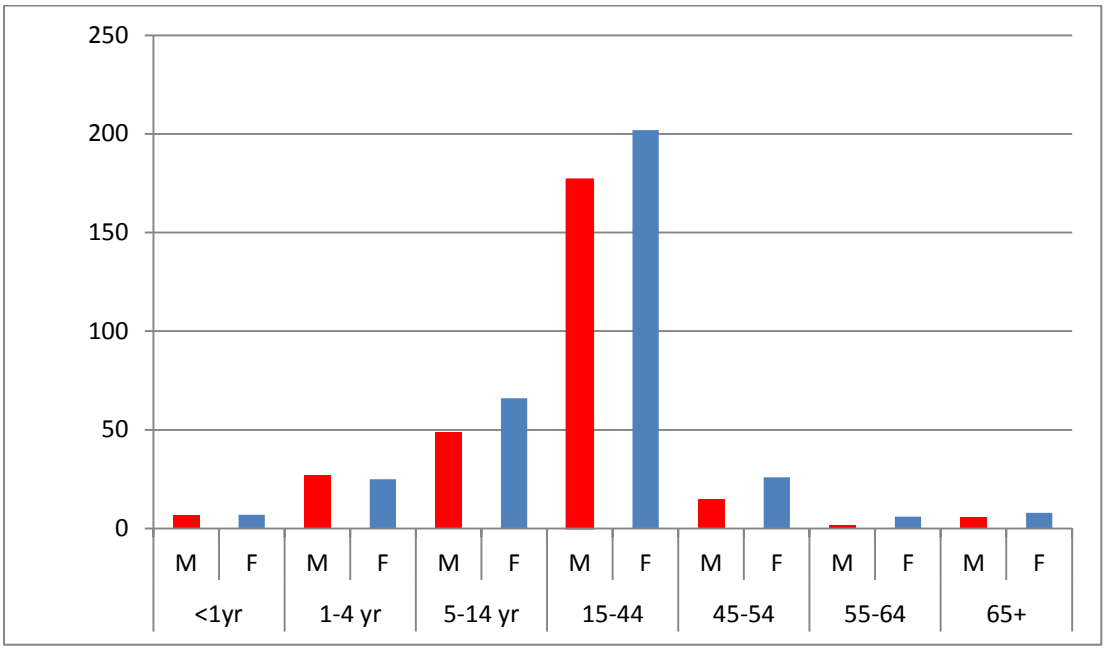
[4] The workshop used SPC's Comprehensive Sexually Transmitted Infection Management guidelines, SPC 2012.
[5] Second Generation Surveillance of Antenatal Women, Seafarers, Policemen and Youth in Kiribati, Kiribati and SPC, 2008



Another data on STI from MHMS Health information unit shows STI by all types that, by definition under the MS1 monthly report, should include gonorrhea, chlamydia and trichomonasis but not HIV and syphilis[6]. This data needs to be further validated when the MS1 reporting format has been amended to include specific types of STIs. Suffice to say that for the purpose of this report and to highlight the importance of age and sex dis-aggregation, Figure 4 shows that STI is most prevalent in both males and females but more in the latter in the age range 15-44 years, the age of highest sexual activity.

[6] The MHMS MS1 monthly return only captures STI as it is without categorizing it into specific types. This is one setback that needs to be addressed to allow for disaggregation of STIs into specific types.

Figure 4: STI, 2014



III National response to the AIDS epidemic

Overview of the national response

Kiribati's national response to HIV and AIDS has always been governed by the availability of external funding sources. As such it relies heavily on international donor support for its programmatic response. The MHMS provides in-kinds contribution to the national response through the provision of housing, office space and transport to its HIV/AIDS and STI Program staff, who are paid by projects funds. It also provides staffing for the Prevention of Parent to Child Transmission (PPTCT) program and Youth Friendly Health Services (YFHS). For 2014, The HIV/AIDS and STI program receives support from the Global Fund Transitional Funding Mechanism (TMF) and New Funding Mechanism (NFM). From civil society perspectives, KFHA receives support through IPPF, NZFPI, AusAID and UNFPA. KFHA's a most recent contribution in 2013 came from Kiribati Road Rehabilitation Contractor MacDow, targeting road workers as potential high risk groups. In 2014 another recent source of funding came from DFAT to address GBV where, so far, a desk officer and office space have been secured with full implementation expected to start in June 2015. KRCS receives its funding directly from GF to assist in blood donation and condom distribution.

The national response to HIV/AIDS and STI will be discussed along GARP ten targets and associated indicators.

Target 1. Reduce sexual transmission of HIV by 50 percent by 2015

Prevention of sexual transmission of HIV

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

1. HIV Testing and VCCT

Although there are now approximately 40 professional counselors and nine (9) accredited VCCT sites on South Tarawa and Betio, these sites however are not always fully manned by qualified counselors in view of staff retirements, movements and postings. To deal with this problem HIV/AIDS and STI staff conduct regular visits to these sites to conduct HIV testing counseling.

Again we use Table 4 as a basis for our discussion. It shows the total number of HIV and STI tests (syphilis, gonorrhea, chlamydia and trichomona) conducted in 2014 and gathered and complied from a number of sources (laboratory, blood donations, VCCT, PPTCT, STI clinics, Gynecological clinic, outer islands outreach activities and KFHA). Part of this data was also obtained and validated using data from the recent HIV/AIDS and STI Workshop conducted by SPC in Kiribati from Friday 27 March to Wednesday 1 April 2015[7]. While this is not a representative sample of the population the proportion of positive STIs, is a concern as this closely correlates with HIV transmission. The prevalence of chlamydia ranging from 5-10% in this population especially in women, confirms earlier findings of the high prevalence of this condition in the population.[8] Out of 4577 HIV tests conducted in 2014 only two were positive.

1.2 Condom promotion, distribution and MSM

Condom promotion and distribution has essentially been carried out by the Kiribati Red Cross Society (KRCS) with funding support for distribution coming from Global Fund while supplies are provided for from MHMS Pharmacy and Medical Stores. KRCS has more than 40 volunteers who are responsible for carrying out most of the KRCS community work. Towards the end of last year and up to the time of the writing of the report, condome distribution has ceased due to non-availablility of

[7] The workshop used SPC's Comprehensive Sexually Transmitted Infection Management guidelines, SPC 2012.
[8] Second Generation Surveillance of Antenatal Women, Seafarers, Policemen and Youth in Kiribati, Kiribati and SPC, 2008

supplies from National Pharmacy and Medical Stores. Furthemore, GF supports to KRCS will end in June 2015 pending the development of the next Concept Note and Workplan for the year 2016-2017. These plans are currently being developed by the national CCM and are expected to be presented at the next PIRMCCM to be held in May 2015 in Fiji[9].

KFHA and KRCS have been very active in conducting condom distribution. KFHA has in particular been working with MSM in this area and it is enlightening to note that MSM which in previous reports could not be fully accounted for, are now being dealt with as it should be. In this respect, KFHA and HIV Program have been able to identify and provide HIV prevention programs to 50 MSM especially on Betio area. In 2013, KFHA carried HIV and STI testing to 12 of the then 30 MSM and one tested positive for syphilis. No tests were done to MSM in 2014. Condom distribution has traditionally been done to public bars, night spots and hotels. The latest inclusion in now kava bars which are getting to be very popular in Kiribati.

1.3 Programs for mobile populations/seafarers

1.3.1 Seafarers

Marine Training Centre (MTC) has its own counsellor and laboratory and is responsible for carrying out awareness programs and HIV and STI tests to its new recruits and seafarers meaning those who have already worked on overseas boats. Those who will be travelling overseas either for the first time or returning to work are tested for HIV. Interview with the MTC counsellor revealed the following situations:

a. All those who will be travelling overseas to work are subjected to compulsory HIV testing
b. Those who choose to be tested by MTC laboratory would face the risk of having their results publicly known by staff of the institution and others;
c. Those who prefer to remain confidential would request to have their test done by KFHA. But still the issue of confidentiality cannot be assured when the results are submitted back to MTC. The results are delivered straight to the employer without the knowledge the counsellor; and
d. Those who are found to be HIV positive would not be allowed to travel

It is obvious that this is the employer's policy of "no HIV test no work" that impinges on the individual's rights and confidentiality in addition to putting potential seafarers who are otherwise healthy in a compromised situation with respect to their income earning capacity. At the time of the writing of the report, it was not

[9] Interview with Secretary-General, KRCS, who incidently is also the President of the Kiribati National CCM.

possible to obtain from MTC the number of recruits and seafarers receiving counselling or testing or treatment for HIV/STI. It would appear that some of the data are with KFHA and others with MTC laboratory. Furthermore, communication with the health information unit and national laboratory showed that MTC does not share data with them. There is a need to have proper data reporting and coordination between KFHA, MTC, Laboratory and Health information Unit with the latter to be the focal point for all national health data including HIV and STI.

1.3.2 Other mobile population: South Tarawa Road Rehabilitation Project

During the last 2014 GARP report it was reported that KFHA received funds from Mc Dow the contractor that is curretly implementing the South Tarawa Road Rehabilitation Project, to address the HIV and STI needs of its mobile employees. For this report KFHA has conducted in 2014 HIV and STI workshops to 74 staff of Mc Dow contractor.

1.4 Blood Transfusion and donation

There were about 1300 blood donation done in 2014 and all were subjected to HBsAg, Syphilis, HIV and HCV screening testing. There were two who were positive for HIV (0.16%), two who were positive for syphilis (0.16%) and one who was positive for HCV (0.8%). For HBsAg, positivity ranges from 2 to 19%. Again although this data is not representative of the population it is fair to say that HB infection rate in Kiribati has come down from as high as 27% in the early 1990s to less than 10% now[10].

[10] Before early 1990 Kiribati had a very high Hepatitis B infection rate. HBV was added to the schedule in 1990. A study in 1998 among 10-13 years old (before introduction of Hep. B vaccine) showed a prevalence rate of 27%. A later study of pre-school children who have had Hep. B vaccine showed a prevalence rate of 4%

Table 4: Blood transfusion and donor statistics, 2014

	HBsAg				Determine Syphilis			HIV		HCV	
Month/Result	**Negative**	**Positive**		**%**	**Negative**	**Positive**		**Negative**	**Positive**	**Negative**	**Positive**
		Male	**Female**			**Male**	Female				
January	145	12	1	13	170	3	0	173	0	157	0
Febuary	69	7	0	7	75	1	0	76	0	68	0
March	46	3	0	3	48	1	0	49	0	76	0
April	71	1	2	4	73	1	0	74	0	70	0
May	85	5	1	6	85	0	0	85	0	79	0
June	80	9	0	9	88	1	0	89	0	135	0
July	132	5	0	5	133	2	0	136	1	137	0
August	108	2	0	2	106	2	0	110	0	107	1
September	129	11	1	12	138	2	1	140	1	140	0
October	118	10	5	14	121	3	1	122	0	127	0
November	104	8	2	10	112	5	0	116	0	113	0
December	115	4	1	5	119	1	0	121	0	82	0
TOTAL	1202	77	13	19	1270	22	2	1291	2	1288	1
Totals			**1292**				**1292**		**1293**		**1292**

Source: National laboratory

1.5 Programmes for children and adolescents

1.5.1 Youth Friendly Health Services (YFHS)

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

- No existing or operational youth centres on South Tarawa and Betio, and

- The change-over of coordinators with apparent lack of handing over has resulted in discontinuity and delay in implementation.

Since the last report there have been several changes with respect to who coordinates this program. Now the senior nursing officer who looks after it is devoting much of her time in school health programs.

There have also been some collaborative effort between MHMS, UNICEF and NGO such as KFHA and KRCS involving outer island peer education. Furthermore, PHN are being asked to include YFHS in their daily work or identify one day for YFHS. This would require some structural changes including workload assessments, capacity buildings, a need for office space inside clinics for counselling etc.

1.5.2 Communication for Development (C4D)

Another program targeting youth and adolescents is the Communications for development (C4D) Project, a UNICEF funded program targeting youth has been active since 2010. For the previous years prior to 2013 it has been quite active in: conduct community and radio awareness during national sport completion (Te Runga 2013); village community groups awareness; truancy in schools; development and production of HIV DVD; HIV awareness and testing during National Youth Day 2013; public awareness during 2013 Independence Celebrations, and awareness to 40 Kava bars on South Tarawa and Betio.

However the funding for this project ended in September 2014 and since then it has essentially been non-existent. The only activity it was able to carry out was youth awareness program through one week of radio spots during the National Youth Day in August 2014.

It is obvious that donor partner support is needed to revitalize and maintain the momentum of this important youth program.

1.5.3 Youth Christian Living (YCL)

The Kiribati Protestant Church (KPC) now the Kiribati Uniting Church (KUC) also provides HIV and STI related services to its youth through Youth Christian Living (YCL) with funding from the World Council of Churches (WCC) distributed through the Pacific Council of Churches (PCC).

1.6 Community mobilization

Apart from the annual World AIDS Day which falls on December, there is still not enough impetus and drive to organize community mobilization and support for people with HIV on regular basis. The national CCM working in close collaboration with the HIV/AIDS and STI program and with assistance from a qualified ACSM or

community health officer should take leading roles in this aspect of the national HIV response.

1.7 Behavioral change programs

Surveys to assess the level of awareness and knowledge to bring about positive behavioral change have not been conducted since the last behavioral surveys in 2008 and DHS in 2009 and. As such it would not be possible to compare trends between the 2013 and 2015 GARP reports. Public awareness campaigns are on-going however.

Target 3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths

3. Prevention of mother-to-child transmission

3.1 Prevention of Parent to Child Transmission (PPTCT)

PPTCT is a UNICEF funded project with goal *'to promote HIV-free child survival in Kiribati through an integrated comprehensive approach to HIV and STI prevention and care for women and men at the reproductive stage of life and their children'*. It is coordinated by PNO in charge of Ante Natal Clinic. Through PPTCT all ANC mothers are given VCCT and tested for HIV in nine ANC clinics/centers on South Tarawa and Betio. All ANC clinics reports to ANC/TCH on monthly basis using MS1 and ANC/TCH then reports to HIU. Since the last year's (2014) report there have been two senior nursing staff to look after this unit. The turnover rate is still high.

3.2 ARVs for PMTCT

Currently for 2014 there are no HIV positive pregnant or lactating mothers. However two children both females, one aged 4 years and the other 6 years and both HIV positive from their mothers have still not received ARV.

The six year old girl has both parents HIV positive and the mother who also had active TB died in 2014. ARV treatment approval is still being awaited from the father who now prefers NTP staff, based on their DOTS work with the deceased mother to give them ARV drugs as a way to divert attention from him, and his child's HIV status.

The reason for the delay to the four year old girl initiation of ARV treatment is her HIV positive mother's significant fear of accidental disclosure of her child's HIV status.

Obviously there is a need to address this situation quite urgently especially for the two children. The HIV Program staff, HIV core team including SPC HIV advisor who visited Kiribati in early April are working on it.

3.3 Non-ARV-related component of PMTCT

The reported number of ANC attendant of 252 is only from Central Hospital data and all were tested for HIV with no positive results. From South Tarawa alone, where 50% of the population resides, we in fact should expect more than 1,000 NAC attendants taking into consideration the annual number of deliveries of ranging from 2,500 to 3,000 births a year. Greater efforts are needed to pool all ANC records together.

Target 4. Reach 15 million people living with HIV with life saving antiretroviral treatment by 2015

3 Universal access to treatment

HIV treatment is still very much at its infancy stage mostly because of the very high turn-over rate of staff of the HIV/AIDS and STI Program including the clinician who is in charge of AVR treatment. Just a year ago when the 2014 GARP report was produced, there were no staff in post to look after the HIV/AIDS and STI Program and a clinician who was supposed to be in charge of HIV treatment was not in country. The current staff, which is made up of one Monitoring and Evaluation Officer and two HIV field officers have only been in post since July 2014. A new clinician was also appointed as Medical Officer for TB, HIV and Leprosy. The chief cause of this staff high turn-over rate is the chronic and recurrent cessation and disruption of funds from GF. Although there are 28 people who should be eligible for ARV therapy only 5 are on treatment and the whereabouts of the remaining 23 is unknown.

4.1 HIV testing

There are nine (9) accredited VCCT sites on South Tarawa and Betio. These sites however are not always fully manned by qualified counselors in view of staff retirements, movements and postings. Of the nine sites only KFHA and MTC laboratory actually do initial HIV rapid tests.

4.2 Adult and pediatric antiretroviral treatment

There is only one site that is responsible for giving both adult and pediatric ART, but even that site, perhaps because of the issue on confidentiality is rarely talked about. Members of the Core HIV Clinical team consists of the HIV clinician, the pharmacist,

the senior laboratory technician and the HIV Program staff meet on regular basis to discuss progress on HIV treatment.

4.3 Support and retention

Of the five HIV cases that are on treatment, the couple with known identity have been on treatment for more than 60 months and three for more than 24 months. Contacts between HIV Program staff or clinician with the HIV positive cases on treatment have not been regular in view of continuously changing staff. It is hoped that with the new HIV Program staff and clinician in post and with the assistance and advice from SPC HIV specialist, more regular contacts and support will be made. Contacts time should include laboratory follow studies up especially CD4 counts counts and if feasible, viral loads. Support to PLWHA is on-going as far as the two publicly known HIV positive cases are concerned in terms of regular follow-ups, conduct of CD4 count and other support services provided mostly by the HIV/AIDS and STI Program staff.

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

Target 5. Reduce tuberculosis (TB) deaths in people living with HIV by 50 percent by 2015

5.1 TB screening and diagnostics for PLHIV

The actual TB/HIV collaborative activities began to be implemented around the middle of 2014 with series of meetings between NTP, HIV Program and Diabetes Program that culminated in the development and approval of two national guidelines: a) ***Guideline for care and control of TB and HIV/AIDS in Kiribati: Recommended collaborative TB/HIV activities,*** and b) ***Guideline for care and control of TB and Diabetes in Kiribati: Recommended collaborative TB/Diabetes activities.*** The objectives of the TB/HIV collaborative guideline are to:

a. Conduct TB/HIV surveillance as appropriate in the epidemiological context
b. Diagnose TB and HIV as early as possible through early HIV testing of TB patients and TB screening of people living with HIV
c. Ensure that people with both TB and HIV have early access to life saving treatment

d. Improve infection control at both TB and HIV care facilities/clinics, and
e. Prevent new cases of TB and HIV

The implementation of this guideline started in January 2015 and out of the 5 HIV patients on ARV, two have been screened for TB with negative results.

5.2 TB treatment for PLHIV

In 2014 only one patient was diagnose with HIV and TB. This took place at a very stage of the diseases and the patient died not long after initiation of both ARV and TB drugs.

Target 6. Close the global AIDS resource gab by 2015 and reach annual global investments

6. Governance and sustainability

Kiribati's national response to HIV and AIDS has always been governed by the availability of external funding sources. As such it relies heavily on international donor support for its programmatic response. The MHMS provides in-kinds contribution to the national response through the provision of housing, office space and transport to its HIV/AIDS and STI Program staff, who are paid by projects funds. It also provides staffing for the Prevention of Parent to Child Transmission (PPTCT) program and Youth Friendly Health Services (YFHS). For 2014, The HIV/AIDS and STI program receives support from the Global Fund Transitional Funding Mechanism (TMF) and New Funding Mechanism (NFM). It must be emphasized that GF support to HIV response is dwindling all the time making implementation of future programs very much in doubt. From civil society perspectives, KFHA receives support through IPPF, NZFPI, AusAID and UNFPA. KFHA's a most recent contribution in 2013 came from Kiribati Road Rehabilitation Contractor MacDow, targeting road workers as potential high risk groups. In 2014 another recent source of funding came from DFAT to address GBV where, so far, a desk officer and office space have been secured with full implementation expected to start in June 2015. KRCS receives its funding directly from GF to assist in blood donation and condom distribution. These funding sources are summarized in the funding matrix.

6.1 Planning and coordination

The national coordinating authority for all national HIV responses, with HIV/AIDS and STI Unit as the secretariat is the National Country Coordinating Mechanism (CCM). It serves to coordinate and support the development, implementation and management of grants funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). For the case of Kiribati the role of CCM has always been unclear

especially quite recently and now with the apparently dwindling GF support. The newly recruited HIV Program staffs are already facing financial difficulties in maintaining basic office operations and logistics like telephones, internet and transport. Yet they are being asked to do more than they can in terms of completing complex templates to provide timely reporting to GF.

Target 7. Eliminate gender inequalities and gender based abuse and violence and increase the capacity of women and girls to protect themselves from HIV

There are no recent data on this indicator, but the following are still pertinent:

a. Kiribati Family Support and Health Study found that 68% of women who had ever been in a relationship reported experiencing physical and/or sexual violence by an intimate partner

b. Health information unit reports that there were 221 cases of intimate partner violence (IPV) in 2014. This data is not representative

c. The recently newly formed ministry, Ministry of Women, Youth and Social Affairs (MWYSA), headed by a women Minister is one of the recent effort by Government to recognize the important roles of women and girls in the community as well as providing avenue to deal with GBV.

Target 8. Eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms

8. Critical enablers

8.1 Policy dialogue

a. **The Kiribati MHMS HIV/AIDS and STI Program** is supported by GF while the MHMS provides support to other HIV-related programs through housing and staffing the Prevention of Parent to Child Transmission (PPTCT) clinic within the Antenatal Clinic (ANC), the UNICEF-supported Youth Friendly Health Services (YFHS), originally the UNFPA supported Adolescent Health Development (AHD) program, and some MHMS HIV & STI Unit staff. The MHMS also supports a HIV and AIDS Clinician. Funding support for Kiribati national response to HIV/AIDS and STI come mainly from GFATM fund, NFM.

However in view of high turn-over rate and small number of staff who needs appropriate training, this unit needs to be significantly strengthened.

b. **The National HIV/AIDS Strategic Plan 2013-2016** has been endorsed by the MHMS as the working documents. The plan, with a vision to *"Reduce to bearest minimum all STIs and assure zero new HIV infections, zero preventable deaths HIV & AIDS, and zero discrimination associated with HIV"*; and the goal of: *"Achieving together a supportive environment to reduce the impact of HIV & other STIs on individuals, families and the community in Kiribati",* identifies five priority areas:
Priority 1: Prevention of HIV and other STIs, Prevention of Parent to Child Transmission, Safe Blood supply and assurance of Universal precautions.
Priority 2: Community leadership and an enabling environment to reduce stigma and discrimination
Priority 3: Diagnosis, treatment and support of people living with HIV
Priority 4: Quality diagnosis, management and control of STIs
Priority 5: Strengthening management and coordination of the national response

c. **Kiribati NSP 2013-2016 M&E and GARP Report 2014 – a meaningful link.** When creating data collection tools in Monitoring and Evaluation we will always relate them with indicators of the programme or project because that is really what we want to measure and report on. The NSP 2013-2016 has in place the M&E framework for monitoring a number of its key objectives under the five priority areas. Fifteen (15) of Kiribati NSP 2013-2016 M&E indicators were derived from either MDG or UNGASS and therefore are also captured in this Kiribati GARP 2015 report core indicators. This GARP report can therefore be seen as evaluation of the Kiribati National Strategic Plan 2013-2016.

8.2 Law reform and enforcement

It was also noted that much of Kiribati's health-related legislations like *Public Health Ordinance* and *Offence against morality* under the Penal Code are over 30 years old (and based on United Kingdom legislation) and requires updating to meet new needs and international requirements. There are currently no national instruments specifically legislating HIV/AIDS. Some international conventions and national efforts in addressing (indirectly) the HIV epidemic in Kiribati includes[11]:

- Convention on the right of the Child (CRC, 1995);
- Convention on the elimination of all forms of violence against women (CEDAW, 2004);

[11] Statement by the Vice President Hon Ms Teima Onorio for the 57th Commission on the status of women, theme: Eliminating all forms of violence against women and girls, 2013.

- The Child Young People and Family Welfare Bill (2012)[12],
- The Family Peace Bill that aims to address all forms of violence against women.

At the policy level, Government has approved:

- Eliminating Sexual and Gender based violence (ESGBV) Policy;
- National Action Plan 2011-2021;
- The Child Young People and Family Welfare Policy, and
- The Gender Access and Equality Policy and Implementation Plan 2013-2016.

8.3 Stigma reduction

Although there is no data with respect to discriminatory attitudes, the following sources of data are still relevant: a) extract from Kiribati DHS 2009; b) interview with PLHIV and c) Two parents attitude and behavior to ensure that their children's positive HIV status remain unknown:

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

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b) Key informant interview with one PLWHA speaking on behalf of herself an partner showed that discrimination towards them and her spouse was intense during the initial stage of the epidemic. This has steadily waned over the years and now she considers it "no longer an issue". On their parts they do not have any problem in traveling around and using public transports.

c) The parents of the two young girls age 4 and 6 years old who are HIV positive from their mothers remain quite strong in their stance to have the HIV status of their children remain unknown for very strong fear of discrimination and stigma.

[12] First Parliamentary reading in 2012, update is required.

In summary, stigma and discrimination against HIV positive people in Kiribati can become an issue or not depending on the context under which it is perceived and the specific case as a person being assessed, evaluated or judged.

Target 9. Eliminate HIV-related restrictions on entry, stay and residence

No data collection is required for this indicator but it may be opportune to mention here that MTC does appear to have a standing policy where seafarers are subjected to compulsory HIV testing and those found to be positive would definitely not be allowed to travel. It can be surmised from that policy that the work environment that these HIV positive seafarers would be working in, if indeed they are allowed to travel, would certainly be hostile, unsafe and uncompromising.

Target 10. Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts, as well as to strengthen social protection systems

Synergies with development sectors

10.1 Gender programmes

a) Ministry of Women Youth and Social Affairs (MWYSA). The recently newly formed ministry, Ministry of Women, Youth and Social Affairs (MWYSA), headed by a women Minister is one of the recent effort by Government to recognize the important roles of women and girls in the community as well as providing avenue to deal with GBV.

b) Women's Day. The annual celebration of Women's Day that falls on March every year has become an important annual events for Government and civil society. It would attract people from all walks of life with the women's groups from major church denominations taking the leading role in highlighting women's role within the context of the annual event theme. The fact that there are four women in Parliament with three women Government Ministers makes this annual event the more visible in the eyes of Government. It will continue to gather strength from year to year.

c) DFAT contribution to GBV. DFAT in 2014 has approved funds to KFHA to address GBV. This project started off in 2014 with recruitment of desk officer and office space. It will be implemented by June 2015.

10.2 Ministry of Education (MoE) – HIV and curriculum development

The MoE has already included HIV in its curriculum starting from Class 3 (now called Year 3) onwards under the subject matter: *"Healthy Living".* Healthy living deals with a number of important health topics including communicable disease that includes TB, HIV and others. Recent communication with Curriculum Development and Research Centre (CDRC) indicated that in 2014 they are upgrading the *Healthy Living* subject matter to include senior primary schools, Years 5 and 6.

10.3 Workplace

Workplace policy on HIV is non-existent. One of the tasks of the new HIV/AIDS and STI Program staff is to come up with that.

10.4 Synergies with health sector

The MHMS provides in-kinds contribution to the national response through the provision of housing, office space and transport to its HIV/AIDS and STI Program staff, who are paid by projects funds. It also provides staffing for the Prevention of Parent to Child Transmission (PPTCT) program and Youth Friendly Health Services (YFHS). The MHMS also supports a HIV and AIDS Clinician who currently is the Medical Officer for TB, HIV and Leprosy. Clear and well defined roles of the national CCM should be well communicated with the Senior Management, the policy division and governing body of the MHMS.

IV. Best practices

KFHA track records and excellent role in prevention, diagnosis management of HIV has gone a long way in assisting Kiribati to deal with the HIV epidemic. With staff that are fully trained[13] in laboratory, clinical and program management, and a wide range of funding sources including GF, IPPF, NZFPI, DFAT, UNICEF/UNFPA and lately the Kiribati Road Rehabilitation Program, KFHA's role in assisting national efforts in the response against HIV should be recognized and strengthened. As alluded to earlier in Section 1.3.2, KFHA has conducted HIV and STI awareness workshop to 74 staff of the contractor Mc Dow for the Road and Rehabilitation Project . For 2014, an additional funding from DFAT of just over $100,000 has been received to address Gender Based Violence (GBV)[14]. For a start in 2014, one officer and office space have been obtained and full implementation of GBV project will start in June 2015. It should be well noted with sincere appreciation that the MHMS is currently referring cases for vasectomies to be done by KFHA. Table 5 shows KFHA range of activities and impressive record for 2014 where it should be noted that KFHA has gone beyond its traditional role in addressing sexual and reproductive health (SRH) needs of women and adolescents, but also to cover non-SRH needs like NCDs (diabetes and hypertension) as an added interest of the principal donors, the IPPF[15]. This has resulted in total services (all types) provided of about 21,000 for 2014 with mobile clinics catching more cases (17,756) than Static (KFHA Office) Clinic. Table 6 narrows down those services to HIV and STI related services under SRH activities showing a total of 12,464 cases with, again, mobile clinic taking away about 10,000 and static clinic just over 2,000. In the table

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

[14] Interview with KFHA SRH Officer

[15] Interview with KFHA SRH Officer

it should also be noted that KFHA in 2014 did 584 HIV pre, post-test and HIV testing, distributed 1,781 male and 70 female condoms, gave syndromic treatment to 210 STI cases, and etiological management to 247 STIs and 25 syphilis cases. Of the total HIV pre-tests counseling much less was given post-tests counseling mostly due to their negative results.

Table 5: Service Delivery Points (SDP) - Service Outlets by Channel and Location. Services include all type, both SRH including HIV and STI, and non-SRH, KFHA 2014

SDP	Urban	Peri-Urban	Rural	Please explain any change in numbers from previous year
Static Clinic	3,063			The number of clients attending KFHA clinic in 2014 increased to 3,063 compared to 2,832 in 2013. KFHA team have worked hard promoting KFHA services to the community in various ways.
Mobile Clinic/Unit	17,756			Through mobile clinics KFHA youths and staff had performed exceedingly well during 2014 providing services to 17,756 clients compared with the record in 2013 of 13,103.
Associated Clinics				
Private Physician				
CBD / CBS				
MA Social Marketing				
Commercial Marketing				
Government				
Other Agencies				
Total	**20,819**			

Table 6: Service Delivery Points - HIV and STI related services only at Static and Mobile clinics, KFHA 2014

Services	New User under 25			New User 25 and over			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
KFHA Static clinic: HIV and STI statistics 2014									
HIV and AIDS - Counselling - Pre-test	59	83	142	40	50	90	99	133	232
HIV and AIDS - Counselling - Post-test	39	63	102	20	37	57	59	100	159
HIV and AIDS - Counselling - Risk reduction	59	83	142	40	50	90	99	133	232
HIV and AIDS - Investigation - Lab test - Diagnostic Rapid test	59	83	142	40	50	90	99	133	232
STI / RTI - Counselling - Pre-test	59	83	142	40	50	90	99	133	232
STI / RTI - Counselling - Post-test	39	63	102	20	37	57	59	100	159
STI / RTI - Counselling - Risk reduction	59	83	142	40	50	90	99	133	232
STI/RTI - Management - Syndromic	46	23	69	24	43	67	70	66	136
STI/RTI - Management - Etiological - Other	5	29	34	9	60	69	14	89	103
STI/RTI - Management - Etiological - Gonorrhoea.	10	4	14	4	2	6	14	6	20
STI/RTI - Management - Etiological - Syphilis	5		5	6	4	10	11	4	15
Male condom - Consultation	465		465	14		14	479	0	479
Female condom - Consultation		33	33			0	0	33	33
Totals	904	630	1534	297	433	730	1201	1063	2264
KFHA Mobile clinic: HIV and STI statistics 2014									
HIV and AIDS - Counselling - Pre-test	124	81	205	74	73	147	198	154	352
HIV and AIDS - Counselling - Post-test	90	60	150	68	73	141	158	133	291
HIV and AIDS - Consultation (Community Consultation)	1,230	1,084	2314	325	503	828	1555	1587	3142
HIV and AIDS - Investigation - Examination	124	81	205	74	73	147	198	154	352
STI / RTI - Counselling - Pre-test.	124	81	205	74	73	147	198	154	352
STI / RTI - Counselling - Post-test	90	60	150	68	73	141	158	133	291
STI / RTI - Consultation.	1,230	1,084	2314	325	503	828	1555	1587	3142
STI/RTI - Management - Syndromic	6	9	15	8	51	59	14	60	74
STI/RTI - Management - Etiological - Other	4	27	31	10	107	117	14	134	148
STI/RTI - Management - Etiological - Gonorrhoea	2	1	3			0	2	1	3
STI/RTI - Management - Etiological - Syphilis	3		3	3	4	7	6	4	10
STI/RTI - Investigation - Examination	124	81	205	74	73	147	198	154	352
STI/RTI - Investigation - Lab test	124	81	205	74	73	147	198	154	352
Male condom - Consultation	1,246		1246	56		56	1302	0	1302
Female condom - Consultation		37	37			0	0	37	37
Totals	4521	2767	7288	1233	1679	2912	5754	4446	10200
Grand Totals	5425	3397	8822	1530	2112	3642	6955	5509	12464

V. Major challenges and remedial actions

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

- **Data management – the central role of Health Information Unit**. This would probably be the most pressing problem of all. Kiribati faces data management setbacks in monitoring and evaluating its national HIV and AIDS response. Currently, HIV, AIDS and STI data is collected, managed, stored and reported on by multiple parties involved in the national response (MHMS Health Information Unit, MHMS HIV & STI Unit, MHMS Safe Motherhood Program, Reproductive and Sexual Health Program, PPTCT, YFHS, C4D and NGOs e.g. KRCS, KIFHA and MTC). The Program also also collects urine samples for STI[16] (chlamydia) from public health clinics around South Tarawa and Betio including KIFHA to the National Laboratory at TCH where they are forwarded to Mataika Laboratoy in Fiji. Copy of results are forwarded to the DPHS and for positive results treatment is initiated. The Health Information Unit (HIU) does not receive any of these results.
- High turnover rate of staff of the HIV/AIDS and STI Program. At the time of the writing of this report:
    - Newly recruited staff have just been in post since July 2014. During the 2014 GARP report there were no HIV Program staff then. This essentially means that since the last 2014 GARP report, no significant progress has been made in this area.
    - During the last 2014 GARP report one clinician was just joining the HIV program and he is still with the program as of now. There are good signs that he will remain with the program permanently. This is a significant improvement and we should be able to see improvement in patient initiation of treatment based on standardized WHO guidelines, improvement in follow up, support and retention.
- CCM involvement in the process. For a start, with dwindling GF support, the role of CCM in the preparation of GARP report may need to be revised. In view of the large membership of CCM a smaller key informant group would be preferred.

The following recommendations and remedial actions are put forward:

- Training of **all HIV-related public health programs coordinators** including HIC in data management. This should cover evaluation of bidirectional links, communications and reporting between programs and especially with HIC as the national focal point in data management and information flow. The training also should include standardization (template) of all reporting forms including data disaggregation.
- New recruits of young doctors to supplement current staffing issues will go a long way in identifying the most appropriate clinician to go for further training

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

in public health and HIV medicine and to occupy permanent posting as a HIV/AIDS and STI Program Coordinator.

- Evaluation of the coordination mechanism of HIV/AIDS and STI program under the governance of CCM needs to be conducted to streamline process, improve coordination and facilitate efficient implementation of the National HIV/AIDS and STI Strategy. This in fact has been done[17]. The Senior Management Committee needs to approve it for full implementation.

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

See Target 6. *Close the global AIDS resource gab by 2015 and reach annual global investments*, and the funding matrix

VII. Monitoring and evaluation environment

The HIV/AIDS and STI Program has a high turnover rate of staff. The sole reason given is the repeated cuts and often insufficient funds from GF financial supports. This has resulted in poor and delayed implementation and poor program performance. The new staff have only been in post since last July 2014 and with the new M&E officer on board it is expected that M&E component of the national HIV response would improve. The HIV/AIDS and STI Program Strategic Plan 2013-2016 is the working document that the MHMS has approved to guide the HIV/AIDS and STI work. The NSP 2013-2016 has in place the M&E framework for monitoring a number of its key objectives under the five priority areas. A number of Kiribati NSP 2013-2016 M&E indicators[18] were derived from either MDG or UNGASS and therefore are also captured in this Kiribati GARP 2015 report core indicators. This GARP report can therefore be seen as evaluation of the Kiribati HIV National Strategic Plan 2013-2016. Unfortunately funding has been lacking and at the end of the day the Program would end up relying on GF again for support which has not always been forthcoming. The Program is currently being funded by GF through the development of its concept note and costed work-plan. The M&E officer reports to GF on PUDR every six months covering all activities and statistics on condom promotion, HIV and STI awareness, VCCT. Despite all this there is a disconnect and poor coordination and sharing of data.

It is stressed here that data management including recording on standardized forms, data disaggregation, timely reporting, storage, coordination and sharing, is one major area that requires technical assistance. And it needs to be addressed as a priority.

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

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

ANNEXES

Annex 1: List of participants to the consultation/preparation meeting 16 March 2015

Name	Role	Organization
Mareta Tito	HIV Nurse	HIV/STI Program
Sapina Benitera	M&E Officer	HIV/STI Program
Teanibuaka Tabunga	Deputy Director Public Health, Data quality officer, HIC	MHMS
Dr Alfred Tonganibeia	Medical Officer, NTP/HIV/Leprosy	MHMS
Biribo Karaiti	Pharmacy	MHMS
Kiatoa Tio	Project Management Accountant	MHMS
Toata Titaake	PNO Safe Motherhood Program	MHMS
Monika Tarabo	HIV Counselor	MHMS
Tirutinia Kaitara	ANC/PPTCT	MHMS
Tongaa Tieei	In charge OBW, VCCT, HIV Counselor	MHMS
Tabeta Toon	PLWHA	NGO
Buraua Itimwemwe	PLWHA	NGO
Ueraoi Kamoa	Kiribati Red Cross Society (KRCS)	NGO
Dr Takeieta B Kienene	Local TA, NTP	MHMS

Annex 2: List of participant to the validation workshop Friday 27 March 2015

Name	Role	Organization
Teanibuaka Tabunga	Head, Health Information Unit and Deputy Director Public Health Services	MHMS
Mweritonga Rubeiariki	Communication for Development (C4D), Health Promotion Section	MHMS
Tabeta Buraua	PLWHA	PLWHA
Mareta Tito	HIV Field Officer	HIV Program, MHMS
Salaamo Taing	TB Nurse	MHMS
Emaima Tauteba	Field Officer	UNICEF

Annex 3: List of key informants interviewed

Name	Role	Organization
Teanibuaka Tabunga	Head, Health Information Unit and Deputy Director Public Health Services	MHMS
Mweritonga Rubeiariki	Communication for Development (C4D), Health Promotion Section	MHMS
Mareta Tito	HIV Field Officer	HIV Program, MHMS
Salaamo Taing	TB Nurse	MHMS
Emaima Tauteba	Field Officer	UNICEF
Bineta Ruaia	Senior Laboratory Technician	MHMS
Sapina Benitera	M&E Officer	HIV/AIDS STI Program
Tirutinia Kaitara	ANC/PPTCT	MHMS
Meaua Tooki	Secretary-General, KRCS, and President of national CCM	KRCS and CCM
Amota Tebao	Sexual and reproductive health officer	KFHA