Kiribati:

Kiribati National HIV and STI Strategic Plan

2013-2016

Navigating the way forward on HIV and other STIs

Developed by Kiribati National Stakeholders with the support of Regional Partners

Contents

Abbreviations

AAFR	Alcohol Awareness and Family Recovery
AIDS	Acquired Immune Deficiency Syndrome
AMAK	Aia Maea Ainen Kiribati (Kiribati Women's Federation)
AHD	Adolescent Health and Development
ARV	Antiretroviral drugs (used to treat HIV)
BPA	Broadcasting and Publication Authority
BTS	Blood Transfusion Service
CBO	Community Based Organization
CDO	Capacity Development Organization
DHS	Demographic Household Survey
DPHS	Director of Public Health Services
FSP-K	Foundation of the South Pacific Kiribati
Gilbert Islands	The Gilbert Group of Kiribati incudes islands from Makin in the north to Arorae in the south, including Banaba Island (Ocean Island) in the west
HIV	Human Immunodeficiency virus
IEC	Information, Education and Communication
KFHA	Kiribati Family Health Association
KIOSU	Kiribati Overseas Seamen Union
HIV CCM	Kiribati HIV AND AIDS/TB HIV CCM
KAP	Knowledge, Attitudes, Practices
KISWA	Kiribati Islands Seamen Wives Association
KNACC	Kiribati National Advisory Committee on Children
KNCC	Kiribati National Council of Churches
KPC	Kiribati Protestant Church
KPS	Kiribati Police Service
KRCS	Kiribati Red Cross Society
KSA	Kiribati Scout Association
Linnix	Line and Phoenix Group of Kiribati, to the east of the Gilbert Group Line Islands include: Kiritimati (a.k.a. Xmas Island), Fanning, Washington Phoenix Islands have low inhabitance or are uninhabited and include: Kanton (Canton), Manra, Nijumaroro, Millennium Island
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MISA	Ministry of Environment and Social Development
MHARD	Ministry of Home Affairs and Rural Development
MHMS	Ministry of Health and Medical Service
MISA	Ministry of Internal and Social Affairs
MICT	Ministry of Information, Communication and Transport

MOU	Memorandum of Understanding
MTC	Marine Training Centre
NBTC	National Blood Transfusion Centre
NGO	Non Governmental Organisation
NSP	National Strategic Plan
OI	Opportunistic Infection
PEP	Post Exposure Prophylaxis
PIAF	Pacific Islands Aids Foundation
PLHIV	People living with HIV (and AIDS: everyone with AIDS is infected with HIV)
PPMTCT	Prevention of Parent to Child Transmission
PRISP	Pacific Regional Strategy Implementation Plan
RRRT	Regional Resource Rights Team
SPC	Secretariat of the Pacific Community
SRH	Sexual and Reproductive Health
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV AND AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV AND AIDS
UNICEF	United Nations Children Fund
UNIMANE	Elders, or senior men
USP	University of the South Pacific
VCCT	Voluntary Confidential Counselling and Testing
WHO	World Health Organization
YP	Young People

Acknowledgements

This National HIV and STI Strategic Plan 2012 – 2015 is the result of much hard work, dedication and a strong and successful partnership of many people over the past few years. Therefore, the implementation will be as strong and successful as the partnership that is built around it. Every Ministry, NGO, Community and individual has a role to play in its implementation.

In this regard the process of writing this national plan bodes well for the future and I would like to express my sincere thanks for the tireless effort, dedication and contribution of those involved in the consultation, research, writing and production of this visionary and life-saving strategic plan.

In particular I would like to thank:

- The staff from HIV Secretariat and Ministry of Health and Medical Services who guided the process and kept it on track
- Those who sent in their suggestions and ideas by emails and other forms of media
- Members of the Country Coordinating Mechanism who have contributed key insights and ideas through numerous meeting and consultations
- The polishing up Technical Working Group, who listened carefully to numerous suggestions, guiding the NSP through its various drafts; and
- The regional and international development partner community, including Burnet Institute, Secretariat of the Pacific Community, Pacific Islands Aids Foundation, United Nations Children's Fund; and the Pacific Response Fund, which provided funds and technical expertise to support the consultations and writing process.

Together we have completed this plan. Your efforts will not be forgotten, and we look forward to continuing our collaborations as we embark on the critical task of implementation and monitoring our progress.

With this National Strategic Plan, we pledge our commitment to work together with our partners and stakeholders nationally, regionally and internationally to fulfil and achieve our vision and the goal of this plan.

Te Mauri Te Raoi ao Te Tabomoa

Kam bati n rabwa,

Ms Moia Tetoa
Chairperson of Country Coordination Mechanism

Terms and concepts

- **Incidence** is the number of new infections in a population during a year.
- **Prevalence** is the total number of infected people at a point in time, expressed as a percentage of the population.
- **Drivers of the epidemic** refer to structural and social factors, such as poverty, gender and human rights that increase people's vulnerability to HIV and STI infection.
- **Risk** is the probability that a person may acquire HIV infection. Certain behaviors create, enhance and perpetuate risk. Examples include unprotected sex, having multiple partners, and injecting with contaminated needles.
- **Vulnerability** results from the combination of social and structural or environmental factors that reduce the ability of individuals and communities to avoid HIV infection.

Foreword

It is my great honour and a privilege for me to introduce this National HIV and STI Strategic Plan 2012 – 2015. This plan outlines a comprehensive plan to address the Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections (STIs) till the year of 2015. This plan provides strategic direction and guidance for the national response, including a way forward on coordinating activities, mobilizing resources and sustaining positive impacts in the long term.

The formulation of a national HIV strategy is a process through which a country defines fundamental principles, goal and vision, priority programs, expected achievements and the institutional framework to guide the national response to the epidemic. What makes this "strategic" is that it takes into account the underlying determinants of the HIV and STI situation and how these epidemics affect different social groups. The strategic plan then carefully selects approaches and actions that will address each group to achieve specified results.

The social situation and the HIV and STI situations change over time, so the strategy has to be flexible enough to adapt to these changes and to respond to new information arising from monitoring and evaluation. Thus, the ongoing national response will be based on evidence of the HIV and STI situations and their evolution and effects on specific population groups. It will reflect an understanding of the root causes and main modes of infection in the country.

The strategic plan is a "living document". It will be adjusted as needed during implementation, based on new data from monitoring, studies, evaluation and other sources. This plan response to HIV and STIs focuses on outcomes, not just on what will be done (inputs and outputs). It seeks to promote management of the response that is focused on improving performance. This management, and the involvement of all partners, will use information to improve policy, programming and implementation towards achieving results.

Conclusively this NSP will contribute in the development of the Community as a whole as well as achieving the Kiribati millennium development goals (MDGs).

Peace,Health and Prosperity be with you all.

THIS DRAFT FOREWORD WAS PREPARED BY BRUCE, BASED ON PREVIOUS DRAFTS. IT NEEDS TO BE SIGNED BY EITHER THE CHAIR OF THE CCM, OR THE DIRECTOR OF PUBLIC HEALTH.

(Signature, name, position).

Executive Summary

Kiribati has a low prevalence of HIV, with a total of 52 people diagnosed with HIV at the end of 2009. Transmission is most likely to occur through heterosexual contact, with those most at risk identified as: seafarers, their wives and children, and people providing sexual services (often providing services to seafarers).

55 people were diagnosed as living with HIV in Kiribati between 1991 and 2012. Of these, 10 people – 5 male and 5 female - were diagnosed during the life of the previous strategy, between 2005 and 2011. However, 26 of these people have died of AIDS since 1991. Of these, 4 deaths (3 male and 1 female) were reported between in 2010 and 2011, with no deaths recorded between the years 2005-2009. The HIV Core Care is currently monitoring and treating 7 people living with HIV. This leaves 22 cases unaccounted for since diagnosis in 1991 – assuming surveillance reports of total numbers diagnosed and deaths occurring are accurate. These may be people who were diagnosed and untreated in the broader community or elsewhere; or they may be people who were diagnosed and have since died but were not reported as dying as a result of AIDS.

2009 was the first year in which routine data on other STIs were collected and reported. Kiribati experiences high STI prevalence with 11% of men having symptoms of STIs in the previous 12 months and 6% of women, with approximately 12% prevalence of STIs in younger people.

While almost all women and men in Kiribati have heard of AIDS, comprehensive knowledge of how to prevent HIV infection was less widespread but still reasonably high. Men appear to have slightly better knowledge of HIV than women. Despite this, some misconceptions about how HIV is spread remain widespread. Comprehensive knowledge is most common amongst educated men and women, and less common amongst those men and women with little or no primary schooling.

While more women than men are aware that HIV can be transmitted by breastfeeding, the number of people who are aware that the risk of maternal to child transmission is reduced if an infected mother takes antiretroviral drugs during pregnancy is much lower.

More men than women consider that a wife is justified in refusing sexual intercourse with her husband, or asking her husband to use a condom if she knows he has a an STIs. This suggests that women's self-perception of her right to protect herself differs from men's views. More men than women, particularly in the higher wealth rankings, report having two or more sexual partners since the previous 12 months. Amongst these men, condom use was higher than among women.

Violence against women is prevalent in Kiribati. The degree and likelihood of violence leaves many women vulnerable to emotionally or physically controlling behaviours and a consequent risk of forced sex, and limits the likelihood that women can confidently negotiate safer sexual practices – such as saying no, choosing one faithful partner whose status is known, or using a condom.

Stigma and discrimination on the basis of HIV status or sexual orientation is common. Surveys have concluded that stigma appears to be driven by fear and misunderstanding of how HIV is transmitted. Health communication and education strategies are needed to reassure the public that it is safe to live with and care for people living with HIV. As long as unfounded fears remain and HIV stays a hidden threat in the community, people are unlikely to be tested or seek treatment, which can result in more people infecting others.

Under existing legislation, public health authorities are empowered to provide comprehensive treatment, prevention and care services for HIV. There must be informed consent for pre and post test counselling, which is contrary to the current mandatory requirements for seafarers to test (and treat) for HIV and STIs prior to registering for employment or embarkation.

This Kiribati National HIV and STI Strategic Plan intends to address the 'big picture' for responding to HIV and STIs in Kiribati, and to link the HIV and STI response to the broader Kiribati National Health Plan. It aims to be a realistic document which will be used by the government and community groups to show agreement on the current situation; set the direction for the way forward; follow up and monitor progress in implementation over time; and evaluate how the success of the response will be measured over time.

The Vision is:

Reduce to bearest minimum all STIs and assure zero new HIV infections, zero preventable deaths HIV & AIDS, and zero discrimination associated with HIV.

The Goal of this National Strategic Plan is:

Achieving together a supportive environment to reduce the impact of HIV & other STIs on individuals, families and the community in Kiribati.

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

This priority includes:

1.1 Reducing risk and vulnerability of youth and other key risk groups.
   - Health Promotion and campaigns to increase awareness, knowledge to bring about positive behaviour change with respect to sexual practices.
   - Condom distributions.

1.2 Prevention of Parent to Child Transmission.

1.3 Safe Blood Transfusion and Storage in relation to transmission of blood borne viruses, particularly HIV and Other STIs (hepatitis B), and VNRBD.

1.4 Universal precautions for Government and NGO health workers and other associated workers such as police.

1.5 Integration of vaccine preventable STIs (Hepatitis B and HPV etc...) into control strategies.

1.6 Introduction of Reproductive and Sexual Health into Education Curriculum at all levels, including out of school youths.

Priority 2: Community leadership and an enabling environment to reduce stigma and discrimination

This priority includes:

-
- Promoting legislative reform to reduce stigma and discrimination
- Promoting workplace policies to reduce stigma and discrimination
- Addressing related vulnerabilities – addressing skills to prevent violence arising from gender inequality & promote the regulation of safer drinking environments, such as nightclubs and bars.

Priority 3: Diagnosis, treatment and support of people living with HIV

This priority includes:

- Testing (ensuring links to prevention)
- Diagnosis
- Treatment and ongoing management and monitoring and follow-up
- Care for people living with HIV

Priority 4: Quality diagnosis, management and control of STIs

This priority includes:

- Testing (also links to prevention)
- Diagnosis
- Treatment, ongoing management, monitoring and follow-up

Priority 5: Strengthening management and coordination of the national response

This priority includes:

- Oversight of the national strategic plan implementation
- Strengthening the capacity of agencies, departments and other NGOs who can support the government and non-government health implementing partners to reach youth and other key risk groups.
-
- Strategic information (monitoring and evaluation)
- Governance and leadership (CCM)

1. Background

1.1 Early stages of developing this plan

The National Strategic Plan Technical Working group met with NGOs and government stakeholders in Kiribati in March 2010 to discuss the development of this National Strategic Plan. The scope of the previous National Strategic Plan (2005-2008) had expired two years before. The meeting agreed on three key actions:

- to develop a new national strategic plan;
- to determine the process for developing the plan; and
- to assign responsibilities and timeline for development of the plan.

During 2010, the HIV Coordinator led a review of implementation of activities under the previous plan. As a result, a draft plan was circulated to regional partners for comment in July 2010. Regional Partners suggested that the draft plan could be strengthened with the incorporation of the review's findings which looked at what was implemented, what was spent and what was achieved. It was also suggested that the findings of three research projects undertaken in recent years be incorporated (these are summarised below). By early 2011, there had been a series of new appointments to the HIV and STI Program. This turnover in program staff and the change in the coordinating authority resulted in delays in the planning process.

In May 2011, the Country Coordinating Mechanism (CCM) met with Dr Dennie Iniakwala and Dr Olayinka Aya from SPC to discuss ways to address the situation. Burnet's planning adviser met with the Kiribati Country Coordinating Mechanism (CCM) in July 2011 to discuss how to support Kiribati to finalise the National Strategic Plan. Participants decided to commence the planning with a new review of the national situation and responses.

The Kiribati CCM then led the development of the new strategic plan under the guidance of the HIV M&E and Administration Officer. It was agreed that the process would be participatory, to encourage and consolidate country ownership and leadership. The result would be a new National Strategic Plan which country stakeholders related to – a plan that was realistic and easy to understand.

1.2 The approach used to develop this plan

Four steps were conducted between July 2011 and September 2012:

- A 'rapid appraisal situation' assessment in July-August 2011. The HIV M&E and Administration Officer led a small national planning team to conduct a rapid appraisal of the current situation, supported by Burnet via email.
- Burnet staff facilitated an in-country workshop to analyse the data gathered through the rapid appraisal to identify the key issues and recommended actions arising from review of implementation of the previous National Strategic Plan.
- Burnet staff led a broader group of key stakeholders in the development of the first draft results matrix in September and again in October 2011.

- Following consultation with regional partners, Burnet staff returned in August 2012 to work with a small national team to finalize the results matrix, develop targets and indicators, and present these to the Director of Public Health for final review.

SPC's Monitoring and Evaluation Adviser will support development of a Monitoring and Evaluation Framework to complement this plan in the last quarter of 2012.

The initial rapid appraisal was led by the in-country team with support from Burnet. Three questionnaires were completed. These were analysed by Burnet staff, together with a review of recent literature and other research relevant to the HIV and STI Program in Kiribati.

Workshops were held during September and October 2011. Commitment from the CCM and broader group of stakeholders was high, with consistent participation from over 20 representatives from government and NGO health and other sectors. A number of participants commented that the workshop was the first time that they had really understood strategic planning.

Three key steps were undertaken in the situation assessment workshop. Through a range of participatory methods, stakeholders explored the following questions:

Step 1: Community Mapping: Exploring what is currently happening in the Kiribati community in relation to HIV & STIs:

- Who is affected?
- What services and program exist?
- Who accesses the services?
- What did our community look like in 2005?
- What would you want to see in 2015?

Step 2: Exploring the Drivers of the HIV and STI situations:

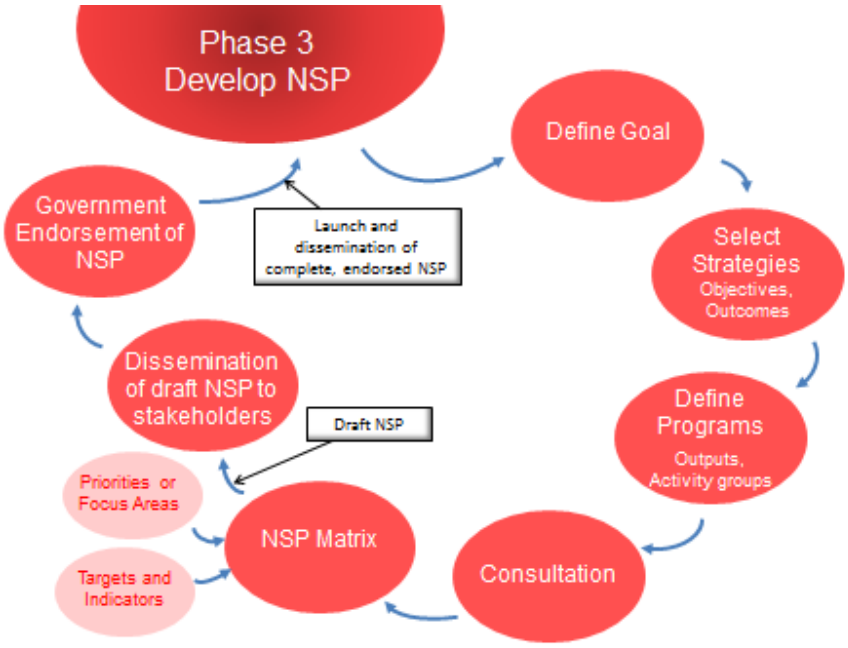
- Risk and vulnerability
- Stigma and discrimination
- Gender

Step 3: Identifying the changes since 2005 in each Priority Area of the current Strategic Plan: exploring stakeholders' experience of the response to HIV and STI to:

- Assess the changes in the HIV & STI situation and response since 2005, using 'Before and Now' charts;
- Scope the 'trends in progress' in relation to priorities and goals;
- Compare this information with the evidence from research and other data in relation to each priority; and then
- Identify 'What questions do we have?' for each priority, for exploration in determining content of the new National Strategic Plan.

The information from this situation analysis was then used by participants to develop the national plan, in accord with the steps agreed to by regional partners and followed by Burnet and the country planning team.

A diagram showing the steps used to develop this National Strategic Plan



Planning participants developed the Goal and identified Strategic Priorities and corresponding Strategic Objectives. They then identified key outputs, actions and measures for each priority area in accord with the program logic outline. This information was then transferred to the draft results matrix. The planning group also considered the draft Ministry of Health and Medical Services National Plan 2012-2015. This plan adheres to the time period of that broader health plan.

The key findings of the Situation Assessment and the Draft National Strategic Plan matrix were presented to the CCM and the Director for Public Health in October 2011. The findings and draft National Strategic Plan Matrix were endorsed by those present at the meeting. In the same week, the Global Fund announced that the expected Round 11 funding opportunity would be postponed. As a result, the imperative for finalising the Plan shifted to a more realistic timeframe which would allow for considered review and discussion by the broader group of stakeholders, including the CCM and stakeholders outside the current implementation group.

This National Strategic Plan is based on the outcomes of discussions by the CCM and associated stakeholders during 2011 and 2012. The National Strategic Plan is a high-level strategic document. The National Strategic Plan will be complemented with annual activity plans for each agency that is involved.

The National Strategic Plan will be supported by a national Monitoring and Evaluation Framework. As noted above, the Monitoring and Evaluation Framework is a separate but complementary document, based on the Results Matrix of this plan. It will be developed in collaboration with SPC's Monitoring and Evaluation team.

2. The Kiribati Context

2.1 The social, geographic, economic and political environment

The independent Republic of Kiribati is located in the central tropical Pacific Ocean. It was previously a protectorate of the British government until 1979, when the three largest islands groups - the Phoenix, Lines and Gilbert islands - joined as one independent nation under democratic self-rule. It is a member of the Commonwealth of Nations, the IMF, the World Bank and the United Nations. Kiribati consists of 32 atolls spread across these three islands groups and the island of Banaba and its territories encompass a span the same size as the breadth of the United States or Russia – with over 90% consisting of ocean.[1]

The preliminary report of the 2010 census[2] indicates a total population in Kiribati of 103,371, with females slightly in the majority (50.7%). Kiribati's main population is based in the capital of South Tarawa. Aggregated data on the age and location of the population is yet to be released. According to the 2009 Demographic Household Survey (DHS), Kiribati has a young population with 38% younger than 15 years of age[3]. The population is growing rapidly, and this trend is expected to continue as the cohort younger than 15 years enter their reproductive years. More females than males are over 70 years old.

The average household size in Kiribati is six members – although it is seven in urban settings and five in rural settings - and usually headed by men. As a result of increasing urbanisation in South Tarawa, vacant land is scare and new housing is needed. There is a high incidence of foster hood in Kiribati, with over 40% of households, particularly in urban areas, fostering children.

Although primarily Micronesian in language and ethnicity, the population also includes Polynesian and Melanesian cultures, arising from waves of invasion and subsequent intermarriage across cultural groups. Christianity is significant, with representation from most major religions.

Kiribati is considered one of the world's poorest and least-developed countries. In 2011, Kiribati was ranked 122 on the Human Development Index[4]. According to the 2009 DHS, wealth is distributed unevenly throughout Kiribati, and concentrated in the urban areas of South Tarawa.

In 2011, the Human Development Index reports life expectancy at birth is 68 years, with an under-five mortality rate of 46 deaths per 1,000 live births. With the arrival of Cuban doctors in recent years, there are claims that infant mortality had decreased. Government expenditure on health was $268 per person in 2006. The 2009 DHS reports that the absence of access to proper toilet facilitates in Kiribati is striking, with the majority of people in Kiribati not having access to improved toilets. In rural areas, four in every five households make do with non-improved toilet facilities. Ninety percent of the DHS respondents reported access to improved sources for drinking water, with access more common in urban settings. Similarly, 90% of urban households have access to electricity, compared with 20% of rural households.

[1] This information is drawn from Wikipedia unless otherwise referenced: http://en.wikipedia.org/wiki/Kiribati, accessed 19 December 2011
[2] 2010 Population Census Preliminary report, July 2011
[3] Kiribati 2009 Demographic and Health Survey, SPC
[4] http://sustineo.com.au/news/the-latest-undp-human-development-index-rankings-further-evidence-of-paradise-lost, accessed 19 December 2011

Although primary education is free and compulsory under a government system for the first six years (now moving to the first nine years), the 2009 DHS showed that many children do not attend primary school for the full six years. Higher education is expanding and many students seek technical, teacher, health or marine training, either within Kiribati or in other Pacific countries (particularly Fiji), Australia or Cuba. People with higher education levels tend to live in urban areas, which are also in the higher wealth ranking. There is little difference between men and women in terms of education achievements.

With its phosphate resources mined out before independence, Kiribati now relies on copra and fishing agreements with other countries (primarily Spain and Japan) and remittances – supplemented by aid - for its economic well-being. Australia, New Zealand, Japan and Taiwan provide substantial aid to Kiribati.

With overcrowding and climate change recognised as significant issues in Kiribati, there is ongoing dialogue with Australia and New Zealand about opportunities for seasonal and permanent migration. In 2008, Kiribati officially requested these two countries to accept Kiribati citizens as permanent refugees. Strategies to address the expected consequences of climate change continue to be discussed at international levels.

2.2 The HIV and STI situations in Kiribati

The previous national plan for 2005-2008 identified 46 cumulative reported cases of HIV diagnosed at the close of 2004. Of these, 36 were men and 16 women, and the majority of infected cases were seafarers. The plan also identified a shift in the gender of cases since 2000, with more women diagnosed. Of the 46 positive diagnoses, 28 were subsequently deemed to have AIDS. Of these, 23 people died (12 male and 11 female), including 4 children. At the beginning of 2005, it was estimated that there were 5 people living with AIDS (3 male 2 female) and 18 living with HIV (15 males and 2 females) including 2 children). Only one person had publicly disclosed his status. The primary mode of transmission was considered to be heterosexual sexual activity; with perinatal transmission the next highest mode. Whilst there had been an increasing trend in reported cases of STIs in the 15-49 age group, disaggregated data was not available to provide a clearer picture of trends. 2002-03 SGS surveillance data of a selected sample of seafarers and antenatal mothers indicated that HSV, Hep B was high, with lower rates of Chlamydia, syphilis and no gonorrhoea.

The most recent data on HIV are summarized in SPC's cumulative reported HIV AIDS and AIDS cases for 2009:

				Cumulative Cases				HIV		
Country	Mid-Year population	New cases for 2009	New deaths for 2009	HIV (inc AIDS)	AIDS (inc deaths)	AIDS related deaths	HIV Cumulative incidence per 100000	M	F	UK
Kiribati	98,989	0	0	52	28	23	52.5	33	19	0
All PICTS exc PNG	3,067,874	82	17	1,419	496	342	46.3	935	476	8

The 2009 Demographic Household Survey (DHS) reports that Kiribati has a low prevalence of HIV, with a total of 52 people diagnosed with HIV at the end of 2009. The DHS survey reports that transmission is most likely to occur through heterosexual contact, with those most at risk identified as: seafarers, their wives and children, and people providing sexual services (often providing services to seafarers).

Case surveillance data from the Kiribati Ministry of Health and Medical Services (MHMS) Laboratory in August 2011 shows a total of 55 cases of HIV diagnosed in Kiribati since 1991. Of these, 10 cases – 5 male and 5 female - were diagnosed during the life of the previous strategy, between 2005 and 2011.[5]

The same data indicates that 26 people have died of AIDS since 1991. Of these, 4 deaths (3 male and 1 female) were reported between in 2010 and 2011, with no deaths recorded between the years 2005-2009 inclusive.[6]

The HIV Core Care team reports that they are currently monitoring and treating 7 people living with HIV. This leaves a potential 22 cases unaccounted for since diagnosis in 1991 – assuming surveillance reports of total numbers diagnosed and deaths occurring are accurate. These may be people who were diagnosed and untreated in the broader community or elsewhere; or they may be people who were diagnosed and have since died but were not reported as dying as a result of AIDS.

While HIV and AIDS data has been routinely collected for a number of years, 2009 was the first year in which routine data on other STIs were collected and reported.[7] Between July and December 2010, Kiribati was one of 12 countries required to submit routine data in compliance with its Global Fund grant. Kiribati was one of 11 PICTS which reported on other STIs routinely in 2009, although not all countries were able to report complete data sets. SPC reports that Kiribati experiences high STI prevalence with 11% of men having symptoms of STIs in the previous 12 months and 6% of women, with approximately 12% prevalence of STIs in younger people.

2.3 The drivers of the HIV and STI situation

It is important to identify the population sub-groups where most new infections are occurring, and the behaviours that appear to be 'driving' the epidemic. For prevention, it is important to understand which groups and behaviours are 'driving' the epidemic. For treatment and care, it is important to get everyone who needs anti-retroviral treatment into the treatment program. This first requires that they seek voluntary counselling and testing. In Kiribati, there have been several independent studies since 2006 which have explored the contributing drivers underlying the HIV and STI situations.

2.4 Risk and Vulnerability

The 2009 Demographic Household Survey (DHS) reported that while almost all women and men in Kiribati have heard of AIDS, comprehensive knowledge of how to prevent HIV infection was less widespread but still reasonably high.[8] Men appear to have slightly better knowledge of HIV than women. Despite this, some misconceptions about how HIV is spread remain widespread. Comprehensive knowledge is most common amongst educated men and women, and less common amongst those men and women with little or no primary schooling.

[5] Data sourced from Director of Laboratory Services, Tarawa, Kiribati, August 2011

[6] There were anecdotal reports of one male death from AIDS in early August 2011 – this advice is yet to be verified and it is unknown whether this death was included in the data reviewed.

[7] SPC STI epidemiological update for Pacific Island countries 2009, p1

[8] Comprehensive knowledge of prevention methods refers to knowledge of: the benefits of limiting sexual intercourse to one uninfected partner; or using condoms; or limiting sexual intercourse to one uninfected partner; or abstaining from sexual intercourse.

While more women than men are aware that HIV can be transmitted by breastfeeding, the number of people who were aware that the risk of maternal to child transmission is reduced if an infected mother takes antiretroviral drugs (ART) during pregnancy was much lower. While education was associated with knowledge, neither age nor residence seemed to influence knowledge.

The majority of women and men know where to obtain an HIV test.

More men than women consider that a wife is justified in refusing sexual intercourse with her husband, or asking her husband to use a condom if she knows he has a an STIs. This suggests that women's self-perception of her right to protect herself differs from men's views.

More men than women, particularly in the higher wealth rankings, report having two or more sexual partners since the previous 12 months. Amongst these men, condom use was higher than among women.

The survey also observed a disconnect between ideals around fidelity and perceived practices. Although two thirds of respondents believed that married men should only have sex with their wives, only 40% of men and 20% of women reported that most married men *only* had sex with their wives. Most men thought that women should only have sex with their husbands, and around half of the men thought that most women are actually faithful. While many agreed that women should wait until they are married for sex, fewer thought that men should wait until marriage.

Five per cent of men aged 15-49 has paid for sex in the last 12 months prior to the survey. These men tended to be young, unmarried and in either the highest or lowest income range. Less than 1 in 4 men used a condom when they last paid for sex.

With many STIs asymptomatic, the DHS survey suggests that STI prevalence is under-reported and reasonably high: 11% of women and 6% of men aged 15-49 reported having had an STI or showing symptoms of an STI in the 12 months preceding the survey. One third of those reporting a symptom or an STI had not sought treatment. SPC analysis shows a comparatively low STI testing rate, with approximately 1000 tests per month, indicating coverage rates equal approximately 5% of the population[9].

While three out of four unmarried male and female youth reportedly know where to obtain a condom, condom use is low throughout Kiribati. Women who start sex early tend to have a low education level and low income. More than two thirds of those men who reported having sex before the age of 18 also reported that they did not know where to get condoms. Less than one third of young males having premarital sex reported using a condom the last time they had sex. While two out of three men know where to obtain a condom, only one in three reported using a condom the last time they had sex. In addition, among young people aged 15-24 years, 2% of women and 24% of men reported having sex while they or their partner were drunk.

[9] SPC Analysis – Nicol Cave STI Campaign Presentation, 2011 October

With a high proportion of men have sex at a young age, only 13% of men using condoms, and even fewer women reporting condom during first sex, there is a need for continued and better targeted communication and behaviour change strategies to increase condom use.

Although many women start having sex at a later age, and most wait for marriage, the survey suggests that women remain at risk of infection. Many women report that they would not protect themselves if their husband had an STI, and less than one quarter stated that most married men they know are faithful. STI prevalence is higher among women, and one third of people showing symptoms do not seek treatment. The DHS report recommends that education and communication strategies should aim to remove stigma around STIS so that people can recognise and avoid risk, and feel confident to seek treatment when symptoms do occur.

SPC has recommended that Kiribati target high risk groups (youth in particular) to reduce STI prevalence from 13% to 5%, and increase STI testing rates to 25% of the population through a campaign to promote testing and to disseminate key prevention messages.

A survey of Knowledge, Attitudes and Practices (KAP) undertaken by UNICEF Pacific Office and the Government of Kiribati from 2008-2009 to specifically explore risk and vulnerability amongst Kiribati Youth resulted in similar findings. Despite the low prevalence of HIV and AIDS, young boys and girls, men and women in Kiribati are at increased risk and vulnerability to HIV and other Sexually Transmitted Infections (STIs). Behaviours identified included commercial and transactional sex, unprotected sex and some injecting of drugs (though this was limited). These behaviours were compounded by forced sex and rape, the presence of foreign seafarers, incest, substance abuse, pornography, and a lack of knowledge of safe sex.

The report concluded that the younger generation needs support in building their knowledge about HIV and AIDS prevention. A well-improved HIV and AIDS service will help them prevent the infection from taking the lives of their own and their loved ones. Their increased ability to make informed decisions on when they are ready for sex and how to protect themselves from STIs, HIV and AIDS will halt the spread of the viral infection.

Based on analyses of findings, the recommendations are aimed at promoting and strengthening inter-agency coordination and capacity in reducing the vulnerability and impact of HIV and AIDS; and include improvement of HIV and AIDS services that cover most-at-risk, especially vulnerable, and increased risk populations.[10]

A complementary study by the Government of Kiribati and the University of New South Wales (UNSW), *Risky business*, encompassed a series of case studies on sexual knowledge attitudes and behaviours amongst the *Ainen Matawa,* the young women who board foreign fishing vessels to 'sell' sex.[11] The report identified key drivers that contributed to the risks and vulnerability of the transmission of HIV

[10] See Understanding HIV and AIDS Risk and Vulnerability amongst Kiribati Youth – fact sheet

[11] McMillan K, Worth H. Risky Business Kiribati: HIV Prevention amongst women who board foreign fishing vessels to sell sex. Sydney: International HIV Research Group, School of Public Health and Community Medicine, UNSW 2010

and STIs among these young women and the seafarer partners. Findings included poor knowledge; poor access to health services, particularly family planning and STI protection; lack of personal confidence; lack of employment opportunities; gender inequity and the threat of intimate partner violence.

The report recommended a range of strategies to improve access to information and services to reduce individual risk, such as peer education services on board boats; the establishment of sexual and reproductive health networks between clinical services and the *ainen matawa* peer groups to improve access to family planning, condoms and pregnancy services; the development of specifically targeted IEC materials and resources; life skills training to improve personal negotiation and confidence; as well as strategies to reduce stigma and discrimination.

It also recommended the introduction of programs and strategies to address the broader structural 'drivers' of risk and vulnerability for this group. This included programs to address the wider social and economic inequalities associated with gender, especially intimate partner violence. In particular, the report suggesting the establishment of a police liaison group to engage with *Ainen Matawa* to ensure access to protection from abuse; and, more broadly, strategies to reduce economic inequality.

Acknowledging the influence of diverse cultural backgrounds, the report concluded that there was a need to build a better understanding of the motivations and behaviours of seafarers more broadly. It also identified the need to acknowledge the situation for young women in the Line Islands who board boats, as well as the specific situation of sex work on land between locals. It also noted that there is sex between men, which it claimed is often hidden and denied.

Based on a consultative session with a broad range of key national stake holders and key program staff at the NSP Finalization Workshop in March 2013 (Annex A) Population at higher risk of exposure to HIV and other STIs and vulnerable groups are identified as follows:

- Youths
- Antenatal women
- Ainen Matawa (Sex Workers)
- Seafarers and partners, communities around international ports (Xmas Is, Fanning Is, Tarawa, Butaritari)
- Men having sex with men (MSM)
- Disabled and mentally handicapped individuals
- Flower girls (at Kava Bars) and local bar workers
- Bus drivers
- Policemen and security guards
- Health workers
-

2.5 Gender violence

A report of the Kiribati Family Health and Support Study in 2009 analysed data from the first ever nationally representative research on violence against women and related child abuse in Kiribati. The

study found that violence against women is prevalent in Kiribati. The study reported a range of factors that suggest a disturbing level of risk and vulnerability amongst women, in particular:

- More than 2 in 3 women aged 15-49 who had ever been in a relationship reported experiencing physical and/or sexual violence by an intimate partner
- Almost 1 in 2 ever-partnered women aged 15-49 (47%) reported experiencing high emotional abuse by an intimate partner
- Women were much more likely to experience severe forms of physical partner violence such as punching, kicking, or having a weapon used against them, rather than moderate forms of physical partner violence (slapping, having objects thrown at them)
- The experience of physical and/or sexual partner violence tends to be accompanied by highly controlling behaviour by intimate partners
- There is significant overlap between emotional, physical and sexual partner violence with most women reporting experience of all forms of violence.

Men as well as women were interviewed about gender violence. Key findings were:

- The majority of men interviewed reported that intimate partner violence is a serious issue in their communities and believe that it is not an accepted form of behaviour
- Male participants in focus group discussions mentioned four main reasons for the existence of intimate partner violence: jealousy, alcohol, acceptability of violence as a form of discipline and gender inequality
- Men acknowledged that violence could have broad ranging and serious effects on women and children
- Male perpetrators most often get angry with their wives when, in their (men's) eyes, they (women) do not live up to the gendered roles that society imposes on women
- All male perpetrators reported that they sometimes felt remorseful after beating their wives; however, despite this remorse, they did not seem to change their behaviour.

The degree and likelihood of violence leaves many women vulnerable to emotionally or physically controlling behaviours and a consequent risk of forced sex, and limits the likelihood that women can confidently negotiate safer sexual practices – such as saying no, choosing one faithful partner whose status is known, or using a condom.

2.6 Stigma and Discrimination on the basis of HIV status, gender or sexual orientation

There is limited research data available on the degree of stigma and discrimination on the basis of HIV status or sexual orientation in Kiribati, although most stakeholders consulted during the situation assessment noted its presence to various degrees.

The Kiribati DHS survey undertaken in 2009 briefly addressed attitudes to people living with HIV. The survey found that most men and women said they would be willing to care for a family member with AIDS in their home. However, it also found that far fewer people (49% of women and 54% of men)

agreed that a female teacher with HIV should be allowed to continue teaching. Overall, around three in ten respondents expressed tolerant and accepting attitudes.[12]

The survey concluded that stigma that exists around people living with HIV and appears to be driven by fear and misunderstanding of how HIV is transmitted. It recommended that health communication and education strategies should focus on reassuring the public that it is safe to live with and care for people living with HIV. As long as unfounded fears remain and HIV stays a hidden threat in the community, people are unlikely to be tested or seek treatment, which can result in more people infecting others.

More broadly, a review undertaken by the Pacific Islands AIDS Foundation (PIAF) during 2008 and 2009 reported on the widespread nature of stigma and discrimination in relation to those who are diagnosed with HIV in the Pacific. This review interviewed 12 HIV positive people from across the Pacific, including one of the HIV positive people living in Kiribati.

The review reported that the experience of stigma and discrimination was common amongst those diagnosed with HIV in the Pacific. Individuals not only experienced shock, grief, shame, and guilt after their diagnosis, depression and suicidal thoughts. They also experienced self-stigma which in turn affected their self perceptions and their ability to cope. Others reported being forced to leave their village. Stigma was imposed by friends and family and ranged from outright rejection to subtle social isolation. Churches reinforced stigmatizing attitudes and the experience of discrimination. Breaches of confidentiality were experienced by the majority of participants and acted as a deterrent to HIV-positive people accessing health services and employment opportunities. People living with HIV were socially isolated within their work places and faced difficulties in attaining employment.

A link to social and economic inequality was experienced, with a number reporting that being poor and HIV-positive led them to face difficulties in finding housing, employment, food, and a means to support their families. Poverty made it a struggle to get by day-to-day, which in turn had a direct impact on their ability to maintain their health. HIV-positive women, in particular, described how they faced isolation as a result of stigma and therefore faced significant challenges in being able to support their children and maintain their households.

Despite these experiences, a number of people described strategies which made life easier. These included: being accepted by their families and receiving family support; faith and prayer; and the support of non-government organizations through emergency funds; HIV/AIDS support groups; opportunities for people living with HIV to engage in HIV community education. Public disclosure of their status was an empowering experience and moved them from being HIV-positive to living positively with HIV.

The PIAF report recommends a range of strategies to address and prevent stigma and discrimination, including:

[12] Indicators of stigma and discrimination used in this survey encompass male and female attitudes to the following: would care for a relative with AIDs; would buy food from a person with HIV; would accept a female teacher living with HIV; would not keep secret if a relative had HIV.

- Counselling – including positive people as counsellors; for families as well
- Community awareness – should focus on stigma and discrimination as well as transmission and prevention
- Church - needs to adhere to Nadi Declaration & build ethics and pastoral care
- Health Workers – need to assure and ensure confidentiality – training and supervision
- Legislation and policy – implemented & monitored.

2.7 The Legislative Environment

In 2008 SPC's Regional Rights Resource Team (RRRT) conducted a review of the legislative environment in Kiribati to explore its status in relation to HIV and human rights. The review identified that, under existing legislation, public health authorities are empowered to provide comprehensive treatment, prevention and care services for HIV. There must be informed consent for pre and post test counselling, which is contrary to the current mandatory requirements for seafarers to test (and treat) for HIV and STIs prior to registering for employment or embarkation.

Other laws require review and/or education programs to share their content across the population. These include aspects of the criminal law; prisoners law; anti-discrimination law; legislation pertaining to the legal status of vulnerable groups (e.g. sex workers and men who have sex with men); privacy and confidentiality of individuals in relation to their health status; and the employment law[13]. In addition, the Review advised that codes of practice in various fields require review to ensure the rights of people living with HIV.

3. The nature of this National Strategic Plan

This Kiribati National HIV and STI Strategic Plan intends to address the 'big picture' for responding to HIV and STIs in Kiribati, and to link the HIV and STI response to the broader Kiribati National Health Plan. It aims to be a realistic document which will be used by the government and community groups to show agreement on the current situation; set the direction for the way forward; follow up and monitor progress in implementation over time; and evaluate how the success of the response will be measured over time.

3.1 Guiding Principles

Planning participants recommended that the guiding principles of the previous plan (2005 to 2008) must continue to be the guiding principles for 2012 to 2015. The guiding principles are:

- All people have the right to accurate information about HIV, AIDS, STI, voluntary counseling and testing (VCCT) and sexual and reproductive health.
- All people have the right to a safe blood supply.

[13] ILO advised, informally during 2011 that this legislation was revised 2008 to ensure no discrimination on basis of HIV status - confirm

- All people and groups have the right to protection from HIV infection and to care, support and treatment if they become infected.
- Any person regardless of age, gender, status, or health has the right to live in a healthy and happy community.
- All people living with HIV and AIDS have the right to live peacefully in a community and be protected by non-discriminative values.
- No one should be subjected to mandatory testing.
- People have the right to confidentiality of their STI, HIV or AIDS status, and to have confidentiality in the testing, counseling, treatment, care and support process. A person's HIV positive status should only be revealed, with the informed consent of the person infected.
- Stigmatisation and labelling, or discrimination towards a person living with HIV or AIDS should be considered as a breach of Christian ethics and illegal.
- All people be encouraged to prevent people living with HIV and AIDS from suffering humiliation and discrimination.
- Community members should be encouraged to support and help people living with HIV and AIDS, their spouses, families and others affected.
- Christian families and strong family ties should encourage and enhance genuine and compassionate love, care and pastoral care to meet the needs of PLHIV, their families and other's affected.
- Maintain strong Christian ethics to assist in the prevention and control STI and HIV AND AIDS through abstinence and being faithful to one partner.
- Communities should be encouraged to exercise their control to minimise multiple sex partners and always use condoms.
- Parents and families have a role to play in supervising and controlling their children for the prevention of HIV.
- Parents and families should have open communication with their children about sex, STI and HIV.
- Legislation and policies should be developed, enacted and enforced to support the strategic plan, and other relevant conventions such as the CEDAW and CRC.

3.2 The logframe approach

The Kiribati National HIV and STI Strategic Plan is based on a problem and solution approach to planning, implementing, monitoring and evaluation – and draws on the logical framework, or 'log frame' approach, to depict this.

It deliberately links the Kiribati National Strategic Plan to the Kiribati MHMS National Health Plan (in development), the Pacific Regional HIV Strategy Implementation Plan, and the Pacific Response Fund Logframe, as well as to the strategies and work plans of individual community and other Government of Kiribati agencies.

3.3 The structure of this Strategic Plan

The Kiribati National HIV and STI Strategic Plan includes a description of:

- The Goal for the Kiribati national response to HIV and STIs.
- The Vision which the planning participants aspire to.
- The Priorities for the national response; each priority has associated Objectives, Outputs and Strategic Interventions (the word "strategic intervention" is similar to "activity group", but the latter term was not used because it is used in the regional implementation plan, PRISP, so this may have led to confusion. The priorities each have precisely defined outcomes and indicators, so that the Kiribati CCM can track progress.
- The National Strategic Plan links to the activities described in the current Pacific Response Fund and Global Fund Work plans, and other NGO work plans. The annual activity work plans will have budgets.

3.3 Formatting and wording

During development of the plan there was a discussion on the appropriate words and format to use. The format and wording was to be consistent, as far as possible, with the Ministry of Health and Medical Services National Health Plan, the Pacific Regional HIV Strategy Implementation Plan and the Response Fund and Global Fund work plans.

PRSIP Planning terms	**PRSIP M&E terms**	**MHMS Strategic Plan**	**Agreed wording for Kiribati National Strategic Plan**
Goal	Impact *e.g. health status incidence or prevalence at country level*	Overarching Goal *e.g. health status incidence or prevalence*	Goal, Vision
(Purpose)	Outcome *e.g. changes in disease status/rates or overall situation*	Strategic Objectives *e.g. changes in disease status/rates*	National Impacts *e.g. changes in status/rates or overall situation specific to response to HIV & STIs*

		Priority Area	Priorities (5 priorities)
Objective	Outcome *e.g. changes in behaviours or situation*	Priority Actions 1-5	Objectives for each priority, Outcomes for each objective, and Indicators to measure whether these outcomes are achieved
Outputs	Outputs *e.g. products or services*		Outputs (3-5 for each Priority)
(Activity groups)		Activities	Strategic interventions

4. The structure of this National Strategic Plan

4.1 Goal

Achieving together a supportive environment to reduce the impact of HIV and STIs on individuals, families and the community in Kiribati by 2015.

4.2 Vision

Zero new HIV infections, zero preventable deaths from HIV and AIDS, and zero discrimination associated with HIV and STIs.

4.3 Priorities

- Priority 1: Prevention of HIV and STIs, safe blood supply and occupational health safety
- 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

4.3.1 Priority 1: Prevention of HIV and STIs, safe blood supply and occupational health safety

This priority includes:

- Reducing risk and vulnerability of youth and other key risk groups.

- Strengthening the capacity of agencies, departments and other NGOs who can support the government and non-government health implementing partners to reach youth and other key risk groups.
- Safe Blood Transfusion and Storage in relation to transmission of blood borne viruses, particularly HIV and Other STIs (hepatitis B).
- Blood donor recruitment.
- Universal precautions for Government and NGO health workers and other associated workers such as police.

This priority seeks to build on the following strengths and address these issues:

Evidence and experience indicates that some young people and some adults in the community have a reasonably comprehensive knowledge about HIV transmission and prevention and there is a strong perception that some in the community know about other STIs (and in particular, about their prevention and treatment). However, the limited evidence available indicates that not enough young people or adults in the 15-49 year age group are choosing to use one or more of the three prevention methods effectively (abstain, test/stay faithful to one partner, use a condom). The experience of clinicians and public health workers at the clinics in Betio and elsewhere on South Tarawa shows that more people are accessing STI services (particularly testing and treatment arising from the establishment of VCCT clinics and the youth friendly services).

Although public health workers report that youth and some men from the urban areas of South Tarawa have access to condoms, the DHS Survey indicates that many do not know where to get a condom. Women do not have access to condoms because of a lack of confidence or power (gender inequity). Women are less likely than men to either use, or negotiate, condom use. Some young men and women (voluntary) and ante natal women (routine) get tested for HIV and STIs, but not enough. Those in urban or South Tarawa are the most likely to be tested. Service providers advise that contact tracing and follow-up is difficult in South Tarawa and even more difficult in the outer islands.

Protective behaviours in key population groups have not changed enough. Young people are at particular risk – as are seafarers and their partners, men who have sex with men (in part because there are no programs dedicated to this behaviour) and sex workers and young girls in bars and nightclubs.

Some settings or environments increase vulnerability to risky behaviours, especially for young girls or married men: kava bars, alcohol bars and nightclubs. Prevention services to outer islands are not frequent. Gender or power relations play a role in increasing vulnerability and individual risk behaviours: the Family Support Study on *Gender and Violence*, together with UNICEF's recent baseline study on *Youth Knowledge Attitudes and Behaviours*, and UNSW's *Risky Business* all indicate that young girls and boys are vulnerable to personal physical and emotional violence, forced sex and engagement in transactional sex.

Community and institutional support will be improved to reach all these people effectively. Services will be strengthened, as will the linkages between community prevention and STI testing and treatment.

VCCT counselling, Youth Friendly Clinics, Outreach and Peer Education, especially using Drama and Radio, are effective interventions for young people in Kiribati.

There have been big improvements in the development of a safe and effective blood supply. This will be maintained. There has been an increase in donor recruitment, reflecting a shift in people's thinking about accepting blood from a non-family member.

The stronger capacity in the laboratory also makes a difference to donor recruitment: staff are better trained, particularly in the importance of confidential counselling; there are better policies and procedures (although use of screening questionnaires could improve) and access to better equipment, including more regular supplies of test kits.

There is increase education and dissemination of IEC materials about safe blood donations. More and cheaper IEC materials will be developed to promote blood donations, especially for distribution at special events such as sports events.

There have been no reported incidences of needle-stick injuries, suggesting that overall health worker safety compliance has improved, with regular training and access to supplies. This training will be extended regularly to the outer islands and to key groups such as emergency workers and police, to ensure that universal precautions are common practice.

What will be done in this priority:

There will be improved access to prevention services for 90% of the population, with consequent changes in individuals' knowledge, attitudes, skills and behaviours. Stigma and discrimination will also be addressed. To achieve this change, prevention strategies will increase as a proportion of the national response. A long term decrease in the number of reported HIV and STI cases may be preceded with small increases as more cases are detected and reported.

A safe and adequate blood supply will be maintained for ongoing and emergency needs by encouraging all members of the community to donate blood and accept blood. A feasible and realistic strategy for dealing with emergencies will also be developed. This will ensure that the MHMS implements its training in universal precautions, expanding program reach to ensure that NGO workers as well as Ministry staff are trained and comply with the guidelines and procedures.

Who benefits?

The primary beneficiaries of the prevention programs under this priority will be:

- young men and women in general, and more specifically, pregnant girls and young women and their partners
- seafarers; those engaged in transactional sex work on boats *(ainen matewa*) and on land; commercial sex workers; men who have sex with men (including those who may also have sex with women)
- the broader community or general population

- members of the various Churches and NGOs and other institutions in Kiribati
- nursing mothers
- people involved in accidents and emergencies
- patients in the surgical, emergency and obstetrics wards

Who will deliver services or programs:

The prevention programs will be operated by the full range of service providers: health workers and public health nurses from both the MHMS (including AHD) and the KFHA clinics in South and North Tarawa and throughout the Outer Islands. Voluntary support, participation and leadership will be sought from community and church leaders. In key areas, such as peer education and broader community awareness strategies, community based organisations and NGOs will play key roles, alongside the MHMS HIV Unit, VCCT counsellors and AHD. These will include the Kiribati Red Cross, Kiribati Family Health Association and Kiribati Catholic Youth.

Prevention programs will also collaborate with those in other priority areas, to engage other institutions and organisations such as the Police, district level community councils and village leaders. This will promote linkages between prevention and primary health care, such as testing and control of other STIs. It will also include legislation and policy development in workplaces, government departments and environments where people drink alcohol.

For safe blood supply historically, the Kiribati Red Cross carries lead responsibility, with technical and clinical support from the MHMS's laboratory and medical officers. In recent times, MHMS has taken the lead, but with the re-vitalisation of the Red Cross Management team, it is expected that Red Cross will resume its leadership responsibilities under the guidance of the National Blood Donor Committee. A range of volunteers, consisting of individuals, family members, church and other institutions, AHD, KFHA and Police, provide operational support with key activities.

Where - settings:

This priority will enhance the quality of programs delivered through the following venues or facilities:

- Health clinic
- Youth Friendly Clinics
- Village community settings, including the churches & *mwaneaba*

It will expand current services to ensure access in the following geographic locations:

- Tarawa (South and North)
- Outer islands
- Line Islands Group (includes Kiritimati)

4.3.2 Priority 2: Community leadership and an enabling environment to reduce stigma and discrimination

This priority includes:

- Promoting legislative reform to reduce stigma and discrimination
- Promoting workplace policies to reduce stigma and discrimination
- Addressing related vulnerabilities – addressing skills to prevent violence arising from gender inequality & promote the regulation of safer drinking environments, such as nightclubs and bars.

This priority seeks to build on the following strengths and address these issues:

Broader social and structural factors contribute to individual vulnerability. Much of the current prevention programming addresses only individual risk behaviours. Planning participants agreed that there is now a need to acknowledge the link between individual risk behaviours and broader social and economic environments.

The DHS data shows that, across all age groups, higher incomes and more education were factors that strongly correlated to a more comprehensive knowledge of HIV prevention and transmission, and, in a small proportion of the population, the adoption of protective behaviours. Other research, noted in section 2, demonstrates the perceived link between individual risk behaviours and broader structure and social factors, such as intimate partner violence, alcohol consumption and unemployment (and consequent lower incomes or poverty).

The national strategy aims to ensure that all people in Kiribati are treated equally, regardless of HIV or STI status, sexual orientation or gender. It also aims to protect the whole community from further infection. The experience of the HIV Clinical Core Care team shows that some positive people do not come for treatment because of the fear of being known as positive. This is not good for their health. In contrast, the community also wants reassurance that there are protections from intentional transmission of the virus.

Some, including in the Churches, have different views about the way the national response should treat the confidentiality of those who are positive. Some Church members want to name and identify people living with HIV. This can lead to unfair and unjust situations, it denies all people's right to privacy and confidentiality, and it stops people accessing appropriate health care. Some Church members also think that educating young people and others about how to stay safe and protect themselves from HIV and STIs encourages them to have sex, rather than protects them from sickness.

This priority will focus on strengthening the legislative environment so that Kiribati has the power to enforce human rights and protect those who are positive from unjust and unfair treatment – as well as explore the legislation to clarify whether the community needs stronger laws to protect the community from intentional transmission of this infectious disease.

The legislation will be followed with policy and education programs to support and monitor the enforcement of rights and responsibilities. There will also be work in related areas to address vulnerability for specific population groups:

- for women who are vulnerable to HIV and other STIs in situations of emotional or physical violence, including forced sex, in their intimate relationships;

- for men, women, young and old, in situations when they drink alcohol or kava, or are in places where others are drinking alcohol or kava, as this affects people's judgements about protective behaviours, and can place people at risk of physical and emotional violence;
- for young boys and girls, especially in the Line Islands, who are vulnerable to trafficking because of poverty or youth.

What will be done in this priority:

A working group to address and promote legislative reform has been established. This group will work with others to advocate to national, community, church, village and family leaders to use legislation and policy to create safer environments and reduce stigma and discrimination. This will protect the rights of people who are positive, and ensure that all are treated fairly in workplaces, schools, at home and in the community regardless of gender, sexual orientation or HIV status.

Who benefits?

The primary beneficiaries of the prevention programs under this Priority will be:

- People living with HIV
- Workers
- The broader community
- Parliament
- Youth

It will focus on developing relationships and programs in the following settings:

- Government workplaces
- Parliament
- Villages and community settings
- Drinking environments, such as bars and nightclubs on South Tarawa

Who delivers?

The CCM Working Group on HIV and the Law will work with the MHMS and the HIV Secretariat and the Attorney Generals Department, to lead the review and development of legislative and policy approaches, drawing on the support of the following key stakeholders:

- HIV+ Support Group
- Village elders, community and church and parliamentary leaders
- Civil service leadership

What else needs to occur within this priority:

Stigma and discrimination are difficult issues. It is important that stakeholders work in partnership to advocate, negotiate and explain why legislative and policy change is important, and how it can promote a stronger and healthier Kiribati. The CCM Working Group on HIV and the Law will work 'hand in hand' with the HIV+ support group, MHMS and HIV Secretariat and the Attorney Generals Department, to promote strong networks through legislature & community leadership to create safer environments.

4.3.3 Priority 3: Diagnosis, treatment and support of people living with HIV

This priority includes:

- Testing (ensuring links to prevention)
- Diagnosis
- Treatment and ongoing management and monitoring and follow-up
- Care for people living with HIV

This priority seeks to build on these strengths and address these issues:

Kiribati can provide comprehensive care for people who are HIV positive. The quality of communication and clinical skills in the HIV care team has improved and staff resources have increased substantially. But there is a need to review and improve ongoing monitoring and follow-up care. With a heavy staff workload and high staff turnover, some patients are not monitored routinely. Currently, there are no regular meetings of the Core care team nor is there a handover strategy or briefing of new staff on staff turnover in positions.

The clinical care team (and others) have been aware of a discrepancy in the official reported case data and the number of cases known to be accessing care and support. The current clinical care team are not sure of the numbers of positive cases who are currently living with HIV in Kiribati – 7 are currently being monitored or treated but reported case data indicates more have been diagnosed. With the high staff turnover, case-notes are unreliable.

Stigma and discrimination prevents access to services and to care. People who are HIV positive often do not come to clinics for ongoing monitoring. Most people living with HIV do not tell their families about their status. This priority aims to reduce stigma and discrimination so that people with HIV have improved access to adequate clinical care and other support, and so that there is support for their caregivers.

The diagnosis of HIV has improved since 2005. Stronger technical capacity in the laboratory, together with the introduction of VCCT counselling and supply of test kits, has made big difference to the quality of diagnostic capacity in clinical care services. However, many of the current people under care were diagnosed at late stage, because they sought testing only when symptoms had already emerged. There is a need to encourage earlier diagnosis to improve health outcomes, especially now that there is reliable access to drugs on-island.

Drugs and other supplies are routinely available, although the regularity of supplies – particularly test kits - to the Outer Islands, and to the Line Islands, could improve.

The introduction of VCCT testing, with 9 sites accredited and over 42 counsellors in government and NGO settings trained, has made a difference. However, SPC's rapid review of clinic data for the first six months of 2011 suggested that overall STI testing rates are still low and should be increased.

What this priority will achieve:

This priority intends to consolidate the role of the clinical care team, and enhance communication and collaboration so that the quality of patient care is enhanced. These strategies will also work through the HIV support Group to promote understanding and acknowledgement of stigma and discrimination. This will result in:

- Increase in the level and quality of services in diagnostic, management and care of HIV
- Ensure all confirmed cases are on appropriate treatment
- Access ongoing funding to continue and improve the current level of care
- Promote a healthy happy life for those who are positive and their carers

Who benefits?

The primary beneficiaries of the prevention programs under this Priority will be:

- The clinical care team
- People living with HIV and their families and care-givers
- The broader community

Who delivers?

The Clinical Care team, located in South Tarawa, will take leadership of the development and implementation of activities in this area through a strengthened collaboration of clinical carers, the HIV+ Support Group and the CDO across the VCCT clinics in the MHMS & NGOs – KFHA and AHD

Where?

The Clinics and hospitals, in Government (MHMS including AHD) and NGO settings (KFHA), across Outer islands, Tab North, Tarawa and the Line Islands.

4.3.4 Priority 4: Quality diagnosis, management and control of STIs

This priority includes:

- Testing (also links to prevention)
- Diagnosis
- Treatment, ongoing management, monitoring and follow-up

This priority seeks to build on these strengths and address these issues:

There is better diagnosis capacity in the laboratory and better treatment through syndromic management of STIs, but it is not certain that key risk groups are being reached. Despite increases in the quality of staff skills in diagnosis, management and control, it is thought that coverage is inadequate. Therefore, this priority aims to improve the quality and targeting of some groups for STI diagnosis, management and control.

The clinical care team reports that there is improved coverage of the general population, young girls and women. Clinical care workers say that more people are more likely to come for a test or to take a

condom. However, clinic data does not support the assessment that increased numbers of clients are being tested or treated. There is no data analysis available on key groups identified in earlier strategies. These include:

- civil servants
- seafarers, who may go to their own doctor, though some have come to KFHA since the new clinic opened in 2010
- bar customers and staff
- men who have sex with men.

It is also not clear what difference the increased testing and treatment of chlamydia makes to women and infant health outcomes. Even if the data were analysed, the data collected through routine surveillance is not specific enough to provide this information. The MS1 form is a centralised data system, which all clinics are now required to use, but it asks only for overall program data. It doesn't capture specific data on STIs. Specific surveillance data is necessary. SPC has recommended that Kiribati use the tally forms which are more specific.

Although clinical care workers know that contact tracing has improved, especially with partners outside marriage, it could be better. Some referrals are lost to follow-up. There is a particular need to improve the follow-up of referrals post-test, for HIV as well as STIs.

The approach of this priority will complement the other priorities. For many people, excessive alcohol use is a contributing factor that changes people's behaviour and attitudes and thus increases vulnerability and risk, especially for young girls, married women and teenage mums. This affects the risk of transmission of STIs, when people are unable to negotiate safer sexual practices either because their judgement is impaired, their partner's judgement is impaired, or they endure forced sex. AAFR is the only program specifically addressing alcohol use. Under this priority, the clinical care workers will also focus on education about the links between alcohol use and increased risk of STI transmission.

What this priority will achieve:

This priority intends to consolidate the role of the clinical care team, and enhance communication and collaboration so that the quality of STI diagnosis, management and control is enhanced. These strategies will also work to:

- Reduce complications for reproductive health and for newborns so that Kiribati has strong healthy babies
- Ensure better quality management of STIs, particularly in the Outer islands by:
  - Ensuring that test results are promptly communicated to clients, so that they can be treated promptly
  - Reducing the opportunities for complications from drug resistance or losses to follow-up
  - Strengthening contact tracing and follow up to ensure people are not lost after testing.

Who benefits?

The primary beneficiaries of this priority will be:

- People with STIs
- Hospitals and clinics in Tarawa, Outer islands, Tab North, the Line Islands
- Broader population of Kiribati.

Who delivers?

The responsibility for the delivery of clinical care services to improve the quality of STI diagnosis management and control lies primarily with the MHMS Hospitals & Clinics (including the AHD Program), supported by the HIV Secretariat with responsibility for VCCT. These are complemented by the substantial role of KFHA in providing clinical care services in Betio and the outer islands; and support from st

akeholders in the broader community: church, family and schools.

4.3.5 Priority 5: Strengthening management and coordination of the national response

This priority includes:

- Oversight of the national strategic plan implementation
- Strategic information (monitoring and evaluation)
- Governance and leadership (CCM)

This priority seeks to build on these strengths and address these issues:

Management and coordination of the national response has fluctuated over the life of the previous strategy. Nevertheless, there has been a gradual improvement over time. There is now an established team supporting leadership of the national response – with an equipped and staffed HIV Secretariat Project office. In the HIV Secretariat office, there will still need to be improved access to key support services: internet, water, sanitation, and printing.

Under the leadership of the CCM, the secretariat communicates well with other stakeholders. With the growth of the response, and the HIV Secretariat, this priority will now consolidate the role and responsibilities of the CCM to provide ongoing leadership to steer the response. Strategic planning is getting stronger, building capacity to plan, advocate for increased resources and allocate resources.

There is now a need to strengthen ongoing monitoring and review of the response on a regular basis. There has been some training in monitoring and evaluation, and reports are submitted regularly. There is still a need to develop an M&E Framework to complement this national strategic plan. Planning participants noted that there could be improved analysis and sharing of information, and that there are are gaps in data. Routine surveillance could be stronger. There is a need to build understanding of the data flows and linkages across the program, and to strengthen data collection, analysis and reporting.

What will be done under this priority:

Under this priority, there will be an improved development of a strong and healthy CCM which knows where it is going, and steers the response in the right direction for all of Kiribati, including the Outer islands and the Line Islands. The CCM will:

- Monitor implementation of the National Strategic Plan
- Make decisions together and contribute to the response
- Oversee effective use of funds and resources
- Be led by MHMS with the support and guidance of the HIV secretariat.

Who benefits?
The primary beneficiaries of the programs under this Priority will be the CCM, the HIV Secretariat, and the broader community, particularly youth and key risk groups.

Who delivers?
The MHMS, through the DPHS and the HIV Secretariat, carries primary responsibility for the implementation of the strategies under this priority, under the guidance of the CCM Members.

Collaboration, evidenced by partnerships between Government and non-Government agencies, with the church, unions, and other organisations and institutions, between individuals, families, and the community, is critical for a successful response.

National ownership and leadership in decision-making is the primary factor in a successful response. The CCM will draw in external Technical Assistance when needed.

The CCM, working through the DPHS and HIV Secretariat and in collaboration with other implementing partners, will ensure good planning to collect and use the right data. It will use monitoring and evaluation to analyse achievements.

Effective and accountable financial management is critical, especially with two key funding sources due to expire during the life of this Strategy. The CCM will ensure that the national response is transparent in its operations and actively advocate for ongoing donor support.

5. Funding priorities

The following funding priorities were presented to the CCM at the end of the strategic planning workshop. Annual budgets will be developed for each agency's workplan. The Director of Public Health advised that each agency would complete its own Annual Activity Plan and budget based on the National Strategic Plan.

This plan includes a number of activities which do not have funds. The planning participants identified the following activities as priorities for additional funding.

5.1 Prevention

- Stepping stones roll out beyond year 1 (and beyond Tarawa)

- Ongoing and additional Training of current and new VCCT counsellors and expansion of sites, including materials.

5.2 Treatment and Care for HIV and STIs

- Upgrade of HIV clinician position to full time to facilitate stronger oversight of continuum of care for current clients and support the clinical care team network
- Expansion of Youth Friendly Clinics to other end of Tarawa and to Outer Islands
- Expansion of services in most priority areas to Outer Islands and the Line Islands

5.3 Enabling environment

- Research into alcohol and risk behaviours in licensed environments
- Trafficking issues – determining strategies to eliminate trafficking

5.4 General funding issues

- Global Funds and Response funds are both due to end in 2013, so advocacy for future external funding will be a priority

5.5 Data management

- Routine surveillance
- Increase testing (and reporting) in relation to key groups

5.6 Focal points to be appointed

- Organisational Focal points are needed to support program implementation and establishment – these need to be identified for: Sex workers network; Positive People's network; Workplace policy development; Bus Union; Stepping Stones.

6. Results Matrix

Note that this plan covers the period from 2012-2015 because this is contributes to meeting the goals of the Ministry of Health and Medical Services National Health Strategic Plan, which ends in 2015.

Purpose of the Results Matrix

This Results Matrix summarizes the program logic of the national strategic plan, showing how the goal to be achieved over five years will occur as a result of the five strategic priorities, and how each priority has its own objective, outcomes, indicators of whether these outcomes are achieved, and strategic interventions. The term "strategic interventions" has been used even though the planning workshops discussed "activity groups". The reason for this is that the Pacific Regional Strategy Implementation Plan (PRISP) uses the term "activity groups", and participants agreed that using the same term may lead to confusion between the two plans. Discussion of what each of the components of this Results Matrix means and how it will be implemented is included above in the narrative section of this plan.

Annual Priority Actions

Each year, the Kiribati Country Coordinating Mechanism will consider what should be the annual priority actions. These will be based on this Results Matrix, chosen according to immediate needs and available resources. The implementation and effects of these priorities will be measured according to the information collection methods outlined in the Monitoring and Evaluation Framework. That framework will be developed soon after completion of this national strategic plan, with the assistance of SPC.

Impacts and outcomes

The national impacts for the whole strategy, and the outcomes for each objective, have been determined in the final planning workshop in August 2012, after considering the desired results identified by participants in earlier planning workshops held in 2011 and 2012. Participants decided that there should be four measurable national impacts, for which indicators can be assigned, rather than assigning indicators to the "vision". This is because the vision is like an aspirational dream, and would be cluttered if directly assigned with indicators.

The indicators are in accord with the standard measures requested for the Pacific Regional Strategic Implementation Plan (PRISP II), Global AIDS Progress Reporting (GAPR 2011), and major grants from the Response Fund and the Global Fund. A separate document which notes the links between the indicators in this plan and the regional and global indicators is maintained by the HIV/STI Secretariat and can be made available on request.

Some of the impact and outcome targets were developed in the feedback session of the 2012 Review of Parent to Child Transmission of HIV and Syphilis, which involved many clinical staff and national program staff in considering realistic targets for prevention and treatment of HIV and syphilis. By using the same targets, this national strategic plan and the specific decisions about how to prevent babies being infected are directly in accord with each other.

Not all global or regional indicators are included in this strategic plan because not all are relevant to Kiribati. For example, since there is no visible community of sex workers it is not possible to determine the percentage of sex workers infected with HIV, even though some transactional sex does take place.

Vision: Reduce to bearest minimum all STIs and assure: Zero new HIV infections Zero preventable deaths HIV & AIDS, and Zero discrimination associated with HIV.	
Goal: Achieving together a supportive environment to reduce the impact of HIV and STIs on individuals, families and the communit y in Kiribati by 2015.	
National impacts:	Indicators of whether these impacts are achieved:
A: By 2016, there will be at least 50% reduction in the number of new cases of HIV in the general population: and zero occurence of parents to child transmission.	A.1-1: Percentage of women and men aged 10-24 who are HIV infected. A.1-2: Number and percentage of infants born to HIV-infected mothers who are HIV-infected.
B: By 2016, at least 80% of eligible individuals with HIV will be maintained on ARV.	B.1-3: Percentage of eligible adults and children currently receiving antiretroviral therapy. B.1-4: Number of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.
C: By 2016, a 30% reduction in the prevalence of STIs.	C.1-5: STI prevalence amongst pregnant women who attend antenatal services (indicated by Chlamydia).
D: By 2016, there will be a significant reduction in stigma and discrimination associated with HIV or STIs.	D.1-6: Evidence of people surveyed expressing accepting and caring attitudes towards people living with HIV.

Priority 1: Prevention of HIV and other STIs, Prevention of Parent to Child Transmission, Safe Blood supply and assurance of Universal precautions.recautions	
Objective 1.1: Reducing risk and vulnerability of youth and other key risk groups. Increase understanding and preventive behaviours for HIV & STIs in young people and other key risk groups through quality prevention programs in South Tarawa, Outer Islands and the Line Islands.	
Outcomes of this objective:	Indicators of whether these outcomes are achieved:
1.1.1: By year 2016, 80% of young men and women aged 10-24 will have good understanding of how to prevent transmission of HIV and STIs.	1.1.1-7: Percentage of young men and women aged 10-24 who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission. (2009: 44% female 48.6% males aged 15-24)
By 2015, 100% of young people will have regular and easy access to condoms and reproductive health information.	Percentage of young people aged 10-24 years who have regular access to condoms and reproductive health information (disaggregated by age groups 10-14,15-19 and 20-24).
By 2015, a 50% reduction in numbers of people who have sex before the age of 15.	Percentage of young women and men who aged 15-24 who have had sexual intercourse before the age of 15. (2009: 1.6% female 13.8% male)
By 2015, a 60% reduction in numbers of people who have more than one sexual partner.	Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months. (2009: 1.8% female 10.5% male)
By 2015, 50% of adults who have more than one sexual partner will use condoms.	Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse. (2009: 2.4% female 33.2% male)
By 2015, 90% of pregnant women will have access to antenatal care services and skilled care at birth.	Percentage of pregnant women attending an antenatal care service at least once. (2011: 87%)
By 2015, 90% of HIV infected mothers and exposed infants will receive prophylaxis to reduce the risk of transmission of HIV to the infants.	Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother to child transmission.
By 2015, a safe blood supply.	Percentage of units of blood collected from voluntary non-remunerated blood donors.
By 2015, safe and confidential programs support people living with HIV to lead healthy and fulfilling lives.	Support network for people living with HIV exists. Evidence that people living with HIV gain support from other organisations.

Output 1.1:

Strengthen the capacity of organisations and institutions in the private and public sector across Kiribati to advocate and educate their members about HIV and STIs, in partnership with health NGOs and MHMS

Strategic interventions:

1.1.1 Conduct quarterly review meetings of the CCM to confirm each agency's work plan and responsibilities, discuss challenges and identify needs for improvements (as outlined in Output 5.2 on Monitoring and Evaluation, and Output 5.4 on Financial Management, all agencies will report quarterly to the CCM)

1.1.2 Review and develop IEC materials on HIV and STIs, including TB-HIV collaboration and Prevention of Parent to Child Transmission (PPTCT) ; evaluation of IEC materials coordinated by the HIV/STI Secretariat under the umbrella of the CCM; screening, pre-test and approvals of IEC materials will take place before mass printing and distribution; Health Promotion (MHMS) will oversee printing of IEC materials

1.1.3 Conduct Training workshops in HIV, STIs TB-HIV collaboration, transmission prevention and PPTCT with stakeholders from target organisations and institutions throughout Kiribati

1.1.4 Develop a funding proposal process, including criteria, for the Community Action Grants (awarded by the CCM) for participating agencies and institutions

1.1.5 Conduct Training of Trainers (TOT) Workshops to build skills in facilitation and writing proposals to HIV stakeholders for follow-up workshops delivered by key stakeholders throughout Kiribati; TOT for nurses and health inspectors on outer islands will be included to enable a multiplier effect, because the South Tarawa trainers are unable to cover all islands due to high costs

1.1.6 Conduct community education and awareness by trained facilitators in 1.1.5 to targeted populations

Output 1.2:

Increase access of young people and other most at risk and vulnerable groups to quality VCCT programs throughout Kiribati

Strategic interventions:

1.2.1 Establish VCCT Counsellors committee to oversee the ongoing operation and expansion of the VCCT program:

- Develop a strategy for using re-deployed VCCT- trained staff in other locations than the current accredited-VCCT sites, including options for a mobile VCCT program
- Agree on a training plan for the current and expanded program, including options for increasing accreditation/responsibilities of counsellors to take bloods in specific settings
- Revisit recommendations of the PCASS report to improve quality counselling

1.2.2 Review and distribute VCCT policy guidelines to all 9 VCCT sites and supporting health staff in Government and NGO health centres and hospitals

1.2.3 Conduct refresher training for all 42 accredited counsellors

1.2.4 Identify and recruit additional staff for training and then location in current and new VCCT clinics

1.2.5 Continue operation of the nine accredited VCCT clinics in South Tarawa (including upgrade of KRCS clinic), establish VCCT clinics in some of the 33 outer Islands and in the Linnix

1.2.6 Assess data requirements for VCCT operations and revise reporting format in collaboration with the HIV Secretariat M&E officer

1.2.7 Train all VCCT staff in data entry and reporting requirements

1.2.8 Establish Peer Educators Network to ensure integration of VCCT as part of overall outreach and peer education awareness and education programs in villages and community

1.2.9 Conduct quarterly meetings of VCCT to review challenges and identify needs for improvement

Output 1.3:

Increase access of young people, including most at risk and vulnerable to information and services through an expanded and improved peer education program in South Tarawa, the Outer Islands and including the Linnix

Strategic interventions:

1.3.1 Conduct Annual Review and Planning Meeting of Implementing Partners with CCM to evaluate each agency's annual output and plan for the next year

1.3.2 Develop an agreed strategy for consolidating peer education activities in South Tarawa and expanding peer education to the Outer Islands and including the Linnix

1.3.2 Develop a strategy for education of parents, to ensure own understanding of HIV and STIs and their support for peer education for youth

1.3.3 Review, develop and standardise training materials (including life skills training materials) for Peer educators in all agencies delivering services in South Tarawa, Outer Islands and the Linnix

1.3.4 Conduct refresher training for all current and lapsed peer educators including KNPEC committee members HIV 101,life skills training in assertiveness, negotiation and decision-making referral processes to YFS and VCCT clinics

1.3.5 Conduct outreach peer education activities during national events throughout Kiribati

1.3.6 Provide sufficient supply of condoms and carry out effective and efficient distribution to identified locations in South Tarawa, Outer Islands and the Linnix, and evaluate success annually:

- Establish committee to standardise activities for distribution, feedback from bars, strategies for cost effective provision of condoms
- Strengthen strategies on how to coordinate, distribute and use condoms, spot check to ensure bar workers look after condoms and make them accessible
- Identify focal persons for condom supply amongst peer educators at different levels and for different target groups
- Ensure condom focal persons report to Pharmacy on monthly consumption
- Health Inspectors for ships will ensure condoms are provided on the ships
- Nurses will coordinate and monitor Sexual and Reproductive Health (SRH) activities in their communities (e.g. condom distribution and peer education activities)

1.3.7 Conduct quarterly Peer Educator Network M&E meetings to confirm workplans and assess progress of peer education program activities and youth friendly health services outputs

1.3.8 Assess data requirements for peer education programs, revise reporting formats in collaboration with the HIV Secretariat M&E officer, and train all peer education staff in reporting requirements (cross reference to Output 5.2 on Monitoring and Evaluation; Kiribati National Peer Education Committee to provide the training)

Output 1.4:

Deliver Family Life Education to all schools in Kiribati

Strategic interventions:

1.4.1 Finalise the curriculum for all levels of junior and secondary school with the MOE

1.4.2 Discuss the curriculum with parents to obtain support and consent for the delivery of the curriculum

1.4.3 Implement the curriculum as a pilot in three schools in Outer Islands and Tarawa

1.4.4 Evaluate the pilot and revise the curriculum

1.4.5 Develop training program and train teachers at all levels for delivery of the curriculum nation-wide

1.4.6 Implement the curriculum nation-wide

1.4.7 Assess data requirements for school education programs and revise reporting format in collaboration with the HIV Secretariat M&E officer

1.4.8 Train all education staff in the reporting requirements

Output 1.5:

Eliminate new paediatric HIV and congenital syphilis: prevent transmission to newborns

Strategic interventions:

1.5.1 CCM to review and endorse new Prevention of Parent to Child Transmission (PPTCT) Guidelines following review in 2012

1.5.2 Health System Strengthening to ensure improved coverage of joint HIV, STI and MCH services

- Develop comprehensive training curriculum which includes PPTCT/STI/MCH
- Provide training on PPTCT to Health Workers to scale up the PPTCT/STI services in South Tarawa, the Outer Islands and the Line Islands
- Introduce task shifting approaches in accord with regional guidelines, so that more women and their male partners can be tested for HIV and STIs
- Improve social mobilization so that majority of people understand how transmission to newborns can occur and be prevented
- Train Ministers of Religion about the potential for infection of newborns with HIV or syphilis, and encourage them to discuss this in pre-marriage counselling so that couples can avoid it
- Increase coverage of PPTCT services through training of nurses and provision of test kits, including introduction of point of care rapid HIV test, in accord with regional protocols as these are rolled out (see Strategic Interventions 4.1.3 and 4.1.4)
- Improve program uptake, by mobilizing pregnant women to attend health centres or clinics to access antenatal care services which include screening for HIV and syphilis

1.5.3 Employ effective interventions to ensure PPTCT

- Ensure primary prevention of HIV and syphilis amongst women of child bearing age through integration with MCH education and IEC materials (this is also linked with other aspects of prevention in Output 1.1, 1.2, 1.3 and 1.4, but ensuring that information about PPTCT is included in VCCT, peer education and schools' Life Skills education)
- Prevent unwanted pregnancies, through linking this HIV and STI strategy with Family Planning, in particular by ensuring that all women living with HIV have access to Family Planning, and promoting involvement of men in first visits to antenatal services (National Family Planning Strategy is currently being developed, and will include family planning choices for women living with HIV)
- Scale up PPTCT and STI services to prevent transmission of HIV and syphilis from pregnant women to their newborns and infants, through testing (see Priorities 3 and 4 for details), provision of treatment where needed (see Priorities 3 and 4), and providing antiretroviral prophylaxis to infected mothers and their newborn children
- Appropriate treatment and care for mothers living with HIV and their children (see Priority 3)

1.5.4 Linkages of services between HIV, STI and MCH programs

- Improve integration of PPTCT and STI into MCH programs

- Appoint representatives of MCH programs to the KCCM
- Ensure supply of testing kits and antiretroviral drugs and STI treatment drugs takes account of the need for provision of those drugs to pregnant women and their newborns and infants (see Outputs 3.4, 4.5)

1.5.5 Improve measurement of PPTCT performance and impact

- Ensure PPTCT is included in improvements to Monitoring and Evaluation (see Output 5.2)
- Improve supervision and monitoring of the PPTCT programs, including training of health workers and quarterly reporting to the CCM (see Output 5.2)
- Ensure documentation and reporting on PPTCT and STI by all health facilities providing these services
- Include PPTCT and STI in regular reviews of MCH

Output 1.6:

Strengthened support network for positive people in Kiribati

Strategic interventions:

1.6.1 Re-establish the support group of institutions and other NGOs as a safe and confidential environment to support positive people and conduct regular (quarterly) meetings

1.6.2 Develop programs to support positive people in consultation with positive people

1.6.3 Advocate with other agencies, such as social welfare or employers, to support positive people to live healthy and fulfilling lives

1.6.4 Re-establish the support group of institutions and other NGOs as a safe and confidential environment to support positive people and conduct regular meetings

Output 1.7:

To maintain sufficient and safe blood supply to the community

1.7.1 Finalise and endorse MOU between Kiribati Red Cross Society and the MHMS

1.7.2 Finalise and endorsed Blood Safety guidelines/policy and protocols

1.7.3 Ensure adequate capacity of safe blood storage or cold chain is made available in all relevant locations

1.7.4 Red Cross and Laboratory to train health workers in MHMS, Red Cross and other NGOs and others on the revised blood safety guidelines and protocols

1.7.5 Red Cross and Laboratory to conduct community awareness program on the revised blood safety guidelines and protocols using community meetings, media and other IEC materials

1.7.6 Development and update database and protocols for data entry and maintenance of client records

1.7.7 Red Cross and Laboratory develop and update IEC and other media materials about the importance of voluntary non remunerated blood donors recruitment and retention

1.7.8 Plan and conduct community awareness programs on donor recruitment and retention and national voluntary non-remunerated blood donor registration, using community meetings, workshops, media and other IEC materials (e.g. World blood donor day; Community outreach and Drama)

1.7.9 Red Cross and MHMS to develop and implement a strategy for conducting mobile blood donations across South Tarawa, including use of a van for mobile blood collection if fund raising for this succeeds

1.7.10 Red Cross and MHMS to develop and maintain a voluntary national register of blood donors by establishing the blood donor social club – Club 5

1.7.11 Develop and updates database and protocols for data entry and maintenance of registered voluntary non remunerated blood donors

Output 1.8: Ensure the occupational safety of health workers and others who may be at risk of accidental transmission through workplace accidents
Strategic interventions: 1.8.1 Review, develop and distribute IEC materials and other protocols targeting health workers and others on universal precautions 1.8.2 Arrange and deliver training workshops for health workers in MHMS and NGOs and other agencies on universal precautions 1.8.3 Ensure that Manual and protocols are made available in proper (relevant) settings 1.8.4 Routinely audit compliance with universal precaution guidelines 1.8.5 Ensure supplies for maintenance of universal precautions are procured and disseminated to relevant locations (including syringes, rations etc) 1.8.6 Procure quality equipment and essential supplies to avoid service disruptions 1.8.7 Conduct a monthly inventory of supplies

Priority2: Community leadership and an enabling environment to reduce stigma and discrimination	
Objective2: Strengthen national and local government, civil society leadership including Churches, Unimwane, Women and Youth leadership, and improve the policy and legislative environment to reduce stigma and discrimination associated with HIV and STIs.	
Outcomes of this objective:	Indicators of whether these outcomes are achieved:
By 2015, there will be no stigma and discrimination associated with HIV or STIs.	Note that this is a national impact, so the indicator is included above.
By 2015, the Unimwane (old men) and the Churches will support the national approach to HIV and STIs, and allow participation of their communities in education and counselling.	Number of people who seek counselling and testing and say they were referred by Unimwane or Churches.
By 2015, there will be legislation in place to ensure that stigma and discrimination is illegal.	National legislation and policy framework adopted by the Parliament.

Output 2.1:

Engage Church leaders and Uminwane to promote understanding, reduce stigma and discrimination.

Strategic interventions:

2.1.1 Deliver annual training and awareness to members of the Kiribati National Council of Churches and other churches not in the council, throughout the Gilbert and The Line Islands Islands, and seek their ideas on what they can do to reduce fear, stigma and discrimination (commence with one day training, each year increase by one day, to three day training in 2015)

2.1.2 Deliver training and awareness to Unimwane Associations throughout Kiribati and seek their ideas on what they can do to reduce fear, stigma and discrimination (one day to three day training workshops)

2.1.3 Deliver training and awareness programs on human rights to other civil society organisations throughout Tarawa and outer islands

2.1.4 Develop guidelines on what church leaders should say to their communities, in collaboration with these leaders

2.1.5 Encourage interaction between Church and Unimwane leaders, health services staff and peer educators

2.1.6 Advocate to Church and Unimwane leaders to support legislation to reduce stigma and discrimination

Output 2.2:

Strengthen legislative capacity to reduce stigma and discrimination through review and enforcement of the Public Health Ordinance and HIV &STI Legislation

Strategic interventions:

2.2.1 Review existing Public Health Ordinance to ensure it promotes and protect the rights of people living with HIV and prohibits stigma or discrimination on the basis of HIV status

2.2.2 Establish a legal technical working group to oversee the process of improving policies and laws, in association with local legal experts, regional partners, and the Attorney General's Office

2.2.3 Develop and implement an education and awareness program about the new ordinance for key target groups and the general public, to ensure that the public accepts the bill

2.2.4 Consult with key stakeholders – including development of a policy paper for the Ministries of Health, Internal Affairs, Fisheries, and the Attorney General, to advocate for new and appropriate legislation

2.2.5 Consult with key stakeholders to finalize the policy paper (e.g. Ministries of Social Affairs, Fisheries and Marine Resources Development, Labour and Human Resources Development, Education, selected NGOs, Churches and Unimwane (Old Men))

2.2.6 Submit the Cabinet paper by MHMS to Cabinet to seek approval for the drafting of the HIV and STI Legislation

2.2.7 Further develop the new law and submissions to Parliament, through the Attorney General, then present the bill to Parliament

Output 2.3:

Strengthen civil service workplaces to reduce stigma and discrimination through development and endorsement of workplace policies

Strategic interventions:

2.3.1 Invite focal points for HIV in each Ministry, as well as those who are responsible for developing work place policies, to join the technical working group which is developing the new HIV and STI legislation

2.3.2 Conduct a training workshop on HIV and the law

2.3.3 Develop and disseminate IEC material and media to raise awareness about stigma, discrimination and the law for specific Ministries and workplaces

2.3.4 Establish small working groups in each Ministry to consult and develop workplace policies to protect the rights of people living with HIV to work in fair and secure environments

2.3.5 Review the seafarers and police workplace policies on HIV – including pre-conditions for mandatory testing – in light of Kiribati 2008 Employment Ordinance and the MHMS VCCT policy and practices

2.3.6 Monitor and report on implementation of workplace policies

Output 2.4:

Establish Stepping Stones Program in Tarawa

Strategic interventions:

2.4.1 Re-establish the Stepping Stones Committee (Stepping Stones is a program to promote community involvement in solving problems relating to HIV, STIs and sexual health – HIV/STI Secretariat will ensure this is re-established)

2.4.2 Conduct TOT training on Stepping Stones (new and previously trained) to develop workplan for roll out – first in Tarawa

2.4.3 Develop IEC materials and media initiatives for rolling out Stepping Stones in Tarawa

2.4.4 Collect and analyse data for regular monitoring and evaluation to assess coverage and effectives of Stepping Stones

Output 2.5:

Improve safety of nightclubs and licensed environments to reduce vulnerability and risk for young women and men

Strategic interventions:

2.5.1 Once the HIV and the Law Working Group is established, invite discussions with representatives from the bars and nightclubs as well as other relevant stakeholders such as AAFR, BTC & TUC Liquor Committee Chairperson

2.5.2 Review current Liquor Licensing Act and regulations and identify any amendments which may make these environments safer; if necessary, propose changes to the liquor licensing legislation and draft a policy paper seeking endorsement by Cabinet

2.5.3 Develop a strategy for enforcing the legislation: including use of IEC and media campaigns for safer drinking environments and education for bar and nightclub staff, employers and people visiting these places

2.5.4 Plan then conduct operational research into the links between alcohol consumption and risk for young people

2.5.5 Use this research to inform the development of the IEC and media campaigns

Output 2.6: Promote awareness of human trafficking in Kiribati, particularly in the Line Islands
Strategic interventions: 2.6.1 Review legislation – the Immigration and Customs Act and other relevant legislation 2.6.2 Develop training and awareness materials for schools and communities; and customs and police; and media 2.6.3 Deliver training and awareness in schools, communities, and through customs and police workplaces 2.6.4 Develop a media campaign for radio 2.6.5 Monitor implementation of awareness programs

Priority 3: Diagnosis, treatment and support of people living with HIV	
Objective 3: Increase coverage and quality of diagnosis, case management and care for people living with HIV	
Outcomes of this objective:	Indicators of whether these outcomes are achieved:
By 2015, a 100% increase in the number of people who know their own HIV status (from 2011 baseline 4,587).	Number of people who receive HIV testing and post-counselling services and receive their results, as per Pacific minimum standards.
By 2015, 90% of pregnant women will know their HIV status.	Percentage of pregnant women who know their HIV status.
By 2015, all people living with HIV who are eligible for treatment will be receiving treatment (eligibility based on low CD4 count).	Note that this is a national impact, so the indicator is included above.

Output 3.1: Access to quality testing and diagnosis of HIV to all clients in Tarawa, Outer Islands and Linnix
Strategic interventions: 3.1.1 Review and update data for HIV positive cases (linked with other data related activities: see Output 5.2) 3.1.2 Continue to offer confidential counselling and HIV testing to all clients in existing VCCT accredited sites 3.1.3 Strengthen preliminary & confirmatory HIV tests and CD4 tests throughout Kiribati, including outer islands 3.1.4 Review protocols and guidelines annually 3.1.5 Maintain an effective inventory system in place in the Laboratories and Pharmacy for the effective and continuous supply of drugs, testing kits and reagents. 3.1.6 Review, and update laboratory protocols and guidelines and maintain quality assurance compliance

Output 3.2:

Ensure Access to Quality Treatment and management of HIV

Strategic interventions:

3.2.1 Review and improve an effective referral between entry sites (eg VCCT and other clinics) and other sites on the Continuum of Care for HIV clients (refer to VCCT Flowchart)

3.2.2 Continue to offer ARV to people living with HIV who are eligible for treatment, and maintain ongoing monitoring of CD4 levels and relevant symptoms

3.2.3 Review and update the guidelines for monitoring treatment and management of HIV and disseminate to all MHMS and other stakeholders staff

3.2.4 Maintain and strengthen links to the ANC program

- ANC Program staff refresher training on updates in HIV diagnosis treatment and management offered every six months
- Annual review and dissemination of PPTCT Guidelines

3.2.5 Provide or arrange refresher training for the CCCT on changes or updates on management protocols; or testing and diagnostic updates (laboratory) through collaboration with regional/external bodies.

3.2.6 Provide HIV caregivers (families) with basic and updated information on HIV

3.2.7 Review and maintain IEC materials to promote recognition of the need for treatment of HIV (linked with STI awareness: see 4.2.6)

3.2.8 Assess the demand for extended services on the outer islands and upgrade the HIV clinician position to full time

Output 3.3:

Establish a network of clinical core care team for HIV to improve coordination and collaboration

Strategic interventions:

3.3.1 Review the referral and information system and protocols to ensure confidentiality and quality follow-up care for HIV+ clients

3.3.2 Maintain case monitoring of comprehensive/continuum of care in relation to patients progress, including statistics, and treatment of OIs

3.3.3 Develop strategies to respond to individual care needs with regard to HIV opportunistic infections (OIs) drugs and other essential supplies

3.3.4 Maintain confidentiality of the CCCT network meetings

3.3.5 Develop a system for all implementers to send their data to the MHMS and also copy this data to the HIV/STI Secretariat

Output 3.4:

Supply of essential drugs and equipment for HIV

Strategic interventions:

3.4.1 Continue to maintain timely stock reporting and ordering of essential drugs and equipments.

3.4.2 Review and update Guidelines and policies annually

Priority 4: Quality diagnosis, management and control of STIs	
Objective 4: Increased coverage and quality diagnosis, treatment and care for people infected with STIs	
Outcomes of this objective:	Indicators of whether these outcomes are achieved:
By 2015, 100% of pregnant women who attend antenatal clinics will know their syphilis status.	Percentage of those women who attend antenatal clinics at least once who are tested for syphilis.
By 2015, 100% of pregnant women and their infants who are infected with STIs will have received effective treatment.	Number and percentage of STI cases (syphilis and chlamydia) treated among the total number of pregnant women tested positive during antenatal care in a program year. Percentage of babies born to mothers who are infected with syphilis who have received treatment.
By 2015, 100% of young men and women infected with STI will have received effective treatment.	Percentage of men and women aged 10-24 who have been diagnosed with STI and have received treatment (disaggregated by specific STIs).
By 2015, 100% of people who are diagnosed with STIs in mobile clinics will have received effective treatment.	Percentage of men and women who have been diagnosed with STI in mobile clinics and have received treatment (disaggregated by specific STIs).
By 2015, 100% of "general people" diagnosed with STIs will have received effective treatment (this includes visa applicants, overseas employment seekers, people who attend clinics because they have symptoms).	Percentage of people in each category who have been diagnosed with STI and have received treatment.
By 2015, all STI treatment sites will have adequate and ongoing supplies of drugs to treat STIs.	Number and percentage of STI treatment sites reporting no stock-outs for more than 14 days of essential STI drugs as per national treatment guidelines.

Output 4.1: Provide and maintain Quality Diagnosis of STI
Strategic interventions: 4.1.1 Continue to offer confirmatory and referral testing services to MHMS laboratory and other overseas reference laboratories 4.1.2 Review, update and disseminate the testing and referral guidelines to all existing laboratories and VCCT sites 4.1.3 Introduce rapid Point of Care testing for STIs in accord with regional protocols as these are rolled out 4.1.4 Develop guidelines for appropriate use of Point of Care testing in outer islands, in collaboration with regional partners 4.1.4 Establish the national recording system for all STI cases 4.1.5 Conduct refresher training of all laboratory staff and VCCT and referral staff in Tarawa, the Line islands and

Outer islands when required

4.1.6 Strengthen inventory systems for testing kits and other diagnostics to ensure accurate and timely testing services are available to clinics

4.1.7 Re-assess and identify gaps with regard to equipment and other medical supplies by Pharmacy and Laboratory Units

4.1.8 Develop a proposal for funding assistance for purchasing new equipment (e.g. Chlamydia test kit equipment) and for additional human resources to strengthen laboratory and pharmacy capacity

4.1.9 Deliver services for STI detection, screening and treatment fortnightly throughout Tarawa and outer islands

Output 4.2:

Provide and maintain Quality Management of STIs

Strategic interventions:

4.2.1 Review, update, print and disseminate management guidelines for STIs

4.2.2 Assess and provide training needs for nurses on STI Case management throughout Kiribati

4.2.3 Improve referral and contact tracing by using email routinely to communicate to Outer islands health clinics to advise of follow up on clients diagnosed in South Tarawa

4.2.4 Improve, update and maintain data collection and recording of positive (and negative) cases for STI management at clinics and MHMS

4.2.5 Maintain regular supplies of STI treatment drugs between pharmacy and clinics

4.2.6 Increase awareness to pregnant mothers and youth on STI management and prevention (including IEC)

Output 4.3:

Prevention of STI recurrence throughout Kiribati

Strategic interventions:

4.3.1 Improve collaboration between MHMS and NGOs, Churches, Island Councils and Police, to agree on strategies to address contact partner tracing throughout Kiribati

4.3.2 Standardize IEC materials on the prevention of STIs throughout Kiribati

4.3.3 Conduct awareness and support (IEC materials, drama, road shows, radio and TV materials)

4.3.4 Train health workers based on the assessment needs at MHMS and NGOs STI clinics – throughout Kiribati

4.3.5 Launch and implement Youth Friendly Health Service guidelines and establish additional youth friendly services throughout Kiribati

4.3.6 Seek funds to support the development of additional youth friendly services throughout Kiribati.

Output 4.4:

Establish and maintain a Clinical Care Network for STI Practitioners/counsellors throughout Kiribati

Strategic interventions:

4.4.1 Review & Strengthen existing policies, procedures and guidelines to control and manage STIs effectively between the MHMS and NGOs clinics.

4.4.2 Conduct quarterly network members meetings on STIs issues

4.4.3 Develop a centralized database to support network between MHMS and NGOs (co-financed with other “data” related activities)

Output 4.5: Ensure effective National Supply of STI Drugs, Equipment and Other Essential Supplies
Strategic interventions: 4.5.1 Maintain adequate supply (reporting and ordering) of drugs, equipment and other essential supplies for STIs 4.5.2 Review and disseminate policy on importing drugs (prohibit private sector from ordering drugs that are not within the approved guideline) 4.5.3 Develop materials to educate STI clients on the importance of drug compliance to avoid drug resistance.

Priority 5: Strengthening management and coordination of the national response	
Objective 5: To deliver good governance and effective, efficient management & coordination of the HIV & STI Program in Kiribati.	
Outcomes of this objective:	Indicators of whether these outcomes are achieved:
By and of 2013, KCCM has a constitution which includes clearly defined membership, roles, responsibilities and decision-making authority.	KCCM constitution is endorsed by MHMS.
By 2015, KCCM is active and coordinating the national response, including holding meetings at least quarterly, and advocating for ongoing funding.	Reports of KCCM meetings and decisions taken. Reports of workshops and international meetings attended by KCCM members. Records of advocacy to donors and records of donor commitments to supporting the Kiribati national response to HIV and STIs.
By end of 2012, a Monitoring and Evaluation Framework has been developed.	M&E Framework developed by HIV/STI Secretariat. M&E Framework endorsed by Ministry of Health.
By end of 2013, all relevant stakeholders have capacity to contribute to Monitoring and Evaluation.	Reports of capacity building workshops in M&E.
Commencing in 2013, annual work plans and budgets are developed, then reviewed and approved by KCCM.	Minutes of KCCM meetings indicate review and adoption of workplans, annually.
By 2013 liaison with, and reporting to, donors is satisfactory.	Program and financial reports are produced on time (times vary between donors: six monthly, annual). Donor feedback indicates satisfactory reporting.

Output 5.1:

Develop strong leadership of the response through the CCM

Strategic interventions:

5.1.1 Develop a standing agenda for the monthly CCM meetings to review implementation of the Response and endorse financial acquittals which includes at least the following:
- Review Programmatic and financial Reports from working groups include CDO, NGOs and implementing partners including report on other HIV & STIs activities funded by other agencies
- Programmatic and financial progress report from HIV Secretariat
- Monthly workplan proposals
- Minutes reviewed and endorsed

5.1.2 Conduct special CCM meetings for urgent matters that cannot wait for monthly meetings including technical working group meetings that may be required by CCM

5.1.3 CCM members to discuss and agree on allocation of responsibilities for implementation of NSP making sure that individual work plans are in alignment with the NSP. All recipients of NSP grants streams 1,2, 3 etc to submit work plan proposals and MOU for approval review by CCM

5.1.4 Hire Local TA to review CCM Constitution and consider the following:
- Membership
- Operational guidelines
- Roles and responsibilities
- Decision-making authority
- Relevant training appropriate for program staff

5.1.5 Capacity building for CCM members
- Conduct annual training workshops on governance and leadership.
- Allow CCM members to attend regional and international meetings and workshops

Output 5.2:

Strengthen use of Strategic Information to inform a strong response to HIV and STIs

Strategic interventions:

5.2.1 Establish a National Planning, Monitoring and Evaluation Technical Working Group (NPME TWG) to address Planning, Monitoring and Evaluation of the response. This NPME TWG should consider and use existing information and data in planning for response.

5.2.2 NPME TWG consults implementing partners and funders to assess data needs, review data current surveillance systems and other data reporting flows, format and resources.

5.2.3 NPME TWG develop Monitoring and Evaluation Framework and Plan for the National Response that aligns with MHMS systems and processes.

5.2.4 Establish a standardise data base systems for data collection and entry, analysis and storage, report and disseminate for decision making, action and feedback by all stakeholders and funders (co-finance from other donors)

5.2.5 Conduct M & E Training of Trainer workshop with all implementing partners in the National Response including NPME TWG.

5.2.6 Submit programmatic and financial acquittal reports to funders as required based on quarterly analysis of implementation

5.2.7 NPME TWG regularly liaise with the Chairs of the Program Working Groups (IEC, Clinical Care, VCCT and others) to consolidate a national progressive report for response

Output 5.3:

Oversee implementation of the National Strategic Plan

Strategic interventions:

5.3.1 Strengthen the HIV secretariat office and staff including:

- Clear Structure of HIV Secretariat Office
- Review Operational and financial Procedures
- Review TORs/Job description for HIV staff
- Conduct performance appraisals for HIV staff
- Support salary for HIV staff
- Improve and support workplace environment, office equipment, supplies and program extension of HIV office

5.3.2 Conduct an annual review of implementation of the National Strategic Plan with the CCM in accord with agreed MEF indicators

Output 5.4:

Ensure strong financial management of the response

Strategic interventions:

5.4.1 Review and estimate budget for NSP, including delivery of the Monitoring and Evaluation Plan
This requires:

- Costing of all NSP programs and activities; the implementing
- RO/UNIT for each program oractivity to develop work plan and budget in a log frame format showing details of costing per unit, per event/instance, single activity and total of all HIV and STI programs or activities they are responsible for, details of funding sources, whether funding has been secured or not, and submit them to HIV Coordinator consolidation, endorsement and presented to CCM for approval
- For HIV and STIs programs and activities funded from the GF and RF, the work-plan and budget detail costing will be prepared by the HIV Coordinator and approved by CCM

5.4.2 Undertake regular financial acquittals and reporting of the NSP implementation for MHMS and fund:
This requires:

- The RO/UNIT implementing agency for each NSP program/activity to submit their financial acquittal reports on a monthly basis to the CCM for info, review and action
- The HIV Project Accountant to submit similar reports to the CCM on a monthly basis for all HIV program/activities funded under the GF and RF
- The HIV Coordinator to submit similar reports on a monthly basis on the program progress, as this report needs to be reconciled against the financial acquittal reports

5.4.3 Project Accountant to advise CCM of funding shortfalls and/or under-utilisation of funds for their advice in regard to re-allocation or reprogramming; this will be done through the monthly financial acquittal reports and

	programmatic reports which the RO/UNIT and Project Accountant and HIV Coordinator will submit to the CCM
5.4.4	With the endorsement of the CCM and MHMS, support efforts to mobilise and advocate for additional funds from donors This requires: • Establish a technical working group to review and develop a strategic plan on mobilising additional funding where required, and to advocate it and monitor the plans progress regularly on a monthly basis • Keep the MHMS and the CCM well informed of progress of the working group, also on a monthly basis.