

2015

# Global AIDS Progress Report of Tuvalu



Ministry of Health of Tuvalu

## Contents

1. Introduction .....	2
1.2 Acknowledgements.....	3
2. Indicator Overview.....	4
3. Status at a glance .....	9
3.1 Geography.....	9
3.2 Tuvalu Economy and Government.....	9
3.3 Demographics .....	9
3.4 Tuvalu National AIDS Strategic Plan.....	10
3.5 Monitoring and Evaluation .....	11
3.6 Health Infrastructure in Tuvalu.....	13
4 HIV in Tuvalu .....	16
4.1 Key populations at risk.....	18
4.2 Testing in pregnant women .....	20
5 ART Treatment, Care and Support.....	20
6 Eliminating gender inequalities .....	21
6.1 Gender and Women.....	21
6.2 Third gender.....	24
7 Stigma associated with HIV.....	25
8. Best practices .....	25

## 1. Introduction

In June 2011, Tuvalu joined the international community to sign the 2011 Political Declaration on HIV and AIDS; reconfirming its previous commitments made in 2001 and 2006. The Political Declaration motivates and compels countries to work towards achieving the Millennium Development Goal Six to halt and reverse the spread of HIV epidemic by 2015. The 2011 Political Declaration demonstrates the spirit of planning for results through setting time bound targets that countries should achieve by 2015.

I am pleased to announce achievements made in responding to the epidemic in Tuvalu, first of all by keeping Tuvalu a low level HIV country. People Living with HIV and AIDS are accessing treatment and we expect that this will translate into improvements in life expectancy.

The Government has recognized the contribution of community organizations, in particular in prevention programmes. The National AIDS Spending Assessment (NASA) 2013 uncovered that the Government contribution to HIV is on the rise and spending priority is given to the education of young population on how to prevent.

The country is not only committed but has demonstrated political support for the response. Such support will be sustained to ensure that we achieve the Universal Access targets. I am pleased that this report demonstrates our collective successes and the achievements are attributed to the people of Tuvalu; the youth who begin their sexual lives having attuned to safer behaviours; the women who visit antenatal care clinics to protect their unborn children; the men who are getting circumcised; the key populations who are coming out to become active partners in HIV prevention efforts and the households who participate in national surveys.

On behalf of the Government, I would like to express gratitude to all multisectoral stakeholders. The collective efforts of the friends of Tuvalu; the Civil Society, development partners, bilateral and multilateral donors, including business can never be overlooked. All this has been made possible by the commendable commitment of the Government of Tuvalu in providing the leadership and guidance that is necessary to spur the country to meet MDGs.

Lastly, I still believe an HIV-free generation is possible; through continued engagement, participation and shared responsibility. For now let us carry this document with pride and the knowledge that significant milestones have been achieved by the country.

Hon Satini Manuela

## 1.2 Acknowledgements

This report was prepared by the Minister of Health of Tuvalu on March 31, 2015 with technical support from UNAIDS Office in the Pacific.

This report was coordinated by the Tuvalu Department of Public Health which is leading the HIV/AIDS programme response in Tuvalu. The data and analyses presented in this report was drawn from a diverse range of sources including (but not limited to): Department of Public Health and the Tuvalu Princess Margaret Hospital, Laboratory and STI Clinic administrative and reporting data; Tuvalu's Demographic Health Survey 2007 and key informant interviews.

Contact person for the report:

Taufala Nia, Ministry of Health of Tuvalu, HIV program Officer – e-mail: [taufania7@yahoo.co.nz](mailto:taufania7@yahoo.co.nz)

## 2. Indicator Overview

<b>Target</b>		<b>Indicators</b>	<b>Value</b>	<b>Source</b>	<b>Comments</b>
<b>Target 1. Reduce sexual transmission of HIV by 50 per cent by 2015</b>	<i>Indicators for the general population</i>	1.1 Young People: Knowledge about HIV Prevention*	60.7% males 39.4% females		DHS 2007
		1.2 Sex Before the Age of 15	14.7% males 1.7% females		DHS 2007
		1.3 Multiple sexual partners	4.0% males 1.1 % females		DHS 2007
		1.4 Condom Use During Higher Risk-Sex*	11.3% males 4.6% females		DHS 2007
		1.5 HIV Testing in the General Population	6.4 % females 19.9% males 15-19 and 21.9% males 20-24		DHS 2007
		1.6 HIV prevalence in young people	0		SGGS 2007
	<i>Indicators for sex workers</i>	1.7 Sex Workers: Prevention programmes	No data		No studies
		1.8 Sex Workers: Condom Use	No data		No studies
		1.9 Sex Workers: HIV Testing	No data		No studies
		1.10 Sex Workers: HIV Prevalence	No data		No studies
	<i>Indicators for men who have sex with men</i>	1.11 Men who have sex with men: Prevention programmes	No data		No studies
		1.12 Men who have sex with men: Condom Use	62.5%		No studies
		1.13 Men who have sex with men: HIV Testing	No data		SGGS 2007
		1.14. Men who have sex with men: HIV Prevalence	0		SGGS 2007
	<i>Testing and Counselling</i>	1.15 Number of Health facilities that provide HIV testing and counselling services	8	MOH	ANC facilities
		1.16 HIV Testing in 15+ (from programme records)	745	MOH	
	<i>Sexually</i>	1.17 Sexually Transmitted Infections (STIs)	no data		

<i>Transmitted Infections</i>	1.17.1 Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit	no data			
	1.17.2 Percentage of antenatal care attendees who were positive for syphilis	1,7%		SGGS 2007	
	1.17.3 Percentage of antenatal care attendees positive for syphilis who received treatment	no data			
	1.17.4 Percentage of sex workers with active syphilis	no data			
	1.17.5 Percentage of men who have sex with men (MSM) with active syphilis	no data			
	1.17.6 Number of adults reported with syphilis (primary/secondary and latent) during the reporting period	no data			
	1.17.7 Number of reported congenital syphilis cases (live births and stillbirth) during the reporting period	no data			
	1.17.8 Number of men reported with gonorrhoea during the reporting period	no data			
	1.17.9 Number of men reported with urethral discharge during the reporting period	no data			
	1.17.10 Number of adults reported with genital ulcer disease during the reporting period	no data			
	<i>Migrants</i>	1.18 Migrants: Condom Use	57%	seafarers	SGGS 2007
		1.19 Migrants: HIV Testing	93.7	seafarers	SGGS 2007
		1.20 Migrants: HIV Prevalence:	0	seafarers	SGGS 2007
<i>Prisoners</i>	1.21 Prisoners: HIV Prevalence	no data			
	1.22 Male circumcision, prevalence	no data			
	1.23 Number of men circumcised last year	no data			
<b>Target 2. Reduce transmission of HIV among people who inject drugs by 50 per cent</b>	2.1 People who inject drugs: Number of needles/IDU	not relevant			
	2.2. People who inject drugs: Condom Use	not relevant			
	2.3 People who inject drugs: Safe Injecting Practices	not relevant			
	2.4 People who inject drugs: HIV Testing	not relevant			
	2.5 People who inject drugs: HIV Prevalence	not relevant			
	2.6 People on opioid substitution therapy	not relevant			

<b>by 2015</b>		2.7 NSP and OST sites	not relevant		
<b>Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths</b>		3.1 Prevention of Mother-to-Child Transmission	0		No cases
		3.1 a Prevention of mother-to-child transmission during breastfeeding	0		No cases
		3.2 Early Infant Diagnosis	0		No cases
		3.3 Mother-to-Child transmission rate (modelled)	0		No cases
		3.3 a Mother-to-child transmission of HIV (based on programme data)	0		No cases
		3.4 Pregnant women who were tested for HIV and received their results	286		
		3.5 Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months	no data		
		3.6 Percentage of HIV-infected pregnant women who had a CD4 test	0		No cases
		3.7 Infants born to HIV-infected women receiving ARV prophylaxis for prevention of Mother-to-child-transmission	0		No cases
		3.9 Percentage of infants born to HIV-infected women started on cotrimoxazole (CTX) prophylaxis within two months of birth	0		No cases
		3.10 Distribution of feeding practices for infants born to HIV-infected women at DTP3 visit	0		No cases
<b>Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015</b>		4.1 ART coverage (adults and children)* , including Number of eligible adults and children who newly enrolled on antiretroviral therapy during the reporting period	0	11 PLHA	No people in ART
		4.2 HIV Treatment: 12 months retention	0		No people in ART
		4.2b HIV Treatment: 24 months retention	0		No people in ART

		4.2c HIV Treatment: 60 months retention			
		4.3 Health facilities that offer antiretroviral therapy	1		
		4.4 ART stockouts	no		
		4.5 Late HIV diagnoses	no data		
		4.6 HIV Care	no data		
		4.7 Viral load suppression	no data		
<b>Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015</b>		5.1. Co-Management of Tuberculosis and HIV Treatment	No data		
		5.2 Health care facilities providing ART for PLHIV with demonstrable infection control practices that include TB control	1		
		5.3 Percentage of adults and children newly enrolled in HIV care (starting isoniazid preventive therapy (IPT))	0		
		5.4 Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit	no data		
<b>Target 6. Close the resource gap</b>		6.1 AIDS Spending - Domestic and international AIDS spending by categories and financing sources			
<b>Target 7. Eliminating gender inequalities</b>		7.1 Prevalence of Recent Intimate Partner Violence (IPV)	33,3%		DHS 2007
<b>Target 8. Eliminating stigma and discrimination</b>		8.1 Discriminatory attitudes towards person living with HIV (new indicator)	66.2% males and 56.9% females		DHS 2007



<b>Target 9. Eliminate Travel restrictions</b>		Travel restriction data collected by Human Rights and Law Division at UNAIDS HQ, no data collected needed			
<b>Target 10. Strengthening HIV integration</b>		10.1 Orphans and non-orphans school attendance*	not relevant		
		10.2 Economic support for eligible households	not relevant		
<b>Policy questions, relevant questions for all 10 targets.</b>					
		P.1 NCPI	not relevant		
		P.1b WHO POLICY QUESTIONS			
		P.1c. European NCPI Supplement			
<b>Key population size estimations</b>		Key population size estimations	no		

## 3. Status at a glance

### 3.1 Geography

Tuvalu formerly known as the Ellice Islands is located in the South Pacific, just to the north of the Fiji Islands. It is the smallest independent country in the South Pacific, comprising of nine low lying coral atolls with a population of 9561. The total land area is only 26 sq. km, with a large ocean economic zone of more than half a million square kilometers. The highest elevation is five meters above sea level making it the first nation to submerge under water from the effects of global warming. The capital of Tuvalu is Funafuti. Tuvalu's total land area is 26 km<sup>2</sup>, which is relatively evenly distributed across the nine atolls. Six out of the nine atolls have lagoons that are open to the ocean; these are Nanumea, Nui, Vaitupu, Nukufetau, Funafuti and Nukulaelae. Nanumaga and Niutao have landlocked lagoons while Niulakita has no lagoon at all. All of Tuvalu's islands are lowlying, the highest being only 4 m or 5 m above sea level. As a result, Tuvalu is at great risk of becoming one of the first nations to succumb to the effects of climate change and sea level rise. Tuvalu's limited land area is generally of low quality with poor fertility and thus is unsuitable for agriculture.

### 3.2 Tuvalu Economy and Government

The first inhabitants were Polynesian people prior to the arrival of the British in the late 19th century. The islands was then administered by Britain as part of a protectorate from 1892 to 1916 and as part of the Gilbert and Ellice Islands colony from 1915 to 1974. Tuvalu became fully independent in 1978 within the Commonwealth after voting for separation in 1974. Tuvalu is a constitutional monarchy and Commonwealth realm with Queen Elizabeth II recognized as Queen of Tuvalu, represented by a Governor-General in Tuvalu. The local parliament has 15 members and is elected every four years. Its members elect a Prime Minister who is the head of government. The Cabinet is appointed by the Governor General on the advice of the Prime Minister<sup>i</sup>. Tuvalu has very limited natural resources, and its main form of income consists of foreign aid. Subsistence farming and fishing remain the primary economic activities. Government revenues largely come from the sale of stamps, coins, fishing licences and worker remittances. Substantial income is received annually from an international trust fund established in 1987 by Australia, New Zealand, and the United Kingdom and supported by Japan and South Korea. This fund grew from an initial \$17 million to over \$35 million in 1999. The sale of its ".tv" internet domain name and the use of its area code for "900" lines generated more revenue for this small nation.

### 3.3 Demographics

Tuvalu has few development opportunities and is highly dependent on development assistance. The country is constrained by its small size and small population of approximately 10 000 people spread across nine islands—47 per cent of the population, 4500 people, reside on the main island of Funafuti. Tuvalu is also limited by few opportunities for economic growth and distance from

economic markets. Tuvaluans rely on the public sector as their principal source of employment and diaspora remittances also help to increase household incomes. The country is vulnerable to climate change and susceptible to a high frequency of natural disasters.<sup>2</sup> On 28 September 2011, the Government of Tuvalu declared a state of emergency due to water shortages. This was the second worst drought on record for Tuvalu. <sup>ii</sup>

There are limited employment opportunities in Tuvalu. The country will participate in Australia's permanent Pacific Seasonal Worker Program from July 2012 which is expected to provide more

opportunities for diaspora remittances.

Total Enumerated population	9,561	4,729	4,832
Urban population (Funafuti)	4,492	2,281	2,211
Rural population (Outer Islands)	5,069	2,448	2,621
Resident population	9,359	4,614	4,745
Urban population (Funafuti)	3,962	1,994	1,968
Rural population (Outer Islands)	5,397	2,620	2,777

### 3.4 Tuvalu National AIDS Strategic Plan

The Tuvalu NSP is currently being updated. The last NSP, which was valid till 2013, has 4 priority areas: 1) Achieving an enabling environment; 2) Prevention of HIV and other STIs; 3) Treatment Care and Support; and 4) Programme Management.

Priority Area 1: Achieving an enabling environment – This area consists of 4 outputs:

1. High-level commitment to the HIV response evident
2. A strategy for the reduction of stigma and discrimination against people infected with and affected by HIV devised and implemented
3. Policies, legislation and traditional laws that discriminate against vulnerable populations including women, sex workers and MSM be reviewed and amended
4. Monitor human rights violations against PLHIV and their family members.

Priority Area 2: Prevention of HIV and other STIs – This is a comprehensive priority area that encompasses all elements of HIV prevention in the community. It has 7 outputs:

1. Behaviour change strategy developed
2. Strategy for HIV and STI prevention among Tuvalu youth devised and implemented
3. Prevention strategies aimed specifically at vulnerable groups designed and implemented
4. Increased condom and lubricant use among the sexually active population
5. Safe blood supply maintained throughout Tuvalu
6. Universal precautions implemented in health care facilities and other relevant settings throughout Tuvalu

Post-exposure-prophylaxis policy (PEP) developed and implemented

Effective Voluntary and Confidential Counselling for HIV and STI Testing (VCCT) and management available throughout Tuvalu.

Priority Area 3: Treatment Care and Support – This area consists of 10 outputs:

A comprehensive national policy for treatment, care and support for PLHIV

A trained multi-disciplinary HIV care team operating in Tuvalu's main hospital

Health facilities adequately resourced to enable treatment and care of PLHIV.

Comprehensive programme of community-based support available for HIV infected and affected people

Strategy for the reduction of stigma and discrimination against people infected with and affected by HIV devised and implemented.

Effective management of STIs on each island of Tuvalu

Laboratory support for HIV and STI diagnosis and management enabled in the Princess Margaret Hospital

Comprehensive programme of prevention of parent-to-child transmission (PPTCT) of HIV implemented.

Male circumcision practiced widely throughout Tuvalu

Effective referral system between Tuvalu's TB and HIV programmes.

Priority Area 4: Programme Management – This area consists of 6 outputs:

Effective multisectoral engagement in the NSP

Improved co-ordination and management of the national HIV response. This output requires a solid commitment to the HIV effort and involves the recruiting of personnel devoted to managing and advancing the HIV response in Tuvalu. Activities will ensure the NSP is reviewed annually and this review informs annual planning. The HIV secretariat will be strengthened with dedicated support personnel, thereby reducing the current reliance on personnel with significant responsibilities in other full-time roles.

Comprehensive programme of HIV and STI surveillance and research implemented and annual figures disseminated. Tuvalu will establish a programme of second-generation surveillance for HIV and other STIs across all islands. HIV sero-surveillance will be undertaken in Funafuti only, but behavioural surveillance and STI sero-surveillance can be developed throughout the islands.

One national monitoring and evaluation framework designed and implemented. This output reflects the UNAIDS principle of "The Three Ones" and will enable Tuvalu to more easily monitor progress in both its national HIV response and within the Pacific Region. Monitoring activities will be ongoing and will inform annual reviews of the NSP implementation.

Evidence-based planning undertaken on an annual basis. This output is fully integrated with the previous two. Annual planning will be based on trends in surveillance data and the outcomes of the preceding annual review of the NSP.

Tuvalu's national HIV response adequately resourced.

### **3.5 Monitoring and Evaluation**

Consolidated monthly reports (CMR) are sent by the nurses based in the health centres in the islands to PMH. The only health statistician based in Funafuti, compiles all the data. Since the CMR, is sent via ships, it takes a long time to arrive thus generating timely reports becomes a challenge.

Sometimes discrepancies or incomplete CMR causes further delays. To address this, the health statistician travels to the island and collaboratively works with the staff stationed there to correct any inconsistencies. HIV data is regarded as "highly confidential" and is kept with the Director of Ministry of Health.

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

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

\* Data handling & collection

\* Data Storage

- \* Data Processing

- \* Compiling & data analysis

The Health Information Products later are transformed into a Health Annual Report.

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

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

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

- \* Facsimile Transmission

- \* Surface Mail Delivery

- \* Hand Safe Delivery (not recommended)

Internet connection was established in outer islands very recently and it is not fully functional yet. There is no specific M&E Plan developed for the NSP of Tuvalu.

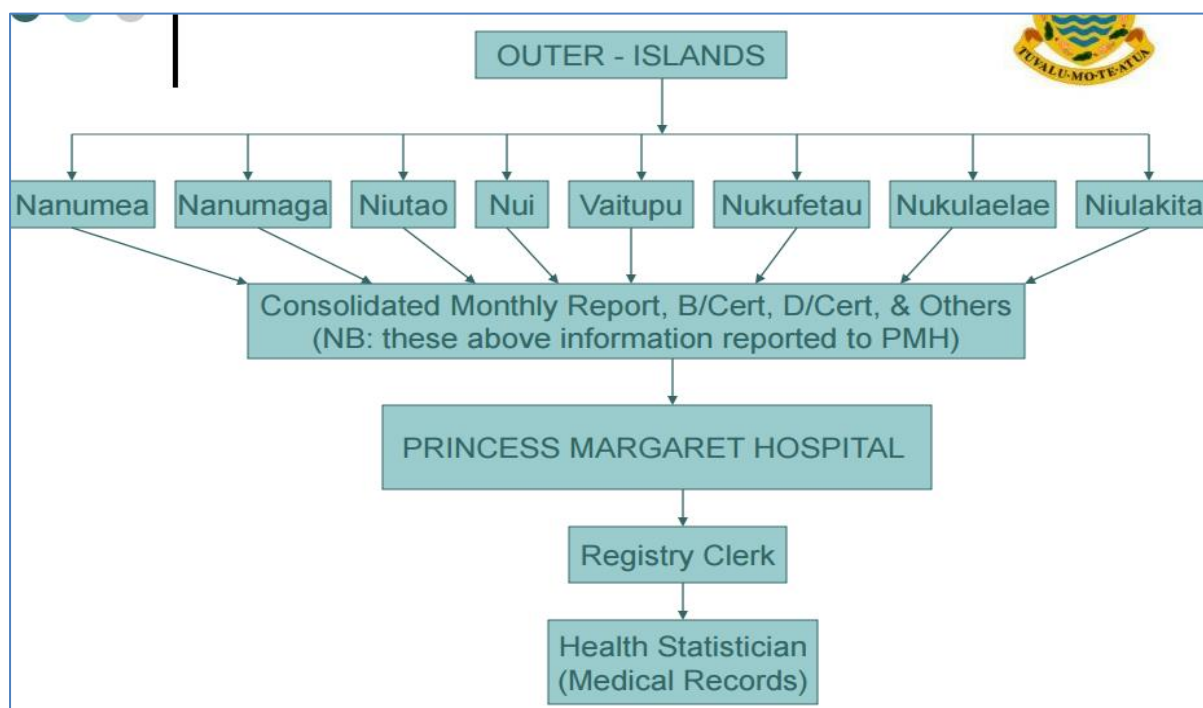
Consolidated monthly reports (CMR) are sent by the nurses based in the health centres in the islands to PMH. The only health statistician based in Funafuti, compiles all the data. Since the CMR, is sent via ships, it takes a long time to arrive thus generating timely reports becomes a challenge. Sometimes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

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

---

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

**Figure 2. Reporting System in Tuvalu**



### 3.6 Health Infrastructure in Tuvalu

The Ministry of Health Tuvalu operates from Funafuti the capital island, where the main referral hospital, Princess Margaret Hospital (PMH) is based. The 30 bed hospital provides secondary level care for the whole population of Tuvalu with referrals to Fiji and New Zealand for a few who need tertiary or specialized medical care. The hospital is run by 8 medical officers, 20 nurses, 10 paramedical staff and 10 support staff. The other eight islands in the group have a medical center manned by two nurses, a nurse assistant and two primary health care workers. Medical treatment and care services are free for all Tuvaluan citizens including free medications, hospital stay, and any in-country referrals from any outer island medical center to PMH. The Ministry of Health operates a medical treatment scheme to cater for all medical referrals outside Tuvalu. New Zealand Health also provides a similar scheme for treatment of Tuvaluans referred to Fiji and New Zealand . The average number of births per year is 241 (1997-2002) with a crude birth rate of 26.0 per 1000 population for the same period. The total fertility rate is 3.7 with the mean age of childbearing at 29.3 years [32]. The average number of deaths per year is 94 with a crude death rate of 10.2 per 1000 population. Life expectancy is 65 years for women and 61 years for men. Non-communicable diseases remain the leading causes of morbidity and mortality with cardiac diseases accounting for the majority of deaths. Diabetes mellitus, hypertension, obesity, and cerebral-vascular disease are among the others. Communicable diseases such as tuberculosis thought to be under control are now increasing with an average of 15 new cases of sputum positive infections every year.

Tuvalu's public spending on health was 10% of GDP in 2010, equivalent to US\$534 per capita. In the most recent survey conducted between 1997 and 2010 there were 109 doctors and 582 nurses and midwives per 100,000 people. Additionally, 98% of births are attended by qualified health staff (2007-12), and 98% of one-year-olds immunised with one dose of measles (2011). In 2010 98% of

the country's population was using an improved drinking water source and 85% had access to adequate sanitation facilities. The most recent survey, conducted in the period 2000-11, reports that Tuvalu has nine pharmaceutical personnel per 100,000 people.

Legislation in Tuvalu prevents the operation of private medical practices and pharmacies, and all facilities available on the islands are public, with 99% of total health funding being provided by the government. The country's one hospital, Princess Margaret Hospital, is located in Funafuti and is capable of providing basic primary healthcare, dental and pharmaceutical services. There are also eight medical centres, located on the outer islands, which are staffed by nurses. Tuvalu's main pharmacy is located in the Princess Margaret Hospital, and is responsible for the procurement of drugs and reproductive health commodities from suppliers. The Department of Pharmacy, which is a branch of the Ministry of Health, is responsible for organising training for nurses working in Tuvalu's medical centres, such that they are proficient in the ordering and management of medicines and drugs.

A significant drain on GoT resources is occurring through the Tuvalu Medical Treatment Scheme. There have been and are continuing a number of reviews of the Scheme, and the MoH is the key player in the management of the Scheme. Cost overruns in the TMTS threaten the ability of the MoH to maintain effective services.

Currently the model of care for OI health services is based on the health centre being staffed by (1) an experienced Nurse Midwife, (2) a Registered Nurse with Diploma level training, (3) a nursing assistant, and (4) a Sanitation Officer. This is a suitable staffing establishment for such communities and the MoH is to be congratulated for achieving such a sustainable and appropriate service. This model and the MoH budget are therefore at extreme risk if the doctors now in training in overseas institutions are to be found positions in the OI when they complete their training. The MoH needs to urgently consider the implications of increasing the medical establishment and impact the current model of care.

The other eight islands in the group have a medical center manned by two nurses, a nurse assistant and two primary health care workers. Medical treatment and care services are free for all Tuvaluan citizens including free medications, hospital stay, and any in-country referrals from any outer island medical center to PMH. The Ministry of Health operates a medical treatment scheme to cater for all medical referrals outside Tuvalu. New Zealand Government (NZAID) also provides a similar scheme for treatment of Tuvaluans referred to Fiji and New Zealand.<sup>7</sup>

PMH is the main centre for child birth. Due to the geography of Tuvalu and shipping being the main mode of transport (which takes between 4 hours – 22 hours of travel each way from Funafuti), each island has a trained mid- wife. First time mothers as well as women with history of previous complicated deliveries or suspected complex cases are always referred to PMH at about 32 weeks of gestation. Around 99% - 100% of births take place in the hospital and are attended by skilled health personnel. <sup>8</sup>In addition, TUFHA and PMH also provide family planning services. VCCT is offered to all pregnant mothers in Funafuti. Counselling is done by a group of certified HIV counsellors.

The early- referral plan from the islands has been a key influence in reducing Infant mortality rate by two – thirds (66.7%) for the period 1992 – 2009.

There is no HIV legislation in Tuvalu. Work is continuing in drafting the new legislation. Currently, there is no Tuvalu National Strategic Plan for HIV/STI but Tuvalu is making use of the Regional Pacific Sexual Health & Well-Being SHARED AGENDA 2015-2019 is the guiding document for all HIV programs. TUNAC is the National HIV coordination mechanism and meets every two months.

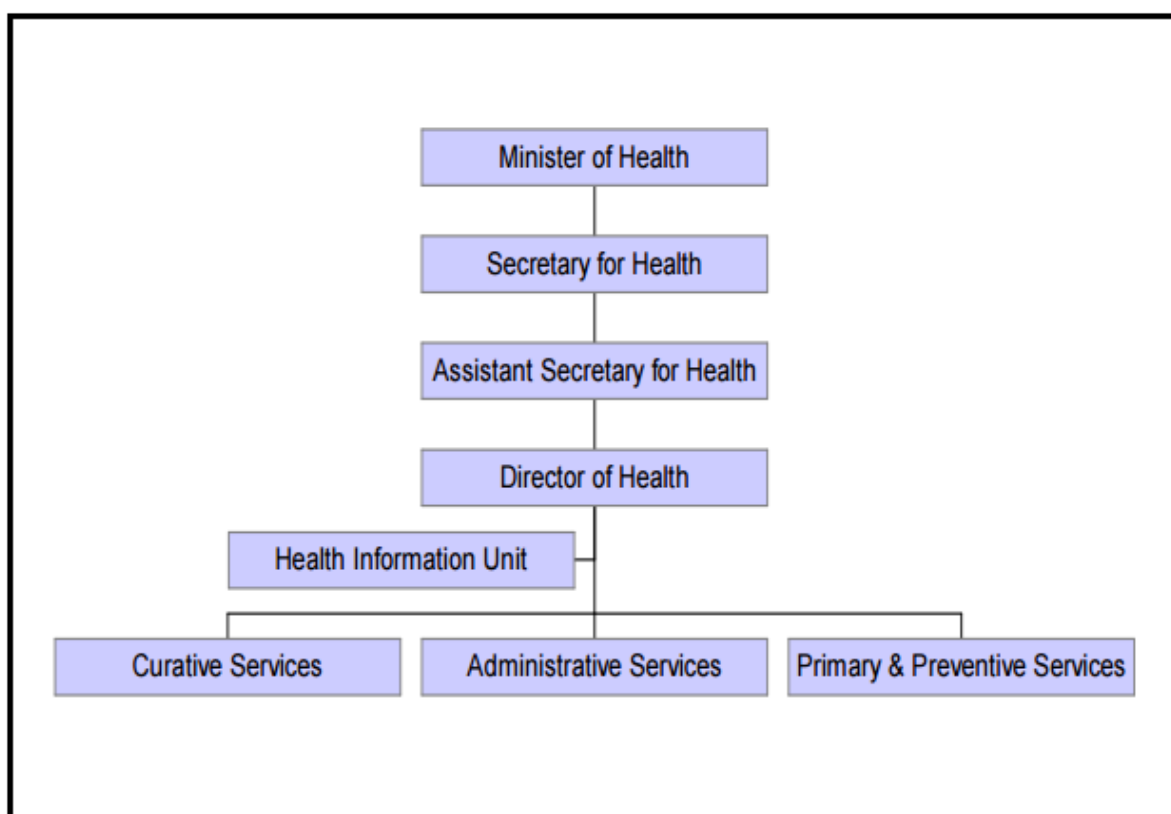
Certified HIV Counsellors provide voluntary and confidential counselling services. Upon consent, a HIV test is performed at PMH. The laboratory at PMH is currently working on a HIV Testing policy.

Infant mortality in Tuvalu was 25 deaths per 1,000 live births in 2012, with an under-five mortality rate of 30 deaths per 1,000 live births. As shown in Graph 1, there has been a consistent decline in the under-five mortality rate since 1990. Although this decline is encouraging, the under-five mortality rate is not yet in line with the country's target of 19 deaths per 1,000 live births, as defined by Millennium Development Goal 4 (MDG 4). In 2010 the three most prominent known causes of death for children below the age of five year were injuries (23 per cent), prematurity (17 per cent) and congenital anomalies (16 per cent). Other contributory causes were birth asphyxia (ten per cent), pneumonia (nine per cent) and neonatal sepsis (six per cent). In the period 2007-12, 98 per cent of births in Tuvalu were attended by qualified health staff.<sup>iii</sup>

The year 2008 marked the beginning of the health reform process, with the development of a new health master plan to guide the work of the Ministry of Health over a 10-year period stretching from 2009 to 2019. The Strategic Health Plan 2009-2019, completed in early 2009, provides the Ministry of Health with the renewed aim to focus on primary health care and disease prevention. In 2011, a review of several pieces of health legislation has been undertaken, including the Nurses Act, the Medical and Dental Act, the Public Health Act and the Pharmacy and Poison Act. The options for development of an umbrella Act for Health Professionals in Tuvalu are also currently being reviewed. Development of the health infrastructure in the outer islands was another successful project that the Ministry of Health started to execute in 2008. The Ministry secured funding through the Government of Japan's Grant Assistance for Grassroots Human Security Projects to build a new medical centre for Vaitupu Island, to be followed by Niutao Island Medical Centre and Nui Medical Centre in 2009. The same project will also cover new medical centres for the remaining outer islands. The new centres will improve the delivery of health services to the outer islands, with better facilities for inpatient care. In Funafuti, the renovation of the Reproductive Health Clinic to house the integrated programmes for Reproductive Health, Maternal Child Health, HIV and STI, TB and Adolescent Health Development was completed in early 2009.<sup>iv</sup>



Figure 1. Organizational Chart of the Ministry of Health, Tuvalu



#### 4 HIV in Tuvalu

The first HIV case in Tuvalu was found in 1995. The cumulative number of HIV cases to date is 11, two of whom have died. Of the 9 people with HIV still alive, none are currently enrolled in ART. In 2013, a total of 791 persons were tested for HIV, which represents 7.5% of the total population; no HIV cases were found. In 2011 three new HIV cases were identified and two in 2012. For a population of approximately 11,000 people, this represents the highest rate of confirmed HIV cases of all 11 countries (MOH Tuvalu, 2012). Of those tested for STIs in the 2011-2013 period, Chlamydia infections were found among 10.5%, 8.8% and 9.0% of those tested respectively; while Syphilis was found among 3.2%, 3.5% and 2.2% of those tested.

Voluntary counselling and testing (VCT) is current practice in Tuvalu for all HIV testing. The country's only laboratory, at Princess Margaret Hospital in Funafuti, is capable of doing HIV Determine and Serodia diagnostic tests. There is no testing available in outer islands. VCCT is performed by certified HIV Counsellors following an HIV Testing Policy for confidential counselling services. Upon consent, a HIV test is performed at PMH. An average number of 791 tests were performed in 2013 for HIV testing with no HIV positive cases registered.

Confirmatory tests, however, are still being sent to Fiji and/or Melbourne, Australia. This process can take weeks (Fiji) and months (Australia) and causes difficulties in the return of results, which can have a significant effect on the management of a case. Apart from voluntary testing, the laboratory also performs screening of all blood products for HIV and other common STIs. The current national policy on HIV testing supports voluntary counselling and testing.<sup>2</sup>

<sup>2</sup> Tuvalu NSP 2009-2013

Seafarers account for most of Tuvalu's HIV cases (7-8 out of 11), while 2 other cases are an infected wife of a seafarer and her child. Thus nearly all HIV cases are linked to the seafarer community. In Tuvalu, there are no known people who inject drugs, nor known sex workers; however, there is anecdotal evidence of informal transactional sex.

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

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

Tuvalu Maritime Training Institute (TMTI) trains the young men who become seafarers in Tuvalu. The school runs an 18 months intensive course on seafaring which includes a comprehensive health subject specifically designed modules to educate them on HIV and STIs. The curriculum has been in place since 1999 and is taught by the clinical nurse based at TMTI. Seafarers who missed out on this opportunity were given refresher courses on HIV and STI organized by the Tuvalu Overseas Seaman Union (TOSU), Tuvalu Red Cross (TRC) with support from the Ministry of Health.

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

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

**Figure 4. HIV testing in Tuvalu**

	2010	2011	2012	2013	2014
Tested to HIV	1004	845	844	791	745
HIV positive	0	0	0	0	0

#### 4.1 Key populations at risk

In the 2007 a SGGS study was conducted in Tuvalu in pregnant women, seafarers, young male having sex with male and youth.

HIV was not detected among pregnant women attending antenatal clinic and seafarers in this study. Chlamydia was the most common STI in women (17.5%), while 8.0% in seafarers. Hepatitis B was most common among seafarers (13.4%) while 9.8% among pregnant women. Syphilis and gonorrhoea were unexpectedly lower in some populations, 5.2% and 0.5% among seafarers and 0.9% and 1.7% among pregnant women respectively. Among pregnant women, the risk of infection with chlamydia increased when onset of sex was below the age of 18 (OR=1.20: p=0.83), having more than one lifetime partner (OR=1.13: p=0.84), and a higher education level (OR=1.4: p=0.63) and living in urban Funafuti (OR=1.20: p=0.83).

Condom use was low (29.8%) despite good knowledge on HIV transmission (MTCT) reported by 98.2% of women. Among seafarers, age was associated with an increased risk of acquiring any STI for those below 25 years (OR=1.55: p=0.36) and hepatitis B infection (OR=2.10: p=0.25). The risk of chlamydia was increased three-fold when condoms were not used (OR 3.12: p=0.06) and when using alcohol (OR=1.50: p=0.45). None was ever engaged in injecting drug use. Knowledge was generally poor among seafarers, contributing to an increased risk (Table 14). Youths are sexually active (43.6%) but only 20.3% used a condom at first sex. Many male youths (13.9%) reported having sex with another male, but only 3 reported having sex with a commercial partner. HIV knowledge was generally good but didn't quite transform into safer behaviours in this study. Alcohol use was high (41.6%) but none was injecting drugs.

The impact of such a result on a small island nation will have implications on the spread of HIV should the interpretation of this result be misleading reversing the general feeling about HIV in Tuvalu to that of a low risk country, i.e. creating a false sense of security. However, despite HIV not having been detected, the STI picture remains a clear indicator suggesting a community at risk of the introduction and spread of HIV infection.

The high prevalence rate of bacterial STIs among pregnant women is of great concern, especially in a population of women believed to be low risk. Chlamydia was detected in 17.5% of 114 pregnant women attending the antenatal clinic in Tuvalu.

Among pregnant women infected with chlamydia nearly half (45%) were married to or partnered to a seafarer.

Condom use among pregnant women was low. The result is quite expected since all women in this study are pregnant and were unlikely to use condoms even within the last 12 months. The survey results gave very low levels of concurrent partners (1.8%) in last 12 months and none reported

having sex in exchange for money or gifts. Only 1.8% reported having more than 1 sexual partner. Whether there is an element of under reporting, it is not fully understood in this study. There is the possibility that in a small community like this in Tuvalu where investigators are known to the sample of women being questioned creates an environment where bias is likely to occur.

**Figure 5. Baseline prevalence of sexually transmitted infections among 114 pregnant women attending Princess Margaret Hospital antenatal clinic, Funafuti, Tuvalu, from August 2005 to February 2006.**

	<i>Number Tested</i>	<i>Number with Infections</i>	<i>Prevalence percent</i>	<i>95% CI</i>
Chlamydia	114	20	17.5	11.3 , 26.2
Gonorrhoea	114	1	0.9	0.0 , 4.9
Syphilis	114	2	1.7	0.2 , 6.3
Hepatitis B	114	11	9.6	5.0 , 16.9
HIV	114	0		

HIV seroprevalence in seafarers was zero. Despite this the detection of bacterial STIs suggested that the seafarer population is vulnerable to the introduction and rapid spread of HIV infection in Tuvalu. Seven out of ten confirmed cases of HIV-positive cases in Tuvalu were seafarers. However with a population of only 9600, the rate of infection is close to that of French Polynesia (Tahiti) and Guam, which have some of the highest numbers of HIV infection in the Pacific outside of Papua New Guinea . The low seroprevalence in this study could be due to the low prevalence of bacterial STIs among Tuvaluan seafarers. Sullivan et al (2003) reported on similar findings in a study in Kiribati [49].The other important factor which may contribute to the low HIV prevalence is the absence of injecting drug use among seafarers in Tuvalu.

**Figure 6. Baseline prevalence of STIs and HIV among 209 seafarers attending Princess Margaret Hospital, Funafuti, Tuvalu from August 2005 – February 2006**

	<i>Number Tested</i>	<i>Number with Infections</i>	<i>Prevalence percent</i>	<i>95% CI</i>
Chlamydia	209	17	8.1	4.8 , 12.6
Gonorrhoea	209	1	0.5	0.0 , 2.6
Syphilis	209	11	5.2	2.6 , 9.2
Hepatitis B	209	28	13.4	9.0 , 18.7
HIV	209	0	0	0

Consistent condom use was reported low between seafarers and all their partners. Among those infected with any STI, 57% were using condoms when having sex with a commercial partner and 16.6% with casual partner. On their return to Tuvalu, these men engage in unprotected sexual contact with their regular partners, increasing the risk of transmission of any STIs three-fold in this population. Seafarers are therefore important bridges for the spread of STIs and potentially HIV into Tuvalu. They have unprotected sex with partners overseas and also with regular partners in Tuvalu. Seafarers are therefore an important population for targeted interventions in this study.

In this survey, 43.6% of the respondents reported having had sex already but few (20.3%) used a condom at their first sexual contact. Sex with commercial partners was reported by a three male youths with all using condoms consistently. Sex with non-commercial partners was reported by 112 youths both male and females, but consistent condom use was much lower (11.6%). These findings were similar to BSS surveys conducted in other Pacific Island countries [29]. UNAIDS/WHO reported that other factors that increase the probability of HIV and other STI transmission during unprotected

sex among young people include sexual violence, forced sex and biological factors such as untreated STIs and males not being circumcised. However these are not thought to be common in Tuvalu.

Sex between male youths was reported in 13.9% of males in this study, with just two thirds of them using condoms. Anal sex within the last 12 months occurred in 8.0%. BSS of male youths in Solomon, Vanuatu and Samoa also found male-to-male sex in young people. There is limited knowledge into the attitudes, sexual practices and risk behaviours of this minority group in the Pacific. Buchanan et al (2007) reported that societal and religious stigma and discrimination, laws that criminalize homosexuality, physical violence and emotional abuse directed at these minority groups not only violate their human rights but make it more difficult to identify them<sup>vi</sup>.

## 4.2 Testing in pregnant women

There are 8 ANC facilities in Tuvalu, one for each island except for the island of Niulakita which has a population of 41. 241 births were recorded by ANC in 2010. There is 100% ANC and skilled delivery coverage in Tuvalu. All standard routine tests are done for mothers on their first booking. They are then referred for VCCT which is offered by a group of certified counselors. HIV screening services for pregnant women is offered by TUFHA and PMH. However ART is provided by PMH only. Zero cases of HIV positive pregnant women have been reported in the period 2010-13. Tuvalu does not have a PMTCT/ PPTCT policy at this stage, but work has begun on drafting this. PMH is a baby friendly hospital and implements the Breastfeeding policy.

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

## 5 ART Treatment, Care and Support

Currently there are no HIV patients in ART in Tuvalu out of 11 PLHA registered.

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

A HIV Clinical Team has been set up at Princess Margaret Hospital to look after people living with HIV and AIDS. This clinical team, consisting of three senior doctors, two senior nurses, a nurse from TUFHA, and a pharmacist, has been trained to fully implement the national anti-retroviral therapy (ART) guidelines endorsed by the Ministry of Health in 2004. Antiretroviral treatment commenced in December 2007 and as of mid-2008, there is just one person undergoing ART. The HIV clinical team is in the process of developing broader care and support systems for people living with HIV and AIDS in Tuvalu.

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

## 6 Eliminating gender inequalities

### 6.1 Gender and Women

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

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

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

Tuvalu ratified the Convention on Elimination of All Forms of Discrimination Against Women in 1999, and is a signatory to the Beijing Platform for Action and the Pacific Platform for Action. In addition, the Department of Women’s Affairs within the Ministry of Health and the Tuvalu National Council of Women strongly advocates for equality and empowerment of women in decision making levels.

The majority of women in Tuvalu are married to seafarers. These women are thereby at an increased risk of contracting HIV and STIs. Most are not aware of the need to screen their husbands on their return from overseas. The only screening available to these women is during pregnancy when they will undergo routine serology for treponemal antibodies, hepatitis B surface antigen and HIV, none for chlamydia. There is a current plan for a national cervical screening program to include STIs but this is still in the pipeline.

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

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

than women (4%). In contrast, women are more likely to be paid in cash and in-kind (9%) than men (1%).

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

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

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

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

The most likely groups of men to agree with at least one of the specified reasons for wife beating include: 1) younger men, those who are employed but not for cash; 2) men who are not married; 3) men with one and two children; 4) men living in Funafuti; 5) men who have no education or only a primary level education; and 6) men in the lowest wealth quintile households. Men with

more than a secondary education (35%) are the least likely to accept wife beating. A higher educational attainment tends to decrease the chances that a man will agree with any of the reasons for wife beating.

The 2007 TDHS included questions about whether a woman is justified in refusing to have sexual relations with her husband if she: 1) knows the husband has an STI; 2) knows the husband has intercourse with other women; and 3) is tired or not in the mood. These three issues have been addressed because they are related to women's rights and health. About 81% of women agree that a wife is justified in refusing to have sex with her husband for all of the specified reasons. Of these, 94% believe that a wife is justified in refusing to have sex if she is tired and 91% believe that a wife is justified in refusing to have sex if she knows her husband has sexual relations with other women. An estimated 88% of women believe that a wife is justified in refusing to have sex if her husband has an STI. Very few women disagree with any of the specified reasons. Young women, women who are unemployed, single women and women with no children are the least likely to agree that a wife is justified in refusing to have sex with her husband for any reason. The percentage of men who believe that a wife is justified in refusing to have sex with her husband under these same specific circumstances. The same proportions of men and women agree on all specific circumstances, except that men are more likely to agree that a wife is justified in refusing to have sex with the husband when she knows that he has an STI. The least likely group of men to agree with all of the reasons for a wife refusing to have sex with her husband include single men, men with no children, men who live in Funafuti, men with a higher education and men living in the highest wealth quintile households. About 52% of men aged 15–49 believe that a husband has the right to get angry and reprimand his wife if she refuses to have sex with him. Nearly equal proportions of men (less than 16%) believe they have the right to: 1) force their wife to have sex; 2) refuse their wife financial support; and 3) have sex with another women if their wife refuses to have sex.. Single men and men living in Funafuti are the least likely to agree that a husband has a right to certain behaviours when his wife refuses to have sex with him. However, education and wealth quintile show a negative correlation against all of the specified behaviours.

Out of the total 501 women interviewed, about 37% have ever experienced physical violence any time since the age of 15, while nearly 25% reported having experienced physical violence in the 12 months preceding the survey. About 1% of women have frequently experienced physical violence, while 23% have experienced violence sometime in the 12 months preceding the survey. The proportion of women who have experienced physical violence is highest among women aged 20–29. Moreover, women aged 25–29 are most likely to report having experienced physical violence often or sometimes in the 12 months preceding the survey (35%). Although there is very little difference between employed and unemployed women with regard to their experience of physical violence, women who are unemployed are slightly more likely to report having experienced physical violence since age 15. Employed women are more likely to experience physical violence (25%) often in the 12 months preceding the survey than women who are unemployed compared to (23%). Women who are married or in a living together arrangement are slightly less likely to have ever experienced physical violence (37%) than women who are currently divorced, widowed or separated (38%). The pattern for recent violence suggests that women with partners are more likely to experience violence currently (22%) than women who are currently divorced, widowed or separated in the past 12 months (25%). The number of children that women have is also related to their experience of physical violence. Women with no or few children are more likely to experience physical violence since age 15 and in the past 12 months than women with more children.

Physical violence is higher among women in Funafuti (38%) than among women in the outer islands (36%). Women in Funafuti are also more likely to have experienced physical violence in the 12 months preceding the survey, and are more likely to have experienced it often during that time. Women with less than a secondary education are slightly more likely to have experienced physical violence than women with a secondary education or more than a secondary education. Although



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

## 6.2 Third gender

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

When the Europeans first explored the South Seas they found large, thriving settlements along many of the islands coastlines. Some of the more inhabited islands such as Tahiti and Hawaii, had populations of up to two hundred thousand and were comparable in size with many European and American towns of the same period. Within these communities, homosexual and transgender natives were well documented by early French and British explorers such as Louis de Bougainville, James Cook, William Bligh and others. Third gender natives were evident in all major Polynesian islands including Tonga, Tahiti, Fiji, New Zealand, Hawaii, Tonga, Samoa, Tuvalu, Vanuatu and to a lesser degree among dark-skinned aborigines that formed smaller tribes along the coasts of Australia and New Guinea. In Polynesia, European Explorers were surprised to encounter societies that had long regarded bisexual, homosexual and transgender conduct as normative. Third-gender natives were common on all of the islands and known by different names. In Tahiti, for instance, male-to-male transgenders that lived and behaved as women were called mahu. In Hawaii Islands, whose inhabitants are believed to have originated from Tahiti, the mahu were also present along with the aikane – sexually related or “friendly” men that were essentially masculine-type homosexuals and bisexuals. In Tuvalu, the word pinapinaaine substitutes for mahu, as does the word fa’afafine (like a woman) in Samoa and fakafefine in Tonga. All these various terms referred to the different types of transgender and homosexual men found among the South Sea natives. Polynesian mahu lived and worked alongside the women and excelled in traditionally female tasks such as basket weaving. They did not perform castration but instead tied their genitals up tightly against the groin. Both mahu and aikane were known for their talent in the elaborate dance ceremonies performed throughout the islands. Bisexuality was quite common in Polynesia and many islands kings kept both male and female partners in their royal huts for intimate relations. Lesbians were less reported in the South Sea although early British ethnographers observed such women in several of the western islands such as Vanuatu.

Nowadays transgender population in Tuvalu is often seen, however there are no studies about their behaviours and risks.

## 7 Stigma associated with HIV

Respondents of the DHS 2007 who had ever heard of HIV and AIDS were asked four questions to measure attitudes toward people living with HIV and AIDS: 1) willingness to care for a family member with HIV in the respondent's home; 2) willingness to buy vegetables from a shopkeeper who has HIV; 3) opinion of whether a female teacher with HIV, but who is not sick, should be allowed to continue teaching; and 4) preference for keeping it secret that a family member is infected with HIV. Table 12.6 shows the proportions of women with accepting attitudes toward each of the four questions, and for all four questions by age group, marital status, education level and wealth quintile. Accepting attitudes were highest for the indicators 1) willingness to care for a family member with HIV (81%); 2) not wanting to keep it a secret that a family member has HIV (64%); and 3) a female teacher with HIV should be able to continue teaching (64%). Accepting attitudes were lowest for the indicator buying fresh vegetables from a shop keeper with HIV (57%). The combined percentage of accepting attitudes for all four indicators was 31% for women aged 15–49. More women who are married or in a living together arrangement (82%) are willing to care for a family member with HIV than women who have never married (78%). Women's attitudes towards those living with HIV are no different in the outer islands than in Funafuti. However, educated women with more than a secondary education are more accepting with regard to all four indicators (43%) than women who have less than a secondary education (29%). Table 12.7 shows the proportions of men with accepting attitudes toward the four questions and for all four questions by age group, marital status, education level and wealth quintile. Accepting attitudes of men towards those living with HIV are highest for the indicators willing to care for a family member (86%) and not wanting to keep it a secret that a family member has HIV (72%). Accepting attitudes are lowest for the indicators willing to buy fresh vegetables from a shop keeper with HIV (67%) and a female teacher with HIV should be able to continue teaching (66%). The combined percentage expressing accepting attitudes toward all four indicators was 31% for all men aged 15–49. The majority of men who are married or in a living together arrangement (88%) are more willing to care for a family member with HIV than those who have never married (85%). A very high proportion of married men (80.3%) would not want to keep it a secret that a family member was infected with HIV compared with men who have never married (62%). Men's attitudes toward those living with HIV are no different in the outer islands than in Funafuti. However, educated men with more than a secondary education are more accepting toward all four indicators (43%) than men who have less than a secondary education (24%).

## 8. Best practices

The Ministry of Health is strongly responsible for all treatment of HIV and other related diseases. TuNAC as a coordinating body actively guides all HIV and STI programs in the country and has a multi-sectoral membership. TuFHA is the leading NGO in conducting health education program on HIV and other related disease in the community and outer islands targeting young people. The HIV policy is still on draft form with the Attorney General's Office to proceed to cabinet for endorsement.

Significant progress was achieved with regards to integrating sexuality education in the national curriculum. Tuvalu drafted the first ever sexuality education curriculum for years 7-13.

Capacity building, with support from UNFPA, Tuvalu commenced the cycle 1 and cycle 2 teachers training in collaboration with MoE and lecturers from the respective national teacher training colleges.

---

i Tuvalu National Budget 2007. Tuvalu Government, Funafuti, Tuvalu 2007

ii DHS 2007 Tuvalu

iii [http://www.commonwealthhealth.org/pacific/tuvalu/child\\_and\\_maternal\\_health\\_in\\_tuvalu/](http://www.commonwealthhealth.org/pacific/tuvalu/child_and_maternal_health_in_tuvalu/)

iv [http://www.wpro.who.int/countries/tuv/34TUVpro2011\\_finaldraft.pdf](http://www.wpro.who.int/countries/tuv/34TUVpro2011_finaldraft.pdf)

v Strategic Plan to respond to HIV/AIDS and STI, 2001-2005, Ministry of Health, Funafuti, Tuvalu 2001

vi Buchanan-Aruwafu. H, Integrated Picture: HIV Risk and Vulnerability in the Pacific. February 2007.

[https://books.google.com.fj/books?id=74awBgAAQBAJ&pg=PA118&lpg=PA118&dq=Tuvalu+Health+Annual+Report&source=bl&ots=EcgOqottCP&sig=k6Ekka9JpC4FVSLZbZk\\_n3iR0-Q&hl=en&sa=X&ei=cBorVYyAJs2Vau3jgbgN&redir\\_esc=y#v=onepage&q=Tuvalu%20Health%20Annual%20Report&f=false](https://books.google.com.fj/books?id=74awBgAAQBAJ&pg=PA118&lpg=PA118&dq=Tuvalu+Health+Annual+Report&source=bl&ots=EcgOqottCP&sig=k6Ekka9JpC4FVSLZbZk_n3iR0-Q&hl=en&sa=X&ei=cBorVYyAJs2Vau3jgbgN&redir_esc=y#v=onepage&q=Tuvalu%20Health%20Annual%20Report&f=false)

vi Tuvalu 2002 Population and Housing Census vol 1- Analytical report, Department of Statistics, Tuvalu Government, Funafuti, Tuvalu 2002

vi Lurie MN, Williams BG, Zuma K, Mkhaya-Mwanbure D, Garnett G, Sweat MD, Gittelsohn J, Karim SS. Who infects whom? HIV-1 concordance and discordance among migrant and non-migrant couples in South Africa. *AIDS*, 2003, 17(15): 2245-2252.

vi DHS 2007

vi

[https://books.google.com.fj/books?id=iZ5RAAAAQBAJ&pg=PA198&lpg=PA198&dq=third+gender+in+Tuvalu&source=bl&ots=PJEyqYxG8P&sig=KAiphQFRm3KoRH0I3bY3zy0QuJ0&hl=en&sa=X&ei=aDOrVbDKLtbeaqD9gfgK&redir\\_esc=y#v=onepage&q=third%20gender%20in%20Tuvalu&f=false](https://books.google.com.fj/books?id=iZ5RAAAAQBAJ&pg=PA198&lpg=PA198&dq=third+gender+in+Tuvalu&source=bl&ots=PJEyqYxG8P&sig=KAiphQFRm3KoRH0I3bY3zy0QuJ0&hl=en&sa=X&ei=aDOrVbDKLtbeaqD9gfgK&redir_esc=y#v=onepage&q=third%20gender%20in%20Tuvalu&f=false)