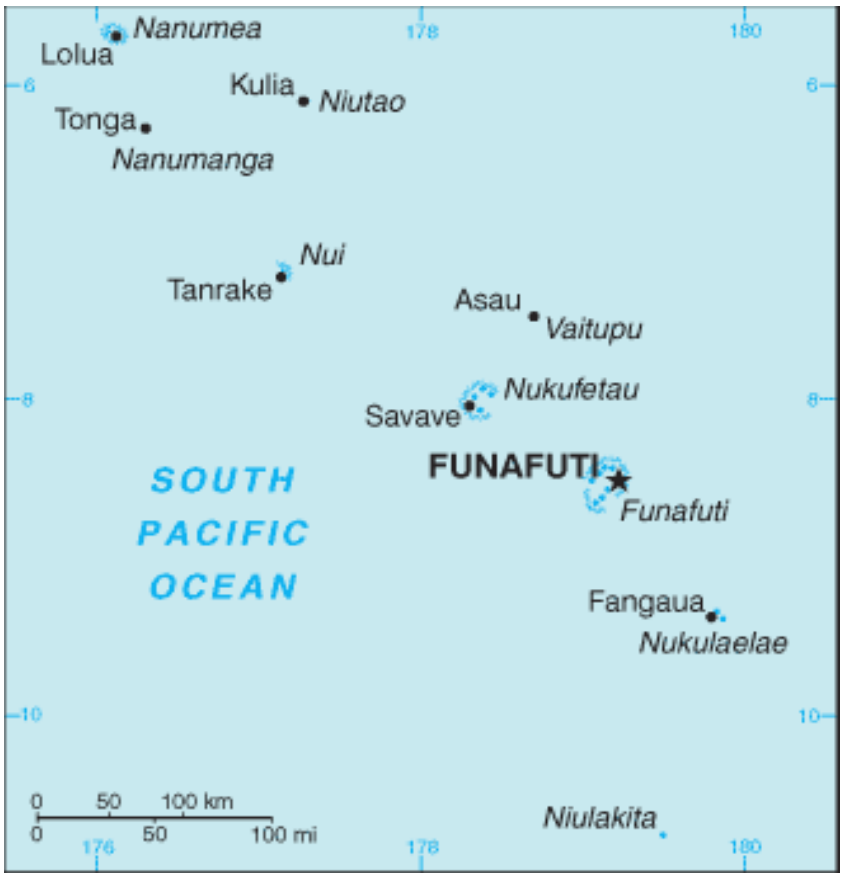
UNGASS 2008 COUNTRY PROGRESS REPORT

Tuvalu

Reporting period: January 2006–December 2007



Prepared by: Tuvalu National AIDS Committee

Submission date: 15 January 2008

Acronyms and Abbreviations

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal clinic
ARV	Antiretroviral
BSS	Behavioural surveillance survey
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HIV	Human immunodeficiency virus
IDU	Injecting drug user
M&E	Monitoring and evaluation
MDG	Millennium Development Goal
MSM	Men who have sex with men
NASA	National AIDS spending assessment
NCPI	National composite policy index
NCM	National coordinating mechanism
NGO	Non-governmental organisation
PLWH	People living with HIV
PMH	Princess Margaret Hospital (Funafuti)
PMTCT	Prevention of mother-to-child transmission
SGS	Second-generation surveillance
STI	Sexually transmitted infection
TANG0	Tuvalu Association of Non-governmental Orgnaizations
TNCW	Tuvalu National Council of Women
TOSU	Tuvalu Overseas Seaman's Union
TUFHA	Tuvalu Family Health Association
TRCS	Tuvalu Red Cross Society
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children's Fund
VCCT	Voluntary confidential counselling and testing
WHO	World Health Organization

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Status at a glance

This report was compiled by the Tuvalu National AIDS Committee (TuNAC), a body which comprises representatives of government agencies and non-governmental organisations that are actively involved in reducing the vulnerability of people in Tuvalu to HIV and AIDS, as well as other health and community risks. All members of TuNAC were actively involved in preparing and reviewing the report in its various drafts. Given the deadline for submission at a time of year when most people in Tuvalu are on holiday, many of them on their home islands or abroad, there was insufficient opportunity to disseminate the report more widely for public comment. However, it is planned to later do so, and to use this report to garner further political, public and community support for our efforts to combat HIV in our small island community.

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

Work towards preventing the spread of HIV/AIDS and STIs gained momentum in this region after 2003, when the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) provided 11 Pacific island countries with a grant of US$3 million for the period 2003-2005. A regional HIV/AIDS initiative supported by the Australian and French governments worth AU$12.5 million commenced in January 2004. This initiative, which runs until 2008, is assisting Pacific island countries and territories to develop a regional strategy and national strategies to strengthen HIV/STI surveillance. UNAIDS and other UN agencies in the Pacific region are engaged in various regional and national projects ranging from prevention, treatment, diagnostics, surveillance and research, including the current Pacific regional strategy 2004 – 2008.[2]

Nonetheless, HIV infections have now been reported in every country or territory in the Pacific island region, barring two of the smallest: Niue and Tokelau. Although the epidemics are still in their early stages in most places, it is well recognised that preventative efforts need to be further stepped up.[3] More than 90% of the 11,200 HIV infections reported across the 21 Pacific island countries and territories by mid-2004 were recorded in Papua New Guinea where an AIDS epidemic is now in full swing. Recorded HIV infection levels are low in the rest of the Pacific island region, and the total number of reported HIV cases exceeds 150 only in New Caledonia (246), Guam (173), French Polynesia (220) and Fiji (171). The data are based on limited HIV surveillance. The high

[1] Secretariat of the Pacific Community: The Pacific Regional Strategy on HIV/AIDS. 2005
[2] Secretariat of the Pacific Community: The Pacific Regional Strategy on HIV/AIDS. 2005; Buchanan-Aruwafu. H, Integrated Picture: HIV Risk and Vulnerability in the Pacific. February 2007
[3] UNAIDS website: www.unaids.org/en/Regions_Countries/Regions/Oceania.asp Dec 13, 2007.

levels of other sexually transmitted infections that have been recorded in some Pacific island countries, including Tuvalu, show that significant risk behaviours exist along with the potential for the rapid spread of HIV throughout the Pacific island region.[4]

Despite its small size and remoteness, Tuvalu has not been spared from the effects of HIV/AIDS. In 1995 the islands recorded the first case of HIV, and since then a total of 10 cases, with three more awaiting confirmation. In this small population of approximately 9,100 people, this translates into one of the highest per capita rates of HIV in the Pacific. Of the 10 known cases, eight people are still alive and two have died of AIDS related illnesses. Seafarers account for seven of all cases of HIV; the others are one housewife, one student and one child. The seven seafarers contracted HIV while working on overseas ships. The student appears to have caught the disease while studying in Fiji. The woman contracted the disease from her seafarer husband. She then transmitted the virus to her infant who became the first case of mother to child transmission (MTCT) in Tuvalu.[5]

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

	Dec 2006	Dec 2007
Sex		
Male	9	9 (2 waiting confirmation)
Female	1	1 (1 waiting confirmation)
Unknown	0	0
Mode of Transmission		
Homo/bisexual	0	0
IDU	0	0
Heterosexual	9	9
Blood products	0	0
Mother to child	1	1
Other/unknown	0	0

Source: Ministry of Health, Tuvalu

Voluntary counselling and testing is current practice in Tuvalu for all HIV testing. The laboratory is capable of doing HIV Determine and Serodia but confirmatory tests are still being sent to Fiji and /or Victoria in Australia. This process can take weeks (Fiji) and months (Australia) and it causes difficulties in the return of results and therefore has 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 Policy on HIV testing advocates for voluntary counseling and testing. Treatment is scheduled to start towards the end of 2007 for those who need it. A clinical core team consisted of two medical officers, a clinical nurse, laboratory technician and pharmacist has been trained to fully implement the national anti-retroviral therapy guideline endorsed by the Ministry of Health, 2004[6]

[4] SPC website: www.spc.int Dec 13, 2007
[5] Tuvalu 2002 Population and Housing Census vol 1- Analytical report, 2002;
[6] Strategic Plan to respond to HIV/AIDS and STI, 2001-2005, Ministry of Health Tuvalu.

There have been *ad hoc* reports of an increasing incidence of sexually transmitted infections (STIs) in Tuvalu but no surveillance systems are in place to properly report and monitor the trends in the country. Information gathered from various clinics found Gonorrhoea and syphilis are the most commonly reported STIs based on syndromic case reporting.[7] Diagnostic facilities for any STI remain a challenge in Tuvalu. The only laboratory in Tuvalu is capable of doing a serology for syphilis, hepatitis B surface antigen, a gram stain for gonorrhoea, wet mount for trichomoniasis and candida infections. There are no facilities to test for chlamydia infection in Tuvalu.[8]

Seafarers, youths and women are among those identified as the most vulnerable in the community. Many young men in Tuvalu seek employment on overseas ships as seafarers which allows them to travel extensively around the world. The nature of their work and their long periods of time away from their wives and families puts them at increased risk of contracting HIV and STI. The average period of absence from Tuvalu for seafarers is 12 months and ranges from 7 months to 15 months. There have been reports of seafarers contracting gonorrhoea in Fiji, a stop-over destination before they return home.[9] These were traced based on the incubation period of gonorrhoea linked with their sexual history, however there is no more firm evidence to support this claim.

Many women in Tuvalu are married to seafarers and are at an increased risk of contracting HIV and STI when their husbands return from overseas. The only screening available to these women is during pregnancy when they will undergo routine serology for treponemal antibodies, hepatitis B surface antigen and HIV, none for chlamydia. There is a current plan for a national cervical screening program to include STIs, still in the pipeline.

Tuvalu's population is relatively young. Just over one third of the population (36.4%) is aged less than15 years.[10] Youths (15 to 24 years) also make up a large proportion of the national population. It has been reported that knowledge on HIV and STI prevention in general is poor in this population.[11] Social changes in Tuvalu have seen an increase in alcohol abuse among youths, teenage pregnancies, and the number of young people engaged in risky sexual behaviours, particularly on the main island of Funafuti. Urban drift and increased international travel all contribute to the growing risk of transmission of HIV and STI in Tuvalu.[12]

To respond to these challenges the Ministry of Health together with non-governmental organizations (NGO), formed the national coordinating body now known as the Tuvalu National AIDS Committee (TUNAC). Taking a multi-sectoral approach, TUNAC combines the efforts of key Government departments, non-governmental organizations, community based organizations and civil society to work towards halting the spread of

[7] Homasi, 2007.
[8] Annual Report. Ministry of Health, Tuvalu Government, 2003; Strategic Plan to respond to HIV/AIDS and STI, 2001-2005, Ministry of Health Tuvalu.
[9] Annual Report. Ministry of Health, Tuvalu Government, 2003
[10] Department of Statistics, 2002,Tuvalu National Census.
[11] HIV and STI Situation Analysis report, Ministry of Health, 1999
[12] Annual Report. Ministry of Health, Tuvalu Government, 2003

HIV and STIs in Tuvalu. This committee under the guidance of the National Strategic Plan (NSP) coordinates all HIV and STI related activities in the country.

Table 2. Core Indicators for the Declaration of Commitment Implementation (UNGASS) 2008 reporting

Indicators	Data Available and Reported Yes or No	Method of Data Collection
National Commitment and Action		
Expenditures		
1. Domestic and international AIDS spending by categories and financing sources		National AIDS Spending Assessment Financial resource flows
Policy Development and Implementation Status		
2. National Composite Policy Index	Available; reported	Key informant interviews
Areas covered: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation		
National Programmes: blood safety, antiretroviral therapy coverage, prevention of mother-to-child transmission, co-management of TB and HIV treatment, HIV testing, prevention programmes, services for orphans and vulnerable children, and education.		
3. Percentage of donated blood units screened for HIV in a quality assured manner	Available; reported	Patient records
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Available; reported	Patient records
5. Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	Available; reported	Patient records
6. Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV	Available; reported	Patient records
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results	Available; reported	Population-based survey (2007 sero-surveillance survey of antenatal clinic attendees)
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results	Not available	Behavioural surveys
9. Percentage of most-at-risk populations reached with HIV/AIDS prevention programmes	Not available	Behavioural surveys
10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	Not relevant and not available	Population-based survey
11. Percentage of schools that provided life-skills based HIV/AIDS education within the last academic year	Available; reported	Curriculum Unit, Ministry of Education
Knowledge and Behaviour		
12. Current school attendance among orphans and among non-orphans aged 10–14*****	Not relevant and not available	

13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	Available; reported	2007 BSS Youth Survey
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Not available (Available only for seafarers)	Behavioural surveys
15. Percentage of young women and men who have had sexual intercourse before the age of 15	Not available	Population-based survey
16. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	Not available (Available separately for youth, seafarers, antenatal attendees)	Population-based survey
17. Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse*****	Not available (Available only for seafarers)	Population-based survey
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	Not available	Behavioural surveys
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Not available (Available only for youth and seafarers)	Behavioural surveys
20. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected	Not relevant and not reported	Special survey
21. Percentage of injecting drug users who report the use of a condom at last sexual intercourse	Not relevant and not reported	Special survey
Impact		
22. Percentage of young women and men aged 15–24 who are HIV infected*	Not available	HIV sentinel surveillance and population-based survey
23. Percentage of most-at-risk populations who are HIV infected	Not available	HIV sentinel surveillance
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Not relevant and not reported	Programme monitoring
25. Percentage of infants born to HIV infected mothers who are infected	Available; reported	Treatment protocols and efficacy studies

*Millennium Development Goals indicator

Overview of the AIDS epidemic

Until very recently, there was no information in Tuvalu on the prevalence of HIV/AIDS and other STIs. To address this, the World Health Organization in the Western Pacific Regional Office in 2005 and 2006 provided support for the implementation of the first round of Second Generation Surveillance in Tuvalu. The three surveys conducted covered (a) HIV Sentinel Surveillance among 114 pregnant women, (b) STI Prevalence Survey among 209 seafarers and (c) Behavioural Surveillance among 305 young people aged 15 to 24 years. The sero-surveillance surveys provided data on blood serology for HIV, Syphilis, Hepatitis B and urine PCR for Chlamydia and Gonorrhoea. The youth survey provided information on sexual behaviour and knowledge of prevention of HIV and STIs, risky behaviours, alcohol and substance use. Analysis of the survey results further examined the association between Chlamydia and other variables.[7]

HIV was not detected among pregnant women and seafarers, despite the presence of other sexually transmitted infections. Chlamydia, Gonorrhoea, Syphilis, and Hepatitis B was found in 17.5%, 0.9%, 1.7%, 9.8% of antenatal women and 8.1%, 0.5%, 5.2%, 13.4% of seafarers respectively. Women who started sex before the age of 18 were at an increased risk of infection with chlamydia (OR=1.20, 95% CI 0.24, 5.85) and any STI (OR=1.27, 95%CI o.26, 6.23). Infection with chlamydia also increased with those having had more than one partner in life (OR=1.13 95% CI 0.33, 2.75) those in higher education level (OR=1.4 95% CI 0.36, 5.38) and those living in urban Funafuti (OR=1.20, p=0.83), although none were statistically significant. Condom use was low (29.8%) despite good knowledge on HIV transmission (MTCT) reported by 98.2% of women.7

Among seafarers age was associated with an increased risk of acquiring any STI (chlamydia/syphilis/gonorrhoea) among those below 25 years (OR=1.55 95% CI 0.61, 3.96) and Hepatitis B infection (OR=2.1 95% CI 0.59, 7.23), none of which were statistically significant. The risk of chlamydia was three-fold when condoms were not used (OR 3.12 95% CI 0.94, 10.3) and alcohol use (OR=1.50 95% CI 0.51, 4.44). None of the seafarers surveyed were ever engaged in intravenous drug use. Knowledge of HIV and STI prevention was generally poor among seafarers, contributing to an increased risk of transmission.7

The BSS found that youths are sexually active (43.6%) but only 20.3% used a condom at first sex. A good number of male youths (13.9%) reported having sex with another male, but only three reported having sex with a commercial partner. HIV knowledge is generally good but this knowledge evidently did not transform into action. Alcohol use is high (41.6%) but none of the young people surveyed reported using intravenous drugs.7

National response to the AIDS epidemic

Tuvalu is a country of low prevalence of HIV infection. No HIV infection was detected among pregnant women and seafarers in the 2007 SGSS, but this does not mean HIV is

not present in Tuvalu. The detection of other bacterial STIs, endemicity of hepatitis B, high risk behaviours, and low condom use provides a path for the introduction and spread of HIV in Tuvalu.

Being such a small country, with a population of less than 10,000, even a single case of HIV would raise the per capita incidence quite alarmingly. In **2004 (??)** alone, the number of known infections in Tuvalu jumped precipitously, **from 3 to 9 cases**, underlining the high vulnerability of this small country and its very mobile work-force.

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

The conclusion drawn from the analysis of the 2005 -2006 SGS was that the high rates of asymptomatic STI, in particular chlamydia, among seafarers and pregnant mothers call for a still stronger and better coordinated national response to establish appropriate diagnostic, treatment and surveillance systems to avoid complications of the reproductive tract and subsequent long term effects, especially the spread of HIV. A targeted program to screen antenatal mothers and provide treatment and partner referral was proposed. The endemicity of Hepatitis B infection in particular should prompt immediate interventions to encourage immunization of children from birth and the development of a national catch up program for adults. Behavioural change initiatives to enhance young people's ability to take responsibility for making healthier choices, resist negative pressures and avoid risk behaviours were also recommended.[13]

In response to heightened concern about Tuvalu's vulnerability to the HIV epidemic, a comprehensive national HIV and AIDS strategy, 2008-2012, has been developed and its summary is attached to this report, as Annex 3.

Indicator 1: National AIDS Spending Assessment

For the past two years (2006, 2007), the Ministry of Health has been allocated a small annual sum of A$7000 for HIV treatment. All other funds for HIV activities are provided by development partners. Of these, only funds from WHO pass through the Ministry of Finance's Aid Coordination Unit.

Finance provided to NGOs is discussed in the later section on Development Partners.

Table 1 Utilisation of WHO funding for HIV and AIDS, 2004-2007

Year	Projects	Provisions	2004	2005	2006	2007	Balance
2004	Maternal and Child Health aides on Health villages (MCH)	**5,542.00**	5,542.00				-
"	Workshop on HIV surveys	**4,290.00**		1,242.00	3,027.90		20.10
"	Workshop on STI survey	**8,580.00**		5,360.50			3,219.50
2005	HIV Counselling	**9,996.00**	8,677.00	1,259.20		58.00	1.80
"	Sexually Transmitted Infection HIV/ AIDS	**2,031.00**		1,599.75	431.25		-
"	HIV- Counselling Training	**3,000.00**		1,900.00	932.32	167.00	0.68
"	HIV-Care and support for PLWHA	**7,396.00**		7,253.50			142.50

Non-governmental organizations like TANGO, TUFHA receive specific financial support in the area of HIV.

TUFHA as the leading non-governmental organization in the area of sexual and reproductive health receive funds from developmental partners to assist with in country activities on HIV (Table 2)

Table 2. Tuvalu Family Health Association utilization of funds from various regional and international funding agencies.

Year	Projects	Provisions	2005	2006	2007	Total expenditure	Balance
2006	Vision 2000 Fund Project (2006 Financial report)	**97,220.20**		97,220.20		96,587.23	632.97 -
2005	Pacific Regional HIV Project -1st Grant	**10,574.00**	10,574.00			10,074.00	906.59
2006	Pacific Regional HIV Project -2nd Grant	**15,520.59**		15,520.59		10,553.88	4,966.71
2006	Marie Stopes International Pacific Project – 1st Quarter	**4,996.12**		4,966.12		3,450.31	1,545.81
"	Marie Stopes International Pacific Project – 2nd Quarter	**7,111.86**		7,111.86		1,364.62	5,747.24
2007	KAP Survey Project	**16,000.00**			16,000.00	15,983.02	16.98

Source TUFHA

TANGO as the umbrella body for all NGOs in Tuvalu focuses on capacity building and empowerment of NGOs nationwide. One of their roles is the coordination of financial

assistance from the Pacific Regional HIV Project based in Fiji, developing HIV related activities for partner NGOs in country. (Table 3)

Table. Tuvalu Association of NGOs utilization of funds from various regional and international funding agencies.

Year	Projects	Provisions	2005	2006	2007	Total expenditure	Balance
2006	Pacific Regional HIV Project	**50,000**		50,000		50,000	0
	NAC Grants	**30,000**		30,000		30,000	0

Source: TANGO

Developmental partners like UNFPA, WHO, GFATM contribute largely to HIV in Tuvalu.

Indicator 2 National Composite Policy Index
[Countries should specifically talk about the relationship between the existing policy, implementation of HIV programmes, proven behaviour change (from a survey) and HIV prevalence.

National Programme Indicators

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

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

A register is kept in the Princess Margaret Hospital (the main national hospital in Funafuti) of all blood donations and the donors' test results. However, this does not meet the quality assurance standards required by UNGASS.

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

100%. One (male, aged 30-39 yrs) of the 10 known people with HIV started antiretroviral treatment in December 2007. As he is the only person who currently needs this treatment, in fact all people in need of treatment in Tuvalu now receive it.

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

There were no known HIV-positive pregnant women in Tuvalu in 2006 or 2007 and therefore no required treatment to reduce the risk of mother-to-child transmission. There was, however, no availability of antiretroviral treatment in Tuvalu during this period, treatment only coming available in December 2007.

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

There were no known HIV-positive people with TB in Tuvalu in 2006 or 2007 and therefore no required treatment for TB and HIV. There was, however, no availability of antiretroviral treatment in Tuvalu during this period, treatment only coming available in December 2007.

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

These figures cannot be fully decomposed by sex and age-group as these characteristics of people receiving HIV tests were only recorded from August 2007.

Table 2 People tested for HIV in Tuvalu, August-December, 2007

	Males		Females	
Age group	Know	Not know	Know	Not know
> 15 yrs	4		6	
15-24 yrs	70		49	
25-34 yrs	72		43	
35-49 yrs	94		22	
Total	**240**		**120**	

Source: Ministry of Health records

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

This indicator assesses progress in implementing HIV testing and counseling among most-at-risk populations. In order to protect themselves and to prevent infecting others, it is important for most-at-risk populations to know their HIV status. Knowledge of one's status is also a critical factor in the decision to seek treatment. This indicator is calculated separately for each population that is considered most-at risk in a given country: sex workers, injecting drug users and men who have sex with men.

In Tuvalu, there are no recognized sex workers (although there are anecdotal reports of informal kinds of transactional sex) and there are no known injecting drug users. The BSS survey reported on the existence of men who have sex with men but did not survey them directly to find, for example, how many had been tested for HIV. From the youth BSS survey, 13.9% of males aged 15-24 years reported ever having sex with a male.

There are, therefore, no data available about these groups.

A recognised group of people at particular risk in Tuvalu are sea-farers: men who work away from Tuvalu for months or years at a time on foreign-registered ships. This group has had tight surveillance and account for 70% of known HIV cases. This does not necessarily reflect their higher prevalence but possibly their closer monitoring.

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

In Tuvalu, there are no recognized sex workers (although there are anecdotal reports of informal kinds of transactional sex) and there are no known injecting drug users. The BSS survey reported on the existence of men who have sex with men but did not survey them directly to find, for example, how many had been tested for HIV. From the youth BSS survey, 13.9% of males aged 15-24 years reported ever having sex with a male.

There are, therefore, no data available about these groups.

Seafarers and their wives have been provided with specially-designed education programmes by the Tuvalu Red Cross, funded by UNICEF. These education programs

include awareness about HIV and STIs, information about protection, and life-skills training to counter family problems associated with long absences of men, problems that have included family breakdowns and other social problems. Most of these programs have operated on the main island of Funafuti because of limited financial resources to conduct them on the other eight "outer" islands. This is an acknowledged short-coming and there are plans to improve national coverage.

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

There are no children as yet orphaned by AIDS in Tuvalu. Furthermore, the concept of 'orphans' is not relevant to Tuvalu society. Children freely move between the households of their extended families and children who lose one or more parents are readily taken into care by their other relatives.

This indicator is therefore irrelevant to Tuvalu at present.

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

Coverage for primary schools: 100%

Coverage for secondary schools: 100%

Basic education from the age of 6 to 15 years is compulsory, there are schools on all islands, and enrolment in primary education in Tuvalu is therefore very close to 100%. Preschool and primary school curricula include lessons on health science, with language and content appropriate to the children's ages. The senior primary classes (ages 12-14) have full education on STIs and HIV. These classes are monitored by the Ministries of Education and Health, and there are plans to soon review the curricula on these subjects.

At the two secondary schools in Tuvalu, all students participate in science classes, which include human biology and topics relating to HIV and STIs. Different teachers may deal with these topics in different ways.

3.3 Knowledge and Behaviour Indicators

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

The Ministry of Education maintains a database on all children attending school in Tuvalu, but collects no information as to whether these children have living parents or not, or whether they reside with their biological parents.

The concept of 'orphans' is not relevant to Tuvalu society. Children freely move between the households of their extended families and children who lose one or more of their biological parents are readily taken into care by their other relatives.

This indicator is therefore not relevant to Tuvalu and there is no information available.

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

The 2005 - 2006 BSS survey of young people aged 15-24 found that 84% both reported correct knowledge of HIV/AIDS prevention and no incorrect beliefs about HIV/AIDS transmission.[7] Furthermore, 71.6% reported having accepting attitudes towards people living with HIV (%)

This suggests that community education programmes have been successful, at least for young people.

Table 3 HIV/AIDS knowledge, attitudes and access to HIV testing among 305 youths in Tuvalu from August to November 2005.

HIV/AIDS KNOWLEDGE	GENDER			TOTAL	PERCENT (%)
	M	F	T		
Heard of HIV					
Yes	183	116	1	300	98.4
No	4	1	0	5	1.6
Chance of HIV reduced by using a Condom?					
Yes	160	99	1	260	85.2
No	20	13	0	33	10.8
Don't Know	2	4	0	6	2.0
No Answer/ Refuse	5	1	0	6	2.0
Can a person get HIV from a mosquito bite?					
Yes	20	12	0	32	10.5
No	156	90	1	247	81.0
Don't Know	6	14	0	20	6.6
No Answer/ Refuse	5	1	0	6	2.0
One Faithful Partner					
Yes	161	104	1	266	87.2
No	16	6	0	22	7.2
Don't Know	4	6	0	10	3.3
No Answer/ Refuse	6	1	0	7	2.3
Chance of HIV reduced by not having sex (1)					
Yes	164	109	1	274	89.8
No	17	6	0	23	7.5
No Answer/ Refuse	6	2	0	8	2.6
Do you think a healthy person can have HIV?					
Yes	152	97	1	250	82.0
No	23	14	0	37	12.1
No Answer/ Refuse	12	6	0	18	5.9
Can a pregnant mother pass HIV to her unborn baby? (2)					
Yes	180	115	1	296	97.0
No	1	0	0	1	0.3
No Answer/ Refuse	6	2	0	8	2.6
Is it possible to have a confidential HIV test?					

Yes	100	68	1	169	55.4
No	65	41	0	106	34.8
No Answer/ Refuse	22	8	0	30	9.8
Have you ever tested for HIV?					
Yes	16	15	0	31	10.2
No	166	101	1	268	87.9
No Answer/ Refuse	5	1	0	6	2.0
Find out results					
Yes	13	13	0	26	83.9
No	2	0	0	2	6.4

Source: Homasi, 2007

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

In Tuvalu, there are no recognized sex workers (although there are anecdotal reports of informal kinds of transactional sex) and there are no known injecting drug users. The BSS survey reported on the existence of men who have sex with men but did not survey them directly to find, for example, their understanding about HIV.

There are, therefore, no data available about these groups.

Seafarers and their wives are considered a group at special risk in Tuvalu. Out of 209 seafarers covered by the SGS survey, only 27.8% had correct knowledge of HIV/AIDS prevention methods, and only 16.8% reported both correct knowledge of HIV/AIDS prevention and no incorrect beliefs about HIV/AIDS transmission (see table below).

Of the seafarers surveyed, none was found to be HIV positive but other STI rates were high: Chlamydia 8.1%; hepatitis B surface antigen 13.4%; syphilis 5.2%, suggesting that these men either did not understand about transmission of STIs or did not practice safe sex.

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. The development of targeted behavioural interventions for seafarers may eventually exert positive attitudes towards behavioural change leading to safer sexual behaviours and practices.

Table 4 Selected indicators of HIV and sexual behaviour among 209 seafarers attending Princess Margaret Hospital in Funafuti, Tuvalu from August 2005 to February 2006.

Indicator	N = 209
HIV prevalence (%)	0
Median age at first sex	18 (9-30)
Median number of female sex partners in last 12 months	1 (0-10)
Proportion having sex with female casual partners in last 12 months	14.4
Median number of female casual partners in last 12 months	0 (0-10)
Proportion of adult male using condoms at last sex with female casual partner in last 12 months (%)	5.7
Consistent condom use of adult male with female casual partners in last 12 months	2.4
Proportion of adult male reporting having sex with female commercial partners in last 12 months	3.3
Median number of female commercial partners in last 12 months	1 (0-5)
Proportion of adult male using condoms at last female commercial sex (%)	85.7
Consistent condom use of adult male with female commercial partner in last 12 months (%)	57.1
Proportion of adult males reporting sex with men in the last 12 months	0.0
Proportion of adult males reporting use of condoms with last anal sex with male partner (%)	0.0
Proportion who have ever received HIV testing and know the result	93.7
Correct knowledge of HIV/AIDS prevention methods (%) 1	27.8
No incorrect beliefs about HIV/AIDS transmission (%) 2	63.6
Proportion who both report correct knowledge of HIV/AIDS prevention and no incorrect beliefs about HIV/AIDS transmission (%)	14.8

Source: Homasi, 2007

Indicator 15. Percentage of young women and men who have had sexual intercourse before the age of 15

The 2007 Behavioural Surveillance Survey of young people aged 15-24 years has been analysed only in regard to the age at which they first had sex, not as to whether they had sex before the age of 15 years. The information required for this indicator is therefore currently not available.

Almost one half (43.6%) of youths had ever had sex, 62% males and 14.5% females. The median age at first sex was 18 years and ranged from 15 to 24 years for both males and females. Among those who are sexually active, their partners are mostly young people around the same age or younger, with only 20.3% reported using condoms at first sexual intercourse.

Table 5 Selected FHI behavioural indicators for 305 youth in Tuvalu from August to November 2005.

Indicator	**N=305**
Median age at first sex by gender	

Total	18 (15-24)
Male	18 (15-24)
Female	18 (15-24)

Source: Homasi, 2007

Table 6 Sexual experiences of 305 youths aged 15-24 years in Tuvalu from August to November 2005.

SEXUAL EXPERIENCE	GENDER			TOTAL	PERCENT (%)
	M	F	T		
Ever had sex					
Yes	116	17	0	133	**43.6**
No	71	100	1	172	**56.4**
Age at first sex					
<18	84	7	0	91	**68.4**
>18	32	10	0	42	**31.6**
Age Difference between first sex partner					
10 years older	2	0	0	2	**1.5**
5-10 years older	5	5	0	10	**7.5**
Less than 5 years older	36	6	0	42	**31.6**
Same age	47	6	0	53	**39.8**
Younger	26	0	0	26	**19.5**
Is Condom used at first sex					
Yes	23	4	0	27	**20.3**
No	93	13	0	106	**79.7**

Source: Homasi, 2007

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

These data are not available, but there is information of some relevance here.

There are strong social mores against premarital and extramarital sexual activity in Tuvalu. Evidence that many young people are sexually active comes from the 2005 - 2006 BSS, and shown in the following table.

Table 7 Sex with commercial and non-commercial partners among 305 youths in Tuvalu from August to November 2005.

COMMERCIAL SEX PARTNERS	GENDER			PERCENT (%)
Sex with commercial sex partner	M	F	T	
Yes	3	0	0	1.0
No	184	117	1	99.0
No of sex with Commercial Partner				

<5	1	0	0	33.3
>5	2	0	0	66.6
Condom use				
Yes	2	0	0	66.6
No	1	0	0	33.3
Condom use frequently over last 12 mths				
Every time	3	0	0	100
Sometimes	0	0	0	0
Never	0	0	0	0
NON COMMERCIAL PARTNERS				
Non-Commercial Partner				
Yes	97	15	0	36.7
No	90	102	1	63.3
No of sex with Non-Commercial Partner				
<5	38	8	0	41.0
>5	53	4	0	50.9
Don't Know	2	0	0	1.7
No Answer/Refuse	4	1	0	4.4
Condom use				
Yes	61	6	0	59.8
No	35	8	0	38.4
No Answer/refused	1	1	0	1.8
Consistent condom use over last 12 mths				
Every time	11	2	0	11.6
Almost every time	13	1	0	12.5
Sometimes	58	6	0	57.1
Never	15	5	0	17.8

Source: Homasi, 2007

Data from the seafarers SGS show that they too are sexually active, as evident in the following table:

Table 8 Sexual behaviours by age group among 209 seafarers attending Princess Margaret Hospital in Funafuti, Tuvalu from August 2005 to February 2006.

	20-29	30-39		40-49		50-59		Total	
	No	No	%	No	%	No	%	No	%
Ever sex in life									
Yes	71	67	100	50	100	18	100	206	98.6
No	3	0	0.0	0	0.0	0	0.0	3	1.4
Not stated	0	0	0.0	0	0.0	0	0.0	0	0.0
Median age at first sex	18	18		18		18		18	
Sex in last 12 months									
Yes	64	67	100	48	96	18	100	197	94.3
No	10	0	0.0	2	4.0	0	0.0	12	5.7
Not stated	0	0	0.0	0	0.0	0	0.0	0	0.0
Median number of female partners in the last 12 months	2	1		1		1		1	
Number of partners in the last 12 months									
0	10	2	3.0	2	4.0	0	0.0	14	6.7
1	30	60	89.5	48	96	18	100	156	74.6
≥2	34	5	7.5	0	0.0	0	0.0	39	18.7
MSM in life									
Yes	0	0	0.0	0	0.0	0	0.0	0	0.0
No	74	67	100.0	50	100	18	100	209	100.0
Ever diagnosed with STD in last 12 months									
Yes	5	0	0.0	0	0.0	0	0.0	5	2.4
No	69	67	100.0	50	100	18	100	204	97.6
Sex with commercial partner in last 12 months									
Yes	6	1	1.5	0	0.0	0	0.0	7	3.3
No	68	66	98.5	50	100	18	100	202	96.7
Sex with casual partner in last 12 months									
Yes	25	5	7.5	0	0.0	0	0.0	30	14.4
No	49	62	92.5	50	100	18	100	179	85.6

Source: Homasi, 2007

Women in Tuvalu are more likely to meet social expectations of restrained sexual activity. The survey of women attendees at the antenatal clinic reflects this, although the fact that they are pregnant may bias this information.

Table 9 Behavioural characteristics of 114 pregnant women by age attending Princess Margaret Hospital antenatal clinic in Funafuti, Tuvalu from August 2005 to February 2006.

Outcome	<25 years		>25 years		Total	
	No	%	No	%	No	%
Median age at first	20		20		20	
Age at first sex						
<18	14	21.9%	12	24%	26	22.8 %
>18	50	78.1%	38	76%	88	77.2 %
Number of sexual partners in life						
1	56	87.5	37	74.0	93	81.6 %
>2	8	12.5	13	26.0	21	18.4 %
Number of sexual partners in last 12 months						
1	63	98.4%	49	98%	112	98.2 %
>2	1	1.6%	9	2%	2	1.8%
Sex for money or gift in last 12 months						
Yes	0	0	0	0	0	0
No	64	100%	50	100%	114	100 %
Concurrent partner in last 12 months						
Yes	2	3.1%	0	0.0	2	1.8%
No	62	96.9%	50	100.0	112	98.2 %

Source: Homasi, 2007

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

There are no data available for the whole of this age-group and both sexes.
Some relevant information was however provided by the SGS survey of seafarers.

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

Indicator	N = 209
Median number of female sex partners in last 12 months	1 (0-10)
Proportion having sex with female casual partners in last 12 months	14.4
Median number of female casual partners in last 12 months	0 (0-10)
Proportion of adult male using condoms at last sex with female casual partner in last 12 months (%)	5.7
Consistent condom use of adult male with female casual partners in last 12 months	2.4

Proportion of adult male reporting having sex with female commercial partners in last 12 months	3.3
Median number of female commercial partners in last 12 months	1 (0-5)
Proportion of adult male using condoms at last female commercial sex (%)	85.7
Consistent condom use of adult male with female commercial partner in last 12 months (%)	57.1
Proportion of adult males reporting sex with men in the last 12 months	0.0
Proportion of adult males reporting use of condoms with last anal sex with male partner (%)	0.0

Source: Homasi, 2007

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

While some transactional sex occurs in Tuvalu in an informal, disorganised way, no people are at all identifiable as sex workers. No healthcare workers were aware of any of their patients being sex workers.

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

Two SGS surveys conducted in 2007 reported information on men who have sex with men. Of the two surveys, the youth BSS appears to provide the more accurate information on this topic. Among 187 male youths in this study, 26 (13.9%) reported ever having sex with another male and 15 (8.0%) in the last 12 months. Anal sex was reported by 16 (8.6%) with 10 (62.5) of them reporting the use of a condom. In the survey of seafarers, none reported having sex with another male in the past 12 months, and this is not considered to be reliable data.

Table 11 Sexual behaviours of 187 male youths in Tuvalu from August to November 2005.

BEHAVIOUR	***Number***	*Percent (%)*
Sex with male partner in life		
Yes	26	13.9
No	161	86.1
Sex within last 12 months		
Yes	15	8.0
No	172	92.0
Anal sex within last 12 months		
Yes	16	8.6
No	171	91.4
Condom use with male sex partner		
Yes	10	62.5
No	6	37.5

Source: Homasi, 2007

Table 12 Selected indicators of HIV and sexual behaviour among 209 seafarers attending Princess Margaret Hospital in Funafuti, Tuvalu from August 2005 to February 2006.

Indicator	N = 209
Proportion of adult males reporting sex with men in the last 12 months	0.0
Proportion of adult males reporting use of condoms with last anal sex with male partner (%)	0.0

Source: Homasi, 2007

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

This is not relevant to Tuvalu. There are no known injecting drug users. There are other common forms of substance abuse, particularly alcohol, but this does not involve greater risk of HIV transmission.

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

This is not relevant to Tuvalu. See Indicator 20 above.

Impact indicators

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

Data are not available. Serosurveillance in Tuvalu is limited. Testing is only available on the main island, Funafuti. No seroprevalence surveys have been conducted for this age-group.

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

There are no data available for the population groups that are conventionally considered to be most at risk, namely sex workers, men who have sex with men and injecting drug users. There is however information available about seafarers, a population group in Tuvalu that is considered to be at special risk.

Among 209 seafarers, none were found to be HIV positive. The most common STI is Chlamydia, 8.1%, followed by Syphilis 5.2% and Gonorrhoea 0.5% (Table 9). Hepatitis B was found to be high in this population with 13.4 % positive for surface antigen. The overall prevalence for any STI (excluding Hepatitis B) among seafarer was 27.3%. None of the seafarers diagnosed with any of the STIs in this study reported any symptoms of infection.

Most seafarers (94.3%) had sex in the previous 12 months. The median age at first sex was 18 (range 9-30). Age was found to be associated with an increased risk of acquiring

any STI (Chlamydia/Syphilis/Gonorrhoea) among those below 25 years (OR=1.55 95% CI 0.61, 3.96) and Hepatitis B infection (OR=2.1 95%CI 0.59, 7.23) but this finding is not statistically significant.

Approximately 82.8% of seafarers with any STI reported having sex with a regular female partner in Tuvalu in the last 12 months. About 3.3% reported having sex with a commercial female partner and 14.4% with casual female partner in the last 12 months. None of these encounters show any significant increase in risk of having Chlamydia and Any STI. However an increased risk was observed for Hepatitis B infection among seafarers with partners on ships (OR=2.7 95%CI 0.49, 14.7) and casual partners (OR=2.18, 95% CI 0.22, 21.8) none of which is statistically significant.

None of the seafarers in this study reported having sex with a male partner in the last 12 months or in their lifetime.

Among those who are infected with any STI, condom was never used when having sex with a regular partner(s) in Tuvalu (100%) and overseas on ships (96.4%). Those who had sex with a commercial female partner 85.7% reported using condoms but only 57% were using consistently. Among those who had sex with a casual partner in the last 12 months 33.3% reported using condoms at last sexual encounter but very few 16.6% used condoms consistently. The risk of Chlamydia is three fold when condoms are not used but this finding is not statistically significant (OR=3.12 95%CI 0.94, 10.3).

Seafarers who reside on Funafuti (urban) were at a higher risk of any STI, but not statistically significant (p=0.56) Among the different levels of seafarers, ordinary seaman accounted for 27.6% of all STIs in this population. Ordinary seafarers are usually new to seafaring and most have just completed one contract of work overseas.

Knowledge of HIV prevention methods was poor among seafarers. Only 58 (27.8%) of participants had all correct knowledge of HIV protection patterns of condom protection (62.5%), faithful partner (50%) and abstinence from sex (55%).

Only 14.8% seafarers had both correct HIV protection knowledge and belief of HIV transmission. Most (96.7%) of seafarers reported the possibility of a confidential HIV test in their community, Most (93.7%) had been tested for HIV and knew the result.

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

This is not relevant at present for Tuvalu. Antiretroviral treatment only began here in December 2007.

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

To date, only one child has been born an HIV infected mother, well before this reporting period.

Best practices

Tuvalu is a small and fairly conservative Polynesian society where open discussion of sexual matters is still inhibited by custom and sexual behaviour especially of young people is constrained by social expectations, although this situation is changing.

The main means of HIV transmission in Tuvalu is sexual intercourse. Public education has been seen as the main means of addressing the threat of HIV to this society. These programmes have needed to work around the strong traditional constraints on discussing sexual issues and change public attitudes, both towards increasing use of safe sex methods and away from prejudices against people with HIV and other STIs.

Public education programmes have been implemented mainly by non-government organisations: the Tuvalu Family Health Association (TUFHA), which is funded principally by IPPF; the Tuvalu Association of NGOs (TANGO) which has received funding from AusAID and SPC; and the Tuvalu Red Cross, funded mainly by UNICEF.

- TANGO has been working with the Pacific Regional HIV Project to strengthen the capacity of communities to address HIV issues, particularly in the design of public education materials to more effectively communicate in the Tuvaluan cultural context and in Tuvaluan language.

- TUFHA has conducted a variety of programs to raise awareness and improve understanding about family issues and sexual and reproductive health, including HIV and STIs, including group discussions, workshops, drama group productions, school programmes, and other presentations.

- The Tuvalu Red Cross Society has focussed on education programmes and life-skills training for seafarers and their wives.

These types of behavioural and attitudinal changes can be difficult to monitor. In late 2006, TUFHA conducted a KAP survey of unmarried youth aged between 14 and 25 years, to measure the impact of a three year program funded by IPPF and EU. Evidence from this survey and the WHO-funded youth BSS in 2006 point towards a high level of awareness of and knowledge about STIs and HIV among young people, together with a moderate level of condom use. The 2006 sero-surveillance study of seafarers suggests that their behaviour and attitudes have been slower to change, possibly because of their older age.

Another success has been the transfer of leadership of TUNAC from the Ministry of Health to NGOs, enabling TUNAC to develop into an independent body, not a subsection of the Ministry.

Major challenges and remedial actions

The first national HIV/AIDS strategic plan (2001-2005) focussed on:

1. Provision of access to treatment, quality care and support for PLWHA, their families and caregivers;

2. Prevention and control of HIV and STIs through community education and VCCT;

3. Reducing the vulnerability among specific groups (youth, seafarers) by promoting safer sexual behaviour;

4. Providing a safe supply of blood and blood products; and

5. Coordinating a multi-sectoral response.

These were the main areas of work that were successfully achieved throughout this period;

1. Establishing health science education in primary schools, through the design and implementation of health science curricula that includes HIV and STI topics;

2. Establishing a youth centre at the TUFHA Office on Funafuti, which provides youth friendly sexual and reproductive health services;

3. Community education, with a variety of community health activities underway, but mostly on the island of Funafuti;

4. Special projects for seafarers, focussing on alcohol abuse, HIV and STI prevention, and family life-skills;

5. The involvement of the churches in HIV prevention activities;

6. The development of a national policy on HIV and AIDS that was endorsed by Cabinet in 2005. This included the establishment of an HIV/AIDS clinical team in the Ministry of Health and commitment of funds from the national budget.

7. A multi-sectoral approach, spearheaded by TUNAC, a body that comprises representatives of a wide body of stakeholders from both government and NGO agencies.

The current national HIV strategy (2008-2012) focuses on four priority areas:

1. Achieving an enabling environment

2. Prevention of HIV and other STIs

3. Treatment, care and support

4. Program management

The full work-programme for the current national HIV strategy is provided in Annex 3.

Support from the country's development partners

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

1. **GFATM** through the SPC-implemented Pacific Regional HIV Project (PRHP). This funding is channelled through TANGO for community empowerment and education activities.

2. **AusAID**, through the Australian Government's bilateral aid programme to Tuvalu. This funding similarly is channelled through TANGO for community empowerment and education activities.

3. **International Planned Parenthood Federation (IPPF),** which is channelled through TUFHA for community education activities;

4. **WHO**, which assists the Ministry of Health; and

5. **UNICEF**, which provides funding through the Tuvalu Red Cross Society for education programmes and lifeskills training for seafarers and their wives.

Monitoring and evaluation environment

TUNAC is responsible for the overall monitoring and evaluation of the national response to HIV. There is no M&E framework but TUNAC aims at recruiting an M&E specialist to devise an M&E framework for the NSP with clear indicators. In the meantime TUNAC will review the NSP annually to assess progress against targets, draft annual plan every year after completing annual review of current year to include the HIV programs of NGOs and private sector agencies.

There is also a plan to recruit a TA to train M&E officers in CRIS Database and develop a national database for sero and behavioural surveillance enabling regular review and analysis in trends of the epidemic in Tuvalu.

Monitoring of disease trend is currently the work of the Ministry of Health who reports directly to the Tuvalu National AIDS Committee. M&E of disease was previously based entirely on biological surveillance with the use of case reporting of HIV and AIDS in a national register, death registration and STI surveillance are among the other surveillance systems still in use. The first Second Generation Surveillance was introduced in 2005, which includes STI surveillance to monitor the spread of STI in populations at risk of HIV and behavioural surveillance to monitor trends in risk behaviours over time. Tuvalu will take part in the next rounds of SGS which will allow for better assessment of disease trends and behaviour trends in Tuvalu. The introduction of CRIS database should improve the analysis of trends in Tuvalu.

Tuvalu National AIDS Committee is responsible for the overall monitoring of HIV activities covering both Government and Civil society responses. The NSP details the various monitoring and evaluation tools that will monitor the various activities for different

Government agencies and non-governmental organizations. The NSP 2008 – 2012 will be review at the end of every year for the next four years to allow for evaluation and planning.

There is a need to inform the appropriate authorities to design targeted interventions geared to change behaviours and develop strategies fitting to the local situation in Tuvalu. Recommended actions include:

1. Dissemination of the analysis of the 2007 sero-surveillance and behavioural surveillance studies (Homasi, 2007) to the appropriate, national, regional and international partners to review and improve on policy and current strategies in clinical, laboratory services, health promotion strategies, and educational programs in Tuvalu.

2. Include routine antenatal screening for chlamydia and develop protocols for treatment and partner referral.

3. Seafarers and travellers to be offered testing and treatment for chlamydia on their return home. This strategy will need further evaluation and discussion with health authorities.

4. Review of national STI treatment guidelines, protocols and national essential drug lists.

5. Treatment of Chlamydia with single dose of azithromycin

6. Inclusion of azithromycin in the national essential drug list

7. Customize current approaches in syndromic case management tailored to suit current situation in Tuvalu.

8. Strengthen and improve current universal HBV vaccination of infants program.

9. All babies born to HBV positive mothers to receive hepatitis B immune Globulin (HBIG) and HBV vaccine.

    - Ensure EPI standards are maintained in particular the ‘cold-chain’

10. Review current HBV vaccination catch up programs in Tuvalu.

    - Introduce routine testing and catch up vaccination for adult population

    - Introduce routine testing and catch up vaccination for maritime trainees

11. Review current STI and HIV prevention strategies for young people.

    - Consider the introduction of Life Skills program to the education system

    - Monitor and evaluate the current Health Science curriculum at primary schools which includes modules in Sexual Health similar to Family Life Education programs.

- Support the implementation of Adolescent Health and Development (AHD) program focusing on reproductive and sexual health in young people aged 9 to 19 years.

12. Review current health promotion strategies in sexual health.

    - Review health messages – targeted but making sure it doesn't promote denial, shame and false sense of security.

    - Promote awareness of STI symptoms to improve treatment seeking behaviour.

    - Revisit 'the travel pack' used in the early 1990s in Tuvalu where condoms and health messages were given as part of a 'going away' and 'return home' package to travellers.

13. Review condom programs in terms of accessibility, availability and promotion in Tuvalu.

14. Improve laboratory capacity in the diagnosis of STIs.

    - Review current STI laboratory registers

    - Strengthen relationship with referral laboratories (Fiji and Australia)

15. Surveillance and reporting of STIs

    - Improve syndromic case management reporting (especially in rural settings)

    - Improve methods of etiological reporting at Princess Margaret Hospital Laboratory.

16. Evaluate in consultation with WHO the cost effectiveness of BSS. (Suggesting money better spent elsewhere e.g Chlamydia test kits)

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ANNEXES

ANNEX 1: Consultation and Preparation Process

Consultation/preparation process for the Country Progress Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

Which institutions/entities were responsible for filling out the indicator forms?

a) NAC or equivalent	Yes	No
b) NAP	Yes	No
c) Others (please specify)	Yes	No

With inputs from

Ministries:		
Education	Yes	No
Health	Yes	No
Labour	Yes	No
Foreign Affairs	Yes	No
Others (please specify) (Finance)	Yes	No
Civil society organizations	Yes	No
People living with HIV	Yes	No
Private sector	Yes	No
United Nations organizations	Yes	No
Bilaterals	Yes	No
International NGOs	Yes	No
Others (please specify)	Yes	No

Was the report discussed in a large forum?	Yes	No
Are the survey results stored centrally?	Yes	No
Are data available for public consultation?	Yes	No

Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?

Name / title: DR STEPHEN MAFOA KAIMOKO HOMASI

Date: 15 JANUARY 2008

Signature: _____

Address: PRINCESS MARGARET HOSPITAL, FUNAFUTI, TUVALU

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ANNEX 2: National Composite Policy Index 2007

COUNTRY: TUVALU

Name of the National AIDS Committee Officer in charge:

DR STEPHEN MAFOA KAIMOKO HOMASI

Signed:

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Date of submission: 15 JANUARY 2008

[INSERT NCPI document after you have had a meeting with civil society and government for their feedback]

Appendix 7. National Composite Policy Index (NCPI) 2007

TUVALU

Name of the National AIDS Committee Officer in charge:

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INSTRUCTIONS

BACKGROUND

The following instrument measures the UNGASS *National Commitment and Action* indicator, a composite policy index designed to assess progress in the development and implementation of national HIV/AIDS policies and strategies. **It is an integral part of the list of core UNGASS indicators and is to be completed and submitted as part of the 2007 UNGASS Country Progress Report.**

This third version of the National Composite Policy Index (NCPI) has been updated to reflect new HIV/AIDS programmatic guidance and to be consistent with new and agreed to policy and implementation measurement tools.[14]

NCPI data were also submitted in previous UNGASS reporting rounds in 2003 and 2005. Countries are strongly advised to conduct a trend analysis on the key questions and include a description of the findings in the 2007 Country Progress Report.[15]

STRUCTURE OF THE QUESTIONNAIRE

The NCPI is divided into **two parts**:

Part A to be administered to government officials.
Part A covers five areas:

1. Strategic plan
2. Political support
3. Prevention
4. Treatment, care and support
5. Monitoring and evaluation

Part B to be administered to representatives from nongovernmental organizations, bilateral agencies, and UN organizations.

Part B covers four areas:

I. Human rights
II. Civil society involvement
III. Prevention
IV. Treatment, care and support

The overall responsibility for collating and submitting the information requested in the NCPI lies with the National Governments, through officials from the National AIDS Committee (NAC) (or equivalent) with support from UNAIDS and other partners.

[14] Policy and Planning Effort Index or children orphaned and made vulnerable by HIV/AIDS, UNICEF 2005; Scaling up Towards Universal Access, UNAIDS 2006; Setting National Targets for Moving Towards Universal Access, UNAIDS 2006; Practical Guidelines for Intensifying HIV Prevention; UNAIDS 2007

[15] see *Guidelines on construction of core indicators*, UNAIDS 2002 and UNAIDS 2005, respectively, for the key questions in previous NCPI questionnaires

PROPOSED STEPS FOR DATA GATHERING

1. **Designation of two technical coordinators for the study (one for part A; one for part B)**

   Technical coordinators should be given responsibility to undertake the desk review and carry out interviews to answer specific questions. Preferably, the technical coordinator for Part A should be from the NAC (or equivalent) and for Part B should be a person outside the government. These persons should ideally have a monitoring and evaluation background and may request the assistance of consultant(s) with a similar background.

2. **Data gathering**

   Each section should be completed by (a) desk review and (b) interviewing key people most knowledgeable about that topic:
   - S*trategic Plan* and *Political Support*: the Director or Deputy Director of the National AIDS Programme or National AIDS Council, the Heads of the AIDS Programme at provincial and at district levels and UNAIDS
   - *Monitoring and Evaluation*: Officers of the National AIDS Committee or equivalent, Ministry of Health, HIV focal points of other ministries.
   - *Human rights:* Ministry of Justice officials, human rights commissioners, and representatives of human rights nongovernmental organizations and legal aid centres/institutions, persons living with HIV.
   - *Civil society participation:* key representatives of major civil society organizations working in the area of HIV and AIDS, persons living with HIV.
   - *Prevention and treatment, care and support sections:* Ministries and major implementing agencies/organizations in those areas, including nongovernmental organizations and persons living with HIV.

3. **Data entry, analysis and interpretation**

   Once the NCPI is fully completed, the technical coordinators need to carefully review all responses to determine if additional consultations or review of more documents are needed. It is important to analyze the data for each of the NCPI sections and include a write-up in the Country Progress Report in terms of progress made in policy/strategy development and implementation of programmes to tackle the country's HIV/AIDS epidemic. Comments on the agreements/discrepancies between overlapping questions in Part A and Part B should also be included, as well as a trend analysis on the key NCPI data since 2003, where available. The NCPI findings need to be presented, discussed and agreed during the national UNGASS consultation workshop (see 4 below). It is strongly encouraged to enter the final agreed data in the Country Response Information System (CRIS). If this is not possible, an electronic version of the completed questionnaire should be submitted as an appendix to the Country Progress Report.

4. **Consultation workshop organized by the NAC (or equivalent)**

   It is strongly recommended that the NAC (or equivalent) organizes a one-day broad consultation forum to discuss and endorse the major findings of the UNGASS country report, including the results from the NCPI. It is expected that civil society

organizations, including faith-based organizations, gender equality groups, women's rights groups, human rights/legal advocacy organizations, and other major nongovernmental organizations are invited to participate.

NCPI Respondents

[Indicate all respondents whose responses were compiled to fill out (parts of) the NCPI in the below table; add as many rows as needed]

NCPI - <u>PART A</u> [to be administered to government officials]

		Respondents to Part A [indicate which parts each respondent was queried on]				
Organisation	*Name/Position*	*A.I*	*A.II*	*A.III*	*A.IV*	*A.V*
1. Provision of access to treatment, quality care and support for PLWHA, their families and caregivers;	**Dr Stephen Homasi (Ag Director of Health)**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
	Ms Avanoa Homasi Paelate (Health Educator and Promotion Officer, Ministry of Health)					
2. Prevention and control of HIV and STIs through community education and VCCT;	**Ms Maseiga Ionatana (National School Supervisor, Ministry of Education)**					
	Ms Simalua Sopoaga (Research Officer, Ministry of Finance)					

3. **Reducing the vulnerability among specific groups (youth, seafarers) by promoting safer sexual behaviour;**

4. **Providing a safe supply of blood and blood products; and**

5. **Coordinating a multi-sectoral response.**

NCPI - <u>PART B</u> [to be administered to nongovernmental organizations, bilateral agencies, and UN organizations]

Organisation *Name/Position* *Respondents to Part B*

		[indicate which parts each respondent was queried on]			
		B.I	*B.II*	*B.III*	*B.IV*
Tuvalu Red Cross Society	**Ms Eseta Lauti (Secretary General)**	**Yes**	**Yes**	**Yes**	**Yes**
Tuvalu Association of NGOs	**Mrs Annie Homasi (Coordinator)**	**Yes**	**Yes**	**Yes**	**Yes**
Tuvalu Family Health Association	**Ms Emily Koepke (Executive Director)**	**yes**	**Yes**	**Yes**	**Yes**
Tuvalu National Council of Women	**Mrs Pula Maatia (Secretary General)**	**Yes**	**Yes**		
Seventh Day Adventist	**Mrs Pauke Maani**	**Yes**	**yes**		

Note: In the NCPI answers, N/A stands for "Not Applicable"

NATIONAL COMPOSITE POLICY INDEX QUESTIONNAIRE

PART A
[to be administered to government officials]

I. STRATEGIC PLAN

1. Has the country developed a national multi-sectoral strategy/action framework to combat HIV/AIDS?
(Multi-sectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.3)

Yes

Period covered: [write in]
NSP 2001 – 2005
NSP 2008 – 2012 (current)

IF NO or N/A, ***briefly explain why***

IF YES, **complete questions 1.1 through 1.10; otherwise, go to question 2.**

1.1 How long has the country had a multi-sectoral strategy/action framework?

Since the first NSP in 2001

1.2 Which sectors are included in the multi-sectoral strategy/action framework with a specific HIV budget for their activities?

Sectors included	Strategy / Action framework	Earmarked budget

Health	*Yes*	*Yes*
Education	*Yes*	*Yes*
Labour	*Yes*	*No*
Transportation	*Yes*	*No*
Military/Police	*Yes*	*No*
Women	*Yes*	*Yes*
Young people	*Yes*	*Yes*
Tuvalu Youth Council	*Yes*	*Yes*
Finance	*YES*	*N0*

*Any of the following: Agriculture, Finance, Human Resources, Justice, Minerals and Energy, Planning, Public Works, Tourism, Trade and Industry.

IF NO earmarked budget, ***how is the money allocated?***

For those without earmarked budgets, the Ministry of Health and Developmental partners through specific projects provide finance for their activities. But there is no set allocation from their recurrent budgets on an annual basis.

1.3 Does the multi-sectoral strategy/action framework address the following target populations, settings and cross-cutting issues?

Target populations	
a. Women and girls	a. *Yes*
b. Young women/young men	b. *Yes*
c. Specific vulnerable sub- populations[16]	c. *Yes*
d. Orphans and other vulnerable children	d. *No*

[16] Sub-populations that have been *locally* identified as being at higher risk of HIV transmission (injecting drug users, men having sex with men, sex workers and their clients, cross-border migrants, migrant workers, internally displaced people, refugees, prisoners, etc.).

Settings	
e. Workplace	e. Yes
f. Schools	f. *Yes*
g. Prisons	g. *Yes*
Cross-cutting issues	
h. HIV/AIDS and poverty	h. *No*
i. Human rights protection	i *Yes*
j. PLHIV involvement	j. *Yes*
k. Addressing stigma and discrimination	k. *Yes*
l. Gender empowerment and/or gender equality	l. *Yes*

1.4 Were target populations identified through a process of a needs assessment or needs analysis?
Yes

IF YES, when was this needs assessment /analysis conducted?
Year: 1999

IF NO, ***how were target populations identified?***

1.5 What are the target populations in the country?

Seafarers and Youths.

1.6 Does the multi-sectoral strategy/action framework include an operational plan?
Yes

1.7 Does the multi-sectoral strategy/action framework or operational plan include:

a. Formal programme goals? ***Yes***

b. Clear targets and/or milestones? ***Yes***

c. Detailed budget of costs per programmatic area? ***Yes***

d. Indications of funding sources? ***Yes***

e. Monitoring and Evaluation framework? ***Yes***

1.8 Has the country ensured "full involvement and participation" of civil society[17] in the development of the multi-sectoral strategy/action framework?

Active involvement

The Tuvalu National AIDS Committee who oversees the overall plan f HIV

Is made up of all key stakeholders i.e. community based organization, fa based organization, seafarers organizations, youth and women, including k Government departments.

[17] Civil society includes among others: Networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; Community-based organizations; organizations of key affected groups (including MSM, SW, IDU, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

*IF NO or MODERATE involvement**, briefly explain :***

1.9 Has the multi-sectoral strategy/action framework been endorsed by most external Development Partners (bi-laterals; multi-laterals)?

Yes

1.10 Have external Development Partners (bi-laterals; multi-laterals) aligned and harmonized their HIV and AIDS programmes to the national multi-sectoral strategy/action framework?

Yes, some partners

National framework has been developed in line with regional organizations, e.g. Secretariat of the Pacific Community (SPC) and WHO (Western Pacific Region)

2. **Has the country integrated HIV and AIDS into its general development plans such as: a) National Development Plans, b) Common Country Assessments/ United Nations Development Assistance Framework, c) Poverty Reduction Strategy Papers, d) Sector Wide Approach?**

Yes

2.1 ***IF YES,*** in which development plans is policy support for HIV and AIDS integrated?

a)National Developmental Plans – Kakeega II, b). United Nations Devcelopment Assistance Framework, c) Sector wide approach(Ministry of Health)

2.2 ***IF YES,*** which policy areas below are included in these development plans?

✓ Check for policy/strategy included

Policy Area	**Development Plans**				
	a)	**b)**	**c)**	**d)**	**e)**
HIV Prevention	Yes	Yes	Yes		
Treatment for opportunistic infections			Yes		
ART	yes		Yes		
Care and support (including social security or other schemes)	Yes	Yes	Yes		
HIV/AIDS impact alleviation	Yes	Yes	Yes		
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	Yes	Yes	Yes		
Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support	Yes				
Reduction of stigma and discrimination		Yes	Yes		
Women's economic empowerment (e.g. access to credit, access to land, training)	Yes		Yes		
Other: [write in]					

3. **Has the country evaluated the impact of HIV and AIDS on its socio-economic development for planning purposes?**

Yes

3.1 ***IF YES,*** to what extent has it informed resource allocation decisions?
Low *High*

0 1 2 3 4 5

4. **Does the country have a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services such as military, police, peacekeepers, prison staff, etc?**

Yes (Police and peacekeepers)

4.1 ***IF YES,*** which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of one or more uniformed services?

Behavioural change communication	*Yes*
Condom provision	*Yes*
HIV testing and counselling*	*Yes*
STI services	*Yes*
Treatment	*Yes*
Care and support	*Yes*
Others: [write in]	*Yes*

** What is the approach taken to HIV testing and counselling?* ***Is HIV testing voluntary or mandatory (e.g. at enrolment)? Briefly explain:***

HIV testing is voluntary with the appropriate pre-test and post-test counselling procedures in place.

5. **Has the country followed up on commitments towards Universal Access made during the High-Level AIDS Review in June 2006?**

Yes

5.1 Has the National Strategic Plan/operational plan and national HIV/AIDS budget been revised accordingly?

Yes

5.2 Have the estimates of the size of the main target population sub-groups been updated?

Yes

5.3 Are there reliable estimates and projected future needs of the number of adults and children requiring antiretroviral therapy?

Estimates only

5.4 Is HIV and AIDS programme coverage being monitored?

Yes

(a) *IF YES,* is coverage monitored by sex (male, female)?

Yes

(b) *IF YES,* is coverage monitored by population sub-groups?

No

IF YES, **which population sub-groups?**

(c) Is coverage monitored by geographical area?

No

IF YES, **at which levels (provincial, district, other)?**

Due to the smaller size of the country, monitoring is nationwide.

5.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes

Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10

Comments on progress made since 2005:

- Targets more realistic and achievable
- Better coordination of programs
- Government support more evident in 2007

II. POLITICAL SUPPORT

Strong political support includes government and political leaders who speak out often about AIDS and regularly chair important meetings, allocation of national budgets to support the AIDS programmes and effective use of government and civil society organizations and processes to support effective AIDS programmes.

1. **Do high officials speak publicly and favourably about AIDS efforts in major domestic fora at least twice a year?**

President/Head of government	*No*
Other high officials	*Yes*
Other officials in regions and/or districts	*Yes*

2. **Does the country have an officially recognized national multi-sectoral HIV/AIDS management / coordination body? (National AIDS Council or equivalent)?**

Yes

*IF NO**, briefly explain:***

Tuvalu National AIDS Committee (TUNAC) is the governing body overseeing the national response to HIV.

2.1 ***IF YES,*** when was it created?

Year: 1999

2.2 ***IF YES,*** who is the Chair?

Mrs Emily Koepke, Executive Director of Tuvalu Family Health Association (TUNAC) – an NGO partner

2.3 ***IF YES,*** does it:

have terms of reference?	*Yes*
have active Government leadership and participation?	*Yes*
have a defined membership? include civil society representatives? IF YES, what percentage? 60% include people living with HIV? include the private sector?	*Yes* *Yes* *No* *Yes*
have an action plan?	*Yes*
have a functional Secretariat?	*Yes*
meet at least quarterly? review actions on policy decisions regularly? actively promote policy decisions? provide opportunity for civil society to influence decision-making? strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	*Yes* *Yes* *Yes* *Yes* *Yes*

3. **Does the country have a national HIV/AIDS body or other mechanism that promotes interaction between government, people living with HIV, civil society and the private sector for implementing HIV and AIDS strategies/programmes?**

Yes

3.1 ***IF YES,*** does it include?

Terms of reference	*Yes*
Defined membership	*Yes*
Action plan	*Yes*
Functional Secretariat	*Yes*
Regular meetings	*Yes* Frequency of meetings: 2 monthly

IF YES,

What are the main achievements?

Development of the National Strategic Plan

National Coordination of the response

National representation which includes civil society etc

What are the main challenges for the work of this body?

Funding

Lack of a fulltime personnel to work on a daily basis pure on HIV related work (This has been proposed for the NS 2008-2012 and to be implemented in 2008)

4. **What percentage of the national HIV and AIDS budget was spent on activities implemented by civil society in the past year?**

Percentage: *N/A*

5. **What kind of support does the NAC (or equivalent) provide to implementing partners of the national programme, particularly to civil society organizations?**

a. Information on priority needs and services	*Yes*
b. Technical guidance/materials	*Yes*
c. Drugs/supplies procurement and distribution	*Yes*
d. Coordination with other implementing partners	*Yes*
e. Capacity-building	*Yes*
Other: [write in] Pacific Regional Project on HIV (PRHP) through the CDO	

6. **Has the country reviewed national policies and legislation to determine which, if any, are inconsistent with the National AIDS Control policies?**

No

6.1 ***IF YES,*** were policies and legislation amended to be consistent with the National AIDS Control policies?

Yes *No*

6.2 ***IF YES,*** which policies and legislation were amended and when?
Policy/Law: *Year:* [write in]

Policy/Law: *Year:* [write in]
[List as many as relevant]

Overall, how would you rate the political support for the HIV/AIDS programme in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
Comments on progress made since 2005: *There was minimal political support in 2005compared to 2007. Since 2006 the Government has included financial allocation in its national budget specifically for HIV for the first time. Apart from this there is no other strong political push to control the spread of HIV apart from the Ministry of Health and partners in civil society.*											

III. Prevention

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV/AIDS to the general population?

Yes

1.1. ***IF YES***, what key messages are explicitly promoted?

✓ Check for key message explicitly promoted

Be sexually abstinent	***Yes***
Delay sexual debut	**Yes**
Be faithful	**Yes**
Reduce the number of sexual partners	**Yes**
Use condoms consistently	**Yes**
Engage in safe(r) sex	***Yes***
Avoid commercial sex	**Yes**
Abstain from injecting drugs	**Yes**
Use clean needles and syringes	***Yes***
Fight against violence against women	**Yes**
Greater acceptance and involvement of people living with HIV	***Yes***
Greater involvement of men in reproductive health programmes	***Yes***
Other: [write in]	

1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV and AIDS by the media?

Yes

2. Does the country have a policy or strategy promoting HIV/AIDS-related reproductive and sexual health education for young people?

Yes

2.1 Is HIV education part of the curriculum in

primary schools?	*Yes*
secondary schools?	*Yes*
teacher training?	*No*

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes

2.3 Does the country have an HIV education strategy for out-of-school young people?

Yes

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions <u>for vulnerable sub-populations</u>?

Yes

*IF NO**, briefly explain:***

3.1 ***IF YES***, <u>which sub-populations</u> and <u>what elements of HIV prevention</u> do the policy/strategy address?

✓ Check for policy/strategy included

	IDU	MSM	Sex workers	Clients of sex workers	Prison inmates	Other sub-populations * [write in]
Targeted information on risk reduction and HIV education						**Seafarers, students, youths and adolescents**
Stigma & discrimination reduction						**As above**
Condom promotion						**As above**
HIV testing & counselling						**As above**
Reproductive health, including STI prevention & treatment						**As above**
Vulnerability reduction (e.g., income generation)	**N/A**	**N/A**		**N/A**	**N/A**	**N/A**

Drug substitution therapy	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Needle & syringe exchange	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Overall, how would you rate <u>policy</u> efforts in support of HIV prevention in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10

Comments on progress made since 2005:

There is plans to review legislations now.

HIV testing policy has been developed.

Legal Advisers is part of the Tuvalu National AIDS Committee who will facilitate work in this area.

4. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV prevention programmes?

Yes

*IF NO**, how are HIV prevention programmes being scaled-up?***

***IF YES*, to what extent have the following HIV prevention programmes been implemented in identified districts* in need?**

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV prevention programmes	The activity is available in		
	<u>all</u> districts* in need	<u>most</u> districts* in need	<u>some</u> districts* in need
Blood safety	***Yes***		
Universal precautions in health care settings	***Yes***		
Prevention of mother-to-child transmission of HIV	***Yes***		
IEC on risk reduction	***Yes***		
IEC on stigma and discrimination reduction	***Yes***		
Condom promotion	***Yes***		
HIV testing & counselling	***Yes***		
Harm reduction for injecting drug users	***N/A***		
Risk reduction for men who have sex with men			***Yes***
Risk reduction for sex workers	***N/A***		

Programmes for other vulnerable sub-populations	***Yes***
Reproductive health services including STI prevention & treatment	***Yes***
School-based AIDS education for young people	***Yes***
Programmes for out-of-school young people	***Yes***
HIV prevention in the workplace	***Yes***
Other [write in]	

*Districts or equivalent geographical/de-centralized level in urban and rural areas

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
Comments on progress made since 2005: *Better coordination in 2007 led to a better implemented program for that year.*											

IV. TREATMENT, CARE AND SUPPORT

1. **Does the country have a policy or strategy to promote comprehensive HIV/AIDS treatment, care and support?** (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).

   Yes

   1.1 ***IF YES,*** does it give sufficient attention to barriers for women, children and most-at-risk populations?
   Yes

2. **Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV and AIDS treatment, care and support services?**

   Yes

*IF NO**, how are HIV and AIDS treatment, care and support services being scaled-up?:***

***IF YES*, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts* in need?**

✓ Check the relevant implementation level for each activity
or indicate N/A if not applicable

HIV and AIDS treatment, care and support services	The service is available in		
	<u>all</u> districts* in need	<u>most</u> districts* in	<u>some</u> districts* in

		need	need
a. Antiretroviral therapy	***Yes***		
b. Nutritional care	***Yes***		
c. Paediatric AIDS treatment	***Yes***		
d. Sexually transmitted infection management	***Yes***		
e. Psychosocial support for people living with HIV and their families	***Yes***		
f. Home-based care	***Yes***		
g. Palliative care and treatment of common HIV-related infections	***Yes***		
h. HIV testing and counselling for TB patients	***Yes***		
i. TB screening for HIV-infected people	***Yes***		
j. TB preventive therapy for HIV-infected people	***Yes***		
k. TB infection control in HIV treatment and care facilities	***Yes***		
l. Cotrimoxazole prophylaxis in HIV-infected people	***Yes***		
m. Post-exposure prophylaxis (e.g., occupational exposures to HIV, rape)	***Yes***		
n. HIV treatment services in the	***Yes***		

workplace or treatment referral systems through the workplace

o. HIV care and support in the workplace (including alternative working arrangements) ***Yes***

p. Other programmes: [write in]

*Districts or equivalent de-centralized governmental level in urban and rural areas

3. **Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV/AIDS?**

   Yes

4. **Does the country have access to <u>regional</u> procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy drugs, condoms, and substitution drugs?**

   Yes

   4.1 ***IF YES,*** for which commodities?: [write in]
   ARVs, condoms, HIV test kits

5. **Does the country have a policy or strategy to address the additional HIV/AIDS-related needs of orphans and other vulnerable children (OVC)?**

   N/A

   5.1 ***IF YES,*** is there an operational definition for OVC in the country?
   Yes *No*

   5.2 ***IF YES,*** does the country have a national action plan specifically for OVC?
   Yes *No*

   5.3 ***IF YES,*** does the country have an estimate of OVC being reached by existing interventions?
   Yes *No*

   IF YES, what percentage of OVC is being reached? % *[write in]*

Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children?											
2007	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
Comments on progress made since 2005:											

V. MONITORING AND EVALUATION

1. Does the country have one national Monitoring and Evaluation (M&E) plan?

In progress

1.1. *IF YES*, was the M&E plan endorsed by key partners in M&E?

Yes *No*

1.2. Was the M&E plan developed in consultation with civil society, including people living with HIV?

Yes *No*

1.3. Have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

No

2. Does the Monitoring and Evaluation plan include?

a data collection and analysis strategy ***Yes***

behavioural surveillance ***Yes***

HIV surveillance ***Yes***

a well-defined standardized set of indicators ***Yes***

guidelines on tools for data collection ***No***

a strategy for assessing quality and accuracy of data ***No***

a data dissemination and use strategy ***No***

3. Is there a budget for the M&E plan?

Yes

3.1 *IF YES*, has funding been secured?

Yes

4. Is there a functional M&E Unit or Department?

In progress

IF NO, what are the main obstacles to establishing a functional M&E Unit/Department?

4.1 ***IF YES***, is the M&E Unit/Department based

in the NAC (or equivalent)?	*Yes*	*No*	
in the Ministry of Health?	*Yes*	*No*	
elsewhere?			*[write in]*

4.2 ***IF YES,*** how many and what type of permanent and temporary professional staff are working in the M&E Unit/Department?

Number of permanent staff:

Position:	*[write in]*	*Full time / Part time?*	*Since when?:*
Position:	*[write in]*	*Full time / Part time?*	*Since when?:*
Etc.			

Number of temporary staff:

4.3 ***IF YES,*** are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit/Department for review and consideration in the country's national reports?

Yes *No*

IF YES, does this mechanism work? What are the major challenges?

4.4 ***IF YES,*** to what degree do UN, bi-laterals, and other institutions share their M&E results?

Low					*High*
0	1	2	3	4	5

5. Is there a M&E Committee or Working Group that meets regularly to coordinate M&E activities?

No, plan in progress

***IF YES**, Date last meeting: [write in]*

5.1 Does it include representation from civil society, including people living with HIV?

Yes *No*

IF YES, describe the role of civil society representatives and people living with HIV in the working group?

6. Does the M&E Unit/Department manage a central national database?

In progress

6.1 ***IF YES,*** what type is it? *[write in]*

6.2 ***IF YES,*** does it include information about the content, target populations and geographical coverage of programmatic activities, as well as their implementing organizations?

Yes *No*

6.3 Is there a functional* Health Information System?

National level	*Yes*
Sub-national level	*Yes* *No*
IF YES, at what level(s)?	
[write in]	
National level	

*(*regularly reporting data from health facilities which are aggregated at district level and sent to national level; and data are analysed and used at different levels*)

6.4 Does the country publish at least once a year an M&E report on HIV/AIDS, including HIV surveillance data?

No

7. To what extent is M&E data used in planning and implementation?

Low					*High*
0	1	2	3	4	5

What are examples of data use?

What are the main challenges to data use?

8. In the last year, was training in M&E conducted?

Not yet established in progress.

- At national level?	*Yes*	*No*	***IF YES,*** *Number trained:*	*[write in]*
- At sub-national level?	*Yes*	*No*	***IF YES,*** *Number trained:*	*[write in]*
- Including civil society?	*Yes*	*No*	***IF YES,*** *Number trained:*	*[write in]*

Overall, how would you rate the M&E efforts of the HIV/AIDS programme in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10

Comments on progress made since 2005:
Tuvalu National AIDS Committee in its National Strategic Plan prioritise the establishment of an M&E component. This should allow for better assessment of the response in future years.

PART B

[to be administered to representatives from nongovernmental organizations, bilateral agencies, and UN organizations]

I. HUMAN RIGHTS

1. Does the country have laws and regulations that protect people living with HIV/AIDS against discrimination? (such as general non-discrimination provisions or provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.)

No

1.1 ***IF YES,*** *specify:*

[write in]

2. Does the country have non-discrimination laws or regulations which specify protections for vulnerable sub-populations?

Yes

2.1 ***IF YES,*** for which sub-populations?

a) Women	*Yes*
b) Young people	*Yes*
c) IDU	*No*
d) MSM	*No*
e) Sex Workers	*No*
f) Prison inmates	*Yes*
g) Migrants/mobile populations	*Yes*
h) Other:	*[write in]*

IF YES,

Briefly explain what mechanisms are in place to ensure these laws are implemented:

There is a national task force on certain areas for instance, for Young people there is a taskforce on Convention of the Rights of the Child. There is one for CEDAW. Then there's the legal systems.

Describe any systems of redress put in place to ensure the laws are having their desired effect:

Strengthening the present system by empowering general public and law enforcers.

3. **Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for vulnerable sub-populations?**

No

3.1 ***IF YES,*** for which sub-populations?

a) Women	*Yes*	*No*
b) Young people	*Yes*	*No*
c) IDU	*Yes*	*No*
d) MSM	*Yes*	*No*
e) Sex Workers	*Yes*	*No*
f) Prison inmates	*Yes*	*No*
g) Migrants/mobile populations	*Yes*	*No*
h) Other:		*[write in]*

IF YES, ***briefly describe the content of these laws, regulations or policies and how they pose barriers:***

4. **Is the promotion and protection of human rights explicitly mentioned in any HIV/AIDS policy or strategy?**

Yes

5. **Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV and/or most-at-risk populations?**

No

IF YES, ***briefly describe this mechanism***

6. **Has the Government, through political and financial support, involved most-at-risk populations in governmental HIV-policy design and programme implementation?**

Yes

IF YES, ***describe some examples***

Formulation of HIV/AIDS strategic plan

World AIDS Day activities

Outreach program for community education on HIV

Condom distribution

Most of these programs involved the most at risk population in the country

7. Does the country have a policy of free services for the following:

(a) HIV prevention services	*Yes*
(b) Anti-retroviral treatment	*Yes*
(c) HIV-related care and support interventions	*Yes*

IF YES, **given resource constraints, briefly describe what steps are in place to implement these policies:**

Raising public awareness

Advocacy – non discrimination

Distribution of IEC

Provision of free ARV

Free counselling and testing facilities

8. **Does the country have a policy to ensure equal access for women and men, to prevention, treatment, care and support? In particular, to ensure access for women outside the context of pregnancy and childbirth?**

yes

9. **Does the country have a policy to ensure equal access for most-at-risk populations to prevention, treatment, care and support?**

Yes

9.1 Are there differences in approaches for different most-at-risk populations?

No

IF YES, **briefly explain the differences:**

10. **Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?**

No

11. **Does the country have a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?**

No (Ministry of Health is responsible)

11.1 ***IF YES,*** does the ethical review committee include representatives of civil society and people living with HIV?

Yes *No*

IF YES, ***describe the effectiveness of this review committee***

12. Does the country have the following human rights monitoring and enforcement mechanisms?

- Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV and AIDS-related issues within their work

  Yes

- Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment

  Yes

- Performance indicators or benchmarks for
  a) compliance with human rights standards in the context of HIV/AIDS efforts
  Yes

  b) reduction of HIV-related stigma and discrimination
  Yes

IF YES on any of the above questions, describe some examples:

Human rights commission
Law reform commission

Legal Rights Training Officer

13. Have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work?

Yes

14. Are the following legal support services available in the country?

- Legal aid systems for HIV and AIDS casework

  Yes

- Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

  Yes

- Programmes to educate, raise awareness among people living with HIV concerning their rights

  Yes (one on one basis)

15. Are there programmes designed to change societal attitudes of stigmatization associated with HIV and AIDS to understanding and acceptance?

Yes

IF YES, what types of programmes?

- Media *Yes*
- School education *Yes*
- Personalities regularly speaking out *Yes*
- Other *Community workshops, out-reach programs]*

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
Comments on progress made since 2005:											

Since RRT was established in Tuvalu there has been progress in the development of policies to promote human rights in general.

The implementation of the National Plan –Te Kakeega II

Overall, how would you rate the effort to enforce the existing policies, laws and regulations in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10

Comments on progress made since 2005:

The NSP 2008-2012 will enforce work in this area.

II. CIVIL SOCIETY[18] PARTICIPATION

1. **To what extent has civil society contributed to strengthening the political commitment of top leaders and national policy formulation?**

Low					*High*
0	1	2	3	4	5

2. **To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV/AIDS or for the current activity plan (e.g., attending planning meetings and reviewing drafts)?**

Low					*High*
0	1	2	3	4	5

[18] Civil society includes among others: Networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; Community-based organizations; organizations of vulnerable sub-populations (including MSM, SW, IDU, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

3. **To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included**
   a. in both the National Strategic plans and national reports?

Low					*High*
0	1	2	*3*	4	5

   b. in the national budget?

Low					*High*
0	1	2	3	4	5

4. **Has the country included civil society in a National Review of the National Strategic Plan?**

   Yes

   IF YES, when was the Review conducted? *Year: 2006* *[write in]*

5. **To what extent is the civil society sector representation in HIV/AIDS efforts inclusive of its diversity?**

Low					*High*
0	1	2	3	4	5

List the types of organizations representing civil society in HIV and AIDS efforts:
Tuvalu Association of NGO (TANGO)
Tuvalu Family Health Association (TUFHA)
Tuvalu Red Cross Society(TRCS)
Faith Based organizations
Women's organizations
Youth
Media
Private Sector

6. **To what extent is civil society able to access**
   a. adequate financial support to implement its HIV activities?

Low					*High*
0	1	2	3	4	5

   b. adequate technical support to implement its HIV activities?

Low	*High*

0 1 2 3 4 5

Overall, how would you rate the efforts to increase civil society participation in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
Comments on progress made since 2005:											

III. PREVENTION

1. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV prevention programmes?

Yes

IF NO, ***how are HIV prevention programmes being scaled-up?:***

***IF YES*, to what extent have the following HIV prevention programmes been implemented in identified districts in need?**

✓ Check the relevant implementation level for each activity
or indicate N/A if not applicable

HIV prevention — The activity is available in

programmes	all districts* in need	most districts* in need	some districts* in need
Blood safety	***Yes***		
Universal precautions in health care settings	***Yes***		
Prevention of mother-to-child transmission of HIV	***Yes***		
IEC on risk reduction	***Yes***		
IEC on stigma and discrimination reduction	***yes***		
Condom promotion	***Yes***		
HIV testing & counselling	***Yes***		
Harm reduction for injecting drug users	***N/A***		
Risk reduction for men who have sex with men	***N?A***		
Risk reduction for sex workers	***N/A***		
Programmes for other most-at-risk populations	***Yes***		
Reproductive health services including STI prevention & treatment	***Yes***		

School-based AIDS education for young people	***Yes***
Programmes for out-of-school young people	***Yes***
HIV prevention in the workplace	***Yes***
Other [write in]	

*Districts or equivalent geographical/de-centralized level in urban and rural areas

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
Comments on progress made since 2005: *National Strategic plan is in place* *A coordinated response involving both government and non-governmental organization.* *Funding from National Budget 2007* *Expanded support from Developmental partners*											

IV. TREATMENT, CARE AND SUPPORT

1. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV and AIDS treatment, care and support services?

Yes

IF NO, ***how are HIV and AIDS treatment, care and support services being scaled-up?:***

IF YES, **To what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts* in need?**

✓ Check the relevant implementation level for each activity
or indicate N/A if not applicable

HIV and AIDS treatment, care and support services	The service is available in all districts* in need	The service is available in most districts* in need	The service is available in some districts* in need
a. Antiretroviral therapy	***Yes***		
b. Nutritional care	***Yes***		
c. Paediatric AIDS treatment	***Yes***		
d. Sexually transmitted infection management	***Yes***		
e. Psychosocial support for people living with HIV and their families	***Yes***		
f. Home-based care	***Yes***		

g. Palliative care and treatment of common HIV-related infections	***Yes***
h. HIV testing and counselling for TB patients	***Yes***
i. TB screening for HIV-infected people	***Yes***
j. TB preventive therapy for HIV-infected people	***Yes***
k. TB infection control in HIV treatment and care facilities	***Yes***
l. Cotrimoxazole prophylaxis in HIV-infected people	***Yes***
m. Post-exposure prophylaxis (e.g., occupational exposures to HIV, rape)	***Yes***
n. HIV treatment services in the workplace or treatment referral systems through the workplace	***yess***
o. HIV care and support in the workplace (including alternative working arrangements)	***Yes***
p. Other programmes: [write in]	

*Districts or equivalent de-centralized governmental level in urban and rural areas

Overall, how would you rate the efforts in the implementation of HIV and AIDS treatment, care and support programmes in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
Comments on progress made since 2005:											

2. **What percentage of the following HIV and AIDS programmes/services is estimated to be provided by civil society?**

	<25%	25-50%	50-75%	>75%
Prevention for youth				
Prevention for vulnerable sub-populations				
- **IDU**		25-50%		
- **MSM**				
- **Sex workers**				
Counselling and Testing		25-50%		
Clinical services (OI/ART)*				
Home-based care		25-50%		
Programmes for OVC**				

*OI Opportunistic infections; **OVC Orphans and other vulnerable children

3. Does the country have a policy or strategy to address the additional HIV/AIDS-related needs of orphans and other vulnerable children (OVC)?

N/A

5.1 ***IF YES,*** is there an operational definition for OVC in the country?

Yes *No*

5.2 ***IF YES,*** does the country have a national action plan specifically for OVC?

Yes *No*

5.3 ***IF YES,*** does the country have an estimate of OVC being reached by existing interventions?

Yes *No*

IF YES, what percentage of OVC is being reached? % *[write in]*

ANNEX 3: Tuvalu National HIV Strategy, 2008-2012

Ref	Description	Activities	Timing														Activity implementer	Location	Indicators	
			2008											2009	2010	2011	2012			
			J	F	M	A	M	J	J	A	S	O	N	D							
Priority Area 1 - Achieving an enabling environment																				
Output 1.A	High level commitment to HIV response evident																			
		1.A.1	Present final draft NSP 2008-12 to the TuNAC , DCC then Cabinet for endorsement															TuNAC, MOH	Funafuti	NSP 2008 – 12 endorsed	O
		1.A.2	Organise HIV and STI technical briefings for the Health Minister and the MoH executive committee and general information for other government sectors twice a year															TuNAC, Media Dept	Funafuti	Information dissemination mechanism in place	B
		1.A.3	Publish summary of recent developments in HIV responses for distribution to political leaders at all levels twice a year															PMH, TuNAC	Funafuti	Annual Health and HIV Responses Reports	O R

		1.A.4	Lobby leaders, policy makers and senior officials in regards to a review of HIV-related policies	TuNAC	All islands	Report documents	Li
		1.A.5	Involve political leaders and other notable public figures to actively engage in high profile events such as World AIDS Day	TuNAC	All islands	Number of leaders supporting HIV issues in public	P
Output 1.B	Strategy for the reduction of stigma and discrimination of people infected and affected by HIV devised and implemented						
		1.B.1	Develop an advocacy strategy to address stigma and discrimination	TuNAC	Tuvalu	Advocacy strategy document	O
		1.B.2	Identify community leaders, celebrities, AIDS champions and other key people and train them in advocacy for reducing stigma and discrimination in the community	TuNAC	Tuvalu	Number of key people trained in advocacy	T
		1.B.3	Draft national legislation for prevention of stigma and discrimination for presentation to law makers	TuNAC	Tuvalu	Legislation document	O
1.C	Policies, legislation and traditional laws that discriminate against vulnerable populations including women, sex workers and MSM reviewed and amended						
		1.C.1	Assess existing policies & legislation to identify those discriminating against vulnerable populations including women, sex workers and MSM	TuNAC	Funafuti	Report documents	S
		1.C.2	Draft revised policies to protect their human rights in accordance with international law to which Tuvalu is a party	TuNAC and AG Office	Funafuti	Revised policy documents	S

	1.C.3	Present revised policies to supportive members of parliament who will champion their progress through parliament	TuNAC	Funafuti	Revised policy documents	Pr re
	1.C.4	Lobby parliamentarians and other key power brokers for the passing of human rights-based HIV policies	TuNAC	Funafuti	Human rights-based HIV policies passed in parliament	Li
1.D	Monitor human rights violations against people living with HIV and their family members					
	1.D.1	Workshop conducted for relevant parties to develop a human rights monitoring mechanism	TuNAC	Funafuti	Human rights monitoring mechanism established	W
	1.D.2	Awareness programs informing the public that there is a mechanism that addresses human rights issues	TuNAC and Media	All islands	News releases, brochures	Pr

Priority Area 2 - Prevention of HIV and other STIs

2.A	BCC strategy developed					
	2.A.1	Design National behaviour change Strategy	TUFHA, Tuvalu BCC working group	Funafuti	Strategy document	St
	2.A.2	World AIDS Day campaigns in each island	MOH	All islands	WAD photos & report	R
	2.A.3	Identify and train celebrity AIDS Advocates and champions	TUFHA	Funafuti	HIV Champion activities	A C
	2.A.4	TA for life skills program design	TuNAC and MOE	Funafuti	TA recruited	T

		2.A.5	Design "life skills" training program for teachers, health workers, community leaders, NGO personnel, young people and other suitable key players incorporating communication, negotiation skills, sexuality, Gender respect and responsibility, and safe sex	MoE, MoH, TUFHA	Funafuti	Training program curriculum	Li do
		2.A.6	Implement "life skills" training program based on design (see 2.A.5)	MoE, MoH, TUFHA	Funafuti	Report from pilot program	Tr
		2.A.7	Train church leaders and church groups to integrate HIV/STI into their routine work and church activities-Sermons	TUNAC	Funafuti	Training activity reports	Tr
		2.A.8	Train community groups in the Stepping Stones approach to community education	TUFHA, MOH	Funafuti	Training activity reports	W
		2.A.9	Implement **stepping stones program** across the community	TUFHA, TANGO, MOH	Funafuti, Vaitupu, Nui and Nukufetau	Stepping Stones activity reports	Ac
		2.A.10	Produce (print/record/make) culturally specific/ sensitive HIV and STI behaviour change materials	TUFHA, TANGO, MOH, MOE	Funafuti	STI BCC Materials	Li
		2.A.11	Devise national distribution strategy for BCC materials	TUFHA, TANGO, MOH, MOE	Funafuti	Distribution strategy	St
		2.A.12	Design and implement campaign to educate the community about risk behaviours like tattooing and other traditional practices	MoH, TUNAC	Funafuti, Nanumea, Nanumanga, Niutao	Campaign activity reports	

		2.A.13	TA for media strategy																	TUNAC	Funafuti	TA recruited	TA
		2.A.14	Devise media HIV strategy																	TA and TUNAC	Funafuti	Strategy document	St
		2.A.15	Train media personnel in basic HIV and STI knowledge, advocacy skills and methods for reducing stigma & discrimination																	TA and TUNAC	Funafuti	Media training activity report	W
		2.A.16	Design, produce and adopt media kits that can help them to communicate effectively with the public																	TA and TUNAC	Funafuti	Media kits	M
		2.A.17	Write and broadcast a series of radio messages on HIV and STIs (with help from WSB)																	MOH, TUFHA and TUNAC	Funafuti and national broadcast	Radio messages	Br
		2.A.18	Devise and deliver HIV and STI messages using performing artists																	TUFHA and TUNAC	Funafuti, Nukulaelae and Niulakita	Performance photos and reports	Pe
		2.A.19	Arrange for the broadcasting of relevant documentaries on TV when there is a national channel																	TUNAC and Media Dept	Funafuti	TV documentaries	
		2.A.20	Support media outlets to ensure full coverage of national, regional and other relevant HIV events																	TUNAC and Media Dept	Funafuti	Media reports	#
		2.A.21	Support radio stations to air panel discussions and educational radio programs on HIV-related topics																	TUNAC and Media Dept	Funafuti and national broadcast	Radio programs	#

	2.A.22	Arrange with Telecom and design mobile phone spot messages for all to prevent HIV/STI and advertisement of VCCT services.				
	2.A.23	Design messages highlighting HIV-related services and activities	PMH & TUFHA	Funafuti	Brochures and radio messages	M
	2.A.24	Distribute messages highlighting HIV-related services and activities	PMH & TUFHA, Media Dept	Nationwide	Number of radio messages, brochure distribution lists	# pu
2.B	Strategy for HIV and STI prevention among Tuvalu youth devised and implemented					
	2.B.1	TA for youth studies	TUNAC	Funafuti	TA recruited	TA
	2.B.2	Undertake appropriate studies to develop the youth strategy	Nat Council of Youth, TUNAC, EKT	Funafuti, Nukulaelae, Vaitupu and Niutao	Study report	St
	2.B.3	Develop a youth HIV strategy	Youth Council, TUNAC, EKT	Funafuti	Strategy document	St
	2.B.4	Develop/adapt a peer education training manual	TUFHA, Youth Council, MoE	Funafuti	Training manual	Pe
	2.B.5	Identify, train/ retrain youth peer education teams	TUFHA, Youth Council, MoE, EKT	Funafuti, Vaitupu and Nanumea	Training workshop reports	W

		2.B.6	Devise Peer Educator support mechanisms																	TUFHA, Youth Council, MoE, EKT	Funafuti	Support program documents	M
		2.B.7	Adapt existing peer education support materials																	TUFHA, Youth Council, MoE, EKT	Funafuti	Peer education materials	Li m
		2.B.8	Monitor peer education activities																	TUNAC	Funafuti, Vaitupu and Nanumea	Monitoring reports	A
		2.B.9	Establish a national committee to make recommendations regarding HIV education in schools (under NAC)																	MOH, MOE, TUNAC	Funafuti	Recommendations report	C lis
		2.B.10	Review school-based HIV and sex education (Family Life Education) curricula from other Pacific countries and those already existing in Tuvalu																	MOE, TUNAC	Funafuti	Review report	R
		2.B.11	Undertake advocacy to counter opposition to HIV and sexuality education in schools																	TUNAC	Funafuti	Advocacy program reports	A
		2.B.12	Review/ Produce materials to support the teaching of HIV & Sexuality in Tuvalu schools																	MOH, MOE, TUNAC	Funafuti	New teaching materials	R
		2.B.13	Train secondary teachers for pilot implementation of HIV and Sexuality curriculum in selected schools																	MOH, MOE, TUFHA and TANGO	Funafuti	Training workshop reports	Tr

		Code	Activity	Responsible	Location	Output	
		2.B.14	Implement pilot program of HIV education in two secondary schools over a 6 month period	MOE	Funafuti	Pilot program in selected schools	Pi
		2.B.15	Evaluate pilot implementation of HIV & Sexuality curriculum and make necessary changes to the curriculum or the approach used	TUNAC	Funafuti	Evaluation report	E
		2.B.16	Train teachers and parents for nationwide implementation of HIV & Sexuality curriculum	TUFHA and MOH	Tuvalu	Training workshop reports	Tr
		2.B.17	Distribute supporting materials for curriculum to schools throughout Tuvalu	MOE		Distribution lists	
2.C	Prevention strategies specifically targeting vulnerable groups designed and implemented						
		2.C.1	TA for KAPB studies with vulnerable groups	TUNAC	Funafuti	TA recruited	TA
		2.C.2	Undertake KAPB studies to inform behaviour change strategies with vulnerable groups	TUNAC	Funafuti, Vaitupu, Nanumea and Niutao	KAPB study reports	St
		2.C.3	TA for BCC materials development	TUNAC	Funafuti	TA recruited	TA
		2.C.4	Design, pre-test, publish and distribute culturally specific BCC materials for vulnerable groups	TUNAC, MOE, MOH, TUFHA	Funafuti and nationwide	BCC materials	B
		2.C.5	Implement peer education program for sex workers to provide condoms and safe sex education	TUFHA, TUNAC	Funafuti	Peer education activities	Pe re
		2.C.6	Review seafarers HIV education campaign	Maritime college, TUNAC	Funafuti	Education campaign activity reports	R

		Code	Activity	Responsible	Location	Indicator	
		2.C.7	Design HIV prevention campaign for entertainment venues where risk behaviours are known to be prevalent	TUFHA, TANGO	Funafuti	Campaign strategy	D
		2.C.8	Distribute condoms and information on HIV in entertainment venues	TUFHA	Funafuti, Niutao and Vaitupu	Entertainment venue reports	O
2.D	Increased condom and lubricant use among the sexually active population						
		2.D.1	TA for condom studies in Tuvalu	TUNAC	Funafuti	TA recruited	
		2.D.2	Undertake national baseline study to identify rates of condom use, together with attitudes towards condom use (see surveillance activities)	TUFHA and TA	Funafuti, Vaitupu, Nukufetau & Nanumaga	Study outcomes	
		2.D.3	Undertake study to determine quality and availability of condoms and lubricant in Tuvalu	TUFHA and TA	Funafuti, Vaitupu, Nukufetau & Nanumaga	Study outcomes	
		2.D.4	Devise condom promotion strategy incorporating condom social marketing (CSM) based on preliminary research, - condom procurement, storage and distribution; condom quality assurance; community education on condom use; measures to counter potential opposition to condom promotion; and concurrent promotion of personal lubricant	TUFHA and TA	Funafuti, Vaitupu, Nukufetau & Nanumaga	CP strategy	C st

Output	Code	Activity	Responsible	Location	Indicator	
	2.D.5	Secure funding for CSM	TUFHA and TUNAC	Funafuti	Amount of funds secured	B
	2.D.6	Engage suitably experienced agency to manage CSM / lubricant promotion and commence program	TUNAC	All islands	CP campaign activities	C
	2.D.7	Routinely monitor CSM activities, particularly: condom availability; lube availability; condom / lube quality; condom/ lube cost; community attitudes to condoms; condom use; and lubricant use	TUFHA	All islands	CSM data	A
	2.D.8	Improve availability of good quality condoms and lubricant throughout Tuvalu including the outer islands	TUFHA	All islands	Condom availability	S
	2.D.9	Engage in targeted condom and lubricant distribution campaign for identified vulnerable groups	TUFHA	Funafuti, Vaitupu and Nukulaelae	Condom use among vulnerable groups	C
	2.D.10	Engage in advocacy for condom promotion to counter opposition to the campaign	TUFHA	All islands	Condom advocacy campaign	A
2.E	Safe blood supply maintained throughout Tuvalu					
	2.E.1	Implement strategy for maintaining safe blood supply in the hospital incorporating appropriate integration of blood collection, testing, labelling, storage and delivery	PMH	Funafuti	Safe blood supply strategy	Bl
	2.E.2	Train all lab technicians in testing and other relevant technical skills, reporting results and laboratory management	PMH	Funafuti	# lab staff trained	Tr

		2.E.3	Procure adequate supply of HIV and other BBV testing kits																PMH	Funafuti	Availability of HIV and other BBV test kits	H
		2.E.4	Procure all necessary laboratory equipment to ensure a safe blood supply																PMH	Funafuti	Availability of necessary lab equipment	E
		2.E.5	Devise and implement an effective system for ensuring blood specimen test results remain confidential																PMH	Funafuti	Confidentiality protocols	C pl
		2.E.6	Identify and engage a suitable agency with capacity to implement all elements of a non-remunerated blood donor supply system																TUNAC, PMH	Funafuti	Agency recruited	A
		2.E.7	Ensure all blood sample HIV test results are recorded in national sero-surveillance data																PMH	Funafuti	HIV test recording and reporting procedures	N da
		2.E.8	National campaign to increase voluntary blood donation																TRC	Funafuti	Number of blood donation campaigns	C bl
		2.E.9	TA for establishing a blood bank on Funafuti																TUNAC, PMH	Funafuti	TA recruited	
		2.E.10	Establish national blood bank at PMH																PMH, TRC	Funafuti	Blood bank established	
2.F	Universal precautions implemented in health care facilities and other relevant settings throughout Tuvalu																						
		2.F.1	Undertake a study of traditional practices that might enable blood-borne transmission of HIV or other BBVs (eg tattooing)																TUNAC	Funafuti, Vaitupu and Nui	Study undertaken	
		2.F.2	Develop a strategy to change dangerous traditional practices to prevent transmission of HIV																TUNAC	All islands	strategy developed	

2.F.3	Train tattooists and other traditional health practitioners in safe practices and waste disposal	TUNAC	All islands	Number of relevant people trained	
2.F.4	Train health workers in universal precautions	PMH	All islands	Number of HWs trained	Tr
2.F.5	Provide funding (necessary supplies) for all health facilities enabling them to practice universal precautions	MOH	All islands	Funds available for UP implementation	Bu
2.F.6	Devise safe and effective medical waste disposal strategy –	MOH	Funafuti	Waste disposal strategy	St
2.F.7	Implement medical waste disposal strategy	MOH	All islands	Waste disposal methods	W re
2.G	Post exposure prophylaxis policy developed and implemented				
2.G.1	Develop post-exposure protocols for health care and community settings	PMH	Funafuti	Post exposure protocols	P
2.G.2	Train relevant health personnel in PEP	PMH	Funafuti	Number of HWs trained in PEP	Tr
2.G.3	Equip hospital for PEP interventions	PMH	Funafuti	Availability of PEP materials	Eq
2.G.4	Monitor PEP	PMH	Funafuti	PEP protocols implemented	P
2.H	Effective, voluntary and confidential counselling for HIV and STI testing and management available throughout Tuvalu				

		2.H.1	Review and adapt WHO/UNAIDS guidelines on voluntary, confidential counselling and testing (VCCT) for use in Tuvalu																TUNAC	Funafuti	Adapted guidelines	A
		2.H.2	Identify suitable VCCT locations																TUNAC	Funafuti	VCCT sites	V
		2.H.3	Adapt/refurbish counselling rooms to ensure adequate facilities and privacy																PMH	Funafuti	VCCT facilities	A
		2.H.4	Train selected health workers from each island in voluntary and confidential HIV counselling																PMH	Funafuti	Number of HWs trained	T
		2.H.5	Implement VCCT service																PMH and TUFHA	Funafuti	Availability of VCCT	V
		2.H.6	Provide IEC and other behaviour change materials to support VCCT																MOH and TUFHA	Funafuti	Availability of relevant materials in VCCT sites	D
		2.H.7	Undertake study to determine attitudes to HIV and STI counselling																TUNAC	Funafuti	Study undertaken	
		2.H.8	Design and implement community awareness campaign to promote use of HIV and STI counselling centres																TUFHA	Funafuti	Campaign activities	C

Priority Area 3 – Treatment Care and Support

3.A A comprehensive national policy for treatment, care and support for people living with HIV developed

		3.A.1	Procure TA to review and finalise the national policy and strategy for HIV treatment and care development																TUNAC	Funafuti	TA recruited, policy document developed	T

		3.A.2	Disseminate policy to health care professionals and other relevant personnel																MOH	All islands	Number distributed, number of health care professionals implementing policy	P
3.B	A trained multidisciplinary HIV care team operating in Tuvalu's main hospital																						
		3.B.1	Undertake study of HIV-related care and support needs throughout Tuvalu																TUNAC	Funafuti, Vaitupu	Needs analysis report	N
		3.B.2	Update guidelines for the clinical care of people living with HIV in Tuvalu and implement (TA)																PMH HIV team	Funafuti	TA recruited, completed Guidelines	T
		3.B.3	Design ART strategy for Tuvalu																PMH HIV team	Funafuti	Strategy document	S
		3.B.4	Disseminate training needs analysis for medical and multidisciplinary care of people with HIV and devise training program																PMH HIV team	Funafuti	Needs analysis report distributed, and training report	N
		3.B.5	TA for training to relevant health workers in relevant treatment sites																TUNAC	Funafuti	TA recruited, and training report	T
		3.B.6	Train health workers in diagnosis and management of key opportunistic infections																PMH HIV team	Funafuti and Vaitupu	Number of training conducted, training report	T

	3.B.7	Integrate HIV and STI treatment into nursing curriculum and in-country training for health workers	MOH	Funafuti	Curriculum (document) that includes HIV and STI treatment, and in-country training report	N do
	3.B.8	Evaluate multidisciplinary teams approach after one year of operation	TUNAC	Funafuti	Evaluation report	E
	3.B.9	Assess availability of trained HIV counsellors who can support people infected and affected by HIV	TUNAC	Funafuti	Number of trained HIV counsellors	N co
3.C	Health facilities adequately resourced to enable treatment and care of people with HIV					
	3.C.1	TA for ARV requirement estimates	TUNAC	PMH	TA recruited	T
	3.C.2	TA for estimating ARV & opportunistic infection requirements and design procurement and distribution strategy accordingly	TUNAC	PMH	TA recruited, procurement report	T
	3.C.3	Design ARV distribution strategy	PMH	PMH	Strategy document	S
	3.C.4	Procure adequate ARV and other medicines for opportunistic infections	PMH	PMH	Procurement reports	P
	3.C.5	Identify and procure additional equipment and facilities required to provide ART in the outer islands	PMH	PMH	Procurement reports, Medical Centre (outer islands) consolidated reports (CMR)	P
	3.C.6	Add ARVs to the Essential Drugs List (EDL)	PMH	PMH	EDL document listing ARV	E

3.D	Comprehensive program of community-based support available for HIV infected and affected people																					
	3.D.1	Establish peer support network for people infected and affected by HIV																National HIV support group, Church, TUFHA	Funafuti	Peer support network established	P re
	3.D.2	Design a home-based carers training and support program																All medical centres, PMH, HIV team	Funafuti	Home based care program	H pr
	3.D.3	Deliver home based carers training																All medical centres, PMH	Funafuti	Number of training on Home based care	Tr
	3.D.4	Engage the religious community in care and support initiatives																TUNAC	Funafuti		Tr
3.E	Strategy for the reduction of stigma and discrimination of people infected and affected by HIV devised and implemented																					
	3.E.1	Design a community advocacy program to reduce stigma and discrimination																TUNAC and TUFHA	Funafuti	Community advocacy program, IEC material developed	Ac
	3.E.2	Involve community leaders, celebrities, AIDS champions, religious leaders and other key people in advocacy for reducing stigma and discrimination in the community																TUNAC	All islands	AIDS campaigns? Campaign reports?	Al

		3.E.3	Draft national legislation for prevention of stigma and discrimination for presentation to law makers																		TUNAC	Funafuti	National legislation	N do
3.F	Effective management of STIs on each island of Tuvalu																								
		3.F.1	Develop STI management training strategy for health workers based on WHO STI treatment protocols																		Public Health Dept	PMH	Strategy on STI management for health workers	St
		3.F.2	Undertake a STI training needs analysis in Tuvalu																		Public Health Dept	Funafuti, Vaitupu Nukulaelae and Nukufetau	Needs analysis report	N
		3.F.3	Deliver training to outer island clinicians in effective STI management of prevalent STIs incorporating: syndromic management; contact tracing; chemotherapy; Counselling about safe sex; and condom use advice																		Public Health Dept	All islands	Training reports ? number of training conducted	Tr
		3.F.4	Train hospital doctors, nurses and other health professionals in comprehensive STI management																		PMH and Public Health Dept	All islands	Training reports, and number of health professionals trained	Tr
		3.F.5	Establish a STI model clinic in Funafuti that offers comprehensive standardised STI treatment that can be used as a training facility																		PMH & TUFHA	Funafuti	STI model clinic	ST

		3.F.6	Incorporate STI case recording and reporting within the national surveillance program																	MOH	All islands	National Surveillance program incorporating STI	N sy
		3.F.7	Train all health workers in STI case recording and reporting procedures																	PMH	All islands	Training report	Tr
3.G	Laboratory support for HIV and STI diagnosis and management enabled in the Princess Margaret Hospital																								
		3.G.1	Undertake a review of HIV and STI laboratory testing policy and procedures in Tuvalu (TA)																	HIV team, Laboratory	PMH	TA recruited, HIV testing policy document	TA
		3.G.2	Assess the cost-effectiveness and other implications of implementing HIV confirmatory testing in Funafuti(TA)																	HIV team, Laboratory	PMH	TA recruited	TA
		3.G.3	Devise and implement a procurement plan for all necessary equipment, reagents and consumables to enable an ongoing program of STI testing in the outer islands																	PMH Pharmacy/Laboratory, HIV team	Funafuti	Procurement plan	Pr
		3.G.4	Revise testing policy regarding use of rapid tests, ELISA tests and confirmatory testing based on review findings and recommendations of Pacific Regional Strategy																	PMH, Laboratory, HIV team	PMH	Review report	R
		3.G.5	Procure necessary equipment based on revised testing policy																	PMH Pharmacy, HIV team	PMH	Procurement report	Ec
		3.G.6	Train laboratory staff in approved forms of HIV & STI																	PMH laboratory	PMH	Training report	Tr

		3.G.7	Train laboratory staff in ART monitoring techniques such as CD4 counts and viral load counts																PMH Laboratory	PMH	Training report	Tr
		3.G. 8	Ensure policies are in place to maintain confidentiality of HIV results																HIV team, TUNAC		HIV Policy in place	H
3.H	Comprehensive program of prevention of parent to child transmission of HIV implemented																						
		3.H.1	Inform NAC and other relevant personnel on latest PMCT developments and international policy recommendations																HIV team	Funafuti	TUNAC report/minutes	TU
		3.H.2	Finalise PPTCT policy for Tuvalu																TUNAC	Funafuti	Policy document	Pc
		3.H.3	Disseminate strategy and train health workers in implementation																All Medical centres	Funafuti	Numbers distributed	N dc
		3.H.4	Provide community education about the importance of primary prevention of infection in women of childbearing age																Public Health, TUFHA	All islands	PPTCT Education program	Pl
		3.H.5	Implement PPTCT policy across Tuvalu																Public Health	All islands	PPTCT Policy implementation report	Im
		3.H.6	Incorporate HIV counselling at ante natal clinics																PMH, HIV team	Funafuti	ANC HIV records/reports	Al
		3.H.7	Inform NAC and other relevant personnel on latest PMCT developments and international policy recommendations																HIV team	Funafuti	Repetition of 3H1	
3.I	Male circumcision practiced widely throughout Tuvalu																						

3.I.1	TA to undertake survey of circumcision prevalence and practices among males in Tuvalu	TUNAC	Funafuti	TA recruited	T
3.I.2	Identify cultural or other obstacles to universal acceptance of male circumcision	TUNAC	All islands	Problematic cultural taboos, religious beliefs identified	H
3.I.3	Undertake circumcision promotion among health workers, religious leaders and other key individuals	TUNAC	All islands	Health promotion report	C

3.J Effective referral system between Tuvalu's TB and HIV programs

3.J.1	Develop strategy for referral system between TB and HIV programs	PMH	PMH	Strategy document	St
3.J.2	Provide VCCT service to TB patients	PMH	PMH	TB program/referral report	T

Priority Area 4 – Program Management

4.A Effective multisectoral engagement in the NSP

4.A.1	Engage all government sectors in the Response to HIV/AIDS	TuNAC	Tuvalu	Government sectoral plans	
4.A.2	Work closely with other non-state actors	TuNAC	Tuvalu	Regular meetings' minutes	

	4.A.3	Facilitate NAC meetings every two months to monitor progress on NSP	TuNAC	Funafuti	Regular meetings' minutes	
	4.A.4	Provide media briefing on the NAC's role and the NSP, with periodic updates	TuNAC	Funafuti	Number of media/press releases/reports	
	4.A.5	Update NAC members on HIV development in Tuvalu and the region	TuNAC, PMH HIV team	Funafuti	Number of meeting reports	
	4.A.6	Mainstream HIV interventions across sectors rather than introduce vertical HIV initiatives	TuNAC	Tuvalu	Number of sectors working on HIV interventions	
4.B	Improved coordination and management of the national HIV response					
	4.B.1	Recruit personnel to support the secretariat	TuNAC	Funafuti	Personnel engaged	C
	4.B.2	Equip the secretariat with adequate resources to function effectively	TuNAC	Funafuti	Functional Secretariat	R
	4.B.3	Hold review workshops each year to analyse progress on the plan	TuNAC	Funafuti	Workshop reports	W
	4.B.4	Hold planning workshop each year with broad representation from stakeholders	TuNAC	Funafuti	Workshop reports	W
4.C	Comprehensive program of HIV and STI surveillance and research implemented and annual figures disseminated					
	4.C.1	TA to assist with a comprehensive program of second generation surveillance drafted	TuNAC	Funafuti	TA recruited	C

		4.C.2	Identify national sero surveillance sites																	PMH	Funafuti	Sites identified	Li
		4.C.3	Equip and train personnel for sero-surveillance in each site																	PMH	Funafuti	Trained personnel	T
		4.C.4	TA for develop system for reporting sero-prevalence data to national HIV surveillance office																	TuNAC	Funafuti	Reporting system developed	D
		4.C.5	Ensure adequate funding for ongoing national sero surveillance activities																	TuNAC	All islands	Number of proposals funded	R
		4.C.6	Identify key target groups for behavioural surveillance																	TuNAC & TUFHA	Funafuti, Vaitupu, Nukulaelae & Nanumea	Number of key target groups identified	Li
		4.C.7	Finalise and distribute instruments for behavioural surveillance																	TUFHA	Funafuti, Vaitupu, Nukulaelae & Nanumea	Availability of BS instruments	R
		4.C.8	Train personnel in behavioural surveillance in each site																	TUFHA	Funafuti, Vaitupu, Nukulaelae & Nanumea	Number of qualified personnel	Tr
		4.C.9	Implement SGS in sentinel sites																	PMH & TUFHA	All islands	# sites undertaking SGS	Su

		4.C.10	Disseminate surveillance data regularly																PMH, TUNAC	All islands	Data availability	R
4.D	One national monitoring and evaluation framework designed and implemented																						
		4.D.1	Identify & recruit an M&E specialist																TuNAC	Funafuti	Working M&E specialist	C
		4.D.2	Devise monitoring and evaluation framework for the NSP with clear indicators																TuNAC & TA	Funafuti	M&E Framework document in place	M
		4.D.3	Recruit a suitable person to undertake monitoring and supervision activities																TuNAC	Funafuti	Suitable person recruited	co
		4.D.4	Review the NSP annually to assess progress against targets																TuNAC	Funafuti	NSP review reports	C
		4.D.5	Draft annual plan every year after completing annual review of current year																TuNAC	Funafuti	Annual plan document	D
		4.D.6	Identify & recruit an evaluation specialist																TuNAC	Funafuti	Evaluation specialist in place	
		4.D.7	Undertake mid term review of NSP																TuNAC	All islands	Review reports	
		4.D.8	Include the HIV programs of NGOs and private sector agencies in planning and monitoring activities																TuNAC	All islands	Number of multi-sectoral HIV programs	C
		4.D.9	TA to train M&E officer in CRIS database																TuNAC	Funafuti	M&E Officer trained	

	4.D.10	Develop a national database for sero and behavioural surveillance enabling regular review and analysis of trends in the epidemic	PMH HIV unit	Funafuti	National database document	
	4.D.11	Provide M&E training for NAC secretariat, focal personnel and NGOs	TuNAC	Funafuti	M&E training reports	Tr
	4.D.12	Develop and maintain a current map of all HIV response activities, incorporating the work of all players: government and non government agencies	TuNAC	Funafuti	Map produced	
4.E	Evidence based planning undertaken on annual basis					
	4.E.1	Collate and analyse implementation data of the current program	TuNAC	Funafuti	Implementation data reports	In re
	4.E.2	Conduct a national workshop to develop a new annual plan	TuNAC	Funafuti	Workshop reports	W
4.F	Tuvalu's national HIV response adequately resourced					
	4.F.1	Identify & recruit 1 staff for HIV unit	TuNAC	Funafuti	Staff recruited	C
	4.F.2	Provide training for national level HIV Unit coordinators and staff	TuNAC	Funafuti	Training reports	Tr
	4.F.3	Seek funding for additional health staff to deliver HIV-related (PMTCT advisors; counsellors; antenatal clinic nurses; STI clinicians) interventions in the Funafuti hospital	TuNAC	Funafuti	Funds available	F
	4.F.4	Develop and implement training plan for health professionals	PMH	Funafuti	Training plan developed	D de

		4.F.5	Advocate for funding allocations for HIV activities from national budget	TuNAC	Funafuti	Funding allocated in the National budget	Bu do
		4.F.6	Identify major and minor national, regional and international funding sources	TuNAC	Funafuti	List of funding agencies	Fu
		4.F.7	Develop fundraising strategy to enable NSP implementation	TuNAC	Funafuti	Funding strategy in place	Fu
		4.F.8	Encourage and support partner agencies to apply for funding for HIV interventions	TuNAC	Funafuti	Number of partner agencies funded	Li su