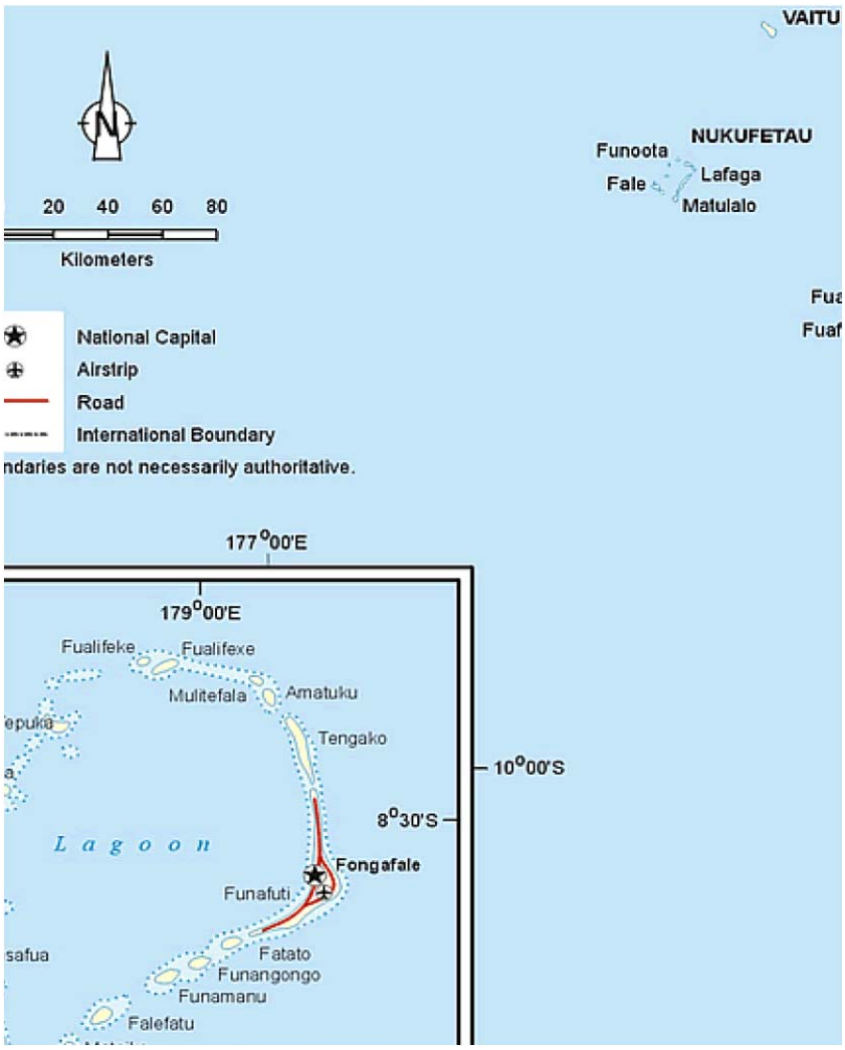
[Reporting period January - December 2013]

Tuvalu Global AIDS Response Progress Report 2014



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1. Introduction

In June 2011, Tuvalu joined the international community to sign the 2011 Political Declaration on HIV and AIDS; reconfirming its previous commitments made in 2001 and 2006. The Political Declaration motivates and compels countries to work towards achieving the Millennium Development Goal Six to halt and reverse the spread of HIV epidemic by 2015. The 2011 Political Declaration demonstrates the spirit of planning for results through setting time bound targets that countries should achieve by 2015.
I am pleased to announce achievements made in responding to the epidemic in Tuvalu, first of all by keeping Tuvalu a low level HIV country. People Living with HIV and AIDS are accessing treatment and we expect that this will translate into improvements in life expectancy.

The Government has recognized the contribution of community organizations, in particular in prevention programmes. The National AIDS Spending Assessment (NASA) 2013 uncovered that the Government contribution to HIV is on the rise and spending priority is given to the education of young population on how to prevent.
The country is not only committed but has demonstrated political support for the response. Such support will be sustained to ensure that we achieve the Universal Access targets. I am pleased that this report demonstrates our collective successes and the achievements are attributed to the people of Tuvalu; the youth who begin their sexual lives having attuned to safer behaviours; the women who visit antenatal care clinics to protect their unborn children; the men who are getting circumcised; the key populations who are coming out to become active partners in HIV prevention efforts and the households who participate in national surveys.

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

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

Hon Leneuoti Matusi
Acting Minister of Health

1.1 Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ARH	Adolescent Reproductive Health
ART	Antiretroviral Treatment
CCM	Country Coordination Mechanism
CDO	Community Development Organization
CMR	Consolidated Monthly Report
CSM	Condom Social Marketing
FBO	Faith Based Organizations
GF	Global Fund
HIV	Acquired Immunodeficiency Syndrome
IEC	Information, Education, Communication
MDG	Millennium Development Goal
MOE	Ministry of Education
MSIP	Marie Stopes International Pacific
NCPI	National Commitment and Policy Index
NSP	National Strategic Plan
NZAID	New Zealand Government Aid
OSSHM	Oceania Society for Sexual Health and HIV Medicine
PIAF	Pacific Islands Aids Foundation
PMH	Princess Margaret Hospital
PMTCT	Prevention of Mother to Child Transmission
PPTCT	Prevention of Parent to Child Transmission
PRISP	Pacific Regional Strategy on HIV and other STIs
RHTP	Reproductive Health Training Program
RRRT	Regional Rights Resource Team
SPC	Secretariat of the Pacific Commission
STI	Sexually Transmitted Diseases
TANGO	Tuvalu Association of Non- Government Organizations
TNCW	Tuvalu National Council of Women
TNYC	Tuvalu National Youth Council
TOSU	Tuvalu Overseas Seaman's Union
TRCS	Tuvalu Red Cross Society
TUFHA	Tuvalu Family Health Association
TUNAC	Tuvalu National Aids Committee
UNFPA	United Nations Population Fund
VCCT	Voluntary Confidential Counseling and Testing

1.2 Acknowledgements

This report was approved by the Minister of Health of Tuvalu on March 31, 2014 with technical support from UNAIDS Office in the Pacific.

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

Contact person for the report:

Taufa Nia, Ministry of Health of Tuvalu, HIV program Officer – e-mail: taufania7@yahoo.co.nz

2. Indicator Overview

Core indicators for Global AIDS Response Progress Reporting

Individual indicators may be used to track more than one target.

Targets	Indicators		Value	Measurement	Comments
Target 1. Reduce sexual transmission of HIV by 50% by 2015 *General population*	1.1	Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*			(link to the survey)
	1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15			(link to the survey)
	1.3	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months			
	1.4	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*			
	1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results			
	1.6	Percentage of young people aged 15-24 who are living with HIV*			
Sex workers	1.7	Percentage of sex workers reached with HIV prevention programmes			
	1.8	Percentage of sex workers reporting the use of a condom with their			

		most recent client			
	1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results			
	1.10	Percentage of sex workers who are living with HIV			
Men who have sex with men	1.11	Percentage of men who have sex with men reached with HIV prevention programmes			
	1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner			
	1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results			
	1.14	Percentage of men who have sex with men who are living with HIV			
Target 2. Reduce transmission of HIV among people who inject drugs by 50% by 2015	2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes			
	2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse			
	2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected			
	2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results			

	2.5	Percentage of people who inject drugs who are living with HIV			
Target 3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths[7]	3.1	Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission			
	3.1a	Prevention of mother-to-child transmission during breastfeeding			
	3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth			
	3.3	Mother-to-child transmission of HIV (modelled)			
Target 4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015	4.1	Percentage of adults and children currently receiving antiretroviral therapy*			
	4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy			
Target 5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015	5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV			
Target 6. Close the global AIDS resource gap by 2015 and reach annual global investment of US$ 22–24 billion in low- and middle-income countries	6.1	Domestic and international AIDS spending by categories and financing sources			

Target 7. Eliminating gender inequalities	7.1	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months *All indicators with sex-disaggregated data can be used to measure progress towards target 7*			
Target 8. Eliminating stigma and discrimination	8.1	Discriminatory attitudes towards people living with HIV			
Target 9. Eliminate travel restrictions		*Travel restriction data is collected directly by the Human Rights and Law Division at UNAIDS HQ, no reporting needed*			
Target 10. Strengthening HIV integration	10.1	Current school attendance among orphans and non-orphans aged 10–14*			
	10.2	Proportion of the poorest households who received external economic support in the last 3 months			
Policy questions (relevant for all 10 targets)		*National Commitments and Policy Instruments (NCPI)*			
* Millennium Development Goals indicator 7 The *Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive* defines this target as: 1. Reduce the number of new HIV infections among children by 90% 2. Reduce the number of AIDS-related maternal deaths by 50% For further information see: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_JC2137_Global-Plan-Elimination-HIV-Children_en.pdf					

3. Status at a glance

3.1 History

Ancestors of modern-day Tuvaluans most likely came from Samoa by way of Tokelau, while others came from Tonga and Uvea (Wallis Island). These early settlers to Tuvalu were all Polynesians, with the exception of Nui Island, which was later settled by Micronesians. According to linguistic evidence, Tuvalu was first settled 2,000 years ago, although traditional stories and genealogies go back only 300 years. Tuvalu's history is passed down from generation to generation through legends, chants and the traditional song and dance of Tuvalu, the fatele.

The first European sighting of Tuvalu was in 1568 by Alvaro de Mendaña de Neira from Spain. It wasn't until the late 1700s, however, that the next European explorers reached the area. By the early 1800s, whalers and other seafarers were traversing the Pacific although stops at Tuvalu were infrequent because of the difficulties of landing ships on the atolls. However, during the mid-1800s, the islands were raided by slave raiders, called 'blackbirders', who forcibly recruited plantation workers for South America, Fiji, Hawaii, Tahiti, and Australia. Tuvalu was one of the hardest-hit of the Pacific Islands with over 400 people taken from Funafuti and Nukulaelae, none of whom returned.

In 1892 the islands became part of the British protectorate known as the Ellice Islands, which was later incorporated into the Gilbert and Ellice Islands Colony in 1916. Between 1943 and 1945, Tuvalu was used as an operations base for Allied forces battling the Japanese in the Pacific.

Thousands of marines were stationed there. In 1974, ethnic differences within the colony between the Polynesians (Ellice Islanders) and Micronesians (Gilbert Islanders) resulted in the Polynesians voting to secede from the colony. The following year the Ellice Islands became the separate British colony of Tuvalu. Tuvalu became an Independent Constitutional monarchy and the 38th (special) member of the Commonwealth on 1 October 1978. In 2000, Tuvalu became a full member of the Commonwealth and the 189th member of the United Nations.1

3.2 Geography

Tuvalu is a 580 km-long chain of nine coral islands lying between latitudes 5ºS and 11ºS, just west of the International Date Line. Tuvalu's total land area is 26 km2, which is relatively evenly distributed across the nine atolls. Six out of the nine atolls have lagoons that are open to the ocean; these are Nanumea, Nui, Vaitupu, Nukufetau, Funafuti and Nukulaelae. Nanumaga and Niutao have landlocked lagoons while Niulakita has no lagoon at all. All of Tuvalu's islands are lowlying, the highest being only 4 m or 5 m above sea level. As a result, Tuvalu is at great risk of becoming one of the first nations to succumb to the effects of climate change and sea level rise. Tuvalu's limited land area is generally of low quality with poor fertility and thus is unsuitable for agriculture.

3.3 Demographics

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

[1] DHS Tuvalu 2007

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

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

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

3.4 Health System in Tuvalu

Tuvalu's public spending on health was 10% of GDP in 2010, equivalent to US$534 per capita. In the most recent survey conducted between 1997 and 2010 there were 109 doctors and 582 nurses and midwives per 100,000 people. Additionally, 98% of births are attended by qualified health staff (2007-12), and 98% of one-year-olds immunised with one dose of measles (2011). In 2010 98% of the country's population was using an improved drinking water source and 85% had access to adequate sanitation facilities. The most recent survey, conducted in the period 2000-11, reports that Tuvalu has nine pharmaceutical personnel per 100,000 people.

Legislation in Tuvalu prevents the operation of private medical practices and pharmacies, and all facilities available on the islands are public, with 99% of total health funding being provided by the government. The country's one hospital, Princess Margaret Hospital, is located in Funafuti and is capable of providing basic primary healthcare, dental and pharmaceutical services. There are also eight medical centres, located on the outer islands, which are staffed by nurses. Tuvalu's main pharmacy is located in the Princess Margaret Hospital, and is responsible for the procurement of drugs and reproductive health commodities from suppliers. The Department of Pharmacy, which is a branch of the Ministry of Health, is responsible for organising training for nurses working in Tuvalu's medical centres, such that they are proficient in the ordering and management of medicines and drugs. [3]

A significant drain on GoT resources is occurring through the Tuvalu Medical Treatment Scheme. There have been and are continuing a number of reviews of the Scheme, and the MoH is the key player in the management of the Scheme. Cost overruns in the TMTS threaten the ability of the MoH to maintain effective services.[4]

Currently the model of care for OI health services is based on the health centre being staffed by (1)

[2] http://aid.dfat.gov.au/countries/pacific/tuvalu/Documents/tuvalu-appr-2011.pdf
[3] http://www.commonwealthhealth.org/pacific/tuvalu/health_systems_in_tuva/
[4] http://www.wpro.who.int/health_services/tuvalu_nationalhealthplan.pdf

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

The Ministry of Health Tuvalu operates from Funafuti the capital island, where the main referral hospital, (PMH) is based. The 50 bed hospital provides secondary level care for the whole population of Tuvalu with referrals to Fiji, New Zealand and India for a few who need tertiary or specialized medical care. The other eight islands in the group have a medical center manned by two nurses, a nurse assistant and two primary health care workers. Medical treatment and care services are free for all Tuvaluan citizens including free medications, hospital stay, and any in-country referrals from any outer island medical center to PMH. The Ministry of Health operates a medical treatment scheme to cater for all medical referrals outside Tuvalu. New Zealand Government (NZAID) also provides a similar scheme for treatment of Tuvaluans referred to Fiji and New Zealand.7
PMH is the main centre for child birth. Due to the geography of Tuvalu and shipping being the main mode of transport (which takes between 4 hours – 22 hours of travel each way from Funafuti), each island has a trained mid- wife. First time mothers as well as women with history of previous complicated deliveries or suspected complex cases are always referred to PMH at about 32 weeks of gestation. Around 99% - 100% of births take place in the hospital and are attended by skilled health personnel. 8In addition, TUFHA and PMH also provide family planning services. VCCT is offered to all pregnant mothers in Funafuti. Counselling is done by a group of certified HIV counsellors.
The early- referral plan from the islands has been a key influence in reducing Infant mortality rate by two – thirds (66.7%) for the period 1992 – 2009.

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

Bi-annual trainings are conducted for junior and senior nurses at PMH to give them feedback about the CMR and as an incentive for improving the reporting process. Special sessions are delivered by field experts on gaps that were highlighted in the CMR.
There is no HIV legislation in Tuvalu. Work is continuing in drafting the new legislation. Currently, the Tuvalu National Strategic Plan for HIV/STI 2009 – 2013 is the guiding document for all HIV programs. TUNAC is the National HIV coordination mechanism and meets every two months.

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

3.5 Monitoring and Evaluation

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

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

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

Currently the Health information System strategy is underway of improving the way of communications by replacing the paper based reporting from outer islands with electronic information. An upgrade the existing HIS is foreseen by means of installation of ICT at their respective Health Clinics so that they can access through the internet.[5]

Based on previous experience the data follow 3 ways of reporting:
* Facsimile Transmission
* Surface Mail Delivery
* Hand Safe Delivery (not recommended)

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

3.6 Health Policy and Planning

The year 2008 marked the beginning of the health reform process, with the development of a new health master plan to guide the work of the Ministry of Health over a 10-year period stretching from 2009 to 2019. The Strategic Health Plan 2009-2019, completed in early 2009, provides the Ministry of Health with the renewed aim to focus on primary health care and disease prevention.
In 2011, a review of several pieces of health legislation has been undertaken, including the Nurses Act, the Medical and Dental Act, the Public Health Act and the Pharmacy and Poison Act. The options for development of an umbrella Act for Health Professionals in Tuvalu are also currently being reviewed. Development of the health infrastructure in the outer islands was another successful project that the Ministry of Health started to execute in 2008. The Ministry secured funding through the Government of Japan's Grant Assistance for Grassroots Human Security Projects to build a new medical centre for Vaitupu Island, to be followed by Niutao Island Medical Centre and Nui Medical Centre in 2009. The same project will also cover new medical centres for the remaining outer islands. The new centres will improve the delivery of health services to the outer islands, with better facilities for inpatient care. In Funafuti, the renovation of the Reproductive Health Clinic to house the integrated programmes for Reproductive Health, Maternal Child Health, HIV and STI, TB and Adolescent Health Development was completed in early 2009.[6]

3.7 Health Care Financing

The Ministry of Health started work on development of a national health account system in 2009 to track all health financial resources and spending within the Government core budgetary system and those outside the Government jurisdiction. The financial system, was implemented in 2013 and it

[5] http://www.uq.edu.au/hishub/docs/Tuvalu.pdf
[6] http://www.wpro.who.int/countries/tuv/34TUVpro2011_finaldraft.pdf

allow better monitoring, evaluation and planning for the Ministry of Health in developing its own financial plans.

The Ministry of Health receives financial support from WHO, the United Nations Population Fund (UNFPA) and the Global Fund.

3.8 Human Rights

The law prohibits discrimination based on race, colour, and place of origin, and the government generally enforced these prohibitions. In 2005 the High Court stated that it was a deliberate decision in the constitution originally to omit gender as a prohibited basis of discrimination; thus, there is no constitutional protection against sex discrimination.[7]

Sexual conduct between men is illegal, with maximum penalties of seven to 15 years' imprisonment depending on the nature of the offense, but there were no reports of prosecutions of consenting adults under these provisions. There were no reports of violence against persons based on sexual orientation or gender identity, but social stigma or intimidation may have prevented reporting of incidents of discrimination or violence.[8]

Persons with HIV/AIDS faced some societal and employment discrimination. Local agents of foreign companies that hired seafarers from Tuvalu to work abroad barred persons with HIV/AIDS from employment. The government and NGOs cooperated to inform the public about HIV/AIDS and counter discrimination. There were no reports of violence against persons based on HIV/AIDS status.[9]

4. Overview of the AIDS Epidemic

4.1 General population, routine statistics data

Data as of 31.12.2013

Type of the epidemics			
Mid Year Population 2011			
Mid Year Population 2011 (15-49)			
First HIV case reported			
Cumulative Incidence per 100,000			
Cumulative number of HIV infection	Male		
	Female		
	Unknown		
Cumulative number of HIV infection in children	Male		
	Female		
	Unknown		
New cases 2013	Male		

[7] TUVALU 2013 HUMAN RIGHTS REPORThttp://www.state.gov/documents/organization/220451.pdf
[8] TUVALU 2013 HUMAN RIGHTS REPORThttp://www.state.gov/documents/organization/220451.pdf, page 11

[9] TUVALU 2013 HUMAN RIGHTS REPORT, page 11

	Female		
	Unknown		
People in ART	Male		
	Female		
	Unknown		
People tested for HIV	Male		
	Female		
	Unknown		
Testing in pregnant women total/tested	100		
Cumulative AIDS-related death	Male		
	Female		
	Unknown		
AIDS-related death 2013	Male		
	Female		
	Unknown		

4.2 HIV testing

Voluntary counselling and testing (VCT) is current practice in Tuvalu for all HIV testing. The country's only laboratory, at Princess Margaret Hospital in Funafuti, is capable of doing HIV Determine and Serodia diagnostic tests. There is no testing available in outer islands. VCCT is performed by certified HIV Counsellors following an HIV Testing Policy for confidential counselling services. Upon consent, a HIV test is performed at PMH. An average number of 791 tests were performed in 2013 for HIV testing with no HIV positive cases registered.
Confirmatory tests, however, are still being sent to Fiji and/or Melbourne, Australia. This process can take weeks (Fiji) and months (Australia) and causes difficulties in the return of results, which can have a significant effect on the management of a case. Apart from voluntary testing, the laboratory also performs screening of all blood products for HIV and other common STIs. The current national policy on HIV testing supports voluntary counselling and testing.[10]

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

4.3 Transmission routes

The probable way of transmission is IDUs with an increase through sexual way.

[10] Tuvalu NSP 2009-2013

4.4 Testing in pregnant women

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

A total number of 276 pregnant women have been registered in Tuvalu with 276 having an HIV test. This is a routine check for all pregnant mothers.

4.5 HIV in Blood Donors

All blood products will be screen for STI's including HIV.

4.6 HIV in Most at Risk Populations

Tuvalu has identified seafarers and MSM as it high risk group. Review and development of new STI and HIV plan for seafarers is underway. Whole – population approach is used for any health promotional programs. The reason for this is the cultural context, beliefs and practices associated with HIV/AIDS. In 2011, the biggest achievement was getting two HIV ambassadors from Fiji, who was sponsored by PIAF (male/female) to publicly speak about their HIV status.

There were no study/research in most at risk populations conducted in Tuvalu nor estimations of sizes or mapping was conducted.

Baseline behavioural surveys of seafarers and young people in the past few years have highlighted risk behaviours among key groups and the need for ongoing and expanded behavioural surveillance. In Tuvalu, there are no known injecting drug users nor recognised commercial sex workers, however, there are anecdotal reports of informal transactional sex arrangements. Seafarers - who account for 70 per cent of Tuvalu's HIV cases - and their wives are particularly vulnerable to infection. Of the 209 seafarers covered by the Second Generation Surveillance (SGS) survey, only 27.8% had correct knowledge of HIV prevention methods and 16.8% reported having both correct knowledge of HIV prevention and no incorrect beliefs about HIV transmission. Of the seafarers surveyed, none was found to be HIV-positive, but the rates of other STIs were high as the following figures show: Chlamydia 8.1%; hepatitis B surface antigen 13.4%; and syphilis 5.2%. These results suggested that the men surveyed either did not understand how STIs were transmitted or chose not to practice safe sex. Clearly, seafarers remain a group within the Tuvaluan community that requires specific HIV prevention interventions.[11]

[11] Tuvalu NSP 2009-2013

4.6 ART Treatment, Care and Support

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

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

Syndromic management of STIs is currently used for the treatment of all STIs in Tuvalu. The protocols are available at all medical centres on the outer islands. Syphilis cases that are detected at PMH are treated according to WHO standard protocols.[12]

5. National response to the AIDS epidemic

The HIV work in Tuvalu is implemented through the Tuvalu National Strategic Plan 2008-2013. A few Strategy documents – Tuvalu HIV Strategy (2001-2005), the draft HIV National Strategic Plan 2006-2010, the Regional HIV Strategy and review of the Tuvalu response to HIV – were used to develop the current 2008-2013 NSP. Aligning the current draft NSP, to the Pacific Regional Strategic Implementation Plan was the best for the country in its response to HIV. Tuvalu's capacity for an organised response to HIV has built momentum in recent years and the current NSP presented an opportunity for the country to build on a solid base of HIV response.

The current NSP noted a repeated pattern in the development of strategies to guide subsequent interventions. Outputs are prefaced by studies in order to inform a specific strategy. This is to ensure that the response to HIV is evidence based rather than predetermined driven.

Implementation of the activities in the NSP is coordinated by the Tuvalu National AIDS Committee (TUNAC), formed as an independent body, when it was transferred out of the Ministry of Health. TUNAC membership comprises of NGOs, FBOs, CBOs and the Ministry of Health.

With Tuvalu's population of 10,000 spread across nine islands, constraints on providing services to these islands are acknowledged, coupled with very limited transportation service. The burden of providing HIV services falls to a very limited number of key people, which is often the case in PICs where key individuals often have several responsibilities.

[12] Tuvalu NSP 2009-2013

Much is often expected from these individuals and it is important to take this limiting factor into account in the strategy to responding to HIV.

Key priority areas and outputs of the HIV Strategic Plan for 2008-2013 are in 4 areas:

1. Achieving an enabling environment ensuring high level political commitment and policy support, reduction of stigma and discrimination, comprehensive review of policy and legislation to be in line with international human rights, and monitoring human rights violations against PLHIV;

2. Prevention of HIV and other STIs ensuring prevention measures are more effectively integrated with other components of the overall response. Social research interventions are developed to address behaviour change, enhanced prevention activities to cater for youth, vulnerable groups such as seafarers and sex work. Accessibility of reproductive health commodities, blood safety, practice of universal precautions, PEP kit training and availability of effective VCCT are all part of the prevention strategies.

3. Treatment Care and Support upscale and upgrade of services provision to PLHIV by medical personnel and members of the community through skills training, development of comprehensive national policy for treatment, care and support, availability of rapid test kits and effective referral system for TB and HIV programs.

4. Programme Management where other sectors are encouraged to assist the health sector in the response, improvement in the coordination and management of the response, effective implementation of surveillance and researches, ensure 'The Three Ones' principle is designed and implemented and that the HIV response is adequately resourced financially and also through a dedicated officer in the HIV unit.

6. Indicators for Target 1: Reduce sexual transmission of HIV by 50 per cent by 2015

1.1 Young people – knowledge about HIV prevention

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

Is indicator/topic relevant? Yes Is data available? Yes

Data measurement tool / source: DHS 2007

Other measurement tool / source:

From date: 2007 to date: 2007

Additional information related to entered data. E.g. reference to primary data source, methodological concerns:

Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source:

Data measurement tool / source: DHS 2007

Sample size - Number of Survey Respondents: 418

Correct answer to all five questions

	All (15-24)	All Males (15-24)	Males (15-19)	Males (20-24)	All Females (15-24)	Females (15-19)	Females (20-24)
Percentage (%): Percentage of respondents aged 15-24 years who gave the correct answer to all five questions		60.7	57.2	65.0	39.4	31.1	45.7
Numerator : Number of respondents aged 15-24 years who gave the correct answer to all five questions							
Denominator : Number of all respondents aged 15-24							

Correct answer to question 1 "Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?"

	All (15-24)	All Males (15-24)	Males (15-19)	Males (20-24)	All Females (15-24)	Females (15-19)	Females (20-24)
Percentage (%): Percentage of respondents who gave a correct answer to question 1		87.0	84.7	89.9	89.0	82.6	93.9
Numerator : Numerator Number of respondents/population who gave correct answer to question 1							

Denominator : Number of all respondents age 15-24	

Correct answer to question 2 "Can a person reduce the risk for getting HIV by using a condom every time they have sex?"

	All (15-24)	All Males (15-24)	Males (15-19)	Males (20-24)	All Females (15-24)	Females (15-19)	Females (20-24)
Percentage (%): Percentage of respondents who gave a correct answer to question 2		88.4	86.6	90.6	46.3	70.4	85.6
Numerator : Number of respondents/population who gave correct answer to question 2							
Denominator : Number of all respondents age 15-24							

Correct answer to question 3 "Can a healthy-looking person have HIV"?

	All (15-24)	All Males (15-24)	Males (15-19)	Males (20-24)	All Females (15-24)	Females (15-19)	Females (20-24)
Percentage (%): Percentage of respondents who gave a correct answer to question 3		89.9	90.7	88.9	69.4	63.8	73.6
Numerator : Number of respondents/population who gave correct answer to question 3							
Denominator: Number of all respondents age 15-24							

Correct answer to question 4 "Can a person get HIV from mosquito bites?" (Or country specific question)

	All (15-24)	All Males (15-24)	Males (15-19)	Males (20-24)	All Females (15-24)	Females (15-19)	Females (20-24)
Percentage (%): Percentage of respondents who gave a correct answer to question 4		77.7	75.3	80.7	73.7	67.2	78.8
Numerator : Number of respondents/population who gave correct answer to question 4							
Denominator : Number of all respondents age 15-24							

Correct answer to question 5 "Can a person get HIV from sharing food with someone who is infected?" (Or country specific question)

	All (15-24)	All Males (15-24)	Males (15-19)	Males (20-24)	All Females (15-24)	Females (15-19)	Females (20-24)
Percentage (%): Percentage of respondents who gave a correct answer to question 5		87.1	84.4	90.5	83.9	76.5	89.6
Numerator : Number of respondents/population who gave correct answer to question 5							
Denominator : Number of all respondents age 15-24							

1.2 Sex before age of 15

Indicator 1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15

Is indicator/topic relevant? Yes
Is data available? Yes
Data measurement tool / source: DHS
Other measurement tool / source:

From date: 2007
to date: 2007

Additional information related to entered data. E.g. reference to primary data source, methodological concerns:
Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source:

Data measurement tool / source: DHS 2007
Sample size - Number of Survey Respondents:

	All (15-24)	All Males (15-24)	Males (15-19)	Males (20-24)	All Females (15-24)	Females (15-19)	Females (20-24)
Percentage (%): Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15		14.7	18.9	9.6	1.l7	2.1	1.4
Numerator : Number of respondents (aged 15-24 years) who report the age at which they first had sexual intercourse as under 15 years							
Denominator : Number of all respondents aged 15-24 years							

1.3 Multiple Sexual Partners

Indicator 1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months

Is indicator/topic relevant? Yes Is data available? Yes
Data measurement tool / source: DHS
Other measurement tool / source:

From date: 2007 to date: 2007

Additional information related to entered data. E.g. reference to primary data source, methodological concerns:
Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source:

Data measurement tool / source: DHS
Sample size - Number of Survey Respondents:

	All	Males (all ages)	Males (15-19)	Males (20-24)	Males (25-49)	Females (all ages)	Females (15-19)	Females (20-24)	Females (25-49)
Percentage (%): Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months		4.0	14.1	17.6		1.1		1.4	
Numerator : Number of respondents aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months									
Denominator : Number of all respondents aged 15-49									

1.4 Condom use during higher risk sex

Indicator 1.4 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*

Is indicator/topic relevant? Yes Is data available? Yes
Data measurement tool / source: DHS 2007
Other measurement tool / source:

From date: 2007 to date: 2007

Additional information related to entered data. E.g. reference to primary data source, methodological concerns:
Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source:
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Data measurement tool / source: DHS
Sample size - Number of Survey Respondents:

	All	Males (all ages)	Males (15-19)	Males (20-24)	Males (25-49)	Females (all ages)	Females (15-19)	Females (20-24)	Females (25-49)
Percentage (%): Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse		11.3				4.6			
Numerator : Number of Respondents (aged 15-49) who reported having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex									
Denominator : Number of Respondents (15-49) who reported having had more than one sexual partner in the last 12 months									

1.5 HIV Testing in General Population

Indicator 1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results

Is indicator/topic relevant? Yes Is data available? Yes
Data measurement tool / source: DHS
Other measurement tool / source:

From date: 2007 to date: 2007

Additional information related to entered data. E.g. reference to primary data source, methodological concerns:
Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source:

Data measurement tool / source:
Sample size - Number of Survey Respondents: 658

	All	Males (all ages)	Males (15-19)	Males (20-24)	Males (25-49)	Females (all ages)	Females (15-19)	Females (20-24)	Females (25-49)
Percentage (%): Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results			19.9	21.9		6.4	1.1		
Numerator : Number of respondents aged 15-49 who have been tested for HIV during the last 12 months and who know their results									
Denominator: Number of all respondents aged 15-49, including those who have never heard of HIV or AIDS.									

1.6 Reduction in HIV prevalence

Indicator 1.6 Percentage of young people aged 15-24 who are living with HIV*

Is indicator/topic relevant? Yes
Is data available? Yes
Data measurement tool / source: Antenatal clinic registries
Other measurement tool / source:

From date: 2013
to date: 2013

Additional information related to entered data. E.g. reference to primary data source, methodological concerns:
Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source:

Data measurement tool / source:
Sample size - Number of Survey Respondents:

	Total (15-24)	15-19	20-24
Percentage (%) : Percentage of young people aged 15–24 who are living with HIV	0		
Numerator : Number of antenatal clinic attendees (aged 15–24) tested whose HIV test results are positive	0		
Denominator : Number of antenatal clinic attendees (aged 15–24) tested for their HIV infection status	276		

1.16. HIV Testing and counselling in women and men aged 15 and older

Women and men aged 15 and older

	All	Males (all ages)	Males (15-19)	Males (20-24)	Males (25-49)	Females (all ages)	Females (15-19)	Females (20-24)	Females (25-49)
Number of people who received HIV testing and counselling in the past 12 months and know their results	791					276			
Number: HIV+ out of the number tested	0					0			

Pregnant women (out of total number above)

	All	Males (all ages)	Males (15-19)	Males (20-24)	Males (25-49)	Females (all ages)	Females (15-19)	Females (20-24)	Females (25-49)
Number Number of pregnant women aged 15 and older (out of the total number above) who received testing and counselling in the past 12 months and received their results						276			

1.17.1. Percentage of women accessing antenatal care (ANC) services who were tested for syphilis - Tuvalu

	All
Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit	100

Numerator Number of women attending ANC services who were tested for syphilis at first ANC visit	276
Number of women attending ANC services	276

1.17.2. Percentage of antenatal care attendees who were positive for syphilis

	All	<25	25+
Percentage of antenatal care attendees who were positive for syphilis	0.7		
Number of antenatal care attendees who tested positive for syphilis	2		
Number of antenatal care attendees who were tested for syphilis	276		

1.17.3. Percentage of antenatal care attendees positive for syphilis who received treatment

	All	<25	25+
Percentage of antenatal care attendees positive for syphilis who received treatment	100		
Number of antenatal care attendees with a positive syphilis serology who received at least one dose of benzathine penicillin 2.4 mU IM	2		
Number of antenatal care attendees with a positive syphilis serology	2		

1.17.6. Number of adults reported with syphilis (primary/secondary and latent/unknown) in the past 12 months

	All
Number of adults reported with syphilis during the reporting period	9
Number of individuals aged 15 and older	7467

1.17.7. Number of reported congenital syphilis cases (live births and stillbirths) in the past 12 months

	All
Number of reported congenital syphilis cases (live births and stillbirths) in the past 12 months	0

Number of live births	248

1.17.8. Number of men reported with gonorrhoea in the past 12 months

	All
Number of men reported with gonorrhoea in the past 12 months	1
Number of males aged 15 and older	3620

1.17.9. Number of men reported with urethral discharge in the past 12 months

	All
Number of men reported with urethral discharge in the past 12 months	1
Number of males aged 15 and older	3620

1.17.10. Number of adults reported with genital ulcer disease in the past 12 months

	All
Number of adults reported with genital ulcer disease during the reporting period	0
Number of individuals aged 15 and older	7467

3.1 Prevention of Mother to Child transmission

Indicator 3.1 Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission

Is indicator/topic relevant? Yes

Is data available? Yes

Data measurement tool / source: Numerator from ANC/PMTCT and ART register

Other measurement tool / source: Ministry of Health Surveillance data

From date: 01/01/2013 to date: 12/31/2013
Additional information related to entered data. E.g. reference to primary data source, methodological concerns:
Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source:
Data measurement tool / source:

	Data value
Percentage (%) : Percentage of HIV-positive pregnant women who received antiretroviral medicine to reduce the risk of mother-to-child transmission	0
Numerator : Number of HIV-positive pregnant women who received antiretroviral drugs during the past 12 months to reduce the risk of mother-to-child transmission during pregnancy and delivery	0
1. newly initiated on ART during the current pregnancy	0
2. already on ART before the current pregnancy	0
3. Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B)	0
4. Maternal AZT (prophylaxis component during pregnancy and delivery of WHO Option A or WHO 2006 guidelines)	0
5. Single dose nevirapine (with or without tail) ONLY Please note that the final published value for PMTCT coverage will not include single dose nevirapine. However, this data is collected in the reporting tool during the phase out period.	0
6. Other (please comment: e.g. specify regimen, uncategorized, etc.) In the Comment Box, for the women reported as receiving an "Other" regimen, please describe the ARV regimen(s) and the number of women receiving each regimen category.	0
If disaggregation's 1 and 2 are not available, please provide the total number of pregnant women on Lifelong ART	0
Denominator : Estimated number of HIV-positive pregnant women who delivered within the past 12 months	2

3.3 Mother to Child Transmission of HIV (Modelled)

Indicator 3.3 Estimate percentage of child HIV infections from HIV positive woman delivering in the past 12 months

Is indicator/topic relevant? Yes Is data available? Yes
Data measurement tool / source: SPC estimations
Other measurement tool / source: Ministry of Health Surveillance Data

From date: 01/01/2013 to date: 12/31/2013
Additional information related to entered data. E.g. reference to primary data source, methodological concerns:
Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source:

Data measurement tool / source: GARPR

	Data value
Percentage (%) : Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	0
Numerator : Estimated number of children who will be newly infected with HIV due to mother-to-child transmission among children born in the previous 12 months to HIV-positive women	0
Denominator : Estimated number of HIV positive women who delivered in the previous 12 months	2

SPC Estimations used. The estimated number of women living with HIV is 2 and the estimated number of children born to women is 0,0074.

3.4 Pregnant Woman who know they HIV Status

Indicator 3.4 Pregnant women who know their HIV status

Is indicator/topic relevant? Yes Is data available? Yes
Data measurement tool / source: Please specify
Other measurement tool / source: Ministry of Health Surveillance Data

From date: 01/01/2013 to date: 12/31/2013
Additional information related to entered data. E.g. reference to primary data source, methodological concerns:
Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source:
Data measurement tool / source: ANC registers

Percentage (%) - Percentage of pregnant women who were tested for HIV and received their results - during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status:

Numerator - Number of pregnant women who were tested for HIV in the last 12 months and received their results - during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status

	Data value
: Total number tested (including previously known positives)	276
: Total number tested and received results (including previously known positives)	276
: Total number testing positive (including previously known positives)	0

(a) Total number of pregnant women attending ANC who were tested during ANC and received results or knew their positive status

	Data value

: Total number tested (including previously known positives)	276
: Total number tested and received results (including previously known positives)	276
: HIV+ out of number tested (including previously known positives)	0

(a.i) Number of pregnant women with unknown HIV status attending ANC who were tested during ANC and received results

	Data value
Number tested	0
Number tested and received results	0
HIV+ out of number tested	0

(a.ii) Number of pregnant women with known HIV+ infection attending ANC for a new pregnancy

	Data value
Number of HIV+ pregnant women 1	0

(b) Number of pregnant women with unknown HIV status attending L&D (labor and delivery) who were tested in L&D and received results

	Data value
Number tested	0
Number tested and received results	0
HIV+ out of number tested	0

(c) Number of women with unknown HIV status attending postpartum services within 72 hours of delivery who were tested and received results

	Data value
Number tested	0
Number tested and received results	0
HIV+ out of number tested	0

Denominator - Estimated number of pregnant women: 276

7. Indicators for Target 6: Close the global AIDS resource gap

Indicator 6.1 Domestic and international AIDS spending by categories and financing sources

7.1. Prevalence of recent intimate partner violence

Percentage (%) Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months – 33,3% (DHS 200&)

8. Discriminatory attitudes towards people living with HIV

Indicator 8.1 Percentage of woman and men age 15-49 who report discriminatory attitudes towards people living with HIV

Is indicator/topic relevant? Yes Is data available? Yes
Data measurement tool / source: DHS 2007
Other measurement tool / source:

From date: 2007 to date: 2007
Additional information related to entered data. E.g. reference to primary data source, methodological concerns:
Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source:

Data measurement tool / source: DHS 2007

As this indicator is new, it is likely that many countries will not be able to report on the indicator during the 2014 reporting round. Instead, countries are requested to report data from the previous version of question 1, 'Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had the AIDS virus?' This question has been routinely collected in DHS in many countries. In future reporting rounds, countries should report on the full indicator.

Sample size - Number of Survey Respondents: 1374

Answered "No" or "It depends" to question 1 "Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?"

	All	Females (all ages)	Females (15-19)	Females (20-24)	Females(25-49)	Males (all ages)	Males (15-19)	Males (20-24)	Males (25-49)
Percentage (%) : Percentage of Respondents (aged 15–49 years) who respond "No" or "It depends" to question 1		66.2	66.1	75.3		56.9	50.5	62.6	
Numerator : Number of Respondents (aged 15–49 years) who respond "No" or "It depends" to question									
Denominator : Number of all Respondents aged 15–49 years who have heard of HIV									

Data for the rest of the questions not available as the study was based on a different set of questions.

9. Indicators for Target 9: Eliminate travel restrictions (No Data Reported)

Travel restriction data is collected directly by the Human Rights and Law Division at UNAIDS HQ, no reporting needed

10. Best practices

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

11. Major challenges and gaps

Challenge 1: Outer island access
Remedial Action: TUFHA and MoH have started health education programs in the islands (except the island of Vaitupu). Three sessions were conducted in year 2011.

Challenge 2: Ongoing stigma towards people living with PLWHA
Remedial Action: Two HIV ambassadors (sponsored by PIAF) were invited from Fiji to talk openly about their HIV status.

Challenge 3: Targeting programs at seafarers who are identified as a MARP population in Tuvalu.
Remedial Action: Review and develop new seafarers STI and HIV Training program

Challenge 4: Targeting MSM who are now being recognized as an emerging MARP in Tuvalu

Remedial Action: Anecdotal studies reveal that MSM are coming out openly about their status to health practitioners and future programs will be designed specifically at them
Challenge 5: Changing the Cultural Perception of HIV and its related diseases. For instance, mass condom promotion is not acceptable in the Tuvaluan community.

Remedial Action: It will take a long time to change these beliefs. Inviting HIV ambassadors to talk openly about their status was an eye- opening event for the people.
Challenge 6: Late disbursement of grants delays projects.

Remedial Action: Discussion with funding bodies to address this issue
Challenge 7: Frequent changes in the reporting format requirement by funding bodies, consumes a lot of time to meet expectations.
Remedial Action: Discussion with funding bodies to address this issue

Challenge 8: Obtaining support from the senior generation for HIV and its related programs
Remedial Action: Design programs to target parents of youths

Challenge 9. Knowledge and behaviours in youth are indicative of the risk of contracting HIC/AIDS and STIs, especially in seafarer.
Remedial Action: Design programs for groups at risk

12. Recommendations

Program Management
- Technical assistance needed
- Increase in funding

 Policy/ Coordination
- Public consultations for HIV policies and legislation
- This will increase awareness to the general public that such polices and legislation exist

 Prevention
- Capacity building for staff on HIV and its related diseases
- Increase awareness of HIV and its related diseases
- Extend preventive programs to outer islands
- Encourage staff to do program evaluation
- Extend screening for HIV and its related diseases to outer islands
- Development of IEC materials in Tuvaluan language

 HIV Testing and Counseling
- Production of regular newsletters on HIV and its related diseases in English and Tuvaluan language
- Recruit more certified HIV counselors

 Treatment, Care and Support
- Ongoing training for clinical core team in treatment, care and support
- Continue funding for ART

 Knowledge and Behavior Change
- To conduct the next BSS survey

 Financing, Human Resources
- Increase in salary for staff working in STI and its related diseases
- Housing allowance for staff
- Incentive for timely and quality reports

 Surveillance
- Computerized database system
- Increase staff motivation to do surveillance
- Conduct surveillance- specific programs

 M & E and Technical Assistance
- Encourage stakeholders to do M&E
- Training on M&E
- On-site technical assistance on M&E