REGIONAL SEXUAL REPRODUCTIVE HEALTH PROGRAMME

KIRIBATI | SAMOA | SOLOMON ISLANDS | TONGA | VANUATU

KIRIBATI

Sexual and Reproductive Health Rights Needs Assessment

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NEW ZEALAND FOREIGN AFFAIRS & TRADE Aid Programme

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ABBREVIATIONS

ABR	Adolescent birth rate
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
CoC	Continuum of Care
CPR	Contraceptive prevalence rate
CSO	Civil Society Organization
EOC	Essential Obstetric Care
EmOC	Emergency Obstetric Care
EmNOC	Emergency Neonatal and Obstetric Care
FBO	Faith Based Organisation
FP	Family Planning
GBV	Gender Based Violence
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HDI	Human Development Index (UNDP)
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant mortality rate
MA	Medical Assistant
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MHMS	Ministry of Health and Medical Services
NSO	National Statistics Office
NGO	Non-Government Organisation
PoA	Plan of Action
PICCT	Provider-initiated confidential counselling and testing [for STIs and HIV]
PICTs	Pacific Island Countries and Territories
PPTCT	Prevention of parent to child transmission [of HIV]
PPH	Postpartum Haemorrhage
SDGs	Sustainable Development Goals
SPC	Secretariat of the Pacific Community
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCCT	Voluntary Confidential Counselling and Testing [for HIV and STIs]
WHO	World Health Organization

EXECUTIVE SUMMARY

The Republic of Kiribati (Kiribati) has achieved mixed progress in incorporating gender and rights into its national sexual and reproductive health (SRH) agenda. This report reviews Kiribati's rights-led approach to sexual and reproductive health and presented within are the results of the Sexual and Reproductive Health Rights (SRHR) Needs Assessment, conducted during an In-Country mission in November-December 2014. The work was commissioned by the Ministry of Health and Medical Services (MHMS), Kiribati; and technical support and funding was provided by UNFPA, Pacific Sub Regional Office and its contracted consultants.

The SRHR Needs Assessment included a comprehensive literature review and in-country qualitative and quantitative data collection from key informant interviews and focus group discussions with key senior MHMS personnel, medical assistants (MAs) working at 15 randomly selected health facilities in South Tarawa, Abaiang and Abemama and with relevant non-government organizations (NGOs).

Consultations were guided by UNFPA's *SRHR Needs Assessment Tools for SRHR, and HIV* (Appendix 2), and collected information on partnerships, policy, SRH service delivery and its key enabling factors, family planning, mother and newborn health, prevention and management of sexually transmitted infections (STIs) and HIV and gender based violence management.

Commitment to rights-based health and social development: Kiribati is committed to preserving the human rights of all I-Kiribati's including the most vulnerable groups: females, children and young people. Kiribati's commitment is evidenced by the signing of a range of international conventions and treaties, including the *Convention on the Elimination of All Forms of Discrimination Against Women* (1995), the *Convention on the Rights of the Child* (1993), and *The Convention on the Rights of Persons with Disabilities* (2007).

Other international commitments for the promotion of gender equity and equality include: Kiribati's pledge to the *International Conference on Population and Development (ICPD) Plan of Action, The Moana Declaration 2013*, where Parliamentarians re-committed to advocating for the International Conference on Population and Development (ICPD) Programme of Action (PoA) and the key actions for implementation, the Millennium Development Goals and endorsement of the *Pacific Sexual Health and well-being Shared Agenda 2015-2019.*

At the national level, the Kiribati National Development Strategies Policy (2008-2011) and the National Health Strategic Plan (2012-2015) guides programme plans and actions. Strategic health objectives include:

- Increase access to and use of high quality, comprehensive family planning services, particularly for vulnerable populations including women whose health and wellbeing will be at risk if they become pregnant;
- Improve maternal, newborn and child health;

- Prevent the introduction and spread of communicable diseases, strengthen existing control programmes and ensure Kiribati is prepared for any future outbreaks;
- Address gaps in health service delivery and strengthen the pillars of the health system; and
- Improve access to high quality and appropriate health care services for victims of gender based violence, and services that specifically address the needs of youth.

A young and growing nation: Kiribati is a demographically challenged Pacific Island nation due to its increasing population, low topography, rising sea levels, need to adapt to climate change and issues with sufficient supplies of fresh water. There are also significant challenges delivering health programmes as 46% of the population live in rural settings and 55% of the population are under 25 years of age.

Health priorities and status: The rising population, combined with the remoteness of many of Kiribati's coral atolls, provides an on-going challenge for the Ministry of Health and Medical Services to provide universal access to sexual and reproductive health services. This spread of the rural population across 33 widely scattered islands poses high risks for unintended pregnancies, unsafe abortions, complications during pregnancy and delivery, especially for teenage girls, as well as the transmission of sexually transmitted infections (STIs) and HIV.

Despite the considerable difficulty in providing adequate basic services to the I-Kiribati, especially the outer island rural population, the overarching goal of Kiribati's National Health Strategic Plan (2012-2015) is *'continuous improvement in the provision and delivery of preventative and curative health services and equitable distribution of the benefits attained nationwide through effective and efficient allocation of scarce resources and good governance (accountability and transparency)'.*

Key issues to address in the Kiribati health sector include:

- High population growth;
- High maternal morbidity (including macro and micro nutrient deficiency) and mortality;
- High child morbidity (including malnutrition and childhood injuries) and mortality;
- High burden and incidence of communicable diseases (TB, leprosy, lymphatic filariasis, STIs and HIV/AIDs;
- High burden and incidence of other diseases (Non-communicable diseases); and
- Gaps in health services delivery.

The percentage of women of reproductive age who are using (or whose partner is using) a contraceptive method at a particular point in time, also known as contraceptive prevalence rate (CPR) is one of the lowest rates (18%) in the region, and is well below the MHMS target of 57%. This in turn equates to Kiribati having a high adolescent birth rate of 49%, which although was high at 60% in 1990, has been down to 39% in 2005.

Gender equity and equality: Gender can be explained as the accepted economic, political, and socio-cultural attributes, constraints, and opportunities associated with being identified in the broader society as a girl, a boy, a woman, a man, or as a gender non-conforming individual and the expectations of each of these as defined at the individual, family, community, and at organizational levels.

Political level representation of women at the national level has improved in Kiribati with a 23% female representation in ministerial positions. Although many of the indicators presented in this report are female orientated, compare to men, women rate poorly on many developmental indicators. Physical and sexual violence against women remains a concern throughout Kiribati, and a women's decision to use family planning and contraceptives is highly influenced by her male partner.

Findings Policy: A key policy finding is the need to expedite the finalization, endorsement and roll out (into local practice culture) of the recently developed *Sexual and Reproductive Health (and HIV linkages) Policy.*

At a national level there are a number of policies that currently guide health and social development including:

- Policy and Clinical Protocols for Minimum Standards of Treatment of Survivors of Gender Based Violence (2013);
- Kiribati Algorithm SOP (Aug, 2013);
- Syndromic Approach Protocol for STIs PPTCT Policy & Guidelines;
- Kiribati HIV Testing & Counselling Policy & Guidelines;
- Youth Friendly Health Services National Operational Guidelines (2010); and
- Obstetrics & Gynaecology Clinical Guidelines for Medical Assistants & Nurses Working In Health Centres and Clinics, Kiribati (2011).

Findings: System: Although Kiribati relies heavily on funding from development partners, which presents a challenge in terms of sustaining specialist services, the country has a well-established, publically funded health system that puts SRHR at the forefront of MHMS operations, as is specified (directly and indirectly) in five of six MHMS key strategic indicators for 2011-2015.

The MHMS Strategic Plan 2012-2015 recommends the use of the Health Sector Coordinating Committee as central to supporting its implementation. It also specifies the importance of relationships with bi-lateral and international development partners and highlights the importance of inter-sectoral coordination including the need to work with other Kiribati government departments and agencies, NGOs and community-based groups.

Findings Service delivery: Of the 15 facilities assessed, they all provided a range of SRH and HIV services, either in house and/or through outreach health programmes that included: antenatal care, family planning services, prevention and management of STIs, maternal (ANC) and newborn care, prevention and management of gender based violence and prevention of unsafe abortion and management of post abortion care. Whilst 6 of the 15 facilities assessed provided all of these services, the remaining 9 provided an average of 3 (Refer to Table 7 within the body of this report).

Conclusions and recommendations: Major challenges to improving SRH and to the delivery of services which meet basic SRHR exist within the Kiribati health system. These include under-staffing, outdated policies and guidelines, inadequate reporting systems and the fiscal and geographical challenges of preventing stock outs of essential drugs and medical consumables in all health facilities, especially the outer islands.

Many of these challenges can be addressed through strong, national-level leadership from within the Ministry of Health and Medical Services Public Health department and through better informed, consultative and collaborative planning and programme implementation.

A key recommendation that can guide a more integrated approach to providing SRH and HIV services in Kiribati is to expedite the finalization, endorsement and roll out into local practice culture, of the recently drafted *Sexual and Reproductive Health (and HIV linkages) Policy.*

As importantly, it is crucial for SRHR advocates and stakeholders both in Kiribati and the region, to rigorously and consultatively identify gender and other social determinants of health within each local context and integrate findings into SRH programme designs, in an effort to address the impact of activities on women, girls, boys, and men, with the ultimate goal of promoting equal access to health care for all.

1. INTRODUCTION

The Republic of Kiribati (Kiribati) is considered to be one of the most demographically challenged Pacific Island nations due to its increasing population, low topography, rising sea levels, need to adapt to climate change and issues with sufficient supplies of fresh water[1].

Kiribati covers a land area of 811 square kilometres and for administrative purposes is divided into three major island groups: the Gilbert Islands (Kiribati), the Line Islands and the Phoenix Islands. The people of Kiribati, known as I-Kiribati, are of Micronesian descent and have a strong traditional and conservative culture. Over 90% of the population live in the Gilbert group of islands, which includes the country's capital, Tarawa.

In 2014, Kiribati had an estimated population of 111,058 living on 33 widely scattered atolls spread over a vast ocean area lying on the equator. The annual population growth rate is 2.1% and the urban population makes up 54% of the population[2].

Like many other Pacific Island countries and territories (PICTs), the most populous areas in Kiribati are confined to the coast as arable land is limited and there are limitations to the availability of land for settlement. The marine environment in Kiribati is vulnerable to pollution and the options for waste management are limited. Many migrants from the outer islands to South Tarawa are living in squatter settlements. Betio, which has one of the highest population densities in the world, also has a large population of squatters who live in poor housing, cramped conditions and have poor access to clean water and proper sanitation[3].

Based on the 2013 Human Development Index (HDI), Kiribati's rate is currently 0.607%, which ranks the country at 133 of 187 countries and territories. This indicates that Kiribati lies in the medium HDI range and has seen an increase of 1.4% when compared with a HDI of 0.599 in 2010[4&5] .

Kiribati is committed to preserving the human rights of all I-Kiribati's including females, children and young people, who are considered to be among the most vulnerable groups. Kiribati's commitment is evidenced by the signing of a range of international conventions and treaties, including the *Convention on the Elimination of All Forms of Discrimination Against Women* (1995), the *Convention on the Rights of the Child* (1993) and the *Convention on the Rights of Persons with Disabilities* (2007). Commitments have also been made to upholding the SRHR of I-Kiribati's, specifically through the promotion of gender equity and equality, evidenced by a commitment to the International Conference on Population and Development (ICPD) Plan

1 Ministry of Health, Kiribati and UNFPA (2014), Family Planning and Reproductive Health Commodity Security Needs Assessment.
2 Ibid
3 UNFPA (2006), Adolescent Sexual and Reproductive Health Situational Analysis for Kiribati.
4 UNDP (2014), Human Development Report 2014, Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience, Explanatory note on the 2014 Human Development Report composite indices, Kiribati HDI.
5 Note: *The HDI is a summary measure for assessing long-term progress in three dimensions of human development: 1) A long and healthy life; measured by life expectancy, 2) Access to knowledge; measured as the average number of years of education received in a life-time for those aged 25 years and older and the total number of years of schooling a child of school-entry age can expect to receive (if patterns of age-specific enrolment rates stay constant throughout the child's life) and; 3) a reasonable standard of living, measured by Gross National Income (GNI) per capita. The HDI is an average measure of basic human development achievements in a country. Like all averages, the HDI masks inequality in the distribution of human development across the population at the country level. HDI is based primarily on international data from the United Nations Population Division, the United Nations Educational, Scientific and Cultural Organization Institute for Statistics and the World Bank.*

of Action, the Moana Declaration 2013, where Parliamentarians re-committed to advocating for the International Conference on Population and Development (ICPD) Programme of Action (PoA) and the key actions for implementation and the Millennium Development Goals. Other commitments have included Kiribati endorsing the Pacific Sexual Health and Well-being Shared Agenda 2015-2019.

1.1 Sexual and Reproductive Health Rights (SRHR)

Sexual and reproductive health rights are fundamental human rights and are integral to the well-being of all populations including adolescents, youth and men and women of reproductive age.

In practise, this means that individuals, both women and men have the means to have a healthy sexual life and have the number of children they want, when they want them. It also means women can deliver their babies safely and have access to quality services and information that will ensure their newborns survive. A comprehensive sexual and reproductive health care package has three key principal components: family planning, sexual health, and maternal health.

In an effort to help decision makers to evaluate future SRHR investments for Kiribati, a needs assessment was commissioned by the Ministry of Health and Medical Services, Kiribati and this report will constitute part of a comprehensive collaboration to inform a revised Reproductive Health Strategy for Kiribati.

1.2 Kiribati's Public Health System

Kiribati has a well-established, publicly funded health system administered by the Central Ministry of Health and Medical Service (MHMS), under the guidance of the Honourable Minister for Health. A parallel traditional health system also exists and I-Kiribati tend to use both formal and traditional systems, however there is no coordination between the two[6].

Apart from the National office, there are four levels of public health services in Kiribati that include:

- Tungaru Central Hospital which is the central referral hospital located in South Tarawa and is operated by doctors, nurses and allied health staff;
- Three other referral hospitals at: Betio (in Tarawa), Kiritimati Island (for the Line and Phoenix Island groups), and Tabiteuea North (for the southern Gilbert Islands). These are also operated by doctors, nurses and allied health staff;
- Thirty health centres that provide primary health care, curative and preventative services, operated by medical assistants, registered nurses who have undergone additional medical assistant training; and
- Seventy five health clinics/dispensaries that provide basic primary clinical care, public health education and awareness programmes and immunisation services, operated by nurse aids, who are trained to recognise the early signs of illness but do not dispense medications[7].

6 WHO (2011), Kiribati, Country Health Profile Information.
7 WHO (2012), Health Service Delivery Profile, Kiribati.

1.3 Overall Health Priorities and Status in Kiribati

The 2012-2015 Kiribati National Health Strategic Plan (NHSP) currently guides health priorities for the country and the MHMS has endeavoured to incorporate a rights based methodology into the plan and it clearly states that strategies and actions need to be relevant, appropriate, equitable and pro-poor.

Despite the considerable difficulty in providing adequate basic services to the I-Kiribati, especially the outer island rural population[8], the overarching goal of Kiribati's Ministry of Health and Medical Services Strategic Plan (2012-2015) is 'continuous improvement in the provision and delivery of preventative and curative health services and equitable distribution of the benefits attained nationwide through effective and efficient allocation of scarce resources and good governance (accountability and transparency)'[9].

The strategic objectives for the MHMS for the period 2012–2015 are to:

- Increase access to and use of high quality, comprehensive family planning services, particularly for vulnerable populations including women whose health and wellbeing will be at risk if they become pregnant;
- Improve maternal, newborn and child health;
- Prevent the introduction and spread of communicable diseases, strengthen existing control programmes and ensure Kiribati is prepared for any future outbreaks;
- Strengthen initiatives to reduce the prevalence of risk factors for NCDs, and consequently reduce morbidity, disability and mortality from NCDs;
- Address gaps in health service delivery and strengthen the pillars of the health system; and
- Improve access to high quality and appropriate health care services for victims of gender based violence, and services that specifically address the needs of youth.

Kiribati has a number of national social plans and policies relevant to ICPD priorities[10]. These include:

- Kiribati Health Strategic Plan (2012-2015)
- National HIV and STI Strategic Plan (2013-2016)
- Kiribati Development Plan (2008-2011)
- Kiribati National Development Strategies (2008-2011)
- National Population Policy (2005)

Other social policies include policies for Youth; Disability; Indigenous people; Urbanization; Family Wellbeing; Gender and Education.

8 UNFPA (2006), Adolescent Sexual and Reproductive Health Situational Analysis for Kiribati.
9 Ministry of Health and Medical Services (MHMS). Strategic plan 2012-2015. Tarawa, Government of Kiribati, 2012.
10 UNFPA (2013), Pacific Regional ICDP Review: Review of the Implementation of the International Conference on Population and Development Programme of Action Beyond 2014, UNFPA Pacific Sub-Regional Office.

The 2013 review of the ICPD PoA in the Pacific also reported that SRH was an integral component of primary health care, that referral mechanisms and guidelines exist and that health workers had received training on the elimination of stigma, SRH, rights and HIV (UNFPA, 2013, p.25)[11]. *Note: A Sexual and Reproductive Health (and HIV linkages) policy has recently been drafted and is currently with UNFPA for finalisation.*

In 2013 the MHMS identified six key health issues (Refer to table 1 below) in the Kiribati National Development Plan (2012-2015), of which 5 (Issue 1-4 and 6) are SRH and HIV centric.

Table 1: Key Health Issues and Strategies[12].

Issues	Strategies
1. High population growth	- Promote family planning services - Strengthen partnerships with FBOs
2. High maternal morbidity (including macro and micro nutrient deficiency) and mortality	- Improve delivery of emergency and obstetric care services - Improve access to antenatal and postnatal care
3. High child morbidity (including malnutrition and childhood injuries) and mortality	- Expand Continuity of Care (CoC), EPI coverage and IMCI services for children at risk
4. High burden and incidence of communicable diseases (TB, leprosy, lymphatic filariasis, STIs and HIV/AIDs)	- Strengthen DOTS services and existing diseases surveillance and outbreak responses for TB, leprosy, lymphatic filariasis, STIs and HIV/AIDS
5. High burden and incidence of other diseases (Non-communicable diseases)	- Improve outreach of NCDs services (curative) - Improve and expand coverage on awareness of the root causes of NCDs (prevention) - Improved screening, detection and access to treatment services for all NCDs
6. Apparent gaps in health services delivery	- Re-assess human resource needs and address gaps/issues - Strengthen post and basic training amongst service providers - Provide equipment and maintenance including training on how to operate complex health machines.

Other key results of the 2013 ICPD PoA review (that correspond to ICPD priorities), indicate that Kiribati has:

- Increased women's availability to SRH information and counselling;
- Assessed the unmet need for contraceptive services; and
- Emergency Obstetric Care (EmOC) programmes in place, however the provision of EmOC in the outer Islands is not adequate.

11 Ibid.
12 Ministry of Health and Medical Services, Kiribati, (2013), Kiribati Health Strategic Plan 2012 – 2015.

In 2012, through UNFPA's regular resources and Australian Agency for International Development (Australian AID) and New Zealand Ministry of Foreign Affairs and Trade (NZMFAT) contributions, support was provided for EmNOC in Kiribati in the form of an EmONC needs assessment training for 10 senior midwives and a refresher training based on National Obstetrics and Gynecology Guidelines. This resulted in up-skilling 10 female and male medical assistants[13].

1.4 Population, Social Development and Health Related Indicators

The population of Kiribati is expected to increase from 111,000 in 2014 to 186,000 by 2050. The rising population combined with the remoteness of many of Kiribati's coral atolls provides an on-going challenge for the Ministry of Health and Medical Services to provide universal access to sexual and reproductive health services. This spread of the rural population across 33 widely scattered islands poses high risks for unintended pregnancies, unsafe abortions, complications during pregnancy and delivery, especially for teenage girls, as well as the transmission of sexually transmitted diseases (STIs) and HIV.

In 2011, the age dependency ratio in Kiribati was 68% (measured as: those 15-29 years as a percentage of those less than 15 years and greater than 29 years). Kiribati has a young population with 55% of the population under 25 years, of which 35% are under the age of 15. The leading causes of death in Kiribati are shown in Table 2[14].

Table 2: Leading underlying causes of death in Kiribati.

Rank	All (Male and Female)		
No.	Cause of Death	No. of Deaths	As a % of all Deaths
1	Ill-defined diseases	80	16.6
2	Other digestive diseases	42	8.7
3	Other cardiovascular diseases	41	8.5
4	Cerebrovascular diseases	33	6.9
5	Lower respiratory infections	30	6.2
6	Diabetes mellitus	26	5.5
7	Diarrhoeal diseases	17	3.5
8	Other infectious diseases	17	3.5
9	Endocrine diseases	16	3.3
10	Protein-energy malnutrition	14	2.9
Total Leading Causes		**316**	**64%**
All Deaths		**494**	**100%**

13 UNFPA (2013), UNFPA Pacific Sub Regional Office, 2012 Annual Report.
14 MHMS Kiribati, (2011), Health Information System data.

Table 3 below provides a narrative summary of mixed progress for Kiribati against MDGs, however current numerical progress data was not available for all MDG's[15].

Table 3: Summary of Kiribati's progress (2013) against MDGs.

MDG	Progress	Description of Progress
	OFF TRACK	• Kiribati's economy continued to recover from the global financial crisis and recovery continued to be driven by infrastructure projects, which were unlikely to create a sufficient number of jobs to "pull households out of hardship and inflation is high so households continued to struggle". • High prevalence of underweight children and evidence of food poverty in the outer islands.
	MIXED PROGRESS	• Although survival and literacy rates had improved, there was a fall in school enrolment rates due to transportation issues and low perceived value of education, especially in the outer islands.
	MIXED PROGRESS	• More girls were attending high school but there was an emerging concern about boys enrolling and staying in high school. • Whilst the representation of women in parliament has increased (to 4 in 2011 elections), there continues to be low economic participation of women.
	MIXED PROGRESS	• Under 5 infant mortality has declined, there is 89% immunisation coverage, Poliomyelitis free since 2002. • Child mortality rates remain high with diarrhoeal diseases and respiratory infections the major cause of child mortality. • There are gaps in the quality of health services, especially to the outer islands.
	MIXED PROGRESS	• The key concern is the difficulty in gauging the number of maternal deaths. • Skilled birth attendants have increased. • The number of traditional birth attendant's has decreased and those remaining now receive basic midwifery training. • Integrated Management of Childhood Illnesses (IMCI) are in place.
	OFF TRACK	• High incidence of STIs with poor referral and treatment services and low condom use. • High levels of stigma and fear could be discouraging the uptake of ART services as 28 positive HIV cases recorded, but only 6 on ART. • No malaria in Kiribati • TB cases increased, due to high density housing and overcrowding in urban areas, although treatment under DOTS has improved.
	OFF TRACK	• As the largest protected marine area in the world, Kiribati is extremely vulnerable to climate change and there is limited capacity to integrate the principles of sustainable development across all sectors. • There are water quality and sanitation issues including untreated sewage and open defecation.

15 Pacific Islands Forum Secretariat (2013), Pacific Regional MDG's tracking report, pg. 16.

1.5 Reproductive Health Indicators

The first three MHMS strategic objectives (2012-2015) as previously discussed (Refer Section in 1.3), reflect substantial prioritisation of maternal, child and newborn health and HIV and STI programmes, however, as shown in summary in table 3, the results against the reported MDG 3, 4 and 5 are mixed and MDG 6 is off track. Table 4 below shows results for Kiribati's key fertility and SRH related mortality indicators.

Table 4: Kiribati fertility and mortality indicators[16].

Crude Birth Rate (CBR) -31.1 (2010)
Total Fertility Rate per woman (2009 – 2010) - 3.9 Teenage fertility rate (2009 – 2010) - 4.9
Mean child-bearing Age - 29.2 yrs. National Average Age First Marriage 22 yrs. (males – 24yrs; females - 21.5 yrs.).
Crude death rate (CDR) –7.8 (2010); National life expectancy at birth - 63.2 yrs. (59.7yrs for males and 67.5 yrs. for females).
National Infant mortality rate (IMR) for 2010 - 45 male infants - 50; females – 39;
Child mortality rate – 45; males – 16; F/males - 11
Under 5 mortality rate – 59; (males - 66; females - 50 (NSO, 2012).
Maternal mortality ratio (MMR) per 100,000 live births was 130 - (WHO, 2012). *Note: MMR is difficult to calculate in countries with small populations (including Kiribati)*

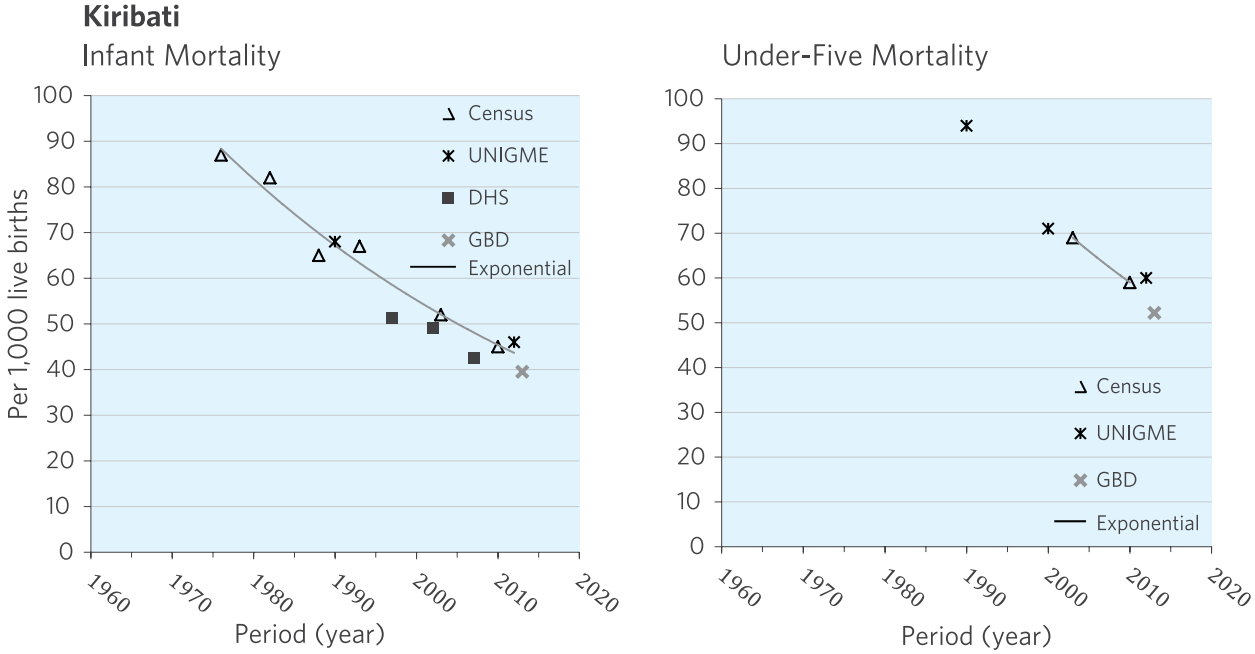
Other sources report:

- 91% of all births are attended by skilled personnel[17]: and
- The total number of maternal deaths reported in 2011 was 3[18].

As reported by SPC (2014) and as depicted in Figure 1 overleaf, "trends in infant and under 5 mortality are declining, but still unacceptably high with infant mortality 40 per 1000,00 live births in 2010" (SPC, pp. 25-26.)[19]

16 National Statistics Office (NSO), Kiribati 2012.
17 Pacific Islands Forum Secretariat (2013), Pacific Regional MDG's tracking report.
18 WHO (2012) Health Service Delivery Profile, Kiribati
19 Secretariat of Pacific Communities (2014), Mortality Trends in Pacific Island States.

Figure 1: Trends in infant and under 5 mortality.



Key: SPC: Secretariat of Pacific Community, UNIGME: United Nations Interagency Group for Child Mortality Estimation, KNSO: Kiribati National Statistics office, WHO: World Health Organization: GBD: Global Burden of Disease Study. Note (SPC 2014): UNIGME and GBD estimates were not included in the trend lines as they are not a primary source of data but were for comparison purposes only.

Universal access to reproductive health is a target under MDG 5 and includes Contraceptive Prevalence Rate (CPR), Adolescent Birth Rate, antenatal clinic (ANC) visits and unmet need for family planning. The most recent results against these indicators for Kiribati include[20]:

- Adolescent birth rate per 1000 females 15-19 years (2011): 11.
- Antenatal coverage – ≥ 1 visit (2009): 88%
- Unmet need for family planning(2009): 28%

The 2010 modern methods Contraceptive Prevalence Rate (CPR) in Kiribati was 18%. This is a deterioration of 14% over a five year period (from 32% in 2005 and 22% in 2007) and is well below the MHMS target rate of 57%.

Figure 1 overleaf shows an increase in adolescent birth rates by 10% in 2010 compared to a decrease of 22% between 1990 -2005 and Figure 2 shows a continued decline in CPR in Kiribati from 2000-2010[21].

20 Mola, G. (2012), Family Planning Needs Assessment.
21 UNFPA (2014), Family Planning and Reproductive Health Commodity Security Needs Assessment -Kiribati

Figure 2: Kiribati Adolescent Birth Rate 1990-2010.

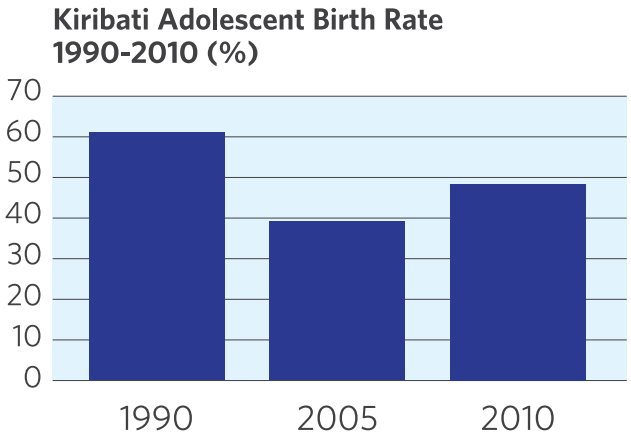
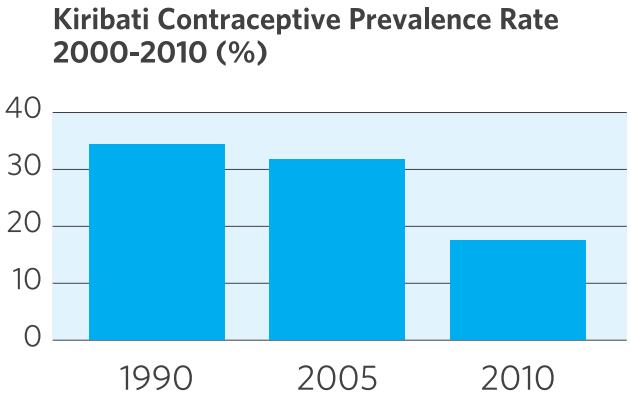


Figure 3: Kiribati CPR Rate 2000-2010.



The CPR rate in Kiribati is one of the lowest in Pacific Island countries. A 2009 demographic health survey showed that women in urban centres are less likely to use a modern family planning method than their rural counterparts. Interestingly, there seems to be access to modern contraceptive methods and services in rural areas[22]. A 2010 pilot outreach project at Temaiku Clinic highlighted that domestic violence was intrinsically linked to decision making around contraceptive use[23].

1.6 STI and HIV prevention and management

In 2013 Kiribati reported prioritising HIV in national programming and reported increased access to STI and HIV programmes and the promotion of condoms to prevent HIV and STI infections, albeit, there is no evidence of sustained long term condom use in most Pacific countries, including Kiribati. It was also reported that Kiribati was also addressing the IDPD Plan of Action (PoA) issue of "eliminating mother-to-child transmission of HIV and treatment for improving the life expectancy of HIV mothers" (UNFPA 2013, pp.27-28)[24].

22 Mola (2012), Family Planning Needs Assessment
23 UNFPA (2013), Annual Report 2012.
24 UNFPA (2013), Pacific Regional ICDP Review: Review of the Implementation of the International Conference on Population and Development Programme of Action Beyond 2014.

Table 5 below shows ANC, HIV, PPTTC and syphilis Indicators 2008-2011.

Table 5: ANC, HIV, PPTTC and syphilis indicators[25]

Indicator	2008	2009	2010	2011
Number of facilities providing ANC services	95	96	96	101
Health Facilities Providing PPTTC & STI Counselling Services	2	2	10	10
Health Facilities Providing ART therapy (including CD4 Testing)	1	1	1	1
Facilities Providing Syphilis Treatment	1	1	1	1
ANC Attendees	2472	2847	2662	2852
% age of ANC Attendees Visiting Health Facilities at Least Once	76	87	82	87
Number and %age of Pregnant Women Tested for HIV			1100 (35%)	1238 (39%)
Pregnant Women Tested Positive for HIV	0	0	0	0
Pregnant Women Tested for Syphilis		1111	793	658
Pregnant Women Tested Positive for Syphilis		40	14	20

1.7 Integration of SRHS and HIV

The impetus to integrate SRHS and HIV includes the need to improve access to a range of these services for both men and women[26]. Apart from the cost saving and sharing aspect of integration, there is a need to integrate SRH and HIV service coverage, as behaviours that prevent HIV transmission also prevent sexually transmitted infections and unintended pregnancies and many HIV infections are sexually transmitted or associated with pregnancy, childbirth, and breastfeeding[27].

There has been a gradual move towards the integration of SRH and HIV programmes across Pacific Island countries. In 2008, in order to meet targets for Universal Access to RH Services and Commodities for MDGs 5A and 5B, the Pacific Ministers for Health Meeting in Nadi, Fiji, through their Pacific Policy Framework (UNFPA,2008), noted that 'sexual and reproductive health, including FP, RHCS and HIV, should be incorporated into national and sub-national development plans'[28].

1.8 Gender Based Violence

As gender based violence (GBV) is prevalent across Pacific Island countries, governments and health systems have worked to integrate GBV prevention and response programmes and training for health workers into their policy agenda. Kiribati has reported providing gender based violence training for health workers and adolescent health programmes that integrate GBV, sexual violence and intimate partner violence prevention and outreach strategies (UNFPA, 2013, p. 28)[29].

25 Ministry of Health and Medical Services, Kiribati (2013), 'Kiribati HIV Testing & Counselling Policy Guidelines', MHMS, (Version 2) 2013
26 Maharaj, P and Cleland, J. (2005), Integration of sexual and reproductive health services in KwaZulu-Natal, South Africa, Oxford University Press & the London School of Hygiene and Tropical Medicine. doi:10.1093/heapol/czi038
27 Warren, C.E., Mayhew, S.H., Vassall, A., Kimani, J. K., Church, K., Dayo Obure, C., Friend du-Preez,N., Abuya, T., Mutemwa, R., Colombini, M., Birdthistle, I., Askew, I and Watts, C., 'Study protocol for the Integra Initiative to assess the benefits and costs of integrating sexual and reproductive health and HIV services in Kenya and Swaziland', BMC Public Health 2012, 12:973 http://www.biomedcentral.com/1471-2458/12/973
28 UNFPA (2009), Pacific Ministers of Health Meeting (2008), Achieving universal access to reproductive health services & commodities: the Pacific policy framework: Pacific Ministers of Health Meeting, November 5-7, 2008 Nadi, Fiji. – UNFPA, Suva, Fiji.
29 Ibid (11)

1.9 Summary of Sexual and Reproductive Health Status in Kiribati

Kiribati have in place a national framework of strategies and policies to address health and social development issues and has endeavoured to incorporate a rights based approach to sexual and reproductive health, which guide health planners and health workers to provide reproductive health services to the I-Kiribati.

Kiribati has made significant achievements in reducing under-five mortality, improving immunisation coverage to 89%, increasing antenatal coverage to 88% and increasing the number of skilled birth attendants.

Although maternal mortality is low in Kiribati, there is a need to establish realistic targets and measure performance in a way that is appropriate for such small population numbers.

Some intractable disparities remain and these include the need to further identify and address the underlying factors that contribute to:

- Poor level of SRH service delivery in and to the outer islands;
- Child mortality rates including water and sanitation issues;
- Unmet need for family planning;
- Low contraceptive prevalence rate;
- Teenage pregnancies;
- High incidence of STI's and poor self-referrals for treatment;
- Low condom use: and
- Poor uptake of ART treatment for all people living with HIV.

"The message from young people is clear—there is no way we can justify a new development framework that does not put young people's issues at the centre of the agenda, including sexual and reproductive health and rights."

Samuel Kissi, Curious Minds
69th session of the United Nations General Assembly[30]

30 UNAIDS (2014), downloaded from: http://www.unaids.org/en/resources/presscentre/featurestories/2014/september/20140923srhr

2. PURPOSE AND METHODOLOGY

The purpose of this needs assessment is to establish the level to which the SRP rights and needs of the population of Kiribati have been met and to assess what needs have not been met. This report provides an overview of the existing available sexual and reproductive health services in Kiribati, identifies the gaps, issues and challenges that exist and provides recommendations to improve rights based sexual and reproductive health services in Kiribati.

The timing of this needs assessment is aligned with the conclusion of the International Conference on Population and Development (ICPD) in 2014, the conclusion of the Millennium Development Goals(MDGs) in 2015 and the design of the Sustainable Development Goals (SDGs) in continuation of the MDGs.

2.1 Desk Review

A thorough desk review was undertaken in April 2015 by a UNFPA Consultant to determine the existence and use of relevant SRH indicators, policies, plans and laws and to assess Kiribati's commitment to a right based approach to sexual and reproductive health services and their delivery across Kiribati.

The desk review explored relevant and available 2000-2014 literature on reproductive health status, service delivery and utilisation and the extent to which services are meeting the needs of the I-Kiribati. National census and demographic information was analysed and findings collated against a range of regional technical reports and reviews.

2.2 Consultative Needs Assessment

The consultative needs assessment was conducted in Kiribati by the Fiji National University (FNU) (contracted by UNFPA), over four weeks in November and December 2014 and included key informant interviews and focus group discussions with health workers in 15 health facilities and dedicated SRH and HIV management personnel from government, non-government and civil society representatives.

Site Selection: After consultation with MHMS personnel at national level, it was agreed to undertake assessments at South Tarawa, Abaiang and Abemama. A total of 21 health workers were interviewed at 15 health facilities were included in this assessment, namely: 4 in South Tarawa, 3 in Betio, Ribono Clinic on Ribono islet and Nuotaea Clinic on Nuotaea islet, 5 in Abaiang and 4 in Abemama. (Refer to **Appendix 4** for a list of Kiribati health facilities visited during this assessment).

The inclusion of Kiritimati (Christmas) Island was considered but logistical challenges prevented its inclusion. This was unfortunate as recent economic developments have seen a migration of I-Kiribati to this once uninhabited island. In 2010 Kiritimati had the third largest population, at 5,586 people compared to other islands of Kiribati. This is slightly more than

Abaiang (5,502 people) and less than North Tarawa (6,102), but small compared to the population of South Tarawa, which is home to around half the total population of Kiribati[31].

Assessment Tool: The Assessment Tool used for key informant interviews with MHMS personnel, health facility managers and for focus group discussions with health workers was provided by UNFPA (Refer to **Appendix 2** for Assessment Tool and to **Appendix 3** for a list of key informants).

2.3 Analysis and Limitations

2.3.1 Analysis:

Section 3 of this report provides the summary and analysis of data collected through the consultative needs assessment. Information is presented in the order established by UNFPA's Pacific Sub Regional Office, within the Need Assessment Tools for Sexual Reproductive Health and Rights, and HIV (Refer to **Appendix 2**). Data discussion and summary tables are presented in the following subsections:

Policy: HIV and STI strategies and policies; gaps and factors which prevent or enable service integration; clinical protocols and service guidelines; stakeholder participation; legislative and legal frameworks which enable/inhibit service development/delivery.

System: Development partners, funding and coordination mechanisms; civil society and stakeholder engagement; planning and management of programmes; human resourcing; capacity development processes and needs; reproductive health commodities; laboratory and programme support services; data management, monitoring and reporting.

Service Delivery: The availability of essential SRH and HIV services; current status of service integration; prevention and management of abortion; response to gender-based violence and sexual assault; peer education and outreach services; condom programming.

2.3.2 Limitations:

Although there are numerous best practice guidelines available to assist national reproductive health programmes to conduct SRH needs assessments[32], they require effective planning and collaborative and consultative setting of timeframes for data collection exercises. For the Kiribati SRHR Needs Assessment, the key issue was the unavailability of key informants during the data collection exercise. The model of conducting key informant interviews and focus group discussions with a sample of health managers and other health personnel during site visits was planned so as to provide a cross section of information for the review, however this cannot be considered as fully comprehensive, as the information collected from the sample does not necessarily reflect all SRHR programmes in the country. This would have been achieved only by visiting all health facilities, which the timing of the assessment did not allow.

31 Republic of Kiribati (2012), Island Report Series (20), Based on a 2008 prepared by the Ministry of Internal & Social Affairs, Updated 2012 by Office of Te Beretitenti & T'Makei Services.

32 UNFPA, 2010; A Guide to Tools for Assessments in SRH; www.unfpa.org/webdav/.../publications/2010/srh_guide/index.html; accessed 18th November 2014.

A further limitation of this assessment is that data was collected from service providers and facilities only and service users were not included in the sample. This would have helped to determine, first hand, if and how their SRHR are met or neglected. Future assessment should consider a combination of senior health planners, implementers and users.

Information collected during the desk review, focus group discussions and key informant interviews has informed the findings of this needs assessment. Consistent with the assessment tools and report format provided by UNFPA's Pacific Sub-Regional Office, the findings are presented in terms of their relevance to reproductive health and family planning programmes and services, particularly in relation to SRHR as depicted by the Kiribati Ministry of Health and Medical Services strategic plans and policies.

Finally, due to an imminent deadline for submission of this report, the desk review and report compilation was done in a very short timeframe, so the literature review may not be as comprehensive as it could be if additional time were available, albeit, every effort was made to research the subject at hand and to provide recent and relevant references.

3. FINDINGS

The findings of the SRPR needs assessment are reported in this section. In the course of analysing the data a number of service gaps, barriers and challenges to service delivery were noted. These may impact the delivery of a comprehensive and best practice rights based sexual and reproductive health and family planning service in Kiribati, therefore where appropriate, recommendations have been made (in section 4 of this report) to address these perceived gaps.

3.1 Policy

The results of the policy component, Section A of the SRHS need assessment tool are reported in this section and they cover three specific areas of policy, namely: System to support SRHR, availability of a SRH policy and guidelines and protocols that support the SRH programme.

3.1.1 Availability of the Policy

There is a SRH Policy for Kiribati (Sexual and Reproductive Health (and HIV linkages) policy) in draft form, which is currently with UNFPA for finalisation. The policy includes the integration of SRH and HIV services and covers the need to strengthen existing Voluntary Confidential Counselling and Testing (VCCT) and HIV prevention programmes by cross training health personnel working in their specific areas of practice.

3.1.2 System to Support SRHR

Kiribati spends 10.7% (as % of GDP) on health. The SRH programme relies heavily on funding from development partners, therefore sustaining progress remains a challenge. Key development partners include UNFPA, UNICEF, UNAIDS, WHO, SPC, Australian Agency for International Development (AusAID) and the Global Fund to fight AIDS, TB and Malaria (GFATM).

Kiribati is a signatory to the International Health Regulations and key national health related legislation in Kiribati includes:

- The Public Health Act;
- The Child Protection Act; and
- The Family Bill.

The MHMS Strategic Plan 2012-2015 recommends the use of the Health Sector Coordinating Committee as central to supporting its implementation and also specifies the importance of relationships with bi-lateral and international development partners. It also states the importance of inter-sectoral coordination including the need to work with other Kiribati government departments and agencies, NGOs and community-based groups

The prioritisation of SRH within the Kiribati health system is captured in four of the six key health issues of Kiribati's Health Strategic Plan 2012-2015. The plan also articulates the strategies needed to address these issues. These strategies include:

- High population growth requires the promotion of family planning services and the need to strengthen partnerships with faith based organisations
- High maternal morbidity (including macro and micro nutrient deficiency) and mortality requires the need to strengthen the delivery of emergency and obstetric care services and improve access to antenatal and postnatal care
- High child morbidity (including malnutrition and childhood injuries) and mortality requires the need to expand Continuity of Care, Expanded Programme on Immunisation coverage and the delivery of IMCI services for children at risk
- High burden and incidence of communicable diseases (TB, leprosy, lymphatic filariasis, STIs and HIV/AIDs) requires the need to strengthen DOTS services and existing diseases surveillance and outbreak responses for TB, leprosy, lymphatic filariasis, STIs and HIV/AIDS.

3.1.3 Guidelines and Protocols

As there is currently no national HIV or STI policy, the HIV and STI Strategic Plan 2013-2016 guides HIV and STI services. Once the national SRH policy is finalised and endorsed, this will also guide HIV and STI practice. Other guidelines available that guide SRH delivery include:

- Policy and Clinical Protocols For Minimum Standards of Treatment of Survivors of Gender Based Violence (2013);
- Kiribati Algorithm SOP (Aug, 2013);
- Syndromic Approach Protocol for STIs
- PPTCT Policy & Guidelines;
- Kiribati HIV Testing & Counselling Policy & Guidelines;
- Youth Friendly Health Services National Operational Guidelines (2010); and
- Obstetrics & Gynaecology Clinical Guidelines for Medical Assistants & Nurses Working In Health Centres and Clinics in Kiribati (2011).

3.2 System

This section provides the results of Section B of the needs assessment and covers partnerships, planning, management and administration, staffing, human resources and capacity development, logistics and supplies, laboratory support, monitoring and evaluation and the health information system.

3.2.1 Partnerships

The MHMS receives significant funding and technical support from development partners and as discussed in 3.1.2. Key development partners include UNFPA, UNICEF, UNAIDS, WHO, SPC, Australian Agency for International Development (AusAID), the Global Fund to fight AIDS, TB and Malaria (GFATM) and Red Cross.

There is evidence of civil society engagement between MHMS and the Kiribati Family Health Association. This non-government organisations target group is youth and they have conducted a number of preventative HIV and STI outreach awareness programmes across Kiribati including 'Life Skills-Making the Right Choices'. They also operate a reproductive health clinic that provides screening and counselling for STIs, HIV counselling.

3.2.2 Planning, Management and Administration

SRH and HIV programmes operate independently of each other with separate planning, management and administrative structures, however there are plans in place for the MHMS to adopt an integrated approach to proving reproductive, maternal health, youth, neonatal, child and adolescent health programmes, known as the RMYNCAH. This integrated service model includes the provision of outreach services to villages and vulnerable communities that require such services.

3.2.3 Staffing, Human Resources and Capacity Development

Kiribati has an aging health workforce and frequently relies on retired staff to fill service delivery gaps. Similar to other Pacific countries, per 1000 population, there are 0.4 doctors, 3.19 nurses and 0.72 midwives and the intake of trainees is not sufficient to meet the future needs of the Health System[33].

SRH (including family planning) services in Kiribati are delivered by registered nurses, midwives and doctors at Tungaru Central Hospital and 3 other referral centres. Health centres are operated by medical assistants and health clinics by nurse aids. Each of the 15 health facilities visited are supervised by Nursing Medical Assistants (MA). All MAs have successfully completed additional training including HIV/STI Counselling and Reproductive Health Training Programmes offered by the Fiji School of Medicine, now the College of Medicine, Nursing and Health Sciences (CMNHS) of the Fiji National University (FNU).

SRH and HIV training are provided as separate packages, e.g. the family planning component of the RH training package does not have a HIV component. There also appears to be a lack of coordination between the MHMS, Kiribati School of Nursing and other training providers and there is a need to offer a better range of training modes, ones that allow health personnel to stay on site rather than having to leave the workplace for training.

3.2.4 Logistics and Supplies

A detailed Family Planning and Reproductive Health Commodity Assessment was undertaken in 2014 in which it was determined that there are national reproductive health commodities procurement systems in place. There are no retail pharmacies in Kiribati and pharmaceuticals and medical supplies are distributed to the outer health facilities from Tungaru Central Hospital. However, regular supply is unreliable, largely due to infrequent and unreliable air and sea modes of transport[34].

33 Allen and Clarke Policy and Regulatory Policy Specialists Ltd (2009), Review of licensing and regulation of health professionals in Kiribati, Manila, WHO Western Pacific regional office.
34 UNFPA (2014), *Family Planning and Reproductive Health Commodity Assessment (DRAFT);* Kiribati Ministry of Health and UNFPA.

WHO recommends the availability of seven lifesaving medicines for facilities that provide essential obstetric care including[35]:

- Oxytocin injection for maternal health prevents and treats Postpartum Haemorrhage (PPH);
- Misoprostol tablets also for PPH;
- Magnesium Sulphate (MgSO4) injection to prevent pre-eclampsia and treats eclampsia;
- Antibiotics;
  - Gentamicin injection to prevent maternal sepsis;
  - Metronidazole injection to prevent maternal sepsis; and
  - Crystalline Penicillin injection to prevent maternal sepsis;
- Ante-natal Corticosteroids to prevent pre-term respiratory distress syndrome in new born babies;
- Chlorhexidine to prevent umbilical cord infections; and,
- Resuscitation devices to treat newborn asphyxia.

Of the 15 health facilities visited, only Betio Maternity Ward had all of the listed medicines. However Crystalline Penicillin was available in all 15 facilities.

3.2.5 Laboratory Support

With the exception of HIV viral load, laboratory testing services including Haemoglobin, Blood grouping and typing, STI diagnosis, HIV screening and diagnosis rapid tests, CD4 count, liver function tests, urinalysis, random blood sugar, and pregnancy testing are conducted at the TCH Laboratory on South Tarawa. There are 4 laboratories serving Kiribati, with 3 fully qualified laboratory scientists, 4 diploma holders and 8 assistant laboratory technicians holding Form 7 level qualifications.

3.2.6 Monitoring and Evaluation

M&E is a challenge for the National HIV/STI and Reproductive Health Programmes. The National Health Information System collects service data for a range of services, but these are not gender or age disaggregated, and do not provide sufficient detail to support programme reporting against strategic indictors and targets. This is a fundamental flaw in a system that prioritises SRH and HIV in its strategic objectives.

3.2.7 Health Information System

SRH indicators needed for reporting are not included in the National Health Information System (NHIS) and health workers are not formally providing SRH statistical reports to the MHMS. Currently the SRH data from NHIS does not adequately inform the reports produced for SRH and while having some demographic information (e.g. place of residence, marital status and age) available, there is little attempt to gather specific data such as age, sex, level of education, number of children, religion, employment status and to link these to FP methods used and STI services.

35 PATH (2013), *Scaling up Lifesaving Commodities for Women, Children, and Newborns – An advocacy Toolkit, Washington DC, USA.p6.*

3.3 Service Delivery

This section provides the results of section C of the SRHR needs assessment and includes HIV integrated into SRH, overall perspective on linkages in SRH and HIV Services, peer education, community engagement/outreach/youth leadership and engagement, family planning, prevention of unsafe abortion, prevalence and management of STIs, youth friendly health services (YFHS) and condom programming.

3.3.1 Family Planning Services

Only 1 of the 15 health facilities visited did not provide family planning services, namely the maternity ward at Betio Hospital. This newly established ward, opened in May 2014, primarily does normal deliveries. The midwives from the ward also attend to post-partum mothers who deliver at home. Family planning services for areas surrounding the Betio Maternity Ward are provided by health clinics in the Betio Town Council area.

Family planning services were observed to be available and accessible. When women do not visit the clinic on their scheduled dates, nurses do home visits to provide family planning services and this is also practiced by health staff on the outer islands. The most common modern family planning methods used are jadelle, condoms, pills and periodic injections.

Depo-Provera is the most commonly used modern family planning method for Catholics, as using a longer term method is against their religion. It was reported that there have been cases where women have attended the health clinic to remove their implants without the full term of the method being reached.

3.3.2 Antenatal Care

Ante natal care services were provided at all 15 health facilities visited. Of these the health centres and clinics offered antenatal care clinic services and the hospitals provided antenatal care prior to delivery.

A UNICEF study conducted in Kiribati in 2013 found that almost all women received some form of antenatal care, at some point in the pregnancy[36]:

- Almost all women in Kiribati received care from a skilled provider during their last pregnancy;
- More than 70% of women were seen by a skilled health attendant, usually a nurse or midwife, at least four times during their pregnancy;
- Only 36% of women had their first visit before the fourth month of pregnancy;
- Only 64% of women had blood and urine samples taken, compared with almost all women in urban South Tarawa Women living in rural areas tended to have their first ANC visit later than urban women;
- Less than half of all pregnant women reported being informed of the signs of pregnancy complications;

36 UNICEF (2013), Kiribati: Tracking Progress in Maternal and Child Survival, A Case Study Report, 2013, pg. 14.

- 44% of women had two or more tetanus toxoid injections during their last pregnancy; and
- 48% reported that their last pregnancy was protected because of previous vaccinations.

Although almost all women receive some form of antenatal care, at some point in the pregnancy there is room for improvement to:

- Encourage women to attend their first ANC visit in the first trimester;
- Promote the importance of ANC at every opportunity; and
- Assess the quality of services provided at ANC clinics.

3.3.3 Prevention of Unsafe Abortion and Management of Post-Abortion Care

9 of the 15 health facilities visited provide prevention of unsafe abortion and management of post abortion care services; however records of instances of presentation to health facilities for unsafe abortion were not available. These 9 health facilities are based at the two main town areas, Tarawa Urban Council and Betio Town Council and the outer islands, however, anecdotal evidence suggests it is rare to see cases of abortions. For the cases that are seen, they are stabilized and if there is a need for referral, they are transferred by ambulance to Tungaru Central Hospital.

The discussions around prevention of unsafe abortions and management of post abortion care suggested the reliance on traditional methods of care in the outer islands. However, even in the absence of records, there is anecdotal evidence of unsafe abortions and little is known of post-abortion care for those cases.

3.3.4. Prevention of Parent to Child transmission of HIV

Five health facilities stated that they are capable of providing the services of PPTCT. These are Temanoku Health Clinic, Taburao Health Center, Ubanteman Health Clinic, Bairiki Clinic and Tanimaiaki Clinic on Abaiang Island. However since there are no identified cases of HIV positive women (pregnant or otherwise) in the areas being serviced and assessed, the implementation of the services nor the level of integration of PPTCT to RH services were not established.

3.3.5 Prevalence and Management of STIs

Similar to the provision of family planning services, all but 1 facility (Betio Maternity ward) provide prevention and management of STI services. However, the services provided for STI were limited in the outer Islands of Abaiang and Abemama, therefore the current status of STI and HIV prevalence is not known for the people living in these two islands. The health facilities in these two outer islands only conduct awareness programmes on prevention on STI's. There is no routine sample collection to test for STIs but syndromic treatment is applied where appropriate and patients are referred to TCH for further testing and treatment.

3.3.6 HIV and SRH Integration

Of the 15 health facilities visited, 4 provide HIV voluntary confidential counselling and testing (VCCT). The health facilities are Temanoku Health clinic, Banreaba Health Clinic, Bikenibeu East Clinic and Bairiki Clinic, all located on South Tarawa. One health facility, Ubanteman Health Clinic, based on Abaiang, offers HIV counselling only.

Temanoku Health Clinic started their VCCT service in May, 2014 but the clinic does not provide treatment and there has been no positive cases seen to date. An issue raised by the Temanoku clinic counsellor was the handling of positive cases where patients refuse to receive treatment when referred to Tungara Central Hospital. Except for STI and HIV screening of first ANC clinic, there is no integration between the SRH services and HIV counselling and testing as HIV services and SRH are offered at different rooms by different clinic staff.

Banreaba Clinic provides sample collection and counselling services one day a week. There are no full time counsellors at the clinic and the staff at the clinic have expressed the need to have one full time counsellor to be present throughout the week to carry out HIV counselling and testing. SRH services and HIV services are yet to be integrated.

Bikenibeu East Clinic does provide HIV services and similar to the above clinics, there is little integration seen between the SRH and HIV services.

Bairiki Clinic has integration, however it is limited to 1st visit ANC mothers who receive HIV testing and counselling. Ubanteman health clinic in Abaiang Island provides counselling to those who present with STI symptoms. All 15 facilities had no record of HIV positive cases. However when asked if they could treat opportunistic infections related to HIV, 4 respondents from Bairiki Clinic and Banreaba Clinic in South Tarawa and Ubanteman Clinic and Taburao Health Center in the outer islands said they could provide treatment for HIV opportunistic infections.

Pshyco-social support services specific for HIV patients is not currently provided by the clinics assessed as 'there are no positive cases'. However there is counselling available at some clinics for STI patients at risk of HIV infections. All 15 health facilities provide HIV prevention information as part of their community outreach and advocacy and there is integration of HIV prevention information and SRH during community advocacy, medical staff advocate on both issues of SRH and HIV and AIDS.

It was reported by all respondents that privacy and confidentiality is maintained at all health facilities. For clinics such as Temanoku and Bairiki there are separate rooms for HIV/STI counselling and testing. For those clinics that do not have specific HIV/STI rooms, the patients are seen individually in an examination room.

The MHMS does provide a range of HIV related information communication and education materials, however these are generic and there are no IECs specific to sub populations at high risk of HIV infections.

In summary, integration of HIV counselling and testing services into existing services such as STI testing and counselling offered at ANC units and for postnatal care is limited and will need a dedicated effort to identify human resource needs, the needs of the communities, infrastructure lay out requirements and the need to identify suitable clinic times.

3.3.7 Peer Education Programmes

The National Peer Education Committee involves Ministry of Health, Ministry of Women, Kiribati Family Health Association and Red Cross, however there is a need for more effective interagency consultation and communication.

Of the 15 health facilities assessed, only Abetiku Islet clinic has a peer education group that is supported by KFHA and the council of elders.

There is also a youth committee in the islet that provides support to the clinic peer education group. Young adolescents conduct peer education on SRH issues through dramas and they also illustrate the use of condoms.

Peer educators work mostly on South Tarawa and Betio. There is little knowledge about peer educators programmes on the other islands. Interviews at Abaiang and Abemama suggest that youth volunteers and peer educators from KFHA had provided SRHR programmes in Abaiang and Abemama in 2014.

Abetiku Islet peer educators mainly target youth and sex workers and also provide SRH awareness to the wider Abetiku population. They do not specifically target other vulnerable groups like sex workers. A register of the programmes delivered is not maintained, however questions raised by the villagers are documented and forwarded to the medical assistant for attention. The response rate to these queries was unknown.

Kiribati Family Health Association has a dynamic Peer Education Programme. They visit organizations on a voluntary basis however, they do receive some financial support. These peer educators are supported by the KFHA organizational structure which is governed by a board of directors. KFHA also uses dramas and role plays to deliver key SRHR messages on teenage pregnancy, HIV, STI and family planning.

KFHA coverage area is South Tarawa and 5 outer islands namely; Butaritari, Marakei, Abaiang, Aranuka and north Tarawa. In terms of registers, these peer educators are given daily evaluation forms that capture demographic information such as age and sex of the people they educate.

These forms are collected at the KFHA office by the youth officer and data on the number of people the peer educators reach is available at the KFHA office. Red Cross peer educators keep a tally of people reached which is available at the Red Cross office.

Kiribati Red Cross Peer Education Programme provides train the trainer programmes on HIV community awareness. Behaviour change is also part of the training package for Red Cross volunteers. When carrying out awareness in the communities, peer educators receive an allowance of 10 dollars. If peer education work is a full day activity then peer educators also receive meal allowances.

The consultations with MHMS established that peer educators who work with secondary schools are provided with SRH materials – about the use of condoms to avoid pregnancies and STI/HIV transmission. The Abetiku Islet clinic on Abemama uses posters to conduct peer education and pamphlets are distributed to the villagers. They also distribute female and male condoms and are also given lubricants to distribute.

KFHA has a number of IEC materials that they distribute including posters, pamphlets, bags, and wrist bands. Condom packets distributed by KFHA have instructions on how to use the condoms in the Kiribati language and the peer educators also distribute lubricants. KFHA have trained approximately 450 peer educators in the last two years. For KFHA, a total of 20 trained peer educators per year is sufficient to carry out their peer education programmes.

Community based educators are also trained by KFHA and trainers from the peer education committee and tertiary institutions such as the Kiribati Institute of Technology and the University of the South Pacific. Peer education training is also done by police, at the nursing school, USP and the Marine Training Center.

There are 3 participants from each organization who are trained to carry out SRH awareness to their peers. KFHA at times utilizes peer education trainers from the MHMS and the ministry of women to conduct peer education training sessions.

KHFA offers regular (on average 3 times a year) peer educator training however there is a need to increase the capacity of trainers as identified by KFHA peer education officer. At KFHA there are 5 peer education trainers, 3 male and 2 are female. Trainers are trained both in and out of country. There is a need for more trainers and also training of trainers to increase their capacity. The list of all peer educators in the county could not be obtained.

3.3.8 YFHS and Condom Programming

Condoms are available at all health facilities and the general public is encouraged to visit those facilities to collect free condoms. Most clinics offer male condoms only and none of the clinics actively advocates for the use of lubricants with the condoms. Only the islet clinic of Abetiku and KFHA have supplies of female condoms. Even though lubricants are available at some of the clinics, they are not used. A lack of knowledge about their use was evident among some of the health workers interviewed.

3.3.9 Community Outreach Programmes

Twelve of the 15 health facilities visited, except for the Betio Maternity Ward and Riboono Islet clinic provide outreach community awareness programmes (Refer to Table 6 overleaf).

Table 6: Community Outreach Programmes.

Health facility	Community Outreach Programme	Target Group
Betio Town Council		
Temanoku clinic	NCD Continuum of care Immunization Family Planning Maternal and Child Health	NCD risk population, post-natal mothers, children under 5 years old, reproductive aged women
Betio Maternity Ward	No Community Outreach Programme	
Tarawa Urban Council		
Banreaba Clinic	NCD Continuum of care Immunization Family Planning Maternal and Child Health	NCD risk population, post-natal mothers, children under 5 years old, reproductive aged women
Bairiki Clinic	Immunization Elderly COC Disabled health Maternal and Child Health	Post-natal mothers, children under 5 years old, elderly, disabled
Bikenibeu Clinic	Immunization Maternal and Child Health	Children under 5 years, Post-natal mothers
Abemama Island		
Kariatibike Health Center	NCD Immunization Maternal and Child Health	NCD risk population, Children under 5 years, post-natal mothers
Kabangaki Clinic	Family Planning Immunization Maternal and Child Health	Reproductive aged women, Children under 5 years, post-natal mothers
Baretoa Clinic	1 Immunization 2 Maternal and Child Health	Children under 5 years, post-natal mothers
Abaiang Island		
Taburao Health Center	Immunization Elderly COC Disabled health Maternal and Child Health	Post-natal mothers, children under 5 years old, elderly, disabled
Ubanteman/ Ubwarano	STI Immunization Maternal and Child Health	Youth, children under 5, post-natal mothers
Tanimaiaki Clinic	Pneumonia Hypertension Diabetes, Diarrhoea	General population
Riboono Islet Clinic	No Community Outreach Programme	
Nuotaea Islet Clinic-	Child Health Care programme Immunization	Post-natal mothers, children under 5

3.3.9 Community and youth engagement and leadership

Youth Friendly Health Services work is guided by the Youth Friendly Health Services National Operational Guidelines. This guideline was developed in collaboration with UNICEF, UNFPA and SPC joint programme on Adolescent Health and Development (AHD). The Ministry of Health and Medical Services, Ministry of Education and NGO's are involved in providing youth friendly services in Kiribati.

An objective of the guideline is to provide technical support and operational guidance to government authorities, NGO's service providers in planning and implementation of Youth SRH services. The guideline is also a framework for the provision of standardized YFHS. The guideline also promotes the integration of YFHS into primary health care facilities. Most at risk groups are also part of the guideline objectives.

There are four youth friendly health services based at secondary schools on South Tarawa including at Junior Secondary School, Santa Maria Secondary School, KGV School and Sacred Heart High School. To date there has been no evaluation of any of these programmes so it is unknown if these programmes include HIV and SRH programming.

A nurse coordinates the YFHS programme and its mandate is in keeping with the objectives of the national guidelines. A plan on using a peer assistant was developed and implemented in Sacred Heart High School only. A group of selected students had a 1 day training on basic communication skills to help identify their peers with SRH issues.

Members of the National Youth Council have received training on life skills of which SRH issues are included and the MHMS Adolescent Health Development Programme in partnership with UNICEF involved youth in developing this guideline that was published in 2010.

There are no SRH committees in any of the communities assessed. There are other village committees including church groups and women's group but these groups do not work with SRH. In the outer islands, a village welfare group works with the health centres and clinics to carry out community outreach. The group includes the medical staff from the health facility, the police and 8 to 10 village members.
The group conducts awareness on sanitation and also sets up sanitation protocols for the villages to follow. Those that do not adhere to the protocols are fined $1 and this money is collected and used by the village welfare group for operation costs (e.g. Fuel for transport).

The number of organizations that provide outreach on HIV to the communities is limited to KFHA and Red Cross trains its peer educators on HIV awareness and these peer educators are assigned communities to conduct outreach which includes drama productions to portray HIV messages.

Community outreach programmes targets the general population which may or may not include sex workers, men having sex with men or transgenderism, however there is no social behavioural change communication strategy for adolescents, youths and other key populations.

IEC materials are available in the country however there was no evidence of IECs that establish a link between SRHR and HIV. In some health clinics there is a need to restock their IEC material supplies. SRH posters for the clinics and for community outreach are lacking in outer islands clinics such as at Abetiku Islet clinic, Ubanteman Clinic and Riboono clinic. Pamphlets for community outreach needs to be supplied to both outer island clinics and clinics in South Tarawa.

Year 3 and 4 secondary schools students are taught the healthy living subject which compromises sex education and reproductive health. Secondary school teachers have requested counsellors as there is an increase in teenage pregnancy amongst secondary school students.

In 2014 a number of secondary school teachers underwent basic counselling training. Secondary schools have requested that YFHS support their schools, as outreach programmes do not provide comprehensive sexuality education at primary and secondary schools.

3.3.10 Gender based violence (GBV) prevention and management

Information in this section was provided by the National GBV Coordinator.

The need to eliminate all forms of violence against women awareness programmes are integrated in antenatal care services and family planning services.

Eight of the 15 health facilities assessed provide GBV services. Only 1, Bairiki clinic offers HIV services for its GBV survivors. Bairiki Clinic provides HIV and STI tests for rape victims and reports to the HIV Unit. Counsellors collect samples and send this for testing. The police also request separate testing for their evidence. There is no link between the clinic and the police in terms of testing of HIV and STI.

Rape cases first present at the emergency room and are then referred to the gynecology clinic. Most rape cases go to the police first before they come to the hospital. Consent to be examined and treated is requested of all survivors of GBV. Informed consent also advises survivors about steps of action available to them in terms of the course of action they need to take to report the assault with the police.

As required by Kiribati law and the judiciary, all GBV survivor cases are reported to the police. Nurses and doctors in the emergency rooms collect patient information and record this in the GBV standard form. There, three copies are made of these forms which are given to the hospital for its records, police and to the client if they ask for it. GBV survivors that have not sought police assistant are referred to the nearest police station. Cases that fear for their safety are referred to the Crisis Center that provides shelter. GBV patients who require mental health services are referred to the hospital psychiatrist for examination.

Sexual assault evidence collection kits are provided to the emergency and gynecology units at Tungaru Central Hospital and at Betio Hospital. One rape kit is used for one rape case and the kits contents are sufficient to examine the rape patients.

There are no specific GBV examination rooms but patients are seen in the gynecology examination room and the emergency room and treatment is available for cases of GBV. Kits are also supplied to the Hospital at Christmas Island and Tab North Hospital. Kits are provided by the Lab at the main Hospital in Nawerewere and there have been no reports of shortage of kits received by the GBV coordinator.

A gynecology examination room is used to examine sexually abused GBV survivors whilst GBV survivors that are physically abused (but not raped) are seen in the emergency room. Out of the 4 hospitals that offer GBV services, the hospital at Christmas Island might have problems of keeping evidence locked away as identified by the GBV coordinator at the main Hospital on South Tarawa. GBV records are stored together with other types of medical records at Tungaru Central Hospital, however there is a need to allocate specific storage area for GBV records.

There are often delays in examination of GBVs due to a lack of staff to perform a medical examination. There are 3 gynaecologists at Nawerewere Hospital that oversee the examination of sexually assaulted patients.

There are other general practitioners that have received training on how to handle GBV survivors and if the need arises, they refer the patients to the gynaecologists. For, 3 doctors and 2 nurses at Tungaru Central Hospital have received forensic training. GBV training was held 3 times in 2014 but training on managing the sexual assault of children has not, to date, been offered.

Hospital staff are sometimes required to give evidence in court although information on the experience of medical staff in court was not provided. The GBV coordinator also stated that she has not received any compliments or complaints about staff therefore staff attitudes in relation to managing GBVs cannot be determined here.

Pregnancy tests are available for the victims. Pregnancy tests are supplied only to the emergency room by the lab. There was a stock out of pregnancy tests at the gynecology unit at the time of this assessment. Information on availability post exposure prophylaxis tablets for both HIV and STI couldn't be obtained.

Issues highlighted by the GBV coordinator included: Waiting time for rape victims, there are times, rape victims have to wait to be medically examined as there are shortages of doctors, and there is a need to address this issue. Emergency Contraceptive pills are available in the hospitals for sexual assault cases but there are no sanitary towels in examination rooms and there are no clean clothes for survivors of GBV available in the hospitals and this is seen to be a police responsibility. The unavailability of reporting forms is also sometimes an issue.

Summary of SRH Service Provision

Table 7 below provides a summary of the SRH services provided at the 15 facilities visited, all of which provide a component of this SRHR assessment.

Table 7: Summary of SRH services (provided at Kiribati health facilities visited).

Health facility	Family Planning services	Prevention & management of STI	Maternal (ANC) and newborn care	Prevention and management of gender based violence	Prevention of unsafe abortion and management of post abortion care
Betio Town Council					
Temanoku clinic	Yes	Yes	Yes	Yes	Yes
Betio Maternity Ward	No	No	Yes	No	Yes
Tarawa Urban Council					
Banreaba Clinic	Yes	Yes	Yes	No	No
Bairiki Clinic	Yes	Yes	Yes	Yes	Yes
Bikenibeu Clinic	Yes	Yes	Yes	No	No
Abemama Island					
Kariatibike Health Center	Yes	Yes	Yes	Yes	Yes
Kabangaki Clinic	Yes	Yes	Yes	No	Yes
Baretoa Clinic	Yes	Yes	Yes	Yes	Yes
Abetiku Islet	Yes	Yes	Yes	No	Yes
Abaiang Island					
Taburao Health Center	Yes	Yes	Yes	Yes	No
Ubanteman/Ubwarano	Yes	Yes	Yes	Yes	Yes
Tanimaiaki Clinic	Yes	Yes	Yes	No	Yes
Riboono Islet Clinic	Yes	Yes	Yes	No	No
Nuotaea Islet Clinic-	Yes	Yes	Yes	No	No
Tungaru Central Hospital - ANC Clinic	Yes	Yes	Yes	Yes	Yes

4. CONCLUSION AND RECOMMENDATIONS

Kiribati is committed to protecting the human rights of all I-Kiribati's including the most vulnerable; women, children and young people, through its Constitution, its membership of the United Nations, by ratifying international conventions and treaties and through the development of gender and rights-based national and sectoral policies.

Similar to the challenges that face many Pacific Island countries and territories like geographical isolation, economic, cultural and fiscal constraints present stumbling blocks to the development agenda and the effective and timely implementation of services, sexual and reproductive health services included.

Within the health system, major challenges to improved SRH and to the delivery of services which meet basic SRHR include under-staffing, outdated policies and guidelines, inadequate reporting systems and the fiscal and geographical challenges of preventing stock outs of essential drugs and medical consumables in all health facilities, especially the outer islands.

Many of these challenges can be addressed through further strengthening national leadership from within the Ministry of Health and through informed, consultative and collaborative planning and programme implementation. Strategic priorities must be established based on available evidence and through consultation with key affected populations and other stakeholders to ensure supply meets demand.

The need for a more coordinated approach to public and private partnerships with strong leadership, effective strategic planning will also help to identify service and demand gaps and will also maximize the use of minimal resources to avoid rework and wastage of resources.

There is also a need to continue to work to strengthen legislation, policy and political and social commitment to gender equality and equity at all levels must be established to strengthen SRHR. While this is within the domain of the Ministry of Health and Medical Services to lead the SRHR agenda, gender equality and equity is a multi-sectoral responsibility, and must be more adequately addressed throughout all government ministries.

On a final note, it is important for all SRHR advocates and stakeholders both in Kiribati and the region, to rigorously and consultatively identify gender and other social determinants of health within each local context and integrate findings into SRH programme designs, in an effort to address the impact of activities on women, girls, boys, and men, with the ultimate goal of promoting equal access to health care for all.

SUMMARY OF RECOMMENDATIONS

Policy Recommendations

- Finalize and endorse the recently compiled *Sexual and Reproductive Health (and HIV linkages) policy for Kiribati* and work collaboratively with key stakeholders to integrate the policy into local practice culture.
- Review the integrated Reproductive Health, Maternal Health, Neonatal, Child and Adolescent Health (RMNCAH) Programme to assess the level of inclusion of a rights based SRH and HIV service model and revise accordingly.
- Determine the suitability of the RMNCAH Programme for national use and if applicable, provide technical logistical and funding support to roll out the programme nationally.
- Establish a National Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Committee that advocates for a rights based approach to the provision of these services.

System Recommendations

- Consistent with the roll out of the *Sexual and Reproductive Health (and HIV linkages) policy*, review SRH curriculum and individual training packages so as to maximize training opportunities for health workers and also to ensure a standardized approach to providing current best practice SRH and HIV information in Kiribati. Establish realistic and achievable national SRHR targets, and systems of data collection and reporting at the service-delivery, provincial and national levels which can be easily used and collated.
- Establish realistic and achievable national maternal mortality targets, using actual number of deaths (not MMR) to monitor and report progress.
- Review the SRH reporting requirements to the national Health Information System and develop a simple system of reporting that will allow key elements of the *Sexual and Reproductive Health (and HIV linkages) policy* to be monitored for progress and evaluated intermittently.
- Equipping and regular re-stocking of sexual assault examination and testing kits, inclusive of post-exposure prophylaxis for HIV and STIs for all designated health facilities, and develop and disseminate (with training) protocols for their use.

Service Delivery Recommendations

- Increase women's availability to SRH information and counselling.
- Encourage women to attend their first ANC visit in the first trimester.
- Assess the quality of services provided at ANC clinics.
- Research the underlying factors associated with the unmet need for family planning and contraceptive services and devise and implement social behavioural change and marketing strategies to address these factors.

- Assess the quality of Emergency Obstetric Care (EmOC) programmes, especially in the outer islands. The roll out of the Sexual and Reproductive Health (and HIV linkages) policy is an opportunity to advocate for the need to strengthen coordination and linkages between SRH and HIV and also to educate health workers about the rights based approach to these services.
- Review the forensic assessment and reporting of sexual assault cases within health facilities and develop a national policy that guides a standardized approach to managing these cases and stipulates the basic requirements (including equipment and consumables) necessary to provide a quality, confidential and best practice service.

Other considerations may include the need to further identify and address the underlying factors that contribute to:

- Poor level of SRH service delivery in and to the outer islands;
- Child mortality rates including water and sanitation issues;
- Teenage pregnancies;
- High incidence of STI's and poor self-referrals for treatment;
- Low condom use: and
- Poor uptake of ART treatment for all people living with HIV.

APPENDIX 1: REFERENCES

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APPENDIX 2: NEED ASSESSMENT TOOLS FOR SEXUAL REPRODUCTIVE HEALTH AND RIGHTS AND HIV.

Need Assessment Tools for Sexual Reproductive Health and Rights, and HIV

Purpose

The needs assessment tools cover a broad range of linkages and issues including policy, systems and services.

Assessment Components	Key areas of assessment
1. Policy	- Political Positions-National Policies/Guidelines - Funding/Budgetary Support - Policy: Leadership (Champions)/Political Will
2. System	- Partnerships - Planning, Management and Administration - Staffing, Human Resources and Capacity Development - Logistics/Supplies - Laboratory Support - Monitoring and Evaluation - Health information system
3. Service delivery	- HIV integrated into SRH - Overall Perspective on Linkages in SRH and HIV Services - Peer education programme - Community engagement/outreach/ youth leadership and engagement - Family planning services - YFHS and - Condom programming - VAW survivor services and support
4. Humanitarian	- Availability of the policy - System to support SRHR - Guideline and protocol

Source: Draft tools provided by UNFPA, Pacific Sub-Regional Office.

Methodology

- Stakeholder consultation
- Conduct desk review
- Conduct interviews: formal, informal, or group discussion
- Data collection/information

Target Audiences

1. Policy: Coordinator, Programme managers, director for health services
2. System: Coordinator, Programme managers
3. Service delivery: target for any type of health care workers working at the clinical level, youth and communities (clients)

Measurable:

Components	Information collection
Service Availability: look at the physical presence of services	• Facility density • health worker density • service utilization
Service readiness: Look at Capacity to deliver services	• Basic amenities • equipment & supplies • diagnostics • essential medicines & commodities • Human resource Capacity: capacity at facility level, Training need (RH, FP), and training curriculum
Specific service readiness areas	Family planning, Antenatal care, Neonatal care Obstetric care and child health (curative, immunization) HIV, PPTCT, TB, Malaria, YFHS and Chronic Diseases, VAW
EmOC indicators	Availability and distribution of facilities fully functioning at EmONC levels: • Institutional delivery rate • Met need • Population-based caesarean rate • Direct obstetric case fatality rate • Intrapartum stillbirth and early neonatal death rate • % maternal deaths due to indirect causes

Guidance documents:

- SARA and EMONC
- A Guide to Tools for Assessments in Sexual and Reproductive Health
- Rapid Assessment Tool for Sexual & Reproductive Health and HIV Linkages, A Generic Guide
- Responding to Intimate Partner Violence and Sexual Violence against Women, WHO clinical and policy guidelines

Assessment Questionnaire

A. Policy

SECTION 1: Political Positions National Policies/Guidelines				
			Comments	**Source of information**
1. Is there a national HIV strategy/policy	Yes ☐	No ☐	Add column for countries	
2. What is the title of strategy and timeframe				
3. Is there a national SRH strategy/policy?	Yes ☐	No ☐		
4. Probe question for Q5 Does the country also have an evidence based National Health Sector policy that Incorporates RH and HIV? *(For SRHR Results matrix indicator 3.2a)*				
5. What is the title of strategy and timeframe				
6. Are there any direct policy relevance to linkages between SRH and HIV in the country?	Yes ☐	No ☐		
7. Does SRH policy include HIV prevention, treatment, care and support issues? (VCCT-FP, BCC on HIV-SRH)				
8. Has SRH policy been made a priority in term of – Funding, legislation, or health sector strategy				
9. Probe question for Q10 - Does the country have a protocol for family planning services in place? - Which stakeholders are responsible for carrying out the protocol? List. - Are the procedures in line with human rights standards? - Are the procedures for delivering FP services free from discrimination, coercion and violence? *(For SRHR Results framework indicator 1.4a)*				

10. List any service protocols, policy guidelines, manuals, etc., that are specifically geared towards increasing SRH and HIV link				
11. Is there a participatory platform that advocate for increased investments in marginalized adolescents and youth, within development and health policies and programmes? Y/N. If so, describe. *(For SP/MCP5 Output 3.1 Indicator 4)*				
12. Determine whether there is a legislative framework to supports (or does not support) the implementation of SRH and HIV linkages.				
13. What are the laws affecting key groups (SWs, IDUs, MSM, other) and what is their impact?				
SECTION 2: Funding/Budgetary Support				
14. What are the main of funding source for SRH and HIV If possible, give a break down				
15. Are there specific cases of donors putting restrictions on HIV programmes regarding SRH components or vice versa				
16. Within the budgets for specific SRH services, what is the proportion allocated to HIV prevention and care?				

B. System

SECTION 1: Partnership				
			Comments	**Source of information**
1. Who are the major development partners for SRH?				
2. Who are the major development partners for HIV?				
3. If any, who are the major champions supporting (policy, financial and/or technical) SRH and HIV linkages?				

4. Is there any multi-sectoral technical group working on linkages issues?	Yes ☐	No ☐		
5. What is the role of civil society in SRH programming e.g. Advocacy, planning, implementation, and monitoring				
6. Are the following elements of civil society involved in the SRH and/or HIV responses? PLHIV, Young people, key populations,				
SECTION 2: Planning, Management and Administration				
7. Probe question for Q8 What programmes (national/donor funded) are in place to prevent STI's and HIV among young people? List. *(For SP/MCP5 output 3.1 indicator 3)*	Yes ☐	No ☐		
8. Is there a joint planning of HIV and SRH programmes?				
9. To what extent have SRH services integrated HIV and have HIV services integrated SRH				
10. Probe question for Q11 - Are there any CSOs supporting the institutionalization of programmes to engagement and boys on gender equality 9including GBV), SRH and RR? If so describe status and list CSOs. *(For SP/MCP5 output 2.1 indicator 6)*				
11. What institutions are providing integrated services for HIV and SRH? (Ex. government facilities? NGOs, FBO, private sector.)				
12. Is there a policy on GBV or VAW? Is the health sector referred to in national Domestic Violence legislation?				

SECTION 3: Staffing, Human Resources and Capacity Development				
13. What are the highest priority training needs in the health sector, i.e. who needs to be trained on what subjects or skills?				
14. Where is SRH training offered (pre service, post service)				
15. What is the enrolment for the training				
16. Does capacity building on SRH and HIV integrate guiding principles and values? (e.g. Stigma, gender, male involvement, attitude with key population...etc.)	Yes ☐	No ☐		
17. Are there training materials and curricula on SRH which include HIV prevention, treatment and care at programme and service-delivery levels and as part of pre-service training?	Yes ☐	No ☐		
18. Are curricula and training materials revised and updated regularly?	Yes ☐	No ☐		
19. In relation to staff for SRH and HIV programmes, what are the biggest challenges? (retention, recruitment, task shifting, Workload and burnout, Quality)				
20. What solutions have you found to those challenges?				
SECTION 4: Logistic and Supply (Summary of RHCS Assessment)				
21. To what extent do logistics systems support service-delivery integration? (separate supply, planning, recording and monitoring)				

SECTION 5: Laboratory Support				
22. Do laboratory facilities serve the needs for both SRH and HIV services? (Haemoglobin, Blood grouping and typing, STI diagnosis, HIV diagnosis, including rapid tests, CD4 count? HIV viral load, liver function tests, urinalysis, random blood sugar, and pregnancy testing)	Yes ☐	No ☐		
SECTION 6: Monitoring and Evaluation				
23. How do the monitoring and evaluation structures capture results of SRH programmes? (Access to services, uptake of services, Quality, client satisfaction, client profile)				
24. What indicators are being used to capture integration between SRH and HIV? (e.g. HIV clients receiving SRH services, SRH clients receiving HIV services)				
25. To what extent does supportive supervision at the health service-delivery level support effective SRH Services?				
26. Is the data collected on SRH and HIV disaggregated by sex, age and HIV status?	Yes ☐	No ☐		
27. Is the current HIS captured all essential information on SRHR?				
28. Describe the information flow.				
29. Does the essential SRH indicator are capture in the clinic report form?				
30. Are client registers for use of SRHR/GBV/ YFHSs services established in the various health clinical outlets, SDPs, and community centers? List places having this data collection register for clients.				

C. Service delivery

SECTION 1: Mapping facilities and service available	
1. Which of the following essential SRH services are offered at this facility?	1. Family planning ☐ 2. Prevention and management of STI ☐ *(For SRHR results matrix indicator 3c)* 3. Maternal (ANC) and newborn care ☐ *(For SRHR results matrix indicator 3c)* 4. Prevention and management of gender-based violence ☐ 5. Prevention of unsafe abortion and management of post-abortion care ☐ 6. Other (specify):..... 7. None ☐ 8. Unsure, don't know 9. 7 lifesaving maternal/ RH medicines from the WHO list. ☐ *(For SRHR results matrix indicator 1.2a)*
2. Which of the following essential HIV services are integrated with SRH services at this facility?	1. HIV counselling and testing ☐ (if yes) a. VCT ☐ b. PICT ☐ 2. Treatment for OIs and HIV ☐ 3. Home-based care ☐ 4. Psycho-social support ☐ 5. HIV prevention information and services for general population ☐ 6. Condom provision ☐ 7. PPTCT(four prongs) ☐ a. prong 1: prevention of HIV among women of childbearing age and partners ☐ b. prong 2: prevention of unintended pregnancies in HIV+ women ☐ c. prong 3: prevention of HIV transmission from an HIV+ woman to her child ☐ d. prong 4: care & support for the HIV+ mother and her family ☐ 8. Specific HIV information and services for key populations a. IDUs (e.g. Harm Reduction) ☐ b. MSM ☐ c. SWs ☐ d. Other key populations (specify): ..... 9. Other services (specify):..... 10. No integration ☐ 11. Unsure, don't know ☐

SECTION 1: Mapping facilities and service available		
3. How does your facility offer HIV services within:	1. Prevention and management of STI services ☐ 2. Maternal and newborn care services ☐ 3. Prevention and management of gender-based violence ☐ 4. Prevention of unsafe abortion and management of post-abortion care ☐ 5. Family planning? ☐	
4. Are the privacy and confidentiality of clients maintain at services delivery	Yes ☐ No ☐ Please clarify:	
5. Are the following equipment available Nationally	a. Sanitary towels in the examination room	Yes ☐ No ☐
	b. Consent forms	Yes ☐ No ☐
	c. Sexual assault evidence collection kits	Yes ☐ No ☐
	d. Clean clothes for survival use if they have to leave clothes for the forensics/ evidence	Yes ☐ No ☐
6. Is the emergency contraceptive available at the clinic	Yes ☐ No ☐	
7. Problem experienced with the sexual assault evidence collection kits	a. Keep evidence locked away	Yes ☐ No ☐
	b. Share the rape kits and see if medical staff have comments on the contents	Yes ☐ No ☐
	c. Availability of treatment in examination room	Yes ☐ No ☐
8. Available of tests and treatment a. Where people who have been raped first present (OB/GYN, ER, other) b. Triage or reason of delays in examination of patient c. Where do patient normally wait d. Who examine the patients e. How the patient information normally collected and stored		
f. Do you have forensics training or protocol	Yes ☐ No ☐	
g. Has staff been involved in giving evidence in court? What was the experienced?		

SECTION 1: Mapping facilities and service available			
9.	What was the comment reaction of the staff toward rape cases		
10.	Where does the victims normally refer to:	a. Legal b. Psychological c. Shelter	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
11.	Are the following testing and treatment are available for the victims	a. Pregnancy test b. PEP for HIV c. PEP for STI	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
12.	Do the staff have undergo training on	a. Sexual violence (adult) b. Sexual assault (children) c. Physical assault	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
13.	Is VAW integrated in ANC care	Yes ☐ No ☐	
14.	Is VAW integrated in family planning services	Yes ☐ No ☐	

SECTION 2: Peer Education Programme		Comments	Source of information
15.	Which Organizations are involved in Peer Education Programmes?		
16.	Are Peer educators supported by an administrative structure? If so, what is the structure?		
17.	Do peer educators receive financial support for their work?		
18.	Do Peer educators cover the entire country? If not, which parts?		
19.	**Probe question for Q20** Do the peer educators keep a record/ register of the above people that they educate? If so, how many of the people from the above groups have peer educators reached or provided services to over the last two years? What is the target number of young people to be reached by peer educators per annum? *(For SRHR results matrix indicator 2.2a)*		
20.	Do Peer educators work with: • Young people • Sex workers • LGBT		
21.	Are materials available on SRH issues for peer educators to use and distribute?		

SECTION 2: Peer Education Programme		
	Comments	**Source of information**
22. Do the peer educators distribute condoms (male/female) and/or lubricant?		
23. Probe question for Q24 How many peer educators have been trained in SRHR over the last two years? How many more needs to be trained per annum? *(For SRHR results matrix indicator 8a)*		
24. Are peer educators offered regular training? If so how often and by whom?		
25. Are there trained trainers in country?		
26. How many peer education trainers are there? How many of them are female? How much more trained trainers does the country need? *(For SRHR results matrix indicator 8b and 8c)*		
27. If available get list of all peer educators in the country, their location, age, and gender.		

SECTION 3: Community outreach		
	Comments	**Source of information**
28. List the organizations/ institutions provide outreach on SRH to communities. And list the target groups		
29. List the organizations/ institutions provide outreach on HIV to communities. And list the target groups		
30. Are there existing SRH committees in the communities consisting of community members and religious leaders? Y/N Explain and list. How many community leaders, gatekeepers and religious leaders have been trained on SRHR? *(For SRHR results matrix indicators 10b and 10d)*		
27. Do the community outreach reach out to the key population (SWs, MSM and transgender)		

28. Probe question for Q29 Does the country have a SBCC (Social Behavioural change Communication) Strategy for adolescents, youth and those from key populations? Y/N *(For SP/MCP5 Output 1.1 Indicator 11)*		
29. 28. Are there any IEC materials on SRHR available in the country?		
30. Any available IEC materiel focus on linkages (SRHR and HIV)?		
31. Probe question for Q32 Is the national CSE/FLE education curriculum aligned with international standards? Y/N *(For SP/MCP5 Output 3.1 indicator 5)*		
32. Do the outreach programme provide Comprehensive sexuality education at primary and secondary		

SECTION 4: Youth leadership		
	Comments	**Source of information**
33. Does the country have a strategy/policy/ guidelines/national standard on YFHS? If so, describe.		
34. How many facilities offer some form of youth friendly health services? List them.		
35. Have YFHS facility assessments been done? If so, in which facilities?		
36. How are organizations of young people involved in responses to HIV and in SRH programming (part of situation analysis, planning, budgeting, implementing, evaluation, youth engagement)		
Youth Involvement		
35. Is there a youth advisory committee on SRH, HIV in the country?		
36. Does the national youth council deal with SRH issues? If so, how?		
37. Are young people consulted in health sector policy development, planning and/ or reporting?		

SECTION 5: Condom Programming		
38. Where are condoms (male and female) available?	☐ health centers ☐ bars & nightclubs ☐ shops Other: _____	
39. Are condoms for sale in the country?		
40. Is lubricant available in the country? Where?		
41. Are there community-based distributors in the country?		
42. Are condoms available equally in rural areas as in urban areas?		

D. Humanitarian

1. Does the policy reflect some kind of needed response in times of crisis/ disaster?	
2. Does the system enable or support SRHR in times of crisis?	
3. Are there service delivery guidelines for SRHR during humanitarian crisis?	
4. Does the country have a humanitarian contingency plan that include elements for addressing SRH needs of women, adolescents and youth including services for survivors of sexual violence in crises? Y/N. If possible obtain contingency plan document. *(For SP/MCP5 indicator 12 output 1.1)*	

APPENDIX 3: LIST OF KEY INFORMANTS

	Officer's Name	Health facility	Position	Type of Interview
1	Teribauea Irata	Temanoku clinic	Medical Assistant	Clinic visit
2	Tabuki Romatoa	Betio Maternity Ward	Senior Nursing Officer	Clinic visit
3	Berite Rotau	Banreaba Clinic	Nursing Officer	Clinic visit
4	Buari Titiku	Bikenibieu East Clinic	Medical Assistant	Clinic visit
5	Terieri Titan		Nursing Officer	Clinic visit
6	Teraaiti Merang	Kariatibike Health Center-Abemama island	Medical Assistant	Clinic visit
7	Ane Kabatia	Kabangaki Clinic	Nursing Officer	Clinic visit
8	Roiti Tiorim	Abesiku Islet - Abemama Island	Nursing Officer	Clinic visit
9	Kabwebwe Temake	Taburao Health Center	Medical Assistant	Clinic visit
10	Diana Eriata	Ubanteman/Ubwarano	Nursing Officer	Clinic visit
11	Aotai Kotua	Riboono Islet Clinic-Abaiang	Nursing Officer	Clinic visit
12	Ruta Tarangauea	Nuotaea Islet Clinic-Abaiang	Nursing Officer	Clinic visit
13	Buraieta Morris	Baretoa Clinic -Abemama	Nursing Officer	Clinic visit
14	Terengauea Nganga	Bairiki Clinic	Medical Assistant	Clinic visit
15	Tokataake Katauea		Nursing Officer	Clinic visit
16	Tietie. Temoone	Tanimaiaki Clinic Abaiang	Nursing Officer	Clinic visit
17	Emaima Tautebwa	YFHS	Former YFHS Nurse	Key informant Interview
18	Ione Tataua	HIV Unit	YFHS Nursing Officer	Key informant Interview
19	Mareta Tito		HIV senior Nurse	Key informant Interview
20	Taonibeia Terubea		HIV Field Officer	Key informant Interview
21	Norma Y	Kiribati Family Health Association (FFHA)	Executive Director	Key informant Interview
22	Rieote Tong		Senior Clinical Nurse	Key informant Interview
23	Tamoa Iotebe		Healthy Family Project coordinator	Key informant Interview
24	Abi Tara		Youth Officer	Key informant Interview

APPENDIX 4: LIST OF HEALTH FACILITIES

(South Tarawa, Betio, Abaiang Island and Abemama Island)

Locations	Total No of health facilities and Names of Facilities Visited	No Visited	Names of facilities visited
South Tarawa (10)	• Tarawa Urban Council • Buota/Bonriki Clinic • Temaiku Clinic • Bikenibeu-East Clinic • Bikenibeu West Clinic • Eita Clinic • Banraeaba Clinic • Teaoraereke Clinic • Nanikai Clinic • Bairiki Clinic • ANC Clinic, TCH	4	Bikenibeu-East Banraeaba Clinic, Bairiki Clinic, ANC Clinic, TCH
Betio (5)	• Takoronga Clinic • Temanoku Clinic • Temakin Clinic, Betio Maternity Ward • Betio Hospital	3	Temanoku Clinic Maternity Ward -Betio Hospital
Abaiang Island (9)	• Taburao Health Center • Taneau Clinic • Tanimaiaki Clinic • Tuarabu Clinic • Koinawa Clinic • Borotiam Clinic • Ubanteman Clinic • Ribono Clinic - clinic on Ribono islet • Nuotaea Clinic on Nuotaea islet	5	Taburao Health Center Tanimaiaki Clinic Ubanteman Clinic Ribono Clinic Nuotaea Clinic
Abemama Island (6)	• Kariatebike Health Center • Tekatirirake Clinic • Kabangaki Clinic • Baretoa Clinic • Tabiang Clinic • Abetiku Clinic on Abetiku Islet	4	Kariatebike Health Center Kabangaki Clinic Baretoa Clinic Abatiku Clinic

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