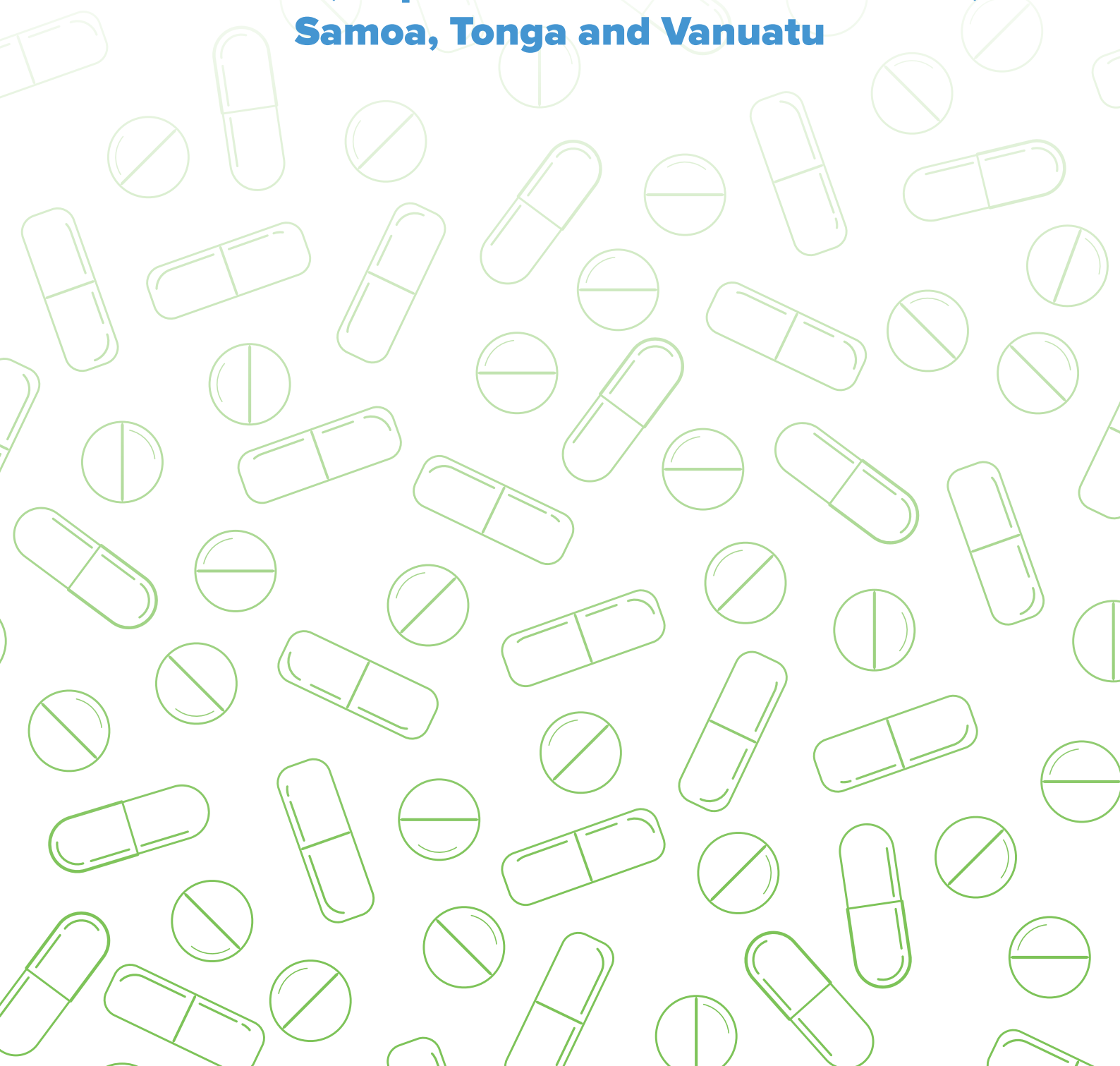




**Pre-exposure prophylaxis feasibility
assessment and implementation framework
in Kiribati, Republic of the Marshall Islands,
Samoa, Tonga and Vanuatu**



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Acronyms

3TC	Lamivudine
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
BIMBA	Boutokaan Inaomataia ao Mauriia Binabinaine Association
CAB-LA	Long-acting injectable cabotegravir
CCM	Country Coordinating Mechanism
FSW	Female sex worker
FTC	Emtricitabine
GDP	Gross domestic product
HIS	Health information system
HPAC	Health Programme Advisory Committee
IEC	Information, education and communication
KFHA	Kiribati Family Health Association
MHHS	Ministry of Health & Human Services (Marshall Islands)
MHMS	Ministry of Health and Medical Service (Kiribati)
MOH	Ministry of Health (Samoa, Tonga, Vanuatu)
MSM	Men who have sex with men
NGO	Non-governmental organization
PLHIV	People living with HIV
PrEP	Pre-exposure prophylaxis
PIRMCCM	Pacific Islands Regional Multi-Country Coordinating Mechanism
PSGDN	Pacific Sexual and Gender Diversity Network
RMNCH	Reproductive, maternal, newborn, child and adolescent health
SDG	Sustainable Development Goal
SFHA	Samoa Family Health Association
SOGIE	Sexual orientation, gender identity and gender expression
STI	Sexually transmitted infection
TDF	Tenofovir disoproxil fumarate
TFHA	Tonga Family Health Association
UNDP	United Nations Development Programme
VFHA	Vanuatu Family Health Association
WHO	World Health Organization

Definitions of key populations

The United Nations Development Programme (UNDP) definitions for key populations have been used throughout this report when referring to programme activities and for reporting classifications.¹ The use of key population terminology is not intended to imply that key populations are culturally homogenous across and within Pacific Island countries. From an epidemiological and risk behaviour perspective, key populations are socially marginalized, often criminalized, and face a range of human rights abuses that increase their vulnerability to HIV. In the context of HIV, key populations include:

- men who have sex with men (MSM)
- transgender people, especially transgender women
- sex workers
- people who inject drugs
- people living with HIV
- prisoners and people in closed spaces
- seafarers.

Key populations targeted through the Global Fund-financed Integrated HIV/TB and Malaria grants for the Multi-Country Western Pacific in the countries included in this report (Kiribati, Republic of the Marshall Islands, Samoa, Tonga and Vanuatu) include female sex workers (FSWs), MSM, transgender women and seafarers (Kiribati only).

Sex workers

The global definition of sex workers includes female, male and transgender adults (18 years of age and above) who receive money or goods in exchange for sexual services, either regularly or occasionally. Kiribati, Marshall Islands, Tonga and Vanuatu define sex workers as females, while Samoa includes females, males and transgender adults.

Men who have sex with men

The regional definition for MSM includes males who have sex with males, regardless of whether or not they also have sex with women or have a personal or social gay or bisexual identity. In the Pacific context this definition excludes self-identified transgender women.

Transgender women

The regional definition of transgender women includes people who are born biologically male, self-identify as female and whose sexual preference differs across countries. There are country-specific terms used, including *binabinaine* in Kiribati, *fa'afafine* in Samoa and *fakaleitileiti* or *leititi* in Tonga.

Seafarers

The regional definition includes any male aged 17 years and over who is engaged in working on a ship that is docked or based in the country.

¹ United Nations Development Programme, 'Key Populations Definitions and Recommended Service Delivery Packages within the Multi-Country Western Pacific Integrated HIV/TB Programme (2022–2027)', UNDP, Bangkok, 2018.

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Executive summary

Key findings

Knowledge and awareness: There was low awareness about pre-exposure prophylaxis (PrEP) for HIV prevention among all health care workers, community workers and representatives of key populations interviewed in all countries. Most countries anticipated no government or community opposition to PrEP for key populations.

Acceptability: The procedures for conducting country-led consultations and making the final decision on whether or not to implement PrEP have not been determined and should be confirmed. Despite their low level of knowledge and awareness, all stakeholders consulted indicated that PrEP would be acceptable for some populations. In all countries, the stakeholders indicated that eligible serodiscordant couples² would use PrEP if offered. In all countries, transgender women would use PrEP if offered; however, the size of the population and level of engagement with transgender women varied across countries. Female sex workers (FSWs) and men who have sex with men (MSM) remain largely hidden, and anticipated uptake is unknown for most countries surveyed. PrEP intentions and preferences among key populations are not known, and a formal assessment using research methodology should be conducted as a priority. Some health care workers, community workers and representatives of key populations were concerned about potential adherence to oral PrEP regimens, and stated a clear preference for long-acting injectable cabotegravir (CAB-LA) when feasible.

Opportunities: In all countries it may be feasible to integrate PrEP for eligible serodiscordant couples into the existing programme for clinical management of people living with HIV (PLHIV), due to the small number of people and existing linkages. Relationships between ministries of health, civil service organizations representing key populations, and non-governmental organizations (NGOs) differed across the countries but were strongest in Tonga and Samoa. Hospital-based communicable disease clinics in Samoa and Tonga are suitable for pilot implementation of PrEP due to the scope and expertise of the services provided and their engagement with transgender women. Stakeholders indicated that PrEP provision should be overseen by a medical doctor, and there is limited integration of medical doctors in outreach activities; however, medical doctors are stationed at static clinics. There may be the potential to integrate PrEP into outreach activities engaging transgender women in Samoa and Tonga initially, and potentially other countries after a pilot phase, if sufficient resources are provided to ensure appropriate levels of human resources and commodities. PrEP is not included as a key HIV prevention tool in many countries' national HIV policies; however, several countries are in the process of updating national HIV policies, providing an opportunity to include PrEP.

Barriers: Although there has been some progress in improving attitudes to transgender women and MSM, stigma and discrimination remain. Regulatory approval for PrEP is not currently in place and is required if PrEP is to be procured through national systems; however, stakeholders indicate a clear preference for procurement of PrEP by UNDP through a bulk purchase scheme. There is concern for the capacity for regular testing among PrEP users due to frequent stock-outs of test kits in most countries. Country Coordination Mechanisms are not active in most countries. Existing resources are insufficient to integrate PrEP into existing programmes.

Recommendations

- Engage the Pacific Sexual and Gender Diversity Network (PSGDN) to conduct a PrEP intentions and preferences study with all member countries, with appropriate support from a research institution, to inform the implementation of PrEP in Pacific Island countries.
- Support internal consultation for countries to determine if there is national-level consensus to proceed with PrEP implementation.

2 Eligible serodiscordant couples are serodiscordant couples where the PLHIV has detectable and unsuppressed viral load.

- In 2024, initiate a preparatory phase for PrEP in all countries supported by the Pacific Islands Regional Multi-Country Coordinating Mechanism (PIRMCCM), including the regional coordination and sharing of the following:
 - obtaining regulatory approval;
 - establishing a bulk purchase scheme for procurement of PrEP for PIRMCCM-supported countries, and ensuring that CAB-LA is included in scope for future procurement;
 - development of information, education and communication materials for health care workers and potential PrEP users; and
 - development of monitoring and evaluation tools, including development of a regional electronic registry for PrEP management and monitoring and evaluation.
- In 2025, launch a pilot implementation of PrEP:
 - with eligible serodiscordant couples in Kiribati, Marshall Islands, Samoa and Tonga; and
 - with transgender women in Tonga and Samoa; and
 - consider expansion in 2026 and 2027 to include delivery via outreach activities (in Samoa and Tonga) and other key populations and sites after the pilot implementation.
- Continue to establish and/or strengthen integrated sexual health services in all countries, including ensuring that commodities for HIV prevention are consistently available, with particular focus on resolving issues associated with HIV test kit stock-outs.
- Include the three recommended core indicators in the monitoring and evaluation framework:
 - PrEP Indicator 1: total number of PrEP recipients;
 - PrEP Indicator 2: PrEP coverage; and
 - PrEP Indicator 3: volume of PrEP prescribed.
- Explore the potential to customize products such as DHIS2 or Tamanu to develop an enhanced PrEP registry that records non-identifiable, longitudinal individual-level data in an open-source, patient-level electronic registry for patient monitoring and reporting, with dashboards displaying core indicators by country and regionally.

1.

Introduction



Pre-exposure prophylaxis (PrEP) is the use of an antiretroviral medication by HIV-negative people to reduce the risk of HIV acquisition. To date, the World Health Organization (WHO) has recommended three methods of PrEP to prevent HIV transmission for use by people at risk of HIV infection: oral PrEP, dapivirine vaginal ring and long-acting injectable cabotegravir (CAB-LA).³

In September 2015, WHO issued a strong recommendation that oral PrEP should be offered as an additional prevention choice for people at substantial risk of HIV infection, as part of combination HIV prevention approaches.⁴ Oral PrEP is very safe, with no side effects for 90 percent of users, whereas about 10 percent of people who start PrEP will have some mild, short-term side effects such as gastrointestinal symptoms, dizziness or headaches.⁵ Daily PrEP involves taking a co-formulated tablet containing tenofovir disoproxil fumarate (TDF) once a day on an ongoing basis for the desired period, and subsequent guidance in 2019 provided the additional option of event-driven PrEP for MSM only.⁶ When used as prescribed (i.e. with optimal adherence), daily PrEP is a highly effective HIV prevention strategy, reducing the risk by about 99 percent.⁷

WHO added tenofovir disoproxil fumarate (TDF) for PrEP to the core list in the 20th WHO Model List of Essential Medicines in 2017.⁸ The list includes TDF as a mono-formulated tablet or co-formulated with emtricitabine (TDF/FTC) or lamivudine (TDF/3TC).⁹ TDF for hepatitis B had been previously included on the 19th Essential Medicines List in 2015.¹⁰

Effectiveness depends on adherence (taking a pill daily), and poor or inconsistent adherence to daily oral PrEP has emerged as a key barrier to effective HIV prevention. Several studies have struggled to optimize adherence, particularly in low- and middle-income settings.¹¹ Thus, the development of a more potent, less user-dependent, longer-acting dosing regimen has become necessary to overcome challenges to consistent use and poor adherence.

In January 2021, WHO recommended the dapivirine vaginal ring (DVR) as an additional option for HIV prevention for women at substantial risk of HIV infection.¹² The ring delivers dapivirine over the course of a month directly to vaginal tissue to help protect against HIV at the site of potential infection. Limitations of the DVR include use in women only, protection for one month only, user dependence, potential for urogenital side effects, and need for frequent refills.

-
- 3 World Health Organization, 'Differentiated and simplified pre-exposure prophylaxis for HIV prevention. Update to WHO implementation guidance', Technical brief, WHO, Geneva, 2022.
 - 4 World Health Organization, 'Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV', WHO, Geneva, 2015.
 - 5 World Health Organization, Module 1: Clinical, in: 'WHO Implementation tool for pre-exposure prophylaxis (PrEP) of HIV infection', WHO, Geneva, 2017.
 - 6 World Health Organization, 'Prevention and control of sexually transmitted infections (STIs) in the era of oral pre-exposure prophylaxis (PrEP) for HIV', WHO, Geneva, 2019.
 - 7 Grant RM, Anderson PL, McMahan V, Liu A, Amico KR, Mehrotra M, et al. Uptake of pre-exposure prophylaxis, sexual practices, and HIV incidence in men and transgender women who have sex with men: a cohort study. *Lancet Infect Dis.* 2014 Sep;14(9):820–829; Liu AY, Cohen SE, Vittinghoff E, Anderson PL, Doblecki-Lewis S, Bacon O, et al. Preexposure Prophylaxis for HIV Infection Integrated With Municipal- and Community-Based Sexual Health Services. *JAMA Intern Med.* 2016 Jan 1;176(1):75; Grant RM, Lama JR, Anderson PL, McMahan V, Liu AY, Vargas L, et al. Preexposure chemoprophylaxis for HIV prevention in men who have sex with men. *N Engl J Med.* 2010 Dec 30;363(27):2587–2599.
 - 8 World Health Organization, 'WHO updates Essential Medicines List with new advice on use of antibiotics, and adds medicines for hepatitis C, HIV, tuberculosis and cancer', WHO, Geneva, 2017, <https://www.who.int/news/item/06-06-2017-who-updates-essential-medicines-list-with-new-advice-on-use-of-antibiotics-and-adds-medicines-for-hepatitis-c-hiv-tuberculosis-and-cancer>.
 - 9 World Health Organization, 'WHO model list of essential medicines, 20th list', WHO, Geneva, 2017, <https://www.who.int/medicines/publications/essentialmedicines/en/>.
 - 10 World Health Organization, 'The Selection and Use of Essential Medicines. Report of the WHO Expert Committee, 2015 (including the 19th WHO Model List of Essential Medicines and the 5th WHO Model List of Essential Medicines for Children)', WHO, Geneva, 2015.
 - 11 Sidebottom D, Ekström AM, Strömdahl S. A systematic review of adherence to oral pre-exposure prophylaxis for HIV - how can we improve uptake and adherence? *BMC Infect Dis.* 2018 Nov 16;18(1):581.
 - 12 World Health Organization, 'WHO recommends the dapivirine vaginal ring as a new choice for HIV prevention for women at substantial risk of HIV infection', WHO, Geneva, 2021, <https://www.who.int/news/item/26-01-2021-who-recommends-the-dapivirine-vaginal-ring-as-a-new-choice-for-hiv-prevention-for-women-at-substantial-risk-of-hiv-infection>.

In July 2022, WHO added CAB-LA to its list of recommended options for HIV prevention.¹³ CAB-LA is an intramuscular injectable, long-acting form of PrEP, with the first two injections administered four weeks apart, followed thereafter by an injection every eight weeks. Limitations of CAB-LA include dosing frequency of every two months requiring frequent visits to health care facilities, non-removability of the dosage form in case of adverse reactions or a change in user preference, current high cost of the final product, and long pharmacokinetic tail after PrEP discontinuation.¹⁴

In July 2023, WHO updated its HIV treatment algorithm to include three defined terms and their corresponding risk levels for transmission of HIV to sexual partners:

- undetectable: not detected by WHO-validated test/sample type used; zero risk
- suppressed: detected but $\leq 1,000$ copies/mL; almost zero risk or negligible risk
- unsuppressed: viral load of $>1,000$ copies/mL; increased vulnerability of transmitting HIV.¹⁵

PLHIV who have an undetectable viral load have zero risk of transmitting HIV to their sexual partner(s). Oral and other forms of PrEP for HIV prevention will therefore add limited additional benefit to reducing the risk of HIV transmission in serodiscordant couples where one partner has undetectable viral load.

There are concerns that the introduction of PrEP may pose risks, such as an increase in risky sexual behaviour (for example, decrease in condom use), and have an impact on the budget in already constrained health systems. In response, WHO has emphasized that:

- sexually transmitted infection (STI) services are often underprioritized and poorly funded nationally and by international donors, and PrEP presents an opportunity to think strategically about how more comprehensive services can be supported by governments and other stakeholders;¹⁶
- PrEP should be implemented as part of a broader package of services, which includes HIV testing services, assisted partner notification, provision of male and female condoms and lubricants, contraception choices, screening and treatment of STIs, and opportunities to vaccinate for viral hepatitis A and B, and human papilloma virus;¹⁷ and
- health services should integrate PrEP within existing STI services—for example, within services that target key populations (such as MSM, sex workers, people who inject drugs, and transgender people) or provide HIV testing, STI screening, condoms and other family planning services.¹⁸

At the end of 2022, 100 countries reported PrEP uptake data to UNAIDS. Among the 2.5 million PrEP users globally, over 60 percent were in Africa.¹⁹ Despite WHO recommendations and high effectiveness, PrEP implementation has been slow in Pacific Island countries, and no country is currently offering PrEP as part of a combination HIV prevention approach.

Pacific Island countries include 22 countries comprising thousands of islands and atolls. They are marked by expansive geography, relatively small populations and diverse cultures, and they range from lower- to upper-middle-income economies. HIV vulnerability is high across the Pacific due to factors such as widespread migration and mobility, dense sexual networks, a large caseload of untreated STIs, low knowledge about HIV

13 World Health Organization, 'WHO recommends long-acting cabotegravir for HIV prevention', WHO, Geneva, 2022, <https://www.who.int/news/item/28-07-2022-who-recommends-long-acting-cabotegravir-for-hiv-prevention>; World Health Organization, 'What's the 2+1+1? Event-driven oral pre-exposure prophylaxis to prevent HIV for men who have sex with men: Update to WHO's recommendation on oral PrEP', WHO, Geneva, 2019.

14 Liegeon G, Ghosn J. Long-acting injectable cabotegravir for PrEP: A game-changer in HIV prevention? *HIV Med.* 2023 Jun 5;24(6):653–663.

15 World Health Organization, 'The role of HIV viral suppression in improving individual health and reducing transmission', Policy Brief, WHO, Geneva, 2023.

16 World Health Organization, 'Prevention and control of sexually transmitted infections (STIs) in the era of oral pre-exposure prophylaxis (PrEP) for HIV', WHO, Geneva, 2019.

17 Ibid.

18 World Health Organization, Module 13: Integrating STI services, in: 'WHO implementation tool for pre-exposure prophylaxis (PrEP) of HIV infection', WHO, Geneva, 2022.

19 UNAIDS, 'People Receiving Pre-Exposure Prophylaxis (PrEP)', UNAIDS, Geneva, 2023, <https://aidsinfo.unaids.org/>.

and STIs, high levels of transactional sex, and significant levels of intimate partner violence. Despite the high vulnerability to HIV, available data suggest that most Pacific Island countries have low HIV prevalence.

In developing evidence-based clinical guidelines, WHO considers the values and preferences of users. Understanding knowledge, acceptability and potential barriers and facilitators to PrEP uptake is critical to its success. No assessment of the values, preferences and acceptability of oral or injectable PrEP has been conducted in any Pacific Island country; therefore, the Pacific has not been represented in systematic reviews that collate evidence on the values, preferences and acceptability of oral PrEP²⁰ or injectable PrEP.²¹ Given the diverse geographic, demographic and cultural factors across the Pacific Island countries, it is important to also consider the values, preferences and acceptability of oral and injectable PrEP when designing a PrEP implementation framework for the Pacific.

There is increasing impetus to address the low uptake of PrEP in the Pacific region and develop a plan for PrEP implementation, especially for countries represented under the Pacific Islands Regional Multi-Country Coordinating Mechanism (PIRMCCM). PIRCCM is the regional governance mechanism for the Global Fund-financed Integrated HIV/TB and Malaria grants for the Multi-Country Western Pacific, representing 11 Pacific Island countries (Cook Islands, Federated States of Micronesia, Kiribati, Republic of the Marshall Islands, Nauru, Niue, Palau, Samoa, Tonga, Tuvalu and Vanuatu).

To address the limited uptake of PrEP in Pacific Island countries and to support planning for potential PrEP implementation, a situational and feasibility assessment was conducted in 2023 in five Pacific Island countries (Kiribati, Republic of the Marshall Islands, Samoa, Tonga and Vanuatu).

20 Koechlin FM, Fonner VA, Dalglish SL, O'Reilly KR, Baggaley R, Grant RM, et al. Values and Preferences on the Use of Oral Pre-exposure Prophylaxis (PrEP) for HIV Prevention Among Multiple Populations: A Systematic Review of the Literature. *AIDS Behav.* 2017 May 29;21(5):1325–1335.

21 Lorenzetti L, Dinh N, van der Straten A, Fonner V, Ridgeway K, Rodolph M, et al. Systematic review of the values and preferences regarding the use of injectable pre exposure prophylaxis to prevent HIV acquisition. *J Int AIDS Soc.* 2023 Jul 13;26(S2).

2.

Purpose and methodology



A situational analysis was conducted between July and September 2023 to identify opportunities for and barriers to oral PrEP implementation and scale-up in the five countries. The analysis was based on interviews with UNDP focal points and additional key stakeholders (see Appendix 1). Interviews were supplemented by a literature review to identify key policy and epidemiological reports, and grey literature was identified through discussion with stakeholders.

The HIV landscape in each country was described under the following domains:

- HIV epidemiology (including number of people diagnosed and size of key populations)
- HIV response (including policy, programme coordination, management of PLHIV, health services, testing, procurement, and activities funded under the Multi-Country Western Pacific Integrated HIV/TB Programme).

The feasibility of PrEP implementation was assessed under the following domains for each country:

- knowledge and awareness
- acceptability
- opportunities
- barriers.

For countries that choose to implement PrEP, the recommended implementation steps to roll out PrEP were guided by the OPTIONS Plan 4 PrEP Toolkit created by the OPTIONS Consortium, which supports national planning for the roll-out of oral PrEP.²² The toolkit was designed and used to support planning for the introduction of oral PrEP for HIV prevention in Kenya, Zimbabwe and South Africa; however, it was also designed to help users in other countries planning to introduce and roll out oral PrEP and other PrEP products. The OPTIONS Plan 4 PrEP Toolkit uses a four-factor value chain including:

- budgeting and planning
- logistics and support
- PrEP delivery and uptake
- monitoring and evaluation.

²² OPTIONS Consortium, Step 1: Situation Analysis, in 'Oral PrEP Introduction Planning Toolkit 1', OPTIONS Consortium, 2021.

3.

Description of the HIV landscape



3.1 HIV landscape in Kiribati

Country context

Kiribati comprises 32 small atolls and one raised coral island that cover an area of 800 square kilometres and are dispersed over 3,500,000 square kilometres along the equator. Most of the islands are less than 2 kilometres wide and less than 2 metres above sea level, making Kiribati one of the most vulnerable countries globally to climate change and rising sea levels. The capital, South Tarawa, covers around 15 square kilometres and consists of several islets connected by a series of causeways. Half of the population live in South Tarawa, and population density due to rapid urbanization is a persistent issue. Kiritimati Island is Kiribati's other major shipping port and the country's second major population centre, located 3,000 kilometres east of South Tarawa and requiring transit flights through either Fiji or Hawaii. Kiribati is part of the larger island group of Micronesia.

The World Bank estimated the population of Kiribati to be approximately 131,000 people in 2022, of whom 43 percent live in rural areas, and 36 percent were under 15 years of age.²³ Kiribati is classified as a lower-middle-income country, with a gross domestic product (GDP) per capita of US\$1,702 in 2022.²⁴ The maritime industry, and foreign fishing vessels in particular, are crucial to the economy of Kiribati. Wages and other remittances from i-Kiribati seamen and fishermen on overseas ships are major sources of income for local families. Earnings from access fees for Kiribati's large and exclusive economic zone and the licensing of foreign fishing vessels comprised 70 percent of the country's fiscal revenues in 2020.²⁵

The Government of Kiribati is the main provider of health services. The country is administratively divided into six health districts: Tarawa & Banaba, Central, Northern, South Eastern, South Western and Linnix. There are four hospitals, including the central referral hospital, Tungaru Central Hospital located in South Tarawa. Hospitals are supported by 35 health centres and 75 village health clinics and dispensaries.²⁶ Health centres are mostly staffed by medical assistants (nurses with postgraduate training in midwifery and public health), and village health clinics are mostly staffed by public health nurses. Medical officers and nurses are stationed at the four main hospitals, and specialist medical practitioners are stationed at Tungaru Central Hospital and one secondary hospital. While progress has been made towards universal health coverage in Kiribati, rates remain low compared to other countries in the Western Pacific. According to the 2018 'WHO Universal Health Care and Sustainable Development Goal (SDG) Country Profile', Kiribati has limited service capacity and access, as well as low coverage of essential services.²⁷ Similar to other countries in the region, Kiribati has a high burden of non-communicable diseases, which has risen progressively over the last 30 years.

HIV epidemiology

Number of people diagnosed with HIV

As of the end of 2022, a total of 63 people had been diagnosed with HIV in Kiribati;²⁸ among these people, 48 have died, 8 PLHIV are monitored by the Ministry of Health (MOH), and 7 people have been lost to follow-up. All eight PLHIV in Kiribati are on antiretroviral therapy (ART), and seven are virologically suppressed.²⁹ The number of serodiscordant couples is unknown. Modes of transmission reported to date include mother-to-child transmission and heterosexual contact. Six of the eight PLHIV live in South Tarawa.

23 World Bank, 'Country overview: Vanuatu', World Bank, Washington, DC, 2023, <https://data.worldbank.org/country/VU>.

24 Ibid.

25 International Monetary Fund, 'Fisheries Developments in Kiribati: Sustainability and Growth', IMF, Washington, DC, 2023.

26 United Nations Population Fund, 'Kiribati Health Facility Readiness and Service Availability (HFRSA) Assessment: Kiribati', UNFPA, Suva, 2020, <https://pacific.unfpa.org/en/publications/kiribati-health-facility-readiness-and-service-availability-hfrsa-assessment>.

27 World Health Organization, 'Universal Health Care and Sustainable Development Goal Country Profile: Tonga', WHO, Manila, 2018, <https://apps.who.int/iris/handle/10665/272311?locale-attribute=zh&>.

28 M. Tito, personal communication, 25 August 2023.

29 United Nations Development Programme Pacific Office in Fiji, 'Multi-Country Western Pacific Integrated HIV/TB Programme Key Performance Indicators 2022', UNDP, Suva, 2023.

Key populations at increased risk of HIV infection

Overview of key populations

The local term *binabinaine* is inclusive of gay men, bisexual men, transgender women and people with fluid gender in Kiribati.³⁰ For this reason, transgender women and MSM are considered collectively in Kiribati rather than distinct groups; this differs from the definition included in the definitions of key populations.³¹ Cultural acceptance and integration of *binabinaine* vary across Kiribati. Consensual sex between adult men is illegal in Kiribati.³² The civil society organization Boutokaan Inaomataia ao Mauriia Binabinaine Association (BIMBA) was established in 2016 to support the human rights, health and well-being of *binabinaine* in Kiribati. The organization is well connected to international and regional sexual diversity organizations and is a member of the Kiribati HIV Country Coordinating Mechanism (CCM) and AIDS Task Force. BIMBA is located within the HIV Unit at Tungaru Central Hospital. Despite positive steps to change attitudes, stigma and discrimination remain against *binabinaine*, and discreet outreach strategies are used for engagement by stakeholders. Although there are no known cases of HIV among *binabinaine* in Kiribati, and levels of HIV awareness and knowledge are high, HIV vulnerability remains high due to inconsistent condom use with regular and casual partners and low HIV testing rates.³³

The local term *ainen matawa* refers to women who sell or transact sex with foreign fishermen at bars and on foreign fishing vessels.³⁴ Compared to informal and intermittent FSWs in other Pacific Island countries, several *ainen matawa* identify as such in Kiribati. Small networks of *ainen matawa* may live together, socialize and move around vessels together. Women who are identified as *ainen matawa* suffer from marginalization and discrimination.³⁵ Solicitation of sex work is illegal in Kiribati.³⁶ There are *ainen matawa* in both Betio and Kiritimati; however, around 70 percent are believed to be based in South Tarawa.³⁷ To date, HIV has not been detected among the *ainen matawa* population; however, they are considered vulnerable for several reasons: (1) partners of *ainen matawa* are mostly seafarers travelling through Kiribati, and seafarers are at increased risk of HIV and STIs;³⁸ (2) while recent data are limited, previous studies have reported a high rate of STIs among *ainen matawa*,³⁹ and STIs facilitate HIV transmission; and (3) while knowledge about HIV was found to be high among *ainen matawa* in the most recent assessment conducted, condom use is inconsistent, and there is a low HIV testing rate.⁴⁰

Many i-Kiribati work as merchant seafarers on international vessels in the maritime industry, and foreign fishing vessels in particular are crucial to the economy of Kiribati.⁴¹ Seafarers are considered to have a greater risk of HIV and STIs due to working and living away from spouses and partners, single-sex working and living arrangements, and the availability of sex workers in ports. Around a quarter of seafarers in Kiribati reported

30 Worth H, McMillan K, Rawstorne P., 'Kiribati: Pacific Multi-country Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations', ASHM, Sydney, 2016; Burnett R., 'Narratives of Culture and Development in Kiribati: Reconciling Tensions to Advance Gender Equality', Master of Arts in Pacific Studies, University of Auckland, Auckland, 2022.

31 United Nations Development Programme, 'Key Populations Definitions and Recommended Service Delivery Packages within the Multi-Country Western Pacific Integrated HIV/TB Programme (2022–2027)', UNDP, Bangkok, 2018.

32 Kiribati, Penal Code, Revised Edition 1977, Section 153, http://www.paclii.org/ki/legis/consol_act/pc66/.

33 Worth H, McMillan K, Rawstorne P., 'Kiribati: Pacific Multi-country Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations', ASHM, Sydney, 2016.

34 McMillan K, Worth H., 'Risky Business Kiribati: HIV prevention amongst women who board foreign fishing vessels to sell sex', ASHM, Sydney, 2010.

35 Ibid.

36 Kiribati, Penal Code, Revised Edition 1977, Section 167(f), http://www.paclii.org/ki/legis/consol_act/pc66/.

37 Ibid.

38 Toatu T, White P, Hoy D, Iniakwala D, Edwin A Merrilles O, Gopalani SV. Prevalence of HIV and sexually transmitted infections among young women engaged in sex work aboard foreign fishing vessels in Kiribati. *Western Pac Surveill Response J.* 2018;9(1):8–15.

39 Ibid.

40 McMillan K, Worth H., 'Risky Business Kiribati: HIV prevention amongst women who board foreign fishing vessels to sell sex', ASHM, Sydney, 2010; Toatu T, White P, Hoy D, Iniakwala D, Edwin A Merrilles O, Gopalani SV. Prevalence of HIV and sexually transmitted infections among young women engaged in sex work aboard foreign fishing vessels in Kiribati. *Western Pac Surveill Response J.* 2018;9(1):8–15.

41 International Monetary Fund, 'Fisheries Developments in Kiribati: Sustainability and Growth', IMF, Washington, DC, 2023.

having paid for sex in the previous 12 months, and condom use with last sex with a casual female partner was low. Over half of seafarers in Kiribati had accessed HIV services in the previous 12 months.⁴²

Population size estimates for key population coverage and targets

The 2023 updated population size estimates for transgender women, MSM and FSWs in Kiribati are below.

Transgender women	Men who have sex with men	Female sex workers
642	362	626

Source: United Nations Development Programme, 'Estimation of the size of key populations in the Multi-Country Western Pacific Integrated HIV/TB Programme countries: Men who have sex with men, transgender women, female sex workers, seafarers, and prisoners', UNDP, Suva, 2022.

HIV response

National HIV strategy and associated guidelines

The Kiribati Ministry of Health and Medical Services (MHMS) HIV policy was endorsed in 2018. The policy outlines Kiribati's current approach to addressing HIV/AIDS and STIs and is complemented by HIV and STI guidelines. It identifies several strategies for HIV prevention, including behaviour change communication, HIV testing services, condom promotion, prevention of mother-to-child transmission, treatment of STIs, infection prevention and control activities, and post-exposure prophylaxis. Although the HIV policy does not specifically mention PrEP as a key HIV prevention method,⁴³ the National HIV/STI Programme Guidelines (2018) notes that people who test negative for HIV should be referred and linked to relevant HIV services, including PrEP.⁴⁴ However, in practice, this has not been implemented, and no one has been offered or received PrEP in Kiribati.

HIV programme coordination

The HIV Unit within the MHMS is co-located at Tungaru Central Hospital in South Tarawa. It is staffed by an HIV coordinator, an HIV nurse, and two peer workers targeting key populations (see below for more information). The HIV coordinator recently resigned, and the position is currently vacant. The HIV Unit works closely with the (acting) communicable disease specialist at Tungaru Central Hospital, who is the only medical officer overseeing HIV treatment in Kiribati. The Kiribati HIV CCM and Core Care Team are both active, with meetings approximately twice per year.

Clinical management of people living with HIV

Currently, all PLHIV in Kiribati are managed at Tungaru Central Hospital, although all four hospitals report capacity to provide HIV treatment.⁴⁵ One medical officer based in the Tungaru Central Hospital oversees care for PLHIV in Kiribati. Levels of stigma and discrimination against PLHIV in Kiribati are high; therefore, ART is delivered to PLHIV directly, to avoid the need to attend hospital and risk disclosure. The HIV nurse, located within the HIV Unit, delivers ART to PLHIV at home regularly and discreetly, and coordinates monitoring tests and reviews. PLHIV in South Tarawa receive a one-month supply of ART, while those in outer islands receive a three-month supply by mail. Epidemiological and clinical data for PLHIV are paper-based, but non-identifiable, individual-level data are entered regularly into an online Excel-based registry for clinical review.

Sexual health services

There are no static government-run sexual health services in Kiribati. Previous reports have recommended that the Kiribati Family Health Association (KFHA) and BIMBA should be supported to establish peer

42 Ibid.

43 Kiribati Ministry of Health & Medical Services, 'Kiribati HIV Policy', MHMS, South Tarawa, 2018.

44 Kiribati National HIV/STI Programme, 'National HIV/STI Guidelines', MHMS, South Tarawa, 2018.

45 United Nations Population Fund, 'Kiribati Health Facility Readiness and Service Availability (HFRSA) Assessment: Kiribati', UNFPA, Suva, 2020, <https://pacific.unfpa.org/en/publications/kiribati-health-facility-readiness-and-service-availability-hfrsa-assessment>.

programmes and sexual health services based in Betio that specifically target transgender women, MSM and FSWs.⁴⁶

KFHA is a non-governmental organization (NGO) part of the International Planned Parenthood Federation. It is based in South Tarawa and has a sexual and reproductive health clinic that predominantly serves young people. It also conducts outreach programmes consisting of education and awareness programmes on HIV and STIs and rapid testing for HIV.

The Marine Training Centre Clinic is a clinic within the broader Marine Training Centre, a training school for seafarers founded in 1967. The Marine Training Centre Clinic is in Betio, approximately 25 km from the Tugaru Central Hospital. It partners with the MHMS and KFHA to provide HIV and STI prevention training to trainee seafarers as part of the seafarer training curriculum, and refresher training for qualified seafarers. In addition, the clinic offers HIV testing and counselling services to newly recruited and returning seafarers, and also to members of the general public on a pay-for-service arrangement.

HIV testing

HIV testing sites listed in the STI/HIV Guidelines include Tugaru Central Hospital, KFHA and the Marine Training Centre in South Tarawa, London Kiritimati Hospital in Kiritimati, and the Tab North Hospital on Tabebuia Island.⁴⁷ The HIV Unit also provides outreach-based and on-site testing.

UNDP supplies Kiribati with the Abbott Bioline HIV/Syphilis Duo test for rapid and point-of-care testing for key populations. UNDP also provides the Bioline HIV test to be used for routine laboratory testing. The MHMS reports frequent stock-outs of test kits, limiting its capacity to provide ongoing HIV testing services. All reactive rapid test results require confirmatory testing, which is conducted using the Trinity Biotech Uni-Gold™ HIV test and the INSTI HIV-1/HIV-2 antibody test. Confirmatory testing is performed at Tugaru Central Hospital only. If a reactive HIV test is confirmed to be positive, the chief of the laboratory informs the HIV Unit or clinicians sending the HIV test request directly.

Sub-recipients of the Multi-Country Western Pacific Integrated HIV/TB Programme to deliver HIV prevention programmes, including HIV testing

Kiribati Ministry of Health and Medical Services

The Kiribati MHMS is the only sub-recipient of the Global Fund grant in Kiribati. For HIV prevention activities targeting key populations, the MHMS receives funding for programmes targeting key populations, including MSM, transgender women and FSWs, for the grant period 2021–2023.⁴⁸

In collaboration with BIMBA, the MHMS established an outreach programme for *binabinaine* and provides a monthly allowance for a representative from BIMBA to provide HIV and STI awareness-raising activities, distribute condoms, and refer people for HIV testing through the HIV Unit. In 2022, the MHMS exceeded Global Fund targets to reach MSM and transgender women with HIV prevention programmes (reaching 403 MSM against a target of 249, and 153 transgender women against a target of 135).⁴⁹

The MHMS has also established an outreach programme for *ainen matawa*, and provides a monthly allowance for a peer worker to provide HIV and STI awareness-raising activities and refer people for HIV testing through the HIV Unit. Outreach activities include HIV awareness, condom distribution and point-of-care testing, and recently much of the outreach work has been delivered directly to *ainen matawa* in shared housing. The peer worker uses discreet communication and engagement strategies to ensure *ainen matawa* are not identified in the general community. In 2022, the MHMS met the Global Fund target of reaching 654 FSWs with HIV prevention programmes (actually reaching 652 FSWs).⁵⁰

46 Worth H, McMillan K, Rawstorne P., 'Kiribati: Pacific Multi-country Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations', ASHM, Sydney, 2016.

47 Kiribati National HIV/STI Programme, 'National HIV/STI Guidelines', MHMS, South Tarawa, 2018.

48 United Nations Development Programme Pacific Office in Fiji, 'Multi-Country Western Pacific Integrated HIV/TB Programme Key Performance Indicators 2022', UNDP, Suva, 2023.

49 Ibid.

50 Ibid.

3.2 HIV landscape in the Republic of the Marshall Islands

Country context

The Republic of the Marshall Islands (hereafter referred to as the Marshall Islands) is an archipelago nation located roughly midway between Australia and Hawaii, north of the equator. It comprises 29 atolls, 5 low coral islands and over 1,151 islets, scattered over an exclusive economic zone of 1.2 million square kilometres. The average altitude of the entire country is about 2 metres above sea level, making it very vulnerable to the effects of climate change and rising sea levels. The capital, Majuro, an atoll comprising 64 islets on an elliptically shaped reef connected by landfill, is home to half the population. The Marshall Islands is part of the larger island group of Micronesia. The Marshall Islands is an independent country in a Compact of Free Association with the United States.

The World Bank estimated the population of the Marshall Islands to be approximately 41,500 people in 2022, of whom 21 percent lived in rural areas, and 33 percent were younger than 15 years of age.⁵¹ The country is classified as an upper-middle-income country, with a GDP per capita of US\$6,728 in 2022. Economic activities include agriculture, fishing, tourism, shipping and finance. Remittances from Marshallese people living abroad comprised 11 percent of the country's GDP in 2022.⁵²

The Government of the Marshall Islands works collaboratively with community health councils to provide health care services. The health system comprises 2 hospitals (Majuro Hospital on the Majuro atolls and Ebeye Hospital on the Kwajalein atolls) and 56 health centres. Hospitals provide primary, secondary and limited tertiary care. According to the 2018 'WHO Universal Health Care and SDG Country Profile', the Marshall Islands has low coverage of essential services and relatively limited health service capacity and access.⁵³ Major challenges remain in the prevention and control of infectious and non-communicable diseases and in service capacity and access. Compared to other countries in the region for SDG 3 indicators, the Marshall Islands is far from reaching the targets in reproductive, maternal, newborn, child and adolescent health (RMNCH), except in the rates of skilled birth attendance and neonatal and under-5 mortality.⁵⁴

HIV epidemiology

Number of people diagnosed with HIV

As of the end of 2022, a total of 34 people had been diagnosed with HIV in the Marshall Islands,⁵⁵ among whom 26 have died, 7 PLHIV are monitored by the MOH, and 1 person has emigrated. All seven PLHIV in the Marshall Islands are on ART, and four are virologically suppressed.⁵⁶ The number of serodiscordant couples is unknown. Modes of transmission reported include heterosexual sex, and many cases were acquired overseas. All PLHIV in the Marshall Islands currently reside in Majuro.

Key populations at increased risk of HIV infection

Overview of key populations

The term *kakkwol* refers to men who assume women's roles and carry their bodies in feminine ways or wear women's clothing; however, behaviour may range from extravagantly feminine to conventionally masculine.⁵⁷

51 World Bank, 'Country overview: Marshall Islands', World Bank, Washington, DC, 2023, <https://data.worldbank.org/country/marshall-islands?view=chart>.

52 Ibid.

53 World Health Organization, 'Universal Health Care and Sustainable Development Goal Country Profile: Republic of the Marshall Islands', WHO, Manila, 2018, <https://apps.who.int/iris/bitstream/handle/10665/272314/WPR-2018-DHS-011-mhl-eng.pdf?sequence=1&isAllowed=y>.

54 World Bank, 'Country overview: Marshall Islands', World Bank, Washington, DC, 2023, <https://data.worldbank.org/country/marshall-islands?view=chart>.

55 Y. Mares, personal communication, 31 August 2023.

56 United Nations Development Programme Pacific Office in Fiji, 'Multi-Country Western Pacific Integrated HIV/TB Programme Key Performance Indicators 2022', UNDP, Suva, 2023.

57 Rawstone P, Drysdale R, Nicholls R, Worth H, O'Connor M, McGill S., 'Pacific Multi-Country Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations – Republic of the Marshall Islands', ASHM, Sydney, 2016.

There has been some progress in reducing stigma and discrimination against *kakkwol* in recent years, although some stigma and discrimination remain, particularly for masculine-identifying *kakkwol*. There is no organization that addresses the health and well-being of *kakkwol*, although a small informal group of *kakkwol* meets quarterly. Consensual same sex sexual activity between men is legal.⁵⁸ While there are no known cases of HIV among *kakkwol* in the Marshall Islands, and levels of HIV awareness and knowledge are high, HIV vulnerability remains high due to low condom use, low knowledge of where to go for an HIV test, and low HIV testing rates.⁵⁹

MSM in the Marshall Islands remain a small and largely hidden group. There is limited information about MSM.

Sex workers are a largely hidden population in the Marshall Islands due to the criminalization of such work and the harsh penalties enforced.⁶⁰ The most recent information was gathered in the 2016 Pacific Multi-Country Mapping and Behavioural Study in Majuro, with most FSWs reporting regular paying clients as being seafarers and that they were sometimes viewed as boyfriends. While condom use and HIV knowledge were reasonably high, there were high rates of STI symptoms in the previous 12 months.⁶¹

The 2022 Multi-Country Western Pacific Integrated HIV/TB Programme Key Performance Indicators noted that there were no known cases of HIV among FSWs in the Marshall Islands;⁶² however, the 2016 study stated that two FSWs self-reported that they were previously diagnosed with HIV and were on ART.⁶³

Population size estimates for key population coverage and targets

The 2022 updated population size estimates for transgender women, MSM and FSWs in the Marshall Islands are below.

Transgender women	Men who have sex with men	Female sex workers
193	136	236

Source: United Nations Development Programme, 'Estimation of the size of key populations in the Multi-Country Western Pacific Integrated HIV/TB Programme countries: Men who have sex with men, transgender women, female sex workers, seafarers, and prisoners', UNDP, Suva, 2022.

HIV response

National HIV strategy and associated guidelines

The Marshall Islands does not have a current HIV strategy; however, there are comprehensive guidelines on STI management, ART and the use of antiretroviral drugs for preventing HIV infection, prevention of mother-to-child transmission, and HIV testing. 'The National Guideline on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection' (2017) notes that people who test negative for HIV should be referred and linked to relevant HIV services, including PrEP.⁶⁴ However, in practice, this has not been implemented, and no one has been offered or received PrEP in the Marshall Islands.

58 UNAIDS, 'Legal and policy trends impacting people living with HIV and key populations in Asia and the Pacific 2014–2019', UNAIDS, Geneva, 2021.

59 Ibid.

60 Marshall Islands, Criminal Code, 2011, Section 251, http://www.paclii.org/mh/legis/consol_act/cc201194/; Rawstorne P, Drysdale R, Nicholls R, Worth H, O'Connor M, McGill S., 'Pacific Multi-Country Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations – Republic of the Marshall Islands', ASHM, Sydney, 2016.

61 Rawstorne P, Drysdale R, Nicholls R, Worth H, O'Connor M, McGill S., 'Pacific Multi-Country Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations – Republic of the Marshall Islands', ASHM, Sydney, 2016.

62 United Nations Development Programme Pacific Office in Fiji, 'Multi-Country Western Pacific Integrated HIV/TB Programme Key Performance Indicators 2022', UNDP, Suva, 2023.

63 Rawstorne P, Drysdale R, Nicholls R, Worth H, O'Connor M, McGill S., 'Pacific Multi-Country Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations – Republic of the Marshall Islands', ASHM, Sydney, 2016.

64 Ministry of Health and Human Services, 'National Guideline on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection', MHHS, Majuro, 2017.

HIV programme coordination

The HIV/STD & Viral Hepatitis Programme sits within the Bureau of Primary Health Care Services at the Ministry of Health and Human Services (MHHS). The programme is overseen by a programme manager. Global Fund-financed activities are overseen by a coordinator. The HIV/STD & Viral Hepatitis Programme works closely with two doctors at Majuro Hospital to coordinate care for PLHIV. The National AIDS Committee is not currently operational.

Clinical management of people living with HIV

Treatment, and care for PLHIV are provided at the tertiary level at Majuro Hospital. There are two doctors who prescribe ART. No private doctors currently provide care for PLHIV. PLHIV receive a three-month supply of ART at each visit. There have been some issues noted with ART compliance among PLHIV. Epidemiological and clinical data for PLHIV are paper-based, but non-identifiable, individual-level data are entered regularly into an online Excel-based registry for clinical review.

Sexual health services

There are no static government-run sexual health services in the Marshall Islands.

Youth to Youth in Health is an NGO established in 1986. It was formed to address rapid urbanization and issues affecting young people, including education and participation, family planning, substance abuse and sexual health, including STI and HIV prevention. The MHHS provides nursing staff to provide limited sexual health services, including HIV testing.

HIV testing

HIV testing is available at the two hospitals and at Youth to Youth in Health. UNDP supplies the Marshall Islands with the Abbott Bioline HIV/Syphilis Duo test for rapid and point-of-care testing for key populations. UNDP also provides the Bioline HIV test to be used for routine laboratory testing. HIV testing for other purposes, such as routine antenatal screening, is funded through other programmes. The MHHS reports occasional stock-outs of test kits. All reactive point-of-care tests require confirmatory testing, which is conducted using the Trinity Biotech Uni-Gold™ HIV test and the INSTI HIV-1/HIV-2 antibody test. Confirmatory testing can be performed at Majuro Hospital only.

Sub-recipients of the Multi-Country Western Pacific Integrated HIV/TB Programme to deliver HIV prevention programmes, including HIV testing

The MHHS is the only sub-recipient of Global Fund funding in the Marshall Islands. For HIV prevention activities targeting key populations, the MHMS receives funding for two programmes targeting key populations, including around 40 MSM, 40 transgender women and 45 FSWs, for the grant period 2021–2023.⁶⁵ The coordinator for Global Fund-financed activities oversees all activities. All activities are outreach-based and focus on HIV prevention, with quarterly testing. In 2022, the MHMS did not meet the Global Fund target to reach 41 MSM with HIV prevention programmes (reaching only 29 MSM),⁶⁶ highlighting challenges of engaging with MSM. The MHMS met the target to reach 45 transgender women (actually reaching 46) and exceeded the target of reaching 45 FSWs (reaching 60) with HIV prevention programmes.⁶⁷ In the 2024–2026 funding round, the MHMS will expand its activities to also target prisoners and seafarers.

65 United Nations Development Programme Pacific Office in Fiji, 'Multi-Country Western Pacific Integrated HIV/TB Programme Key Performance Indicators 2022', UNDP, Suva, 2023.

66 Ibid.

67 Ibid.

3.3 HIV landscape in Samoa

Country context

Samoa is located in the Polynesian region of the Pacific Ocean, 1,152 km northeast of Fiji. Only 4 of Samoa's 12 islands—Upolu, Savai'i, Apolima and Manono—are inhabited. While Upolu and Savai'i are the two largest islands by area, Upolu is the most populous and the location of the capital city, Apia. The World Bank estimated the population of Samoa to be approximately 222,000 people in 2022, 83 percent of whom lived in rural areas, and 38 percent were under 15 years of age.⁶⁸ Samoa is classified as a lower-middle-income country, with a GDP per capita of US\$3,743 in 2022.⁶⁹ Most households rely on income from agriculture. Remittances from Samoans living abroad comprised 34 percent of the country's GDP in 2022.⁷⁰

The Government of Samoa is the main provider of health services. The government health system comprises one national referral hospital, three district hospitals and six community health centres. There is a small private sector made up of general practitioners, pharmacies and allied health practitioners, most of whom are based in Apia. According to the 2018 'WHO Universal Health Care and SDG Country Profile', Samoa's overall progress towards universal health care is in the middle range. Samoa has an average level of coverage of services for infectious disease control and RMNCH. Compared to other countries in the region for SDG 3 indicators, gaps remain in immunization coverage and family planning.⁷¹

HIV epidemiology

Number of people diagnosed with HIV

As of the end of 2022, a total of 27 people had been diagnosed with HIV in Samoa;⁷² among them, 15 have died, and 12 PLHIV are currently monitored by the MOH. At the end of 2022, UNDP reported that eight PLHIV on ART were virologically suppressed;⁷³ however, the MOH reports that all current PLHIV are virologically suppressed. The number of serodiscordant couples is unknown. The most common mode of transmission is heterosexual sex; however, a quarter of cases were infected via mother-to-child transmission.⁷⁴ All 12 PLHIV reside in Apia.

Key populations at increased risk of HIV infection

Overview of key populations

The term *fa'afafine* means 'in the manner of a woman' and refers to men who are raised and identify as females; however, behaviour may range from extravagantly feminine to conventionally masculine. It is a unique Polynesian concept, with *fa'afafine* having socially and culturally accepted roles in the family and community.⁷⁵ Key stakeholders emphasize that not all *fa'afafine* are transgender, and that *fa'afafine* may be gender fluid.⁷⁶ For this reason, transgender women and MSM are considered collectively in Samoa rather than distinct groups; this differs from the definition included in the definitions of key populations.⁷⁷

68 World Bank, 'Country overview: Samoa', World Bank, Washington, DC, 2023, <https://data.worldbank.org/country/samoa?view=chart>.

69 World Bank, 'Rural population (% of total population)', World Bank, Washington, DC, 2023, <https://data.worldbank.org/indicator/SP.RUR.TOTL.ZS>.

70 World Bank, 'Country overview: Samoa', World Bank, Washington, DC, 2023, <https://data.worldbank.org/country/samoa?view=chart>.

71 World Health Organization, 'Universal Health Care and Sustainable Development Goal Country Profile: Samoa', WHO, Manila, 2018, <https://apps.who.int/iris/bitstream/handle/10665/272324/WPR-2018-DHS-021-wsm-eng.pdf>.

72 A. Tanumafili, personal communication, 29 August 2023.

73 United Nations Development Programme Pacific Office in Fiji, 'Multi-Country Western Pacific Integrated HIV/TB Programme Key Performance Indicators 2022', UNDP, Suva, 2023.

74 Government of Samoa, 'National HIV, AIDS, and STI Policy 2017-2022', Government of Samoa, Apia, 2017.

75 Tcherkezoff S., Transgender in Samoa: The Cultural Production of Gender Inequality, in: *Gender on the Edge: Transgender, Gay, and Other Pacific Islanders*, University of Hawaii Press, Honolulu, 2014, pp. 115–134.

76 Samoa Fa'afafine Association, 'Introduction Executive Summary – OHCHR Universal Periodic Review Submissions', Samoa Fa'afafine Association, Apia, 2016, <https://uprdoc.ohchr.org/uprweb/downloadfile.aspx?filename=2505&file=EnglishTranslation>.

77 United Nations Development Programme, 'Key Populations Definitions and Recommended Service Delivery Packages

Stakeholders in Samoa report recent advances in engagement with MSM in Samoa; however, due to stigma and discrimination, challenges remain. In 2013, criminalization of the ‘impersonation of a female’ by any male in Samoa was overturned,⁷⁸ but same-sex sexual relations between men remains illegal.⁷⁹ The civil society organization Samoa Fa’afafine Association was founded in 2006 to support and promote the rights and interests of *fa’afafines*. In 2016, the organization expanded to include *fa’afatama*. The Samoa Fa’afafine Association has approximately 2,000–3,000 members, of whom around 800 are active members. While there are no known cases of HIV among *fa’afafine* in Samoa, HIV vulnerability remains high due to moderate HIV knowledge, low use of condoms and low HIV testing.⁸⁰

As is common in many of the Pacific Island countries, few women who sell or transact sex across Samoa identify as sex workers, which has implications for the targeting of HIV prevention programmes and services. In addition, not all sex workers are female, with some *fa’afafine* transacting sex also. The legal framework is not enabling for people who sell or transact sex in Samoa; sex work in private and soliciting for sex work are illegal in Samoa.⁸¹ FSWs are a hidden population in Samoa, and organizations have struggled to reach them. To date, HIV has not been detected among any FSWs in Samoa; however, they are considered at risk of HIV infection for several reasons, including low use of condoms with paying partners and casual non-paying partners, moderate HIV knowledge, low use of sexual health services and low HIV testing rates.⁸²

Population size estimates for key population coverage and targets

The 2022 updated population size estimates for transgender women, MSM and FSWs in Samoa are below.

Transgender women	Men who have sex with men	Female sex workers
922	667	453

Source: United Nations Development Programme, ‘Estimation of the size of key populations in the Multi-Country Western Pacific Integrated HIV/TB Programme countries: Men who have sex with men, transgender women, female sex workers, seafarers, and prisoners’, UNDP, Suva, 2022.

HIV response

National HIV strategy and associated guidelines

The current HIV policy is the National HIV, AIDS and STI Policy 2017–2022, and a new policy is currently in development. The 2017–2022 policy notes that there may be undetected HIV among key populations, which include MSM, transgender people (*fa’afafine* and *fa’atama*), people who inject or use drugs, prison inmates, sex workers, and adolescents who are sexually active. PrEP is not included in the National HIV, AIDS and STI Policy 2017–2022.

HIV programme coordination

The HIV Unit is staffed by a national HIV coordinator and a senior HIV officer. The HIV Unit works closely with the medical officer in charge of the Communicable Diseases Clinic at Tupua Tamasese Meaole Hospital, who is the only medical officer overseeing HIV treatment in Samoa.

within the Multi-Country Western Pacific Integrated HIV/TB Programme (2022–2027)’, UNDP, Bangkok, 2018.

78 Samoa Fa’afafine Association, ‘Introduction Executive Summary – OHCHR Universal Periodic Review Submissions’, Samoa Fa’afafine Association, Apia, 2016, <https://uprdoc.ohchr.org/uprweb/downloadfile.aspx?filename=2505&file=EnglishTranslation>.

79 Samoa, Crimes Act, 2013, Section 67, http://www.paccli.org/ws/legis/consol_act_2018/ca201382/; Samoa Fa’afafine Association, ‘Introduction Executive Summary – OHCHR Universal Periodic Review Submissions’, Samoa Fa’afafine Association, Apia, 2016, <https://uprdoc.ohchr.org/uprweb/downloadfile.aspx?filename=2505&file=EnglishTranslation>.

80 United Nations Development Programme, ‘Pacific Multi-Country Mapping And Behavioural Study: HIV and STI Risk Vulnerability Among Key Populations Key Findings’, UNDP, Suva, 2017.

81 Samoa, Crimes Act, 2013, Section 72 and 73, http://www.paccli.org/ws/legis/consol_act_2018/ca201382/.

82 Worth H, Rawstone P, Gorman H, O’Connor M, McGill S., ‘Pacific Multi-Country Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations: Samoa’, ASHM, Sydney, 2016.

The Health Programme Advisory Committee (HPAC) has replaced the National AIDS Coordinating Council. This committee is intended to coordinate the health sector in Samoa and comprises the MOH and other government ministries, all development partners in Samoa and the Executive Directors of several NGOs, including the Samoa Family Health Association (SFHA) and the Samoa Red Cross. The committee meets regularly and is a forum for further engagement in partner coordination and collaboration on policy dialogue. The scope of the HPAC is broad but does not actively address HIV management. There is also a Sexual and Reproductive Health Stakeholders Committee that includes all of the above, as well as the Samoa Fa'afafine Association.

Clinical management of people living with HIV

According to the current HIV policy in Samoa, treatment and care for PLHIV is provided at hospitals, while testing and referral are expected at all levels of the health system. Currently, 11 PLHIV in Samoa are managed by the Communicable Diseases Clinic at Tupua Tamasese Meaole Hospital with support from the HIV Unit. One person receives ART from Australia. One doctor currently prescribes HIV treatment in Samoa, with clinical mentorship from the UNDP technical adviser. PLHIV receive a two-month supply of ART at each visit.

Sexual health services

There are no government-run health services that specifically provide STI and HIV services in Samoa. Sexual health services are provided through the Communicable Diseases Clinic at Tupua Tamasese Meaole Hospital.

The SFHA is an NGO that is part of the International Planned Parenthood Federation. It has three static clinics (two on Upolu and one on Savai'i) and two mobile units (one on each island) that provide a range of family planning and reproductive health services.

HIV testing

HIV testing and referral are expected at all levels of the health system; however, in practice, testing is not available in all health services and is limited to some health centres and hospitals only. The 2020 Health Facility Readiness Assessment reported that 71 percent of health facilities in Samoa offered HIV services, but only 57 percent had staff trained to conduct testing.⁸³

UNDP supplies Samoa with the Abbott Bioline HIV/Syphilis Duo test for rapid and point-of-care testing for key populations. UNDP also provides the Bioline HIV test to be used for routine laboratory testing. The MOH reports frequent stock-outs of test kits, limiting its capacity to provide ongoing HIV testing services. All reactive point-of-care tests require confirmatory testing, which is conducted using the Trinity Biotech Uni-Gold™ HIV test and the INSTI HIV-1/HIV-2 antibody test. Confirmatory testing can be performed at the Tupua Tamasese Meaole Hospital laboratory only.

Data and stock management

Samoa is currently rolling out an e-health system using Beyond Essential Systems software, Tupaia and Tamanu. Tupaia is a tool to collect and collate data from a range of sources to inform mapping-led visualizations. Tamanu is an electronic health record system and is currently being rolled out in one district hospital as well as Tupua Tamasese Meaole Hospital's specialist clinics.

Sub-recipients of the Multi-Country Western Pacific Integrated HIV/TB Programme to deliver HIV prevention programmes, including HIV testing

Two NGOs in Samoa are funded under the grant to provide HIV prevention activities targeting key populations.

83 United Nations Population Fund, 'UNFPA PSRO Health Facility Readiness and Service Availability (HFRSA) Assessment: Samoa', UNFPA, Suva, 2018, https://pacific.unfpa.org/sites/default/files/pub-pdf/hfrsa_assessment_samoa_11oct.pdf.

The SFHA receives Global Fund funding as a sub-recipient for programmes targeting MSM and transgender women for the grant period 2021–2023. Key programme activities include quarterly outreach visits to approved locations and meeting testing targets each year. The SFHA previously received funding to target FSWs, but the funding and associated targets were transferred to the Samoa Fa’afafine Association for the 2021–2023 grant period.

All SFHA programmes targeting MSM are conducted through outreach visits, and nurses use point-of-care rapid HIV testing. During the COVID-19 pandemic, the SFHA implemented a successful programme to ensure the continuation of outreach activities that maintained strict infection prevention and control measures.⁸⁴

The Samoa Fa’afafine Association receives Global Fund funding as a sub-recipient for programmes targeting transgender women and FSWs for the grant period 2021–2023. Key programme activities include HIV awareness-raising activities through regular sports days and the annual Fa’afafine Pride Festival, in addition to outreach visits to approved locations and meeting testing targets each year. HIV testing is conducted by peer workers and nurses working in other health care settings that are also members of the Samoa Fa’afafine Association, and anecdotally this model of peer-led care is preferred by transgender women and FSWs. In addition, the Samoa Fa’afafine Association office is also able to conduct testing. FSW activities are delivered through outreach visits, and nurses carry out point-of-care rapid HIV testing.

In 2022, the Samoa Fa’afafine Association exceeded the Global Fund target to reach 1,234 transgender women with HIV prevention programmes (actually reaching 1,270 transgender women) but did not reach the target to reach 58 FSWs (reaching only 27).

3.4 HIV landscape in Tonga

Country context

The Tongan archipelago comprises 36 inhabited islands across approximately 740,000 square kilometres. Nuku-alofa is the capital and largest city of Tonga. It is located on the north coast of the island of Tongatapu, in the country’s southernmost island group. The World Bank estimated the population to be approximately 106,000 people in 2022,⁸⁵ of whom 77 percent lived in rural areas.⁸⁶ Tonga is classified as an upper-middle-income country, with a GDP per capita of US\$4,426 in 2021.⁸⁷ Economic activities include tourism, agricultural products and fisheries. Remittances from Tongans living abroad represented 46 percent of the country’s GDP in 2021.⁸⁸

Health services comprise the tertiary referral hospital, Vaiola Hospital, 3 district hospitals, 14 health centres and 34 maternal and child health clinics. Nearly all health services (90 percent) are delivered from the hospitals.⁸⁹ There is a small private sector that contributes to health care, predominantly in Nuku-alofa. Support from NGOs, faith-based organizations and community-based services supplement government services. According to the 2018 ‘WHO Universal Health Care and SDG Country Profile’, Tonga has high coverage of essential services and moderate health service capacity and access.⁹⁰ Major challenges remain in the prevention and control of non-communicable diseases, specifically in tobacco use and the prevalence of raised blood pressure.⁹¹ Compared to other countries in the region for SDG 3 indicators, Tonga shows relatively advanced progress in RMNCH and in infectious diseases, except in family planning and immunization.⁹²

84 United Nations Development Programme, ‘Ensuring uninterrupted HIV, TB and malaria services in the time of COVID-19’, UNDP, Suva, 17 July 2020, <https://www.undp.org/pacific/news/ensuring-uninterrupted-hiv-tb-and-malaria-services-time-covid-19>.

85 World Bank, ‘Population, total’, World Bank, Washington, DC, 2022, <https://data.worldbank.org/indicator/SP.POP.TOTL>.

86 World Bank, ‘Rural population (% of total population)’, World Bank, Washington, DC, 2023, <https://data.worldbank.org/indicator/SP.RUR.TOTL.ZS>.

87 World Bank, ‘Country overview: Tonga’, World Bank, Washington, DC, 2023, <https://data.worldbank.org/country/TO>.

88 Ibid.

89 World Health Organization, The Kingdom of Tonga health system review. *Health Syst Transit*. 2015;5(6).

90 World Health Organization, ‘Universal Health Care and Sustainable Development Goal Country Profile 2018 Tonga’, WHO, Manila, 2018.

91 Ibid.

92 Ibid.

HIV epidemiology

Number of people diagnosed with HIV

As of the end of 2022, 24 people had been diagnosed with HIV in Tonga.⁹³ Five PLHIV are currently monitored by the MOH (as of 23 August 2023), one person died earlier in 2023, and the remainder have died or are lost to follow-up; however, the specific number of each is unknown. At the end of 2022, all six PLHIV in Tonga were on ART, and five were virologically suppressed.⁹⁴ There is one known eligible serodiscordant couple in Tonga. Modes of transmission reported to date include male-to-male sexual contact and heterosexual contact. All five PLHIV currently live in Nuku-alofa.

Key populations

Overview of key populations

The term *fakaleitileiti* or *leitit* has a similar meaning to *fa'afafine* in Samoa (described above). As in Samoa, key stakeholders emphasize that not all *leitit* are transgender, and that *leitit* may be gender fluid.⁹⁵ For this reason, transgender women and MSM are considered collectively in Tonga rather than distinct groups; this differs from the definition included in the definitions of key population.⁹⁶ Consensual sex between adult men is illegal in Tonga.⁹⁷ The civil society organization Tonga Leitis' Association was founded in 1992 to support and promote the rights and interests of *leitit*. Its current focus areas are health and education, law reform, capacity-building and development, and infrastructure and facilities. Since 2017, the Tonga Leitis' Association has also been involved in outreach-based HIV testing. Despite positive steps, stigma and discrimination remain against *leitit* in Tonga.⁹⁸ While there are no known cases of HIV among *leitit* in Tonga, HIV vulnerability remains high due to moderate HIV knowledge, inconsistent condom use with casual and regular partners, and low HIV testing rates.⁹⁹

As is common in many of the Pacific Island countries, few of those who sell or transact sex across Tonga identify as sex workers, which has implications for the targeting of HIV prevention programmes and services.¹⁰⁰ Sex work in private is legal in Tonga; however, soliciting for sex work is illegal.¹⁰¹ FSWs are a hidden population, and organizations have struggled to reach them. To date, HIV has not been detected among any FSWs in Tonga; however, they are considered at risk of HIV infection for several reasons, including low use of condoms with paying partners and casual non-paying partners, moderate HIV knowledge, low use of sexual health services and low HIV testing rates.¹⁰²

Population size estimates for coverage targets

The 2022 updated population size estimates for transgender women, MSM and FSWs in Tonga are below.

Transgender women	Men who have sex with men	Female sex workers
293	428	1,602

Source: United Nations Development Programme, 'Estimation of the size of key populations in the Multi-Country Western Pacific Integrated HIV/TB Programme countries: Men who have sex with men, transgender women, female sex workers, seafarers, and prisoners', UNDP, Suva, 2022.

93 A. Patolo Fineanganofa, personal communication, 23 August 2023.

94 United Nations Development Programme Pacific Office in Fiji, 'Multi-Country Western Pacific Integrated HIV/TB Programme Key Performance Indicators 2022', UNDP, Suva, 2023.

95 Nicholls R, O'Connor M, Rawstorne P, Worth H, McGill S., 'Pacific Multi-Country Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations: Tonga', ASHM, Sydney, 2016.

96 United Nations Development Programme, 'Key Populations Definitions and Recommended Service Delivery Packages within the Multi-Country Western Pacific Integrated HIV/TB Programme (2022–2027)', UNDP, Bangkok, 2018.

97 Tonga, Criminal Offences Act, 1988, Section 136, http://www.paclii.org/to/legis/consol_act/co136/.

98 Nicholls R, O'Connor M, Rawstorne P, Worth H, McGill S., 'Pacific Multi-Country Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations: Tonga', ASHM, Sydney, 2016.

99 Ibid.

100 Ibid.

101 Tonga, Criminal Offences Act, 1988, Section 81(4), http://www.paclii.org/to/legis/consol_act/co136/.

102 Nicholls R, O'Connor M, Rawstorne P, Worth H, McGill S., 'Pacific Multi-Country Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations: Tonga', ASHM, Sydney, 2016.

HIV response

National HIV strategy and associated guidelines

The current HIV policy in Tonga is the National Integrated Sexual and Reproductive Health Strategic Plan 2014–2018,¹⁰³ and a new policy is currently in development. The policy notes that young people, MSM, *leitis*, FSWs, seafarers, people with disabilities, people who abuse alcohol, and people with TB/HIV co-infection may be at increased risk of HIV and STIs.¹⁰⁴ PrEP is not included in the national policy.

The National Integrated Sexual and Reproductive Health Strategic Plan is supported by the National Guideline on HIV Testing Services (2018), the National Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection (2018), the 2018 National Guideline on Prevention of Mother-to-Child Transmission of HIV, Syphilis, Hepatitis B and C, and the National Comprehensive Guideline on STI Diagnosis, Treatment and Management. All of these guidelines note that people who test HIV negative should be referred and linked to relevant HIV services, including PrEP. However, in practice, this has not been implemented, and no one has been offered or received PrEP in Tonga.

HIV programme coordination

The TB/HIV and STI programme within the MOH is co-located at Vaiola Hospital in Nufu'alofo and is overseen by a TB/HIV and STI programme coordinator. The programme works closely with the Communicable Diseases Clinic at Vaiola Hospital, which oversees ART for PLHIV. Only the working committee of the Tonga HIV CCM is active, but there are plans to reactivate the CCM.

Clinical management of people living with HIV

Treatment, and care for PLHIV are provided at the tertiary level through the Communicable Diseases Clinic at Vaiola Hospital. There is one main doctor who prescribes ART; however, one other staff member is able to assist if required. No private doctors currently provide care for PLHIV. ART is ordered through the Communicable Diseases Clinic and picked up by the TB/HIV and STI programme coordinator for distribution to PLHIV at the Communicable Diseases Clinic.

PLHIV receive a one-month supply of ART at each visit and have an HIV viral load and CD4 check every three months. Clinic staff report high adherence to ART.

Sexual health services

There are no static government-run sexual health services; however, the Communicable Diseases Clinic also includes STI management and is staffed by highly trained doctors.

The Tonga Family Health Association (TFHA) is an NGO that is part of the International Planned Parenthood Federation. It has three permanent clinics, although only two are functional currently due to national nursing shortages. The TFHA also provides outreach services and a range of family planning and reproductive health services.

HIV testing

As per the National Guideline on HIV Testing Services, HIV testing is conducted for pregnant women, STI clients, potential blood donors and anyone else requiring a test. Targeted outreach programmes that involve HIV testing include prisoners, FSWs, transgender populations and seafarers. The MOH works in collaboration with the TFHA and the Tonga Leitis' Association to expand HIV testing to at-risk populations in Tonga.

UNDP supplies Tonga with the Abbott Bioline HIV/Syphilis Duo test for rapid and point-of-care testing for key populations. UNDP also provides the Bioline HIV test to be used for routine laboratory testing. The MOH reports frequent stock-outs of test kits, limiting its capacity to provide ongoing HIV testing services. All reactive

103 Tonga Ministry of Health, 'Kingdom of Tonga National Integrated Sexual and Reproductive Health Strategic Plan (2014-2018)', Tonga Ministry of Health, Nuku alofo, 2014.

104 Ibid.

point-of-care tests require confirmatory testing, which is conducted using the Trinity Biotech Uni-Gold™ HIV test and the INSTI HIV-1/HIV-2 antibody test. Confirmatory testing can be performed at the Viaola Hospital laboratory.

Sub-recipients of the Multi-Country Western Pacific Integrated HIV/TB Programme to deliver HIV prevention programmes, including HIV testing

Two NGOs in Tonga are funded to provide HIV prevention activities targeting key populations.

The TFHA receives Global Fund funding as a sub-recipient for activities targeting approximately 300 FSWs for the grant period 2021–2023. All TFHA programmes targeting FSWs are delivered through outreach visits, and nurses carry out point-of-care rapid HIV testing. In 2022, the TFHA exceeded the Global Fund target to reach 291 FSWs with HIV prevention programmes (actually reaching 376 FSWs).

The Tonga Leitis' Association receives Global Fund funding as a sub-recipient for programmes targeting around 250 transgender women and 5 FSWs for the grant period 2021–2023.

In 2022, the Tonga Leitis' Association met the Global Fund target to reach 244 transgender women with HIV prevention programmes (reaching 243), and also reached 3 FSWs despite not having an FSW performance target.

3.5 HIV landscape in Vanuatu

Country context

Vanuatu is an archipelago nation located 1,750 km east of Australia, consisting of 83 islands and spanning over 12,000 square kilometres. Administratively it is divided into six provinces: Malampa, Shefa, Penama, Tafea, Torba and Sanma. The capital, Port Vila, is located on the island of Efate, in Shefa Province, and the second largest urban area is Luganville, on Espiritu Santo Island, Sanma Province. The World Bank estimated the population of Vanuatu to be approximately 327,000 people in 2022, of whom 74 percent lived in rural areas, and just over a third were under 15 years of age.¹⁰⁵ Vanuatu is classified as a lower-middle-income country, with a GDP per capita of US\$3,010 in 2021. Economic activities include tourism, agricultural products and fisheries. Remittances from ni-Vanuatu living abroad comprised 8 percent of the country's GDP in 2022.¹⁰⁶

The Government of Vanuatu is the main provider of health services. The government health system comprises the following four levels: 2 referral hospitals, 34 health centres, 91 dispensaries and 245 community-supported aid posts.¹⁰⁷ There is a small private sector, predominantly in the two main urban centres of Port Vila and Luganville, and a small range of health services offered through NGOs, faith-based organizations and community-based services. According to the 2018 'WHO Universal Health Care and SDG Country Profile', Vanuatu has low coverage of essential services and relatively limited health service capacity and access.¹⁰⁸ Major challenges remain in the prevention and control of infectious and non-communicable diseases, particularly in the prevalence of raised blood pressure and access to improved sanitation. Compared to other countries in the region for SDG 3 indicators, Vanuatu is far from reaching the targets in RMNCH. Immunization coverage and family planning rates are among the lowest in the region, whereas the adolescent birth rate is one of the highest.¹⁰⁹

105 World Bank, 'Country overview: Vanuatu', World Bank, Washington, DC, 2023, <https://data.worldbank.org/country/VU>.

106 Ibid.

107 UNFPA, 'Health Facility Readiness and Service Availability (HFRSA) Assessment: Republic of Vanuatu', United Nations Population Fund, Suva, 2021.

108 World Health Organization, 'Universal Health Care and Sustainable Development Goal Country Profile: Vanuatu', WHO, Manila, 2018, <https://apps.who.int/iris/handle/10665/272329>.

109 Ibid.

HIV epidemiology

Number of people diagnosed with HIV

As of the end of 2022, at least 14 people had been diagnosed with HIV in Vanuatu,¹¹⁰ among whom at least 6 people have died, and 8 PLHIV are currently monitored by the MOH. There are missing data in the HIV database, and it is noted that there may be additional people lost to follow-up who are not included in the database.¹¹¹ At the end of 2022, all eight PLHIV in Vanuatu were on ART, and three were virologically suppressed.¹¹² There are no known eligible serodiscordant couples. Modes of transmission reported include mother-to-child transmission, male-to-male sexual contact and heterosexual contact. Four of the PLHIV reside in Port Vila, and four reside in other provinces.

Key populations at increased risk of HIV infection

Overview of key populations

Unlike in Polynesian countries, there is no colloquial term for transgender people in Vanuatu, and cultural acceptance and integration vary across the country. There has been some progress in reducing stigma and discrimination against people with diverse sexual orientation, gender identity and gender expression (SOGIE) in recent years, especially transgender women and in Port Vila, largely due to the work of the civil society organization VPride Foundation. VPride was founded in 2007 and established to educate, mobilize and advocate on behalf of SOGIE people in Vanuatu. VPride has approximately 600 members, including an active 110 members in Port Vila and 30 members in Luganville. While there are no known cases of HIV among transgender women in Vanuatu, and levels of HIV awareness and knowledge are high, HIV vulnerability remains high due to high rates of STIs,¹¹³ inconsistent condom use with regular and casual partners, low knowledge of where to go for an HIV test, and low HIV testing rates.¹¹⁴

Despite positive steps towards inclusion for transgender women, MSM remain largely hidden in Vanuatu due to stigma and discrimination, and stakeholders report challenges in reaching and engaging MSM for HIV prevention activities. Consensual same sex sexual activity between men is legal.¹¹⁵ As with transgender women, while there are no known cases of HIV among MSM in Vanuatu, and levels of HIV awareness and knowledge are high, HIV vulnerability remains high due to high rates of STIs,¹¹⁶ inconsistent condom use with regular and casual partners, low knowledge of where to go for an HIV test, and low HIV testing rates.¹¹⁷

As is common in many Pacific Islands countries, few women who sell or transact sex across Vanuatu identify as sex workers, which has implications for the targeting of HIV prevention programmes and services. While networks of 'sex workers' exist, they are small, informal and loose arrangements of friends who may sometimes work together. Most sex workers are casual and intermittent workers.¹¹⁸ There is limited information about the type and scale of sex work outside Port Vila; however, there is anecdotal evidence of informal and transactional sex across all provinces, including in remote areas, particularly after natural disasters that require a local and/or international response effort. In addition, VPride reports that an increasing number of transgender women are engaging in transactional sex. The legal framework is not enabling for people who

110 E. Iavro, personal communication, 9 October 2023.

111 Ibid.

112 United Nations Development Programme Pacific Office in Fiji, 'Multi-Country Western Pacific Integrated HIV/TB Programme Key Performance Indicators 2022', UNDP, Suva, 2023.

113 Veronese V, van Gemert C, Bulu S, Kwarteng T, Bergeri I, Badman S, et al. Sexually transmitted infections among transgender people and men who have sex with men in Port Vila, Vanuatu. *Western Pac Surveill Response J.* 2015;6(1):55–59.

114 United Nations Development Programme, 'Pacific Multi-Country Mapping And Behavioural Study: HIV and STI Risk Vulnerability Among Key Populations Key Findings', UNDP, Suva, 2017.

115 UNAIDS, 'Legal and policy trends impacting people living with HIV and key populations in Asia and the Pacific 2014–2019', UNAIDS, Geneva, 2021.

116 Veronese V, van Gemert C, Bulu S, Kwarteng T, Bergeri I, Badman S, et al. Sexually transmitted infections among transgender people and men who have sex with men in Port Vila, Vanuatu. *Western Pac Surveill Response J.* 2015;6(1):55–59.

117 United Nations Development Programme, 'Pacific Multi-Country Mapping And Behavioural Study: HIV and STI Risk Vulnerability Among Key Populations Key Findings', UNDP, Suva, 2017.

118 Ibid.

sell or transact sex in Vanuatu, as sex work in private and soliciting for sex work are illegal.¹¹⁹ There are no known cases of HIV among FSWs in Vanuatu; however, HIV vulnerability is high due to high rates of STIs,¹²⁰ low levels of condom use with transactional sex partners, moderate levels of HIV awareness and knowledge, and very low HIV testing rates.¹²¹

Population size estimates for key population coverage and targets

The 2022 updated population size estimates for transgender women, MSM and FSWs in Vanuatu are below.

Transgender women	Men who have sex with men	Female sex workers
1,048	437	629

Source: United Nations Development Programme, 'Estimation of the size of key populations in the Multi-Country Western Pacific Integrated HIV/TB Programme countries: Men who have sex with men, transgender women, female sex workers, seafarers, and prisoners', UNDP, Suva, 2022.

HIV response

National HIV strategy and associated guidelines

A UNDP-appointed consultant drafted a new National HIV Strategic Plan 2023–2027; however, the MOH subsequently decided to expand the plan to include STIs and viral hepatitis, and the drafted plan was not endorsed. The National Strategic Plan for HIV, STIs and Viral Hepatitis in Vanuatu (2023–2030) is currently under development and is expected to be endorsed before the end of 2023. The drafted plan includes two PrEP-related activities, based on WHO recommendations:

- work with partners to allow for pathways for new products and innovations to become used (e.g. HIV PrEP and post-exposure prophylaxis [PEP], hepatitis C cure)
- provision of ART for all PLHIV, and expanded implementation of PrEP and PEP based on risk (including vaginal ring releasing antiretroviral).

HIV programme coordination

The HIV, STI and Viral Hepatitis Unit within the MOH is located at the MOH headquarters in Port Vila, near Vila Central Hospital. It has an HIV/STI/viral hepatitis coordinator and a viral hepatitis project coordinator. The unit works closely with the communicable disease specialist within the Medical Ward at Vila Central Hospital for coordination of care for PLHIV.

A National AIDS Committee was operational but has since disbanded. The purpose of the committee was to coordinate care for PLHIV, and it involved medical doctors, laboratory officers, nutritionists and the Church; however, it has not functioned for some time. A separate committee was established to monitor use of HIV prevention funding (when available); however, this has also since ceased operation. The MOH is currently discussing the potential expansion of the National Hepatitis B Taskforce to include HIV and STIs; endorsement of this expansion is expected by the end of 2023.

Data on PLHIV are kept in a separate database that is only accessible to the HIV Unit. There are no electronic patient records kept in Vanuatu, including for outpatient care.

119 Vanuatu, Penal Code, 2006, 148, http://www.paclii.org/cgi-bin/sinodisp/vu/legis/consol_act/pc66/pc66.html?stem=&synonyms=&query=penal%20code.

120 Van Gemert C, Stooze M, Kwarteng T, Bulu S, Bergeri I, Wanyeki I, et al. Chlamydia Prevalence and Associated Behaviours Among Female Sex Workers in Vanuatu: Results from an Integrated Bio-behavioural Survey, 2011. *AIDS Behav.* 2014 Oct 16;18(10):2040–2049.

121 United Nations Development Programme, 'Pacific Multi-Country Mapping And Behavioural Study: HIV and STI Risk Vulnerability Among Key Populations Key Findings', UNDP, Suva, 2017.

Clinical management of people living with HIV

Treatment, and care for PLHIV are provided at the tertiary level. All PLHIV in Vanuatu are managed through the medical wards at both Vila Central Hospital and Northern Provincial Hospital. No private doctors currently provide care for PLHIV. PLHIV receive a three-month supply of ART at each visit.

Sexual health services

There are no government-run sexual health services in Vanuatu.

The Vanuatu Family Health Association (VFHA) is an NGO that is part of the International Planned Parenthood Federation. It has two main clinics, in Port Vila and Luganville, and also provides outreach services. The VFHA clinics provide a range of antenatal and sexual and reproductive health services that attract a small consultation fee. A health hotline that provided information on sexual and reproductive health, STIs, HIV and related issues ceased operation in 2017. Port Vila clinic attendees who require laboratory testing have the option of using a new user-pays laboratory on-site at VFHA, although uptake has been low due to the higher cost compared to testing at the Vila Central Hospital laboratory.

Kam Pusem Hed (KPH) Clinic at Wan Smolbag Theatre has operated since 1999. The clinic is located on the outskirts of Port Vila and provides sexual and reproductive health services in addition to a general health clinic. The clinic is staffed by three sexual and reproductive health specialist nurses and one general clinic nurse; it operates from 8am to 5pm on weekdays and 8am to 12pm on Saturdays. There are no fees for services provided. The clinic reported 6,106 sexual and reproductive health consultations in 2021 and 2,280 in 2022. Wan Smolbag also had a small clinic in Luganville, but it closed in July 2023 due to a lack of available nursing staff. KPH Clinic is primarily funded by four core donor partners: the Australian Department of Foreign Affairs and Trade, the New Zealand Ministry of Foreign Affairs and Trade, Oxfam Australia and World Vision.

HIV testing

HIV testing and referral are expected at all levels of the health system; however, in practice, testing is not available in all health services and is limited to some health centres and hospitals only. UNDP supplies Vanuatu with the Abbott Bioline HIV/Syphilis Duo test for rapid and point-of-care testing for key populations. UNDP also provides the Bioline HIV test to be used for routine laboratory testing. The MOH reports frequent stock-outs of test kits, limiting its capacity to provide ongoing HIV testing services. All reactive point-of-care tests require confirmatory testing, which is conducted using the Trinity Biotech Uni-Gold™ HIV test and the INSTI HIV-1/HIV-2 antibody test. Confirmatory testing can be performed at Vila Central Hospital, Northern Provincial Hospital and Lenekel Hospital.

Sub-recipients of the Multi-Country Western Pacific Integrated HIV/TB Programme to deliver HIV prevention programmes, including HIV testing

Two NGOs in Vanuatu are funded to provide HIV prevention activities targeting key populations.

The VFHA receives Global Fund funding as a sub-recipient for programmes targeting around 300 FSWs for the grant period 2021–2023. The key programme activity is to provide quarterly outreach visits to approved locations to achieve testing targets each year. All VFHA programmes targeting FSWs are delivered through outreach visits, and nurses conduct point-of-care rapid HIV testing. In 2022, the VFHA met the Global Fund target for its HIV prevention programmes, reaching 319 FSWs (against a target of 319). The programme reports frequent stock-outs of the point-of-care HIV test, and during stock-outs the nurse collects whole blood and transports specimens to the Vila Central Hospital laboratory for analysis at no cost to the client. The requirement for transportation and laboratory-based testing results in delays for test results. The FSW programme at the VFHA employs one full-time nurse coordinator; however, additional nurses are employed to support specific activities, such as mass testing. UNDP has asked the VFHA to also implement programmes targeting MSM and prisoners in the 2024–2027 grant cycle.

Wan Smolbag has received Global Fund funding as a sub-recipient since 2018. VPride did not meet the sub-recipient eligibility requirements and thus asked Wan Smolbag to fulfil sub-recipient responsibilities on its behalf for the 2021–2023 funding cycle. Wan Smolbag also occasionally receives additional funds from the Global Fund for additional specific, targeted activities.

The key programme activities overseen by VPride as a sub-sub-recipient in the 2021–2023 grant cycle include quarterly outreach visits to approved locations and administering around 300 HIV tests per year to MSM and transgender women. In addition, VPride peer educators provide support to transgender women and help them access services at KPH Clinic, including HIV testing. VPride offers small monetary incentives for MSM and transgender women to access HIV testing, which is intended to cover transport costs and any income lost. VPride has also lobbied KPH Clinic to offer a drop-in service on Tuesdays and Thursdays, and this service has been available since 2023.

In 2022, Wan Smolbag and VPride exceeded Global Fund targets to reach MSM and transgender women with HIV prevention programmes (reaching 148 MSM against a target of 135, and 289 transgender women against a target of 262).

VPride raised some issues around service location: the location of the KPH Clinic requires bus fare and, for those in employment, time away from work to access the services. VPride members have reported a preference for services based in Port Vila city. In addition, VPride highlighted the importance of developing a peer-led health care services (i.e. with health care workers with diverse SOGIE providing care), particularly with regard to client and health care worker comfort, to ensure the sexual health needs of people with diverse SOGIE in Vanuatu are met.

4.

Feasibility assessment



4.1 Feasibility of PrEP implementation in Kiribati

Knowledge and awareness	<ul style="list-style-type: none"> • There was low awareness about PrEP among nearly all health care workers, community workers and representatives of key populations.
Acceptability	<ul style="list-style-type: none"> • Despite the low level of knowledge and awareness, all stakeholders consulted indicated that PrEP would be acceptable to some FSWs and potentially transgender women if offered. • Stakeholders anticipate that serodiscordant couples would use PrEP if eligible; however, the number of serodiscordant couples is unknown. • Stakeholders anticipate potentially high uptake among FSWs due to high levels of HIV awareness among this group. • PrEP intentions and preferences among key populations are unknown, and a formal assessment should be conducted. • Government or community opposition is not anticipated. • Health care workers, community workers and representatives of key populations voiced concerns about adherence to oral PrEP regimens, and a clear preference for CAB-LA over time.
Opportunities	<ul style="list-style-type: none"> • It may be feasible to integrate PrEP for eligible serodiscordant couples into the existing programme for clinical management of PLHIV, due to the anticipated small numbers of serodiscordant couples and existing linkages. • Clinical guidance for offering PrEP has not been developed yet; however, existing HIV guidelines can be expanded to include PrEP if required. An independent consultant currently provides clinical mentoring, and this role could be expanded to include mentoring of PrEP prescribers if resources were provided. • Previous reports have recommended that sexual health services should be established in Betio targeting transgender women, MSM and FSWs.¹²² Implementation of this recommendation would provide suitable infrastructure for the future integration of PrEP services. • The Kiribati HIV CCM and Core Care Team are both active, with meetings approximately twice per year. • Kiribati has participated in several national e-health projects, including a trial of electronic medical records during the COVID-19 pandemic, and it may be feasible to pilot an electronic, cloud-based regional information system on PrEP. For example, a Pacific PrEP information system could be established with restricted access to approved staff that collects patient-level information on PrEP uptake and adherence (see Appendix 2 for potential data items) and collates and displays data visually in dashboards. The system could be established to restrict country-level access and data viewing to approved staff only, with national and regional data dashboards based on the proposed core indicators (see Appendix 3).

¹²² Worth H, McMillan K, Rawstone P., 'Kiribati: Pacific Multi-country Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations', ASHM, Sydney, 2016.

Barriers	<ul style="list-style-type: none">• Key populations face considerable stigma and discrimination.• Consensual sex between adult males and soliciting for sex work are illegal, which may create barriers to uptake if PrEP is offered through targeted programmes.• Key populations are targeted through peer workers using an outreach model for HIV testing that is resource-intensive and cannot be scaled up to integrate PrEP without considerable additional resources and preparation.• Existing government and community-based services provide limited sexual health services, and the traditional model of care may not be appropriate to effectively target and engage key populations.• Stakeholders indicated that PrEP provision should be overseen by a medical doctor.• PrEP is not currently included in the national HIV policy.• Regulatory approval for PrEP is not currently in place and is required if PrEP is to be procured through national systems; however, stakeholders indicated a clear preference for procurement of PrEP by UNDP through a bulk purchase scheme.• There is concern for the capacity for regular testing among PrEP users due to frequent stock-outs of test kits.• Current staffing levels are insufficient to allow for increased clinical requirements; however, there are currently national shortages for nursing and medical staff, and it may be challenging to recruit additional staff.• The MHMS has limited capacity to develop targeted information, education and communication (IEC) materials about PrEP and demand strategies for potential users.
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Implementation recommendations	<ul style="list-style-type: none">• In the short term (1–2 years), it is only feasible to offer PrEP to eligible serodiscordant couples (if any) in Kiribati.• PrEP should not be implemented until sufficient test kits have been procured to support PrEP implementation and stock-outs for existing HIV prevention programmes targeting key populations have been addressed.• Due to the large size of the MSM and FSW populations, it is not feasible to integrate PrEP into existing outreach programmes in Kiribati without significant additional resources. Resources should be invested in the previously documented recommendation to establish targeted sexual health services for key populations in Betio, and this services could include PrEP alongside other HIV prevention methods.
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4.2 Feasibility of PrEP implementation in the Marshall Islands

Knowledge and awareness	<ul style="list-style-type: none">• There was low awareness about PrEP among nearly all health care workers, community workers and representatives of key populations interviewed.
Acceptability	<ul style="list-style-type: none">• Despite the low level of knowledge and awareness, all stakeholders consulted indicated that PrEP might be acceptable to transgender women and FSWs if offered.• Stakeholders anticipate that serodiscordant couples would use PrEP if eligible; however, the number of eligible serodiscordant couples is unknown.• Government or community opposition is not anticipated.• PrEP intentions and preferences among key populations are unknown, and a formal assessment should be conducted.• Health care workers, community workers and representatives of key populations voiced concerns about adherence to oral PrEP regimens, and a clear preference for CAB-LA over time.

Opportunities	<ul style="list-style-type: none"> • It may be feasible to integrate PrEP for eligible serodiscordant couples into the existing programme for clinical management of PLHIV, due to the anticipated small numbers of serodiscordant couples and existing linkages; however, there are some issues with adherence to ART that should be addressed as a priority before PrEP integration is initiated. • Clinical guidance for PrEP has not been developed yet; however, existing HIV guidelines can be expanded to include PrEP if required. An independent consultant currently provides clinical mentoring, and this role could be expanded to include mentoring of PrEP prescribers if resources were provided. • PrEP is referred to as a method for HIV prevention in the National HIV/STI Guidelines; however, specific guidance for use in the Marshall Islands has not been clearly outlined.
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Barriers	<ul style="list-style-type: none"> • There are no organizations representing key populations in the Marshall Islands. • Key populations face considerable stigma and discrimination. • Sex work in private and soliciting for sex work are illegal, which may create barriers to uptake if PrEP is offered through targeted programmes. • Existing hospital services provide limited sexual health services, and the traditional model of care may not be appropriate to effectively target and engage key populations. • Stakeholders indicated that PrEP provision should be overseen by a medical doctor. • Key populations are targeted through peer workers using an outreach model for HIV testing that is resource-intensive and cannot be scaled up to integrate PrEP without considerable additional resources and preparation. • PrEP is referred to as a method for HIV prevention in the National HIV/STI Guidelines; however, protocols have not been developed. • Regulatory approval for PrEP is not currently in place and is required if PrEP is to be procured through national systems; however, stakeholders indicated a clear preference for procurement of PrEP by UNDP through a bulk purchase scheme. • There is concern for the capacity for regular testing among PrEP users due to frequent stock-outs of test kits. • Current staffing levels are insufficient to allow for increased clinical and monitoring requirements. • The HIV CCM is not active in the Marshall Islands.
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Implementation recommendations	<ul style="list-style-type: none"> • In the short term (1–2 years), it is only feasible to offer PrEP to serodiscordant couples in the Marshall Islands. • PrEP should not be implemented until sufficient test kits have been procured to support PrEP implementation and stock-outs for existing HIV prevention programmes targeting key populations have been addressed. • In the longer term (2–4 years), it is may be feasible to offer PrEP to transgender women and FSWs in Majuro through the existing outreach programme, due to the small population size of each group. However, the programme requires considerable strengthening to ensure that the full package of services is available alongside PrEP, including HIV testing, assisted partner notification, provision of male and female condoms and lubricants, contraception choices, screening for and treatment of STIs, and opportunities to vaccinate for viral hepatitis A and B, and human papilloma virus.
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4.3 Feasibility of PrEP implementation in Samoa

Knowledge and awareness	<ul style="list-style-type: none">• There was low awareness about PrEP among nearly all health care workers, community workers and representatives of key populations interviewed.
Acceptability	<ul style="list-style-type: none">• Despite the low level of knowledge and awareness, all stakeholders consulted indicated that PrEP would be acceptable to fa'afafine if implemented. FSWs and MSM remain largely hidden, and anticipated uptake is unknown.• Stakeholders anticipate that serodiscordant couples would use PrEP if eligible; however, the number of eligible serodiscordant couples is unknown.• Government or community opposition is not anticipated.• PrEP intentions and preferences among key populations are unknown, and a formal assessment should be conducted.• Health care workers, community workers and representatives of key populations voiced concerns about adherence to oral PrEP regimens, and a clear preference for CAB-LA over time.
Opportunities	<ul style="list-style-type: none">• It may be feasible to integrate PrEP for eligible serodiscordant couples into the existing programme for clinical management of PLHIV, due to the anticipated small numbers of serodiscordant couples and existing linkages.• Although the Communicable Diseases Clinic at Tupua Tamasese Meaole Hospital does not specifically target fa'afafine, it provides a broad range of HIV prevention services, is staffed by medical doctors and nurses and has good engagement with fa'afafine.• The MOH has strong relationships with the SFHA and the Samoa Fa'afafine Association.• The HPAC is active but has a broad focus.• Clinical guidance for PrEP has not been developed yet; however, existing HIV guidelines can be expanded to include PrEP if required. An independent consultant currently provides clinical mentoring, and this role could be expanded to include mentoring of PrEP prescribers if resources were provided.• Peer-led outreach activities are well received by transgender women, and there may be scope to embed PrEP in outreach programmes targeting transgender women in Samoa; however, consideration would be required regarding how to involve medical doctors in outreach activities to prescribe PrEP.
Barriers	<ul style="list-style-type: none">• While there has been some progress in changing attitudes to key populations, stigma and discrimination remains.• FSWs are hard to engage with HIV prevention activities and do not perceive themselves as sex workers.• Consensual sex between adult men, sex work in private and soliciting for sex work are illegal, which may create barriers to uptake if PrEP is offered through targeted programmes.• PrEP is not included in the national HIV policy; however, the guidelines are currently being updated.• It is not feasible to integrate PrEP into existing outreach and community-based programmes targeting fa'afafine due to the large size of the fa'afafine population in Samoa without an increase in staffing and resourcing (e.g. administration services, transportation, etc.). Stakeholder preference is for PrEP to be offered through static health services (i.e. the Communicable Diseases Clinic at Tupua Tamasese Meaole Hospital), with oversight from a medical doctor.• Stakeholders indicated that PrEP provision should be overseen by a medical doctor.• Regulatory approval for PrEP is not currently in place and is required if PrEP is to be procured through national systems; however, stakeholders indicated a clear preference for procurement of PrEP by UNDP through a bulk purchase scheme.

- There is concern for the capacity for regular testing among PrEP users due to frequent stock-outs of test kits.
- Current staffing levels at the Communicable Diseases Clinic at Tupua Tamasese Meaole Hospital are insufficient to allow for increased clinical and monitoring requirements for PrEP implementation.

Implementation recommendations

- In the short term (1–2 years), it is feasible to pilot PrEP for eligible serodiscordant couples (if any) and fa'afafine through the Communicable Diseases Clinic at Tupua Tamasese Meaole Hospital. It may be feasible to expand services to SFHA static and outreach activities after a pilot period of implementation.
 - Prior to the pilot, the Communicable Diseases Clinic at Tupua Tamasese Meaole Hospital should be strengthened to ensure the full package of services is available alongside PrEP, including HIV testing, assisted partner notification, provision of male and female condoms and lubricants, contraception choices, screening for and treatment of STIs, and opportunities to vaccinate for viral hepatitis A and B, and human papilloma virus.
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4.4 Feasibility of PrEP implementation in Tonga

Knowledge and awareness

- There was low awareness about PrEP among nearly all health care workers, community workers and representatives of key populations interviewed.

Acceptability

- Despite the low level of knowledge and awareness, all stakeholders consulted indicated that PrEP would be acceptable to leitis if implemented. FSWs and MSM remain largely hidden, and anticipated uptake is unknown.
- Government or community opposition is not anticipated.
- PrEP intentions and preferences among key populations are unknown, and a formal assessment should be conducted.
- Stakeholders anticipate that serodiscordant couples would use PrEP if eligible, and there is one known eligible serodiscordant couple.
- Health care workers, community workers and representatives of key populations voiced concerns about adherence to oral PrEP regimens, and a clear preference for CAB-LA over time.

Opportunities

- It may be feasible to integrate PrEP for eligible serodiscordant couples into the existing programme for clinical management of PLHIV, due to the anticipated small numbers of serodiscordant couples and existing linkages.
 - Although the Communicable Diseases Clinic at Vaiola Hospital does not specifically target leitis, it provides a broad range of HIV prevention services, is staffed by medical doctors and nurses and has good engagement with leitis.
 - The MOH has strong relationships with the TFHA and the Tonga Leitis' Association.
 - Peer-led outreach activities are well received by transgender women, and there may be scope to embed PrEP in outreach programmes targeting transgender women in Tonga. However, consideration would be required regarding how to involve medical doctors in outreach activities to prescribe PrEP.
 - Clinical guidance for PrEP has not been developed yet; however, existing HIV guidelines can be expanded to include PrEP if required. An independent consultant currently provides clinical mentoring, and this role could be expanded to include mentoring of PrEP prescribers if resources were provided.
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Barriers	<ul style="list-style-type: none">• While there has been some progress in changing attitudes to leitis, stigma and discrimination remain.• FSWs face considerable stigma and discrimination, are hard to engage with HIV prevention activities and do not perceive themselves as sex workers.• Consensual sex between adult men and soliciting for sex work are illegal, which may create barriers to uptake if PrEP is offered through targeted programmes.• PrEP is not included as a key HIV prevention tool in the national HIV policy; however, the policy is expected to be updated soon. The associated guidelines note that people who test negative for HIV should be referred and linked to relevant HIV services, including PrEP; however, this has not been implemented yet.• Due to the large size of the leiti population in Tonga, it is not feasible to integrate PrEP into existing outreach and community-based programmes targeting leitis without an increase in staffing and resourcing (e.g. administration services, transportation, etc.).• Implementation of PrEP through static health services (i.e. the Communicable Diseases Clinic at Vaiola Hospital) is more feasible.• Stakeholders indicated that PrEP provision should be overseen by a medical doctor.• Regulatory approval for PrEP is not currently in place and is required if PrEP is to be procured through national systems; however, stakeholders indicated a clear preference for procurement of PrEP by UNDP through a bulk purchase scheme.• There is concern for the capacity for regular testing among PrEP users due to frequent stock-outs of test kits.• Current staffing levels at the Communicable Diseases Clinic at Vaiola Hospital are insufficient to allow for increased clinical and monitoring requirements for PrEP implementation.• The Tonga HIV CCM is not currently active.
Implementation recommendations	<ul style="list-style-type: none">• In the short term (1–2 years), it is feasible to pilot PrEP for eligible serodiscordant couples and leitis through the Communicable Diseases Clinic at Vaiola Hospital. It may be feasible to expand services to TFHA static and outreach activities after a pilot period of implementation.• PrEP should not be implemented until sufficient test kits have been procured to support PrEP implementation and stock-outs for existing HIV prevention programmes targeting key populations have been addressed.• Prior to the pilot, the Communicable Diseases Clinic at Vaiola Hospital should be strengthened to ensure the full package of services is available alongside PrEP, including HIV testing, assisted partner notification, provision of male and female condoms and lubricants, contraception choices, screening for and treatment of STIs, and opportunities to vaccinate for viral hepatitis A and B, and human papilloma virus.

4.5 Feasibility of PrEP implementation in Vanuatu

Knowledge and awareness	<ul style="list-style-type: none">• There was low awareness about PrEP among all health care workers, community workers and representatives of key populations interviewed.
Acceptability	<ul style="list-style-type: none">• Despite the low level of knowledge and awareness, all stakeholders consulted indicated that PrEP would be acceptable to some transgender women if implemented. FSWs and MSM remain largely hidden, and anticipated uptake is unknown.• There is the potential for government and community opposition due to the stigma and discrimination faced by key populations in Vanuatu.• PrEP intentions and preferences among key populations are unknown, and a formal assessment should be conducted.• Health care workers, community workers and representatives of key populations voiced concerns about adherence to oral PrEP regimens, and a clear preference for CAB-LA over time.

Opportunities	<ul style="list-style-type: none"> • The MOH has good relationships with the VFHA, Wan Smolbag and VPride; however, collaboration between organizations requires strengthening. • Existing community-based services (KPH Clinic at Wan Smolbag and the VFHA) provide some but not all sexual health services and may be potential sites for PrEP implementation; however, services require strengthening to ensure that they effectively target and engage key populations. • Clinical guidance for PrEP has not been developed yet; however, existing HIV guidelines can be expanded to include PrEP if required. An independent consultant currently provides clinical mentoring, and this role could be expanded to include mentoring of PrEP prescribers if resources were provided.
Barriers	<ul style="list-style-type: none"> • While there has been some progress in changing attitudes to transgender women and MSM, stigma and discrimination remain. • FSWs face considerable stigma and discrimination, are hard to engage with HIV prevention activities and do not perceive themselves as sex workers. • Soliciting for sex work is illegal, which may create barriers to uptake if PrEP is offered through targeted programmes. • PrEP is not included as a key HIV prevention tool in the national HIV policy; however, it is currently being updated and is expected to include PrEP. • It is not feasible to integrate PrEP into VPride’s existing outreach programmes targeting transgender women and MSM, as the programme is led by community workers, without ongoing involvement from nurses or doctors trained in sexual health medicine. • Current staffing levels at the KPH Clinic at Wan Smolbag are insufficient to allow for increased clinical and monitoring requirements for PrEP implementation. • Regulatory approval for PrEP is not currently in place and is required if PrEP is to be procured through national systems; however, stakeholders indicated a clear preference for procurement of PrEP by UNDP through a bulk purchase scheme. • There is concern for the capacity for regular testing among PrEP users due to frequent stock-outs of test kits. • The Vanuatu HIV CCM is currently undergoing re-engagement and is likely to restart as the HIV, STI and Hepatitis B Taskforce.
Implementation recommendations	<ul style="list-style-type: none"> • PrEP should not be implemented until sufficient test kits have been procured to support PrEP implementation and stock-outs for existing HIV prevention programmes targeting key populations have been addressed. • In the longer term (2–4 years), it may be feasible to offer PrEP to transgender women and FSWs; however, ongoing assessment of the health care needs of transgender women and FSWs is warranted. • The KPH Clinic at Wan Smolbag should be strengthened to ensure that the full package of services is available alongside PrEP, including HIV testing, assisted partner notification, provision of male and female condoms and lubricants, contraception choices, screening for and treatment of STIs, and opportunities to vaccinate for viral hepatitis A and B, and human papilloma virus, as well as collaborations with VPride.

5.

Implementation framework



The implementation framework presented here is organized along a simplified oral PrEP ‘value chain’ that charts what is needed for national and subnational introduction of oral PrEP through five major stages, from initial planning through to uptake and ongoing monitoring. The implementation framework is designed to inform resourcing for the period 2024–2026.

5.1 Implementation framework in Kiribati

Component	Current situation	Resources required	Responsible partner	2024	2025	2026
Planning and budgeting						
Impact, cost and cost-effectiveness analysis for PrEP as part of a comprehensive HIV prevention portfolio¹²³	No progress	Technical adviser	UNDP and engagement of a technical adviser or research institute	●		
Country-led consultation and decision on PrEP implementation, taking into account cost-effectiveness analysis (if conducted)	No progress	Information for consultation processes	MOH	●		
Identification and quantification of target populations for oral PrEP	First-phase target populations have been identified (serodiscordant couples). The second phase in Kiribati in 2026 or 2027 may include transgender women and FSWs (dependent on a PrEP preferences and intentions assessment). The number of serodiscordant couples is known. PrEP intentions and preferences among potential PrEP users are unknown.	Support is required for the PSGDN ¹²⁴ to conduct a PrEP preferences and intentions assessment	PSGDN with technical support from a university or research institute UNDP	●		
Inclusion of oral PrEP in current or upcoming national HIV prevention plans	PrEP is included in national HIV guidelines (2018) but has not been implemented. The Kiribati HIV CCM and Core Care Team are both active.	Training or support may be required to implement guidelines	HIV Unit with support from UNDP if required	●		

123 This component is not essential but is recommended in the OPTIONS Plan 4 PrEP Toolkit. An impact, cost and cost-effectiveness analysis requires specialist support and would help to estimate the impact of PrEP—for example, cost savings and impact on incidence.

124 PSGDN is an appropriate organization to lead a PrEP preferences and intentions assessment across Pacific Island countries as the key umbrella organization for organizations and projects working with MSM and transgender people in the Pacific, especially in relation to HIV.

Timeline and plan for oral PrEP introduction and scale-up	Proposed timeline is to implement PrEP with serodiscordant couples in 2025 and possible expansion in 2026 and 2027	Resources may be required to develop a country-level implementation plan, including budget estimates	HIV Unit with support from UNDP if required	●	●	●
Budget for oral PrEP roll-out to target populations	No progress	As above	HIV Unit with support from UNDP	●		
Sufficient funding to achieve targets	Funding for PrEP implementation has not been determined or PIRMCCM	Financial support from partners may be required to fund PrEP implementation	HIV Unit with support from UNDP	●		
Logistics and supply						
Regulatory approval of form(s) of oral PrEP by authorities	No progress	Resources may be required to support the pharmacy department to obtain regulatory approval	Pharmacy department with support from UNDP	●		
Effective demand and supply forecasting mechanisms for oral PrEP	This will be informed by a PrEP preferences and intentions assessment	See above resources required to conduct a PrEP preferences and intentions assessment	PSGDN with technical support from a university or research institute UNDP	●		
Manufacturer identification and contract negotiation to purchase oral PrEP	No progress	Countries prefer procurement of PrEP by UNDP through a bulk purchase scheme	UNDP	●		
Product and packaging design to meet target population needs and preferences	No progress	Regional coordination of product and packaging design is recommended	UNDP	●		
Develop a distribution plan for oral PrEP to reach target populations	Distribution of PrEP to serodiscordant couples is feasible through existing relationships with PLHIV	N/A	HIV Unit with support from UNDP	●		
Effective distribution mechanisms to avoid oral PrEP stock-outs in priority facilities	No progress	The potential for stock-outs is high. Resources are required to strengthen procurement and distribution mechanisms.	MHMS with support from UNDP	●	●	●
PrEP delivery and uptake						
Issue standard clinical guidelines for prescription and use of PrEP	Clinical guidelines require review by a clinical specialist and update	Clinical guidance is required to review and update clinical guidelines	HIV clinical adviser UNDP MHMS	●		

Establish and maintain a clinical mentoring programme	There is an existing HIV clinical adviser, but the role does not include clinical advice on PrEP	The role of the HIV clinical adviser could be expanded to include mentoring of PrEP prescribers	HIV clinical adviser UNDP	●	●	●
Sufficient infrastructure and human resources to conduct initial HIV tests and prescribe oral PrEP in priority channels	There are small numbers of serodiscordant couples in Kiribati, and it is feasible to integrate PrEP into existing outreach programmes for PLHIV without additional infrastructure. Previous reports have recommended that sexual health services should be established in Betio targeting transgender women, MSM and FSWs (see report).	Infrastructure and human resources are required to establish services targeting transgender women, MSM and FSWs in Kiribati	UNDP MHMS	●	●	
Plan to engage health care workers on oral PrEP and delivery to target populations (including mitigating stigma)	No progress	Training is required to follow PrEP clinical guidance. PrEP and stigma reduction training should be embedded in training packages, as there is high staff changeover.	MHMS UNDP HIV clinical adviser	●	●	●
Create tools to help potential clients and health care workers understand who should use oral PrEP	No progress	Regional coordination if required for IEC materials for potential clients and health care workers	UNDP ASHM PSGDN	●		
Develop clear and informative communications on oral PrEP for general public audiences	No progress	Regional coordination of IEC materials for the general public	UNDP ASHM	●	●	
Develop demand generation strategies targeted to unique needs of different populations	No progress. Knowledge about PrEP is low among all potential PrEP users.	The PrEP preferences and intentions assessment will provide evidence for the development of demand generation strategies	MOH	●	●	
Develop resources for clients on how to effectively use oral PrEP	No progress	Regional coordination if required for IEC materials for potential clients and health care workers	UNDP ASHM PSGDN	●	●	

Effective use and monitoring						
Establish core indicators	The WHO Consolidated Guidelines on Person-Centred HIV Strategic Information identifies three core programme indicators related to PrEP (see Appendix 3)	None required.				
Establish plans and build capacity to provide ongoing HIV and creatinine-level testing accessible for oral PrEP users¹²⁵	HIV Unit has linkages to hospital laboratories	Support is required to oversee this activity	HIV Unit Hospital laboratory	●	●	●
Develop a monitoring system to support data collection for ongoing learning	The current HIV registry could be expanded and enhanced for PrEP implementation, incorporating the data items recommended in Appendix 2 ¹²⁶	Resources are required to determine the most suitable software (DHIS2 or equivalent, such as Tamanu) and customize the software to the needs of the programme	UNDP Health information system (HIS) technical advisers	●	●	●

5.2 Implementation framework in Marshall Islands

Component	Current situation	Resources required	Responsible partner	2024	2025	2026
Planning and budgeting						
Impact, cost and cost-effectiveness analysis for PrEP as part of a comprehensive HIV prevention portfolio¹²⁷	No progress	Technical adviser	UNDP and engagement of a technical adviser or research institute	●		
Country-led consultation and decision on PrEP implementation, taking into account cost-effectiveness analysis (if conducted)	No progress	Information for consultation processes	MOH	●		

125 As per updated WHO guidance (2022), measuring kidney function is optional for those aged under 30 years without kidney-related comorbidities (World Health Organization, 'Differentiated and simplified pre-exposure prophylaxis for HIV prevention. Update to WHO implementation guidance', Technical brief, WHO, Geneva, 2022).

126 Non-identifiable clinical HIV data are entered into an Excel-based data registry that is accessible to the UNDP-appointed HIV clinical consultant for review and shared patient review. This is feasible for the small numbers of HIV-positive patients but is not suitable for a potentially large number of PrEP users. It is feasible, and recommended, to develop an enhanced PrEP registry that records non-identifiable data in an open-source patient-level electronic registry for patient monitoring and reporting, with dashboards displaying core indicators by country and regionally. Products such as DHIS2 or Tamanu could be explored for this purpose.

127 This component is not essential but is recommended in the OPTIONS Plan 4 PrEP Toolkit. An impact, cost and cost-effectiveness analysis requires specialist support and would help to estimate the impact of PrEP—for example, cost savings and impact on incidence.

Identification and quantification of target populations for oral PrEP	First-phase target populations have been identified (serodiscordant couples). The second phase in the Marshall Islands may include transgender women and FSWs (dependent on PrEP preferences and intentions assessment). The number of serodiscordant couples is known. PrEP intentions and preferences among potential PrEP users are unknown.	Support is required for the PSGDN ¹²⁸ to conduct a PrEP preferences and intentions assessment	PSGDN with technical support from a university or research institute UNDP	●
Inclusion of oral PrEP in current or upcoming national HIV prevention plans	PrEP is included in national HIV guidelines (2017) but has not been implemented. The National AIDS Committee is not currently operational.	Training or support may be required to implement guidelines. Support may be required to re-establish the National AIDS Committee.	HIV Unit with support from UNDP if required	●
Timeline and plan for oral PrEP introduction and scale-up	Proposed timeline is to implement PrEP with serodiscordant couples in 2025 and potentially transgender women and FSWs in 2026	Resources may be required to develop a country-level implementation plan, including budget estimates	HIV Unit with support from UNDP if required	●
Budget for oral PrEP roll-out to target populations	No progress	As above	HIV Unit with support from UNDP	●
Sufficient funding to achieve targets	Funding for PrEP implementation has not been determined or PIRMCCM	Financial support from partners may be required to fund PrEP implementation	HIV Unit with support from UNDP	●
Logistics and supply				
Regulatory approval of form(s) of oral PrEP by authorities	No progress	Resources may be required to support the pharmacy department to obtain regulatory approval	Pharmacy department with support from UNDP	●
Effective demand and supply forecasting mechanisms for oral PrEP	This will be informed by a PrEP preferences and intentions assessment	See above resources required to conduct a PrEP preferences and intentions assessment	PSGDN with technical support from a university or research institute UNDP	●

128 PSGDN is an appropriate organization to lead a PrEP preferences and intentions assessment across Pacific Island countries as the key umbrella organization for organizations and projects working with MSM and transgender people in the Pacific, especially in relation to HIV.

Manufacturer identification and contract negotiation to purchase oral PrEP	No progress	Countries prefer procurement of PrEP by UNDP through a bulk purchase scheme	UNDP	●		
Product and packaging design to meet target population needs and preferences	No progress	Regional coordination of product and packaging design is recommended	UNDP	●		
Develop a distribution plan for oral PrEP to reach target populations	Distribution of PrEP to serodiscordant couples is feasible through existing relationships with PLHIV	N/A	HIV Unit with support from UNDP	●		
Effective distribution mechanisms to avoid oral PrEP stock-outs in priority facilities	No progress	The potential for stock-outs is high. Resources are required to strengthen procurement and distribution mechanisms.	MHHS with support from UNDP	●	●	●
PrEP delivery and uptake						
Issue standard clinical guidelines for prescription and use of PrEP	Clinical guidelines should be reviewed and updated by a clinical specialist	Clinical guidance is required to review and update clinical guidelines	HIV clinical adviser UNDP MHHS	●		
Establish and maintain a clinical mentoring programme	There is an existing HIV clinical adviser, but the role does not include clinical advice on PrEP	The role of the HIV clinical adviser could be expanded to include mentoring of PrEP prescribers	HIV clinical adviser UNDP	●	●	●
Sufficient infrastructure and human resources to conduct initial HIV tests and prescribe oral PrEP in priority channels	There are small numbers of serodiscordant couples in Marshall Islands, and it is feasible to integrate PrEP into existing outreach programmes for PLHIV without additional infrastructure		MHHS	●	●	
Plan to engage health care workers on oral PrEP and delivery to target populations (including mitigating stigma)	No progress	Training is required to follow PrEP clinical guidance. PrEP and stigma reduction training should be embedded in training packages, as there is high staff turnover.	MHHS UNDP HIV clinical adviser	●	●	●

Create tools to help potential clients and health care workers understand who should use oral PrEP	No progress	Regional coordination if required for IEC materials for potential clients and health care workers	UNDP ASHM PSGDN	●		
Develop clear and informative communications on oral PrEP for general public audiences	No progress	Regional coordination of IEC materials for the general public	UNDP ASHM	●	●	
Develop demand generation strategies targeted to unique needs of different populations	No progress. Knowledge about PrEP is low among all potential PrEP users.	The PrEP preferences and intentions assessment will provide evidence for the development of demand generation strategies	MOH	●	●	
Develop resources for clients on how to effectively use oral PrEP	No progress	Regional coordination if required for IEC materials for potential clients and health care workers	UNDP ASHM PSGDN	●	●	
Effective use and monitoring						
Establish core indicators	The WHO Consolidated Guidelines on Person-Centred HIV Strategic Information identifies three core programme indicators related to PrEP (see Appendix 3)	None required.				
Establish plans and build capacity to provide ongoing HIV and creatinine-level testing accessible for oral PrEP users¹²⁹	HIV Unit has linkages to hospital laboratories	Support is required to oversee this activity	HIV Unit Hospital laboratory	●	●	●
Develop a monitoring system to support data collection for ongoing learning	The current HIV registry could be expanded and enhanced for PrEP implementation, incorporating the data items recommended in Appendix 2 ¹³⁰	Resources are required to determine the most suitable software (DHIS2 or equivalent, such as Tamanu) and customize the software to the needs of the programme	UNDP HIS technical advisers	●	●	●

129 As per updated WHO guidance (2022), measuring kidney function is optional for those aged under 30 years without kidney-related comorbidities (World Health Organization, 'Differentiated and simplified pre-exposure prophylaxis for HIV prevention. Update to WHO implementation guidance', Technical brief, WHO, Geneva, 2022).

130 Non-identifiable clinical HIV data are entered into an Excel-based data registry that is accessible to the UNDP-appointed HIV clinical consultant for review and shared patient review. This is feasible for the small numbers of HIV-positive patients but is not suitable for a potentially large number of PrEP users. It is feasible, and recommended, to develop an enhanced PrEP registry that records non-identifiable data in an open-source patient-level electronic registry for patient monitoring and reporting, with dashboards displaying core indicators by country and regionally. Products such as DHIS2 or Tamanu could be explored for this purpose.

5.3 Implementation framework in Samoa

Component	Current situation	Resources required	Responsible partner	2024	2025	2026
Planning and budgeting						
Impact, cost and cost-effectiveness analysis for PrEP as part of a comprehensive HIV prevention portfolio¹³¹	No progress	Technical adviser	UNDP and engagement of a technical adviser or research institute	●		
Country-led consultation and decision on PrEP implementation, taking into account cost-effectiveness analysis (if conducted)	No progress	Information for consultation processes	MOH	●		
Identification and quantification of target populations for oral PrEP	First-phase target populations have been identified (serodiscordant couples and transgender women). The second phase may include MSM (dependent on PrEP preferences and intentions assessment) and potentially PrEP through outreach activities. The number of serodiscordant couples is known, and the key population size estimate was updated in 2022. PrEP intentions and preferences among potential PrEP users are unknown.	Support is required for the PSGDN ¹³² to conduct a PrEP preferences and intentions assessment	PSGDN with technical support from a university or research institute UNDP	●		
Inclusion of oral PrEP in current or upcoming national HIV prevention plans	No current HIV strategy, and PrEP not included in current guidelines. The HPAC is active.	Support may be required to finalize the new HIV policy and develop updated HIV clinical guidance. Training or support may be required to implement guidelines. Support may be required to brief the HPAC on PrEP.	HIV Unit with support from UNDP if required	●		

131 This component is not essential but is recommended in the OPTIONS Plan 4 PrEP Toolkit. An impact, cost and cost-effectiveness analysis requires specialist support and would help to estimate the impact of PrEP—for example, cost savings and impact on incidence.

132 PSGDN is an appropriate organization to lead a PrEP preferences and intentions assessment across Pacific Island countries as the key umbrella organization for organizations and projects working with MSM and transgender people in the Pacific, especially in relation to HIV.

Timeline and plan for oral PrEP introduction and scale-up	Proposed timeline is to implement PrEP with serodiscordant couples and transgender women in 2025 and possible expansion in 2026 and 2027	Resources may be required to develop a country-level implementation plan, including budget estimates	HIV Unit with support from UNDP if required	●	●	●
Budget for oral PrEP roll-out to target populations	No progress	As above	HIV Unit with support from UNDP	●		
Sufficient funding to achieve targets	Funding for PrEP implementation has not been determined or PIRMCCM	Financial support from partners may be required to fund PrEP implementation	HIV Unit with support from UNDP	●	●	●
Logistics and supply						
Regulatory approval of form(s) of oral PrEP by authorities	No progress	Resources may be required to support the pharmacy department to obtain regulatory approval	Pharmacy department with support from UNDP	●		
Effective demand and supply forecasting mechanisms for oral PrEP	This will be informed by a PrEP preferences and intentions assessment	See above resources required to conduct a PrEP preferences and intentions assessment	PSGDN with technical support from a university or research institute UNDP	●		
Manufacturer identification and contract negotiation to purchase oral PrEP	No progress	Countries prefer procurement of PrEP by UNDP through a bulk purchase scheme	UNDP	●		
Product and packaging design to meet target population needs and preferences	No progress	Regional coordination of product and packaging design is recommended	UNDP	●		
Develop a distribution plan for oral PrEP to reach target populations	Distribution of PrEP to serodiscordant couples is feasible through existing relationships with PLHIV	N/A	HIV Unit with support from UNDP	●		
Effective distribution mechanisms to avoid oral PrEP stock-outs in priority facilities	No progress	The potential for stock-outs is high. Resources are required to strengthen procurement and distribution mechanisms.	MOH with support from UNDP	●	●	●
PrEP delivery and uptake						
Issue standard clinical guidelines for prescription and use of PrEP	Clinical guidelines require review by a clinical specialist	Clinical guidance is required to review and update clinical guidelines	HIV clinical adviser UNDP MOH	●		

Establish a clinical mentoring programme	There is an existing HIV clinical adviser, but the role does not include clinical advice on PrEP	The role of the HIV clinical adviser could be expanded to include mentoring of PrEP prescribers	HIV clinical adviser UNDP	●		
Sufficient infrastructure and human resources to conduct initial HIV tests and prescribe oral PrEP in priority channels	The number of potential PrEP users in Samoa is unknown (and will be informed by the PrEP intentions and preferences assessment). In the short term (1–2 years), it may be feasible to pilot PrEP for serodiscordant couples and transgender women through the Communicable Diseases Clinic at Tupua Tamasese Meaole Hospital. It may be feasible to expand services to the SFHA (outreach and static) after a pilot period of implementation.	If the number of potential users is large, support may be required to expand or enhance the Communicable Diseases Clinic at Tupua Tamasese Meaole Hospital with additional human resources and consumables (including HIV test kits). Support may be required to expand PrEP to the SFHA after the pilot period.	MOH UNDP Communicable Diseases Clinic at Tupua Tamasese Meaole Hospital SFHA	●	●	●
Plan to engage health care workers on oral PrEP and delivery to target populations (including mitigating stigma)	No progress	Training is required to follow PrEP clinical guidance. PrEP and stigma reduction training should be embedded in training packages, as there is high staff turnover.	MOH UNDP HIV clinical adviser	●	●	●
Create tools to help potential clients and health care workers understand who should use oral PrEP	No progress	Regional coordination if required for IEC materials for potential clients and health care workers	UNDP ASHM PSGDN	●		
Develop clear and informative communications on oral PrEP for general public audiences	No progress	Regional coordination of IEC materials for the general public	UNDP ASHM	●	●	
Develop demand generation strategies targeted to unique needs of different populations	No progress. Knowledge about PrEP is low among all potential PrEP users.	The PrEP preferences and intentions assessment will provide evidence for the development of demand generation strategies	MOH	●	●	
Develop resources for clients on how to effectively use oral PrEP	No progress	Regional coordination if required for IEC materials for potential clients and health care workers	UNDP ASHM PSGDN	●	●	

Effective use and monitoring						
Establish core indicators	The WHO Consolidated Guidelines on Person-Centred HIV Strategic Information identifies three core programme indicators related to PrEP (see Appendix 3)	None required		●		
Establish plans and build capacity to provide ongoing HIV and creatinine-level testing accessible for oral PrEP users¹³³	HIV Unit has linkages to hospital laboratories	Support is required to oversee this activity	HIV Unit Hospital laboratory	●	●	●
Develop a monitoring system to support data collection for ongoing learning	The current HIV registry could be expanded and enhanced for PrEP implementation, incorporating the data items recommended in Appendix 2 ¹³⁴	Resources are required to determine the most suitable software (DHIS2 or equivalent, such as Tamanu) and customize the software to the needs of the programme	UNDP HIS technical advisers	●	●	●

5.4 Implementation framework in Tonga

Component	Current situation	Resources required	Responsible partner	2024	2025	2026
Planning and budgeting						
Impact, cost and cost-effectiveness analysis for PrEP as part of a comprehensive HIV prevention portfolio¹³⁵	No progress	Technical adviser	UNDP and engagement of a technical adviser or research institute	●		
Country-led consultation and decision on PrEP implementation, taking into account cost-effectiveness analysis (if conducted)	No progress	Information for consultation processes	MOH	●		

133 As per updated WHO guidance (2022), measuring kidney function is optional for those aged under 30 years without kidney-related comorbidities (World Health Organization, 'Differentiated and simplified pre-exposure prophylaxis for HIV prevention. Update to WHO implementation guidance', Technical brief, WHO, Geneva, 2022).

134 Non-identifiable clinical HIV data are entered into an Excel-based data registry that is accessible to the UNDP-appointed HIV clinical consultant for review and shared patient review. This is feasible for the small numbers of HIV-positive patients but is not suitable for a potentially large number of PrEP users. It is feasible, and recommended, to develop an enhanced PrEP registry that records non-identifiable data in an open-source patient-level electronic registry for patient monitoring and reporting, with dashboards displaying core indicators by country and regionally. Products such as DHIS2 or Tamanu could be explored for this purpose.

135 This component is not essential but is recommended in the OPTIONS Plan 4 PrEP Toolkit. An impact, cost and cost-effectiveness analysis requires specialist support and would help to estimate the impact of PrEP—for example, cost savings and impact on incidence.

Identification and quantification of target populations for oral PrEP	First-phase target populations have been identified (serodiscordant couples and transgender women). The second phase may include MSM (dependent on PrEP preferences and intentions assessment) and potentially PrEP through outreach activities. The number of serodiscordant couples is known, and the key population size estimate was updated in 2022. PrEP intentions and preferences among potential PrEP users are unknown.	Support is required for the PSGDN ¹³⁶ to conduct a PrEP preferences and intentions assessment	PSGDN with technical support from a university or research institute UNDP	●
Country-led consultation and decision on PrEP implementation, taking into account cost-effectiveness analysis (if conducted)	No progress	Information for consultation processes	MOH	●
Inclusion of oral PrEP in current or upcoming national HIV prevention plans	No current HIV strategy, and PrEP not included in current guidelines. The Tonga HIV CCM is not active.	Support may be required to finalize the new HIV policy and develop updated HIV clinical guidance. Training or support may be required to implement guidelines. Support may be required to re-establish the Tonga HIV CCM.	HIV Unit with support from UNDP if required	●
Timeline and plan for oral PrEP introduction and scale-up	Proposed timeline is to implement PrEP with serodiscordant couples and transgender women in 2025 and possible expansion in 2026 and 2027	Resources may be required to develop a country-level implementation plan, including budget estimates	HIV Unit with support from UNDP if required	● ● ●
Budget for oral PrEP roll-out to target populations	No progress	As above	HIV Unit with support from UNDP	●

¹³⁶ PSGDN is an appropriate organization to lead a PrEP preferences and intentions assessment across Pacific Island countries as the key umbrella organization for organizations and projects working with MSM and transgender people in the Pacific, especially in relation to HIV.

Sufficient funding to achieve targets	Funding for PrEP implementation has not been determined or PIRMCCM	Financial support from partners may be required to fund PrEP implementation	HIV Unit with support from UNDP	●		
Logistics and supply						
Regulatory approval of form(s) of oral PrEP by authorities	No progress	Resources may be required to support the pharmacy department to obtain regulatory approval	Pharmacy department with support from UNDP	●		
Effective demand and supply forecasting mechanisms for oral PrEP	This will be informed by a PrEP preferences and intentions assessment	See above resources required to conduct a PrEP preferences and intentions assessment	PSGDN with technical support from a university or research institute UNDP	●		
Manufacturer identification and contract negotiation to purchase oral PrEP	No progress	Countries prefer procurement of PrEP by UNDP through a bulk purchase scheme	UNDP	●		
Product and packaging design to meet target population needs and preferences	No progress	Regional coordination of product and packaging design is recommended	UNDP	●		
Develop a distribution plan for oral PrEP to reach target populations	Distribution of PrEP to serodiscordant couples is feasible through existing relationships with PLHIV	N/A	HIV Unit with support from UNDP	●		
Effective distribution mechanisms to avoid oral PrEP stock-outs in priority facilities	No progress	The potential for stock-outs is high. Resources are required to strengthen procurement and distribution mechanisms.	MOH with support from UNDP	●	●	●
PrEP delivery and uptake						
Issue standard clinical guidelines for prescription and use of PrEP	Clinical guidelines require review by a clinical specialist	Clinical guidance is required to review and update clinical guidelines	HIV clinical adviser UNDP MOH	●		
Establish a clinical mentoring programme	There is an existing HIV clinical adviser, but the role does not include clinical advice on PrEP	The role of the HIV clinical adviser could be expanded to include mentoring of PrEP prescribers	HIV clinical adviser UNDP	●		

Sufficient infrastructure and human resources to conduct initial HIV tests and prescribe oral PrEP in priority channels	The number of potential PrEP users in Tonga is unknown (and will be informed by the PrEP intentions and preferences assessment). In the short term (1–2 years), it is feasible to pilot PrEP for serodiscordant couples and transgender women through the Communicable Diseases Clinic at Vailoa Hospital. It may be feasible to expand services to the TFHA in 2026 after a pilot period of implementation.	If the number of potential users is large, support may be required to expand or enhance the Communicable Diseases Clinic at Vailoa Hospital with additional human resources and consumables (including HIV test kits). Support may be required to expand PrEP to the TFHA after the pilot period.	MOH Communicable Diseases Clinic at Vailoa Hospital UNDP TFHA	●	●	
Plan to engage health care workers on oral PrEP and delivery to target populations (including mitigating stigma)	No progress	Training is required to follow PrEP clinical guidance. PrEP and stigma reduction training should be embedded in training packages, as there is high staff turnover.	MOH UNDP HIV clinical adviser	●	●	●
Create tools to help potential clients and health care workers understand who should use oral PrEP	No progress	Regional coordination if required for IEC materials for potential clients and health care workers	UNDP ASHM PSGDN	●		
Develop clear and informative communications on oral PrEP for general public audiences	No progress	Regional coordination of IEC materials for the general public	UNDP ASHM	●	●	
Develop demand generation strategies targeted to unique needs of different populations	No progress. Knowledge about PrEP is low among all potential PrEP users.	The PrEP preferences and intentions assessment will provide evidence for the development of demand generation strategies	MOH	●	●	
Develop resources for clients on how to effectively use oral PrEP	No progress	Regional coordination if required for IEC materials for potential clients and health care workers	UNDP ASHM PSGDN	●	●	

Effective use and monitoring						
Establish core indicators	The WHO Consolidated Guidelines on Person-Centred HIV Strategic Information identifies three core programme indicators related to PrEP (see Appendix 3)	None required.				●
Establish plans and build capacity to provide ongoing HIV and creatinine-level testing accessible for oral PrEP users¹³⁷	HIV Unit has linkages to hospital laboratories	Support is required to oversee this activity	HIV Unit Hospital laboratory		●	●
Develop a monitoring system to support data collection for ongoing learning	The current HIV registry could be expanded and enhanced for PrEP implementation, incorporating the data items recommended in Appendix 2 ¹³⁸	Resources are required to determine the most suitable software (DHIS2 or equivalent, such as Tamanu) and customize the software to the needs of the programme	UNDP HIS technical advisers		●	●

5.5 Implementation framework in Vanuatu

Component	Current situation	Resources required	Responsible partner	2024	2025	2026
Planning and budgeting						
Impact, cost and cost-effectiveness analysis for PrEP as part of a comprehensive HIV prevention portfolio¹³⁹	No progress	Technical adviser	UNDP and engagement of a technical adviser or research institute	●		
Country-led consultation and decision on PrEP implementation, taking into account cost-effectiveness analysis (if conducted)	No progress	Information for consultation processes	MOH	●		

137 As per updated WHO guidance (2022), measuring kidney function is optional for those aged under 30 years without kidney-related comorbidities (World Health Organization, 'Differentiated and simplified pre-exposure prophylaxis for HIV prevention. Update to WHO implementation guidance', Technical brief, WHO, Geneva, 2022).

138 Non-identifiable clinical HIV data are entered into an Excel-based data registry that is accessible to the UNDP-appointed HIV clinical consultant for review and shared patient review. This is feasible for the small numbers of HIV-positive patients but is not suitable for a potentially large number of PrEP users. It is feasible, and recommended, to develop an enhanced PrEP registry that records non-identifiable data in an open-source patient-level electronic registry for patient monitoring and reporting, with dashboards displaying core indicators by country and regionally. Products such as DHIS2 or Tamanu could be explored for this purpose.

139 This component is not essential but is recommended in the OPTIONS Plan 4 PrEP Toolkit. An impact, cost and cost-effectiveness analysis requires specialist support and would help to estimate the impact of PrEP—for example, cost savings and impact on incidence.

Identification and quantification of target populations for oral PrEP	May include transgender women, MSM and FSWs (dependent on PrEP preferences and intentions assessment). The number of serodiscordant couples is known, and the key population size estimate was updated in 2022. PrEP intentions and preferences among potential PrEP users are unknown.	Support is required for the PSGDN ¹⁴⁰ to conduct a PrEP preferences and intentions assessment	PSGDN with technical support from a university or research institute UNDP	●			
Inclusion of oral PrEP in current or upcoming national HIV prevention plans	No current HIV strategy, and PrEP not included in current guidelines. The Vanuatu National AIDS Committee has disbanded.	Support may be required to finalize the new HIV policy and develop updated HIV clinical guidance. Training or support may be required to implement guidelines. Support may be required to brief the new national committee covering HIV on PrEP.	HIV Unit with support from UNDP if required	●	●		
Timeline and plan for oral PrEP introduction and scale-up	Proposed timeline is to implement PrEP with serodiscordant couples in 2025 and possible expansion to other groups in 2027	Resources may be required to develop a country-level implementation plan, including budget estimates	HIV Unit with support from UNDP if required	●	●	●	
Budget for oral PrEP roll-out to target populations	No progress	As above	HIV Unit with support from UNDP	●			
Sufficient funding to achieve targets	Funding for PrEP implementation has not been determined or PIRMCCM	Financial support from partners may be required to fund PrEP implementation	HIV Unit with support from UNDP	●			
Logistics and supply							
Regulatory approval of form(s) of oral PrEP by authorities	No progress	Resources may be required to support the pharmacy department to obtain regulatory approval	Pharmacy department with support from UNDP	●			

140 PSGDN is an appropriate organization to lead a PrEP preferences and intentions assessment across Pacific Island countries as the key umbrella organization for organizations and projects working with MSM and transgender people in the Pacific, especially in relation to HIV.

Effective demand and supply forecasting mechanisms for oral PrEP	This will be informed by a PrEP preferences and intentions assessment	See above resources required to conduct a PrEP preferences and intentions assessment	PSGDN with technical support from a university or research institute UNDP	●		
Manufacturer identification and contract negotiation to purchase oral PrEP	No progress	Countries prefer procurement of PrEP by UNDP through a bulk purchase scheme	UNDP	●		
Product and packaging design to meet target population needs and preferences	No progress	Regional coordination of product and packaging design is recommended	UNDP	●		
Develop a distribution plan for oral PrEP to reach target populations	Distribution of PrEP to serodiscordant couples is feasible through existing relationships with PLHIV	N/A	HIV Unit with support from UNDP	●		
Effective distribution mechanisms to avoid oral PrEP stock-outs in priority facilities	No progress	The potential for stock-outs is high. Resources are required to strengthen procurement and distribution mechanisms.	MOH with support from UNDP	●	●	●
PrEP delivery and uptake						
Issue standard clinical guidelines for prescription and use of PrEP	Clinical guidelines require review by a clinical specialist	Clinical guidance is required to review and update clinical guidelines	HIV clinical adviser UNDP MOH	●		
Establish and maintain a clinical mentoring programme	There is an existing HIV clinical adviser, but the role does not include clinical advice on PrEP	The role of the HIV clinical adviser could be expanded to include mentoring of PrEP prescribers	HIV clinical adviser UNDP	●	●	●

Sufficient infrastructure and human resources to conduct initial HIV tests and prescribe oral PrEP in priority channels	The number of potential PrEP users in Vanuatu is unknown (and will be informed by the PrEP intentions and preferences assessment). In the short term (1–2 years), it is feasible to pilot PrEP for serodiscordant couples and transgender women through KPH Clinic at Wan Smolbag. It may be feasible to expand services to the VFHA in 2026 after a pilot period of implementation.	If the number of potential users is large, support may be required to expand or enhance KPH Clinic at Wan Smolbag with additional human resources and consumables (including HIV test kits). Support may be required to expand PrEP to the VFHA after the pilot period.	MOH UNDP VFHA	●	●	
Plan to engage health care workers on oral PrEP and delivery to target populations (including mitigating stigma)	No progress	Training is required to follow PrEP clinical guidance. PrEP and stigma reduction training should be embedded in training packages, as there is high staff turnover.	MOH UNDP HIV clinical adviser	●	●	●
Create tools to help potential clients and health care workers understand who should use oral PrEP	No progress	Regional coordination if required for IEC materials for potential clients and health care workers	UNDP ASHM PSGDN	●		
Develop clear and informative communications on oral PrEP for general public audiences	No progress	Regional coordination of IEC materials for the general public	UNDP ASHM	●	●	
Develop demand generation strategies targeted to unique needs of different populations	No progress. Knowledge about PrEP is low among all potential PrEP users.	The PrEP preferences and intentions assessment will provide evidence for the development of demand generation strategies	MOH	●	●	
Develop resources for clients on how to effectively use oral PrEP	No progress	Regional coordination if required for IEC materials health care workers for potential clients and health care workers	UNDP ASHM PSGDN	●	●	

Effective use and monitoring						
Establish core indicators	The WHO Consolidated Guidelines on Person-Centred HIV Strategic Information identifies three core programme indicators related to PrEP (see Appendix 3)	None required.				●
Establish plans and build capacity to provide ongoing HIV and creatinine-level testing accessible for oral PrEP users¹⁴¹	HIV Unit has linkages to hospital laboratories	Support is required to oversee this activity	HIV Unit Hospital laboratory		●	● ●
Develop a monitoring system to support data collection for ongoing learning	The current HIV registry could be expanded and enhanced for PrEP implementation, incorporating the data items recommended in Appendix 2 ¹⁴²	Resources are required to determine the most suitable software (DHIS2 or equivalent, such as Tamanu) and customize the software to the needs of the programme	UNDP HIS technical advisers		●	● ●

141 As per updated WHO guidance (2022), measuring kidney function is optional for those aged under 30 years without kidney-related comorbidities (World Health Organization, 'Differentiated and simplified pre-exposure prophylaxis for HIV prevention. Update to WHO implementation guidance', Technical brief, WHO, Geneva, 2022).

142 Non-identifiable clinical HIV data are entered into an Excel-based data registry that is accessible to the UNDP-appointed HIV clinical consultant for review and shared patient review. This is feasible for the small numbers of HIV-positive patients but is not suitable for a potentially large number of PrEP users. It is feasible, and recommended, to develop an enhanced PrEP registry that records non-identifiable data in an open-source patient-level electronic registry for patient monitoring and reporting, with dashboards displaying core indicators by country and regionally. Products such as DHIS2 or Tamanu could be explored for this purpose.

Appendices

Appendix 1. List of people interviewed

Country	Contact person	Organization
Kiribati	Ataata Teata	BIMBA
Kiribati	Dr. Marou Tikataake	Ministry of Health and Medical Services
Kiribati	Mareta Tito	Ministry of Health and Medical Services
Marshall Islands	Yoshita Mares	Ministry of Health and Human Services
Marshall Islands	Adela Sibok-Nakamura	Ministry of Health and Human Services
Samoa	Dr. Vaimala Salele	Ministry of Health
Samoa	Aaone Tanumafili	Ministry of Health
Samoa	Lealaiauloto Liai Iosefa-Siitia	Samoa Family Health Association
Samoa	Kalolo Sene	Samoa Family Health Association
Samoa	Alexander Su'a	Samoa Fa'afafine Association
Samoa	Natu Tikeri	Samoa Fa'afafine Association
Samoa	Fagalima Tuatagoala	Samoa Fa'afafine Association
Tonga	Angela Patolo Fineanganofa	Ministry of Health
Tonga	Dr. Joseph Takai	Ministry of Health
Tonga	Akanete Lauti	Tonga Family Health Association
Vanuatu	Annie Tassiets	Ministry of Health
Vanuatu	Leila Bell	Ministry of Health/Australian Volunteer
Vanuatu	Edna Iavro	Ministry of Health
Vanuatu	Leias Obed	Vanuatu Family Health Association
Vanuatu	Julius Ssenabulya	Vanuatu Family Health Association
Vanuatu	Siula Bulu	Wan Smolbag
Vanuatu	Gigi Baxter	VPride
Vanuatu	Yannick Tarivuhavaha	VPride
Vanuatu	Minado Paul	Vila Central Hospital
Other	Heather-Marie Schmidt	UNAIDS
Other	Renata Ram	UNAIDS
Other	A/Prof. Catherine O'Connor	Kirby Institute
Other	Karen Salter	ASHM
Other	Lucy Stackpool-Moore	Adviser
Other	Praneel Maharaj	UNDP

Appendix 2. Potential PrEP online register

The 2022 ‘WHO Consolidated Guidelines on Person-Centred HIV Strategic Information’ recommends the collection of longitudinal individual-level data as the basis for routine aggregated reporting.¹⁴³ The following suggested data items are based on the PrEP client register included in ‘Module 5: Monitoring and Evaluation of the WHO Implementation tool for pre-exposure prophylaxis (PrEP) of HIV infection’,¹⁴⁴ and modified to be able to report against the core indicators recommended in the 2022 ‘WHO Consolidated Guidelines on Person-Centred HIV Strategic Information’.¹⁴⁵

Registration table

Field name	Data type	Acceptable values
Linkage key	To be determined	To be determined
Country of registration	Categorical	To be determined
Clinic of registration	Categorical	To be adapted locally
Date of registration	Date	DD/MM/YYYY
Patient ID	Integer	To be determined
Sex	Categorical	Male Female Transgender
Date of birth	Date	DD/MM/YYYY
Age (years)	Integer	##
Mobile phone number	Integer	##### (adapt locally)

Assessment 1

Field name	Data type	Acceptable values
Linkage key		To be determined
Key population	Categorical	Transgender MSM FSW
Date of appointment*	Date	DD/MM/YYYY
Date of HIV test	Date	DD/MM/YYYY
HIV test result	Categorical	Reactive Non-reactive Inconclusive

143 World Health Organization, ‘Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact’, WHO, Geneva, 2022.

144 World Health Organization, Module 5: Monitoring and evaluation, in: ‘WHO Implementation tool for pre-exposure prophylaxis (PrEP) of HIV infection’, WHO, Geneva, 2018.

145 World Health Organization, ‘Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact’, WHO, Geneva, 2022.

Creatinine	Number	###
STI syndrome (yes/no)	Binary	Yes No
STI syndrome (detail)	Categorical, multiple options	Urethral discharge; Genital ulcers; Vaginal discharge; Lower abdominal pain; Scrotal swelling; Inguinal bubo; Other
Date started treatment (if STI syndrome=yes)	Date	DD/MM/YYYY
PrEP product prescribed*	Categorical	Oral PrEP (TDF/FTC) Oral PrEP (TDF/3TC) Oral PrEP (TDF) CAB-LA
Date PrEP prescribed*	Date	DD/MM/YYYY
Date PrEP dispensed*	Date	DD/MM/YYYY
Number of tablets issued*	Integer	##

* Included as a data item in the WHO's recommended minimum dataset for HIV prevention interventions.¹⁴⁶

Follow-up visit 1

Field name	Data type	Acceptable values
Linkage key	To be determined	To be determined
Date of appointment*	Date	DD/MM/YYYY
Date of HIV test	Date	DD/MM/YYYY
HIV test result	Categorical	Reactive Non-reactive Inconclusive
Creatinine	Number	###
Side effects from PrEP use (yes/no)	Categorical	Yes No
Side effects from PrEP use (detail)	Categorical	See codes below
PrEP product prescribed*	Categorical	Oral PrEP (TDF/FTC) Oral PrEP (TDF/3TC) Oral PrEP (TDF) CAB-LA
Date PrEP prescribed*	Date	DD/MM/YYYY
Date PrEP dispensed*	Date	DD/MM/YYYY
Number of tablets issued	Integer	##

¹⁴⁶ Ibid.

PrEP-limiting toxicity codes: GI=gastrointestinal (nausea, diarrhoea, abdominal pain, vomiting); Skin=rash, hypersensitivity reaction; P=peripheral neuropathy (burning/numbness/tingling); CNS=central nervous system (dizziness, anxiety, nightmare, depression, seizures); Hep=hepatic dysfunction (jaundice); Hem=haematological (anaemia, neutropenia); F=fatigue; H=headache; B=bone dysfunction (fractures, osteopenia); M=metabolic (body fat changes, hyperglycaemia, dyslipidaemia); K=kidney dysfunction (nephrolithiasis, renal insufficiency).

* Included as a data item in the WHO's recommended minimum dataset for HIV prevention interventions.¹⁴⁷

Follow-up visit 2

Field name	Data type	Acceptable values
Linkage key	To be determined	To be determined
Date of appointment*	Date	DD/MM/YYYY
Date of HIV test	Date	DD/MM/YYYY
HIV test result	Categorical	Reactive Non-reactive Inconclusive
Creatinine	Number	###
Side effects from PrEP use (yes/no)	Categorical	Yes No
Side effects from PrEP use (detail)	Categorical	See codes below
PrEP product prescribed*	Categorical	Oral PrEP (TDF/FTC) Oral PrEP (TDF/3TC) Oral PrEP (TDF) CAB-LA
Date PrEP prescribed*	Date	DD/MM/YYYY
Date PrEP dispensed*	Date	DD/MM/YYYY
Number of tablets issued	Integer	##

PrEP-limiting toxicity codes: GI=gastrointestinal (nausea, diarrhoea, abdominal pain, vomiting); Skin=rash, hypersensitivity reaction; P=peripheral neuropathy (burning/numbness/tingling); CNS=central nervous system (dizziness, anxiety, nightmare, depression, seizures); Hep=hepatic dysfunction (jaundice); Hem=haematological (anaemia, neutropenia); F=fatigue; H=headache; B=bone dysfunction (fractures, osteopenia); M=metabolic (body fat changes, hyperglycaemia, dyslipidaemia); K=kidney dysfunction (nephrolithiasis, renal insufficiency).

* Included as a data item in the WHO's recommended minimum dataset for HIV prevention interventions.¹⁴⁸

Stopped PrEP

Field name	Data type	Acceptable values
Linkage key	To be determined	To be determined
Date stopped PrEP	Categorical	DD/MM/YYYY
Reasons	Categorical	See below

Stopped PrEP reasons: H=tested HIV+; R=no longer at substantial risk; S=side effects; C=client preference. Specify any other reasons.

* Included as a data item in the WHO 'Recommended minimum dataset for HIV prevention interventions'.¹⁴⁹

147 Ibid.

148 Ibid.

149 Ibid.

Appendix 3. Proposed core indicators

These priority indicators are included in the 2022 ‘WHO Consolidated Guidelines on Person-Centred HIV Strategic Information’:¹⁵⁰ (1) total number of PrEP recipients; (2) PrEP coverage; and (3) volume of PrEP prescribed.

PrEP Indicator 1: Total number of PrEP recipients

Definition	Number of people who received PrEP at least once during the reporting period
Numerator	Number of people who received any PrEP product at least once during the reporting period. Individuals prescribed different products or regimens at different times during the reporting period should be counted only once.
Denominator	Not applicable
Disaggregation	<ul style="list-style-type: none"> • Age (15–19, 20–24, 25–49 and 50+ years) • Gender (male, female or other)¹⁵¹ • Key population (MSM, FSWs, transgender women) • PrEP product and formulation (oral PrEP, CAB-LA) • Experience with PrEP (first time, continuing, or restarting following a period of not taking PrEP) • Provider type (key population-led or community-led organization, public sector provider, other entities such as private for-profit and not-for-profit organizations, including faith-based, international, non-governmental) • Setting (hospital, health clinic, community-based service, etc.)
Related Global AIDS Monitoring or Global Fund indicators	<ul style="list-style-type: none"> • UNAIDS Global AIDS Monitoring (2023) indicator 1.11: number of people who received PrEP at least once during the reporting period • Global Fund HIV indicators KP-6a, 6b, 6c: number of: (a) MSM; (b) transgender people; and (c) sex workers using PrEP in priority PrEP populations

PrEP Indicator 2: PrEP coverage

Definition	Percentage of people prescribed PrEP among those identified as being at elevated risk of HIV acquisition
Numerator	Number of people prescribed or dispensed any form of PrEP at least once during the reporting period. Individuals prescribed different products or regimens at different times during the reporting period should be counted only once.
Denominator	<ul style="list-style-type: none"> • Programme/service provider level: number of people who received a negative HIV test during the reporting period and identified as being at elevated risk of HIV acquisition (including people requesting/receiving any HIV prevention intervention, people from key populations, people with known risk factors or assessed as being at risk of HIV acquisition) • Population level: population-level estimate of the number of people who would benefit from PrEP—for example, as derived from a PrEP needs estimator tool

150 World Health Organization, ‘Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact’, WHO, Geneva, 2022.

151 The category ‘other’ includes trans and gender-diverse people who choose an identity other than male or female.

Disaggregation	<ul style="list-style-type: none"> • Age (15–19, 20–24, 25–49 and 50+ years) • Gender (male, female or other)¹⁵² • Key population (MSM, FSWs, transgender women) • PrEP product and formulation (oral PrEP, CAB-LA) • Experience with PrEP (first time, continuing, or restarting following a period of not taking PrEP) • Provider type (key population-led or community-led organization, public sector provider, other entities such as private for-profit and not-for-profit organizations, including faith-based, international, non-governmental) • Setting (hospital, health clinic, community-based service, etc.)
Related Global AIDS Monitoring or Global Fund indicators	None

PrEP Indicator 3: Volume of PrEP prescribed

Definition	Total volume of PrEP product prescribed
Numerator	The total sum of the volume of PrEP product prescribed for each PrEP recipient during the reporting period
Denominator	N/A
Disaggregation	<ul style="list-style-type: none"> • Age (15–19, 20–24, 25–49 and 50+ years) • Gender (male, female or other)¹⁵³ • Key population (MSM, FSWs, transgender women) • PrEP product and formulation (oral PrEP, CAB-LA) • Experience with PrEP (first time, continuing, or restarting following a period of not taking PrEP) • Provider type (key population-led or community-led organization, public sector provider, other entities such as private for-profit and not-for-profit organizations, including faith-based, international, non-governmental) • Setting (hospital, health clinic, community-based service, etc.)
Related Global AIDS Monitoring or Global Fund indicators	None

¹⁵² The category 'other' includes trans and gender-diverse people who choose an identity other than male or female.

¹⁵³ The category 'other' includes trans and gender-diverse people who choose an identity other than male or female.



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