# COOK ISLANDS

# Integrated National Strategic Plan for Sexual and Reproductive Health 2014 - 2018

National HIV/STI & TB Committee

TE MARAE ORA
COOK ISLANDS Ministry of Health

# MESSAGE FROM THE SECRETARY OF HEALTH

Kia Orana,

Health is everyone's business! One of the aims of this strategy is to raise the priority of sexual and reproductive health issues and to empower people to take ownership and responsibility for their health and the environment that they live in.

The Cook Islands Integrated National Strategic Plan for Sexual and Reproductive Health 2014 – 2018 has been developed through a participative and consultative process involving substantial contribution and support from various individuals.

I therefore wish to extend my appreciation to all those who have contributed to the process of developing this plan for their significant input and commitment to the process.

This strategic plan is needed to combat the rise of sexually transmitted diseases and reproductive health issues. It is needed to minimize the impending overload of the health and hospital systems and to increase the productivity of the Cook Islands workforce.

I believe with the appropriate level of commitment and support from government and cooperating partners, health workers, key stakeholders and the people we serve, the success of this Strategy will be guaranteed.

I encourage all those involved in the implementation of this plan to fully commit themselves to this important national task.

Kia Manuia,

Mrs. Elizabeth Iro
Secretary of Health

# MESSAGE FROM THE NATIONAL HIV / STI / TUBERCULOSIS COMMITTEE

Kia Orana

Ko teia Kaveinga, kua rauka mai teia no roto mai i te au uriuri anga manako tei raveia no runga i te akarakara matatio anga i te au angaanga tei oti meitaki i te raveia i te ta-angaanga anga i te parani tei oti no runga i te Paruru anga i te maki HIV/Aids e pera te akataka i te au tu'anga paruparu tei tau Kia akameitaki ia i roto i te Parani Ou.

Kua raveia teia au uriuri anga manako ki te au tu'anga tei tau i roto i te Kavamani, te au Putuputu'anga tei tau I vao ake i te Kavamani, e pera tetai au Patana i vao ake i te basileia tei tauturu katoa mai i te rave anga i teia angaanga.

I roto i teia Kaveinga Ou, kua akaari mai te ta-angaanga anga i te Kaveinga Taito e, ko tetai mea puapinga rava atu Kia raveia mari ra, Kia akakou mai e Kia angaanga kapiti teia Kaveinga ki te au tu'anga tuketuke e kimi ravenga nei no te oraanga meitaki o te kopapa o te vaine e pera to te tane.

Te irinaki ia nei e, ka riro te au mea tei akatakaia i roto i teia Kaveinga ei akamatutu i te au ravenga Kimi moni no te ta-angaanga i teia Kaveinga.

Kia Manuia

Frances Topa-Fariu
Chairperson
National HIV STI Tuberculosis Committee (NHSTC)

# ACKNOWLEDGEMENTS

This plan is the result of the hard work of many people, and reflects the complex realities of the geopolitical and funding environments as well as the aspirations of those who contributed to it. In particular we acknowledge the work of the following agencies and individuals who contributed to this plan:

**The National HIV, STI and TB Committee (NHSTC), the country coordinating mechanism of the Cook Islands**

**Cook Islands Government agencies:**

- Office of the Prime Minister
- Ministry of Education
- Ministry of Finance and Economic Management and its Department of Statistics
- Ministry of Internal Affairs, Youth Division and Gender Division
- Ministry of Police
- Te Marae Ora / Ministry of Health

**House of Ariki**

**Non-governmental agencies, Community Service Organisations and INGOs**

- Cook Islands Family Welfare Association and CIFWA Youth
- Cook Islands National Disability Council
- Cook Islands National Youth Council
- Cook Islands National Council of Women
- Cook Islands Sports and National Olympic Committee
- Religious Advisory Council
- Te Tiare Association
- Secretariat of the Pacific Community, Public Health Division, and in particular Dr Olayinka Ajayi, Dr Sophaganine Ali, and Ian Wanyeki
- NSP consultant and editor Dr Mark Henrickson

**Cook Islands Red Cross Society**

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## Acronyms and abbreviations

| | |
|---|---|
| AIDS | Acquired Immune-Deficiency Syndrome |
| ANC | Antenatal clinic |
| AusAID | Australian Agency for International Development |
| CCM | Country Co-coordinating Mechanism |
| CDO | Capacity Development Organisation |
| CHS | Community Health Services |
| CSO | Civil Society Organisation |
| GEWE | National Policy on Gender Equality and Women's Empowerment (GEWE) |
| GFATM | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| HHS | Hospital Health Services |
| HIV | Human Immunodeficiency Virus |
| INSP-SRH | Cook Islands Integrated National Strategic Plan for Sexual and Reproductive Health |
| M&E | Monitoring and Evaluation |
| M&EF | Monitoring and Evaluation Framework |
| MoE | Ministry of Education |
| MoH | Te Marae Ora Cook Island Ministry of Health |
| CCM | Country Coordinating Mechanism (Currently NHSTC -National HIV, STI and TB Committee) |
| NHSTC | Cook Islands National HIV, STI and TB Committee |
| NZAID | New Zealand Agency for International Development |
| PEP | Post Exposure Prophylaxis |
| PICTs | Pacific Island Counties and Territories |
| PPTCT | Prevention of Parent to Child Transmission (formerly ...Mother... PMTCT) |
| PLWHA | Person/People Living with HIV and AIDS |
| PRHP | Pacific Regional HIV and AIDS Project |
| PRHS | Pacific Regional HIV Strategy |
| PRSIP | Pacific Regional Strategy and Implementation Plan for HIV and other STIs |
| RF | Response Fund |
| SGS | Second Generation Surveillance |
| SPC | Secretariat of the Pacific Community |
| STI | Sexually Transmitted Infection |
| TB | Tuberculosis |
| UNAIDS | United Nations Joint Program on AIDS |
| UNFPA | United Nations Population Fund |
| UNGASS | United Nations General Assembly Special Session on AIDS |
| UNICEF | United Nations Children's Fund |
| VCCT | Voluntary Confidential Counselling and Testing |
| WHO | World Health Organisation |

## SECTION 1: BACKGROUND AND CURRENT SITUATION

### 1.1 Introduction

1.1.1 Overview and population

The Cook Islands consist of 15 islands and atolls spread over an area of 2 million km$^2$located in the South Pacific Ocean. Although widely dispersed, the islands can be categorized into two main clusters: the northern and southern groups. The southern group comprises nine islands and includes approximately 90 per cent of the total land mass. Most islands of the southern group have fertile soils and tropical vegetation, and this group includes Rarotonga, the largest and most populated island. The north group consists of six islands, primarily low lying coral atolls.

**Figure 1: The Cook Islands and Oceania**


The resident population of the Cook Islands was estimated at 14,974 in 2011(Cook Islands census 2011). There has been a population shift from the outer islands to the main population centres in Rarotonga and Aitutaki with 85% (13,097) living there. Life expectancy at birth is 72.8 years and it has an infant mortality rate of 6.8 deaths per 1,000 live births. The economy is largely dependent on tourism with a majority of tourists coming from New Zealand.

### 1.2 HIV epidemiology in the Pacific region

Excluding PNG, there is a very low prevalence across the region. Five countries (the Cook Islands, Nauru, Niue, Pitcairn and Tokelau) have no known people living with HIV as of 31 December 2011. The estimated prevalence among adults aged between 15-49 years in the remaining 16 PICTs is low and ranges from 0.002% to 0.078%. Since 1984, a total of 1,609 HIV cases have been reported. The 1,363 cumulative HIV cases in four PICTs—Fiji(UNAIDS, 2012), New Caledonia(DASS, 2012), French Polynesia(Nguyen, Mallet, Segalin, Lagarde et al., 2012) and Guam(DPHSS, 2012)—represent 84% of all reported cases, with only 246 cases (16%) from the remaining 17 PICTs. The current distribution of the 631 active cases as of 31 December 2011 is similar (Figures 2 and 3)(Wanyeki, 2011).

**Figure 1: HIV case distribution by PICT (n=631)**

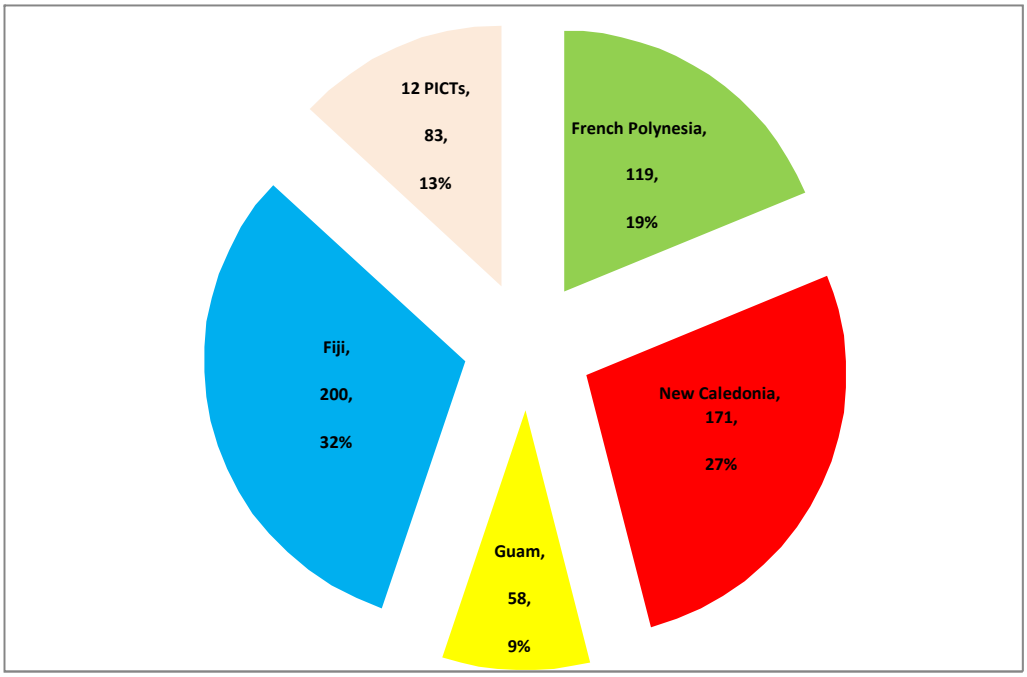
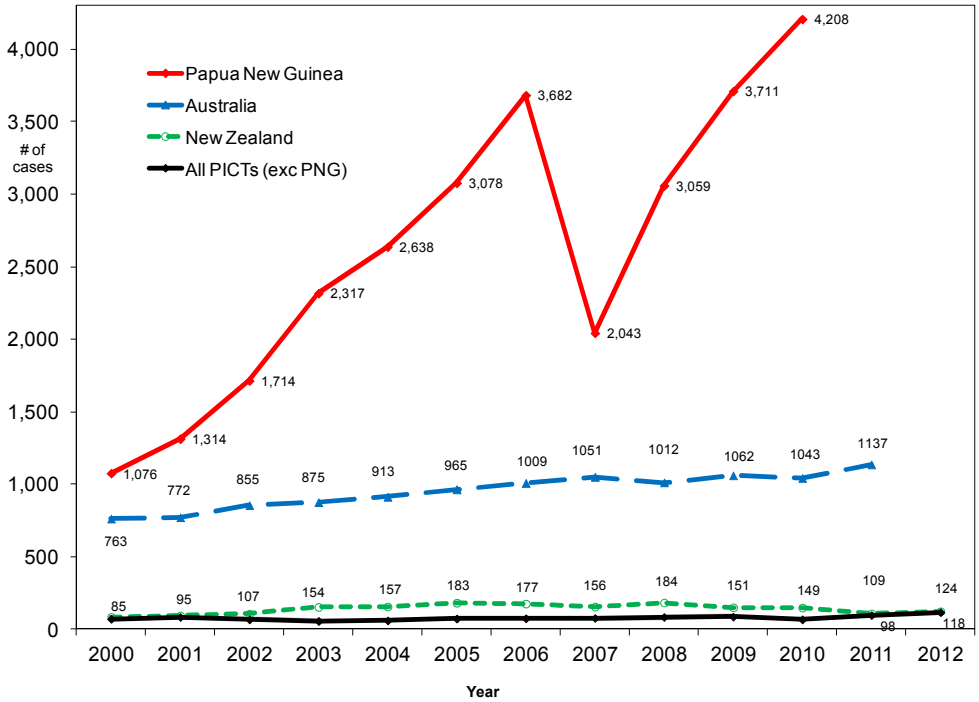



**Figure 3:Incident HIV cases in the Pacific: 2000–2012**



## 1.3 Health services and structure

### 1.3.1 Health services delivery mechanism and facilities

Routine HIV testing is conducted for all blood donors and antenatal (ANC) women. STI and HIV tests can be conducted in all clinics, however, the majority of other clients only use these services when they have symptoms or think they may have been at risk of acquiring an STI. The main laboratory is situated on Rarotonga and all outer islands specimens are sent to Rarotonga to be tested. Clinic hours are between 8am-4pm. Private Doctors send their patients and/ or specimens to the hospital laboratory for testing so all STI results are captured and maintained centrally. There are four accredited VCCT sites, two within the Ministry of Health on Rarotonga at the ANC department of Rarotonga hospital and in the outpatient division of Tupapa Clinic. One is an NGO clinics (Cook Islands Family Welfare Association) and one is in the pa enua (outer island) site at Aitutaki Hospital. Mobile VCCT outreach was conducted on the islands of Aitutaki, Pukapuka and Mangaia in 2012 and on Atiu, Mauke and Mitiaro in 2013

## 1.4 HIV and other STIs

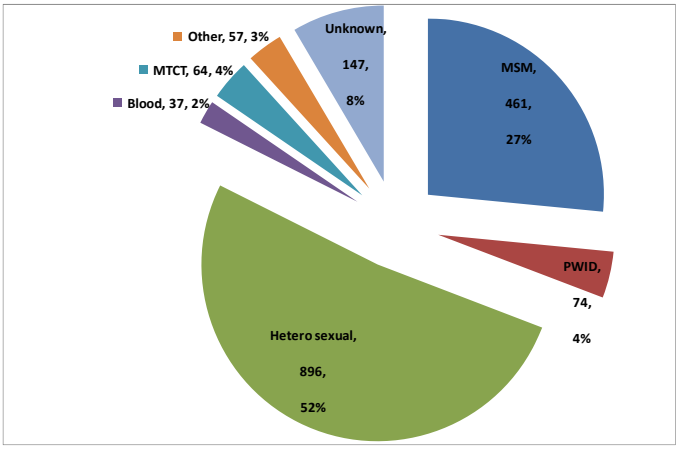
### 1.4.1 National context

HIV became a notifiable infection in the Cook Islands in 2004. As of 31 December 2012 the Cook Islands has reported a total of 3 HIV cases. These were recorded in 1997, 2003 and 2010. It is suspected that infection in all 3 cases occurred outside of the Cooks. The only case that was diagnosed in the Cooks was in late 2010. None of these cases currently live in Cook Islands. In 2010/2011, 2,490 HIV tests were conducted with only one positive case identified; in 2012 1,300 tests were conducted with no positive cases identified.

### 1.4.2 Pacific context

The primary mode of HIV transmission in the 21 PICTs is heterosexual contact, with over half of all HIV infections attributed via this route. Over one quarter (27%) of HIV infections were via men who have sex with men and five percent via injecting drug use (IDU) (Figure 4). Transmission trends vary markedly by country.

**Figure 4: Current routes of HIV transmission in the Pacific region**




## 1.5 Health providers

Te Marae Ora / Cook Islands Ministry of Health is the main provider of health care in the Cook Islands and has a regulatory function in protecting public health and is engaged in environment, water and sanitation issues. Health services range from public health (inclusive of primary care) to secondary and tertiary care. Overall, the Cook Islands are relatively well equipped to provide basic primary and secondary level care. The Cook Islands delivers an adequate range of general clinical services in the core areas of anaesthetics,

general outpatients and emergency, medicine, obstetrics and gynaecology, ophthalmology, paediatrics and surgery. These services are supplemented by visiting specialist teams and access to tertiary services through our referral process to overseas providers. There are a small number of private health providers.

### 1.6 Health status

Cook Islanders have a reasonable standard of health compared to other populations in the Pacific region. There is adequate health coverage in each island, high immunization rates throughout the country, no maternal and low infant mortality rates, and basic resources to meet the needs of the population. However, there are growing problems facing the Cook Islands with regards to NCDs such as diabetes, cardiovascular diseases, hypertension, obesity and their risk factors (e.g., tobacco smoking, excessive alcohol consumption, physical inactivity and poor diet). NCDs are the main cause of mortality. Morbidity is also dominated by NCDs, including circulatory system diseases, respiratory system and endocrine ailments, and nutritional and metabolic diseases. The Cook Islands' STEPS survey 2003,–2004found that in the population aged 25–64 years the prevalence of obesity was61.4%, of hypertension 33.2%, of diabetes, 23.6%, and of elevated blood cholesterol 75.2%.Two major oral diseases (dental caries and periodontal disease) are both chronic and progressive diseases with a considerable 'lifestyle' component, and share the same risk factors with the major NCDs which affect Cook Islanders. Communicable diseases (CDs) also pose some risk. Sexually transmitted infections (STIs) are common in the Cook Islands. The Secondary Generation Surveillance (SGS) conducted in 2006 showed a 22%prevalence rate of chlamydia; 46% of these cases were between the ages of 15 to 29 years. After a robust intervention campaign, a repeat survey in 2012 showed a decrease in prevalence of 50%. The current challenge is to reduce further the prevalence of STIs in the Cook Islands, particularly in light of reduced donor funding for HIV/STI intervention.

Te Marae Ora recognise that women and men face distinct health risks in their working and living environments and have different health needs. The promotion of gender sensitive research to inform the development and implementation of health strategies, policies and programs relating to CDs and NCDs and their determinants, violence against women and children, and natural disasters and health, has been and will continue to be essential in order to understand the gender differentials in the causes ,manifestations and consequences of health issues. Creative research partnerships with academic institutions and international agencies will supplement existing resources within Te Marae Ora.

The nil maternal mortality can be attributed to 100% birth attendance by skilled health professionals. The Cook Islands continue to maintain a low infant mortality rate of less than 7 per 1000 live births. The range of reproductive health rights and services in the Cook Islands has evolved to a comprehensive evidence-based approach.

### 1.7 Process of developing the INSP-SRH and monitoring and evaluation framework

The end term review of the current *Cook Islands National Strategic Plan for HIV and Other STIs* and the development of a broader sexual and reproductive health plan have been realized through three key phases:

**Phase 1: May 2013: Desk Review of Applicable Documents and Reports**

This phase was carried out off-site by key technical staff of the SPC PHD M&E Cluster and Health Protection Unit. Documents reviewed included but were not limited to the following:

1. The current *Cook Islands National Strategic Plan for HIV and Other STIs (2008 – 2013)*
2. The current *Cook Islands NSP M&E Frameworks and Implementation Plan*
3. The current *Cook Islands National STI Treatment Guidelines*
4. Regional *Comprehensive STI Management Guidelines*
5. Cook islands Gender and Women Empowerment Strategic Plan

**Phase 2:27 May – 6 June 2013: Integrated Applied M&E Training, End Term Review and INSP-SRH Development**

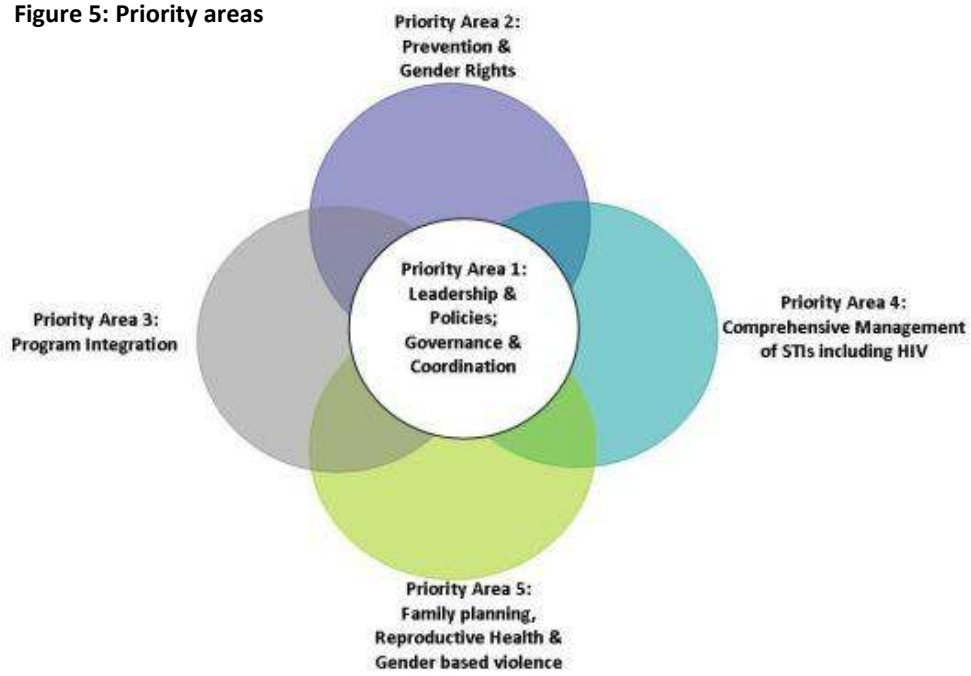
This phase focussed on comprehensive STI control, integration with broader SRH processes and data systems. This phase also included meetings with key stakeholders for feedback as part of the end term review, and a review of the implementation of comprehensive STI control.

**Phase 3: 16—23 June 2014: Finalisation of the NSP and supporting documentation**

This phase built on existing work by stakeholders and Te Marae Ora staff in order to finalise the NSP. The draft NSP was presented to NHSTC members adjustments made in response to feedback, and a comprehensive Te Marae Ora review undertaken. Guiding principles of the NSP include the UN MDGs 4, Reduce child mortality; 5 Improve maternal health; and 6, Combat HIV/AIDS and other diseases. The 'Getting to Zero' targets—zero deaths, zero new infections, and zero discrimination— also underpin this process. The NSP was developed around a conceptual framework with five priority areas (Figure 5). These areas are not ranked in importance or significance, and should be understood as equal 'priorities'.

Priority Area 1: Leadership and policies
Priority Area 2: Prevention and gender rights
Priority Area 3: Program integration
Priority Area 4: Comprehensive management of STIs
Priority Area 5: Family planning and reproductive health

**Figure 5: Priority areas**



## SECTION 2: THE INTEGRATED STRATEGIC PLAN FOR SEXUAL AND REPRODUCTIVE HEALTH (CI NSP) 2014 – 2018

### 2.1 Mission

All Cook Islanders will enjoy the highest standards of health and well-being through equitable access to comprehensive, integrated, effective, quality and evidence-based sexual and reproductive health services, with focus on 'keeping HIV at zero', and reducing to the barest minimum the burden of all forms of STIs, in a supportive society free from all forms of gender discrimination.

### 2.2 Priority Areas (Figure 5)

The NSP Working Group met from June 2012 to October 2013 and identified the following Priority Areasfor the Cook Islands Integrated National Strategic Plan for Sexual and Reproductive Health. These priority areas are integrated with each other and not prioritised within themselves; each is as important as the others:

- Priority Area 1: Leadership and policies
- Priority Area 2: Prevention and gender rights
- Priority Area 3: Program integration
- Priority Area 4: Comprehensive management of STIs
- Priority Area 5: Family planning, reproductive health and gender based violence

This plan is intended to be accompanied by the monitoring and evaluation framework in the next section, and by the related annexes that follow. In the section below each Priority Area has one or more goals associated with it, to which specific objectives and activities are attached. The monitoring and evaluation framework associates specific outcomes, dates and responsible offices, agencies or organisations who will manage the progress of the activity. Annex 4 provides cost estimates by objectives.

### 2.3 Goals, objectives and activities

**Priority Area 1: Leadership and policies**

This theme also includes governance and coordinating functions. The NHSTC (See Annex 1) and Te Marae Ora will provide coordinated leadership of the various stakeholder groups and communities. These groups will advocate for adequate funding and support to implement the NSP, and to ensure that that Cook Islands are representative at key national and international forums. An essential component of leadership is accountability, and key leaders will ensure that stakeholders are accountable to the leadership and people of Cook Islands, and that the leadership in turn is accountable to its stakeholders in sexual and reproductive health issues. In order to ensure this the following goals and objectives are set out:

**Goal 1A:** Ensure that sound, inclusive, sustainable and responsive leadership is in place to ensure resourcing, delivery, monitoring and evaluation of the NSP.

**Objective 1.1** By 2018, broaden active participation and inclusiveness of traditional, political and community leaders at all levels (This objective is linked to GEWE Key Action 6.2: Improve

the coordination of services providers – policy, health and NGO

**Activities** 1.1.1 Conduct STI/HIV awareness activities for leaders at all and NHSTC members

1.1.2 Work with policymakers to enact appropriate legislation, promote related policies, and advocate for a sustainable sector budget.

1.1.3 Facilitate review and change of relevant laws and policies that may be discriminatory or impede access to justice for women, minority groups, including sexual and gender minority groups; this review should include attention to confidentiality protections

1.1.4 Conduct educational activities to orient key stakeholders and the public to relevant legislation

**Objective 1.2** By 2018, strengthen function and operations of the NHSTC or any successor bodies

**Activities** 1.2.1 Rollout the new NSP and monitoring and evaluation frameworks, and orient partners, key stakeholders and the public to the NSP.

1.2.2 Review the functions, operating procedures and processes of the NHSTC

1.2.3 Assist Te Marae Ora and partner agencies to resource the NSP, develop proposals and access funds

1.2.4 Disseminate information about policy decisions, interventions and events relating to the implementation of the strategy to implementing partners and key stakeholders appropriate to the audience

**Objective 1.3** Strengthen the monitoring and evaluation system with demonstrable evidenced-based decision-making

**Activities** 1.3.1 Develop a costed action plan and action the monitoring and evaluation framework and NSP with key stakeholders and implementing partners

1.3.2 Identify focal staff to implement the monitoring and evaluation of the NSP goals and objectives

1.3.3 Develop, roll out and coordinate standardized data collection tools and program and financing templates and protocols among hospitals, health centres, clinics , private practitioners and other collaborating entities

1.3.4 Incorporate monitoring, evaluation and surveillance of prevalence and long-term consequences of STIs, link with private healthcare providers in order to determine the impact of comprehensive HIV strategy over time

1.3.5 Conduct monitoring and evaluation re/training for implementing partners and targeted program staff

1.3.6 Monitor entities' implementation of the strategic plan with the support of a monitoring and evaluation cross-cutting team

1.3.7 Submit regular periodic program quality and financial reports to the NHSTC, Te Marae Ora and Donors

1.3.8 Conduct a mid-term review (MTR) and end term review (ETR) of the NSP including appropriate research on the impact of interventions

**Priority Area2: Prevention and gender rights**

This theme is intended to provide a coordinated national prevention strategy for HIV and STIs, and to inform sexual and reproductive health care throughout the country. It also recognises that such a strategy is not possible without a clear gender rights and comprehensive human rights approach to these challenges. This plan also recognises that gender and sexual discrimination in any of its forms will negatively impact the health of all Cook Islanders. It was identified in the first section of this report that women and men have different personal and environmental health needs, and this theme recognises those different needs. Equally, akava'ine have different health and social challenges and needs. This prevention and rights theme recognises that different communities require different strategies. This plan will integrate with an array of gender-based services, including the Well Women's packages of care and men's health programs. Together with the Ministry of Education this strategy will implement prevention education and stigma reduction programs targeting vulnerable groups including young people in schools. These programs will be research- informed and regularly assessed and evaluated. It is important to ensure that all communities are aware of the availability of VCCT and condoms. It is also important to identify hidden at-risk groups including injection drug users, people who engage in transactional sex, MSM and akava'ine and people with disabilities and mental illnesses.

**Goal 2A:** Deliver high-quality age- gender- and culturally-appropriate risk prevention education and stigma reduction education to individuals, groups and communities at increased risk of HIV and STI.

**Objective 2.1** (Re)Define vulnerable groups and population at higher risk of exposure with re-direction of appropriate interventions for the balance of the NSP period

**Activities**

2.1.1 Undertake a study and/or situational analysis of population groups and geographical areas vulnerable/at higher risk of exposure to STIs including HIV and identify contributing factors

2.1.2Identify and implement initial activities to reduce HIV and STI transmission to vulnerable populations as identified through SGS and related assessments

2.1.3 Conduct sensitization and anti-stigma campaigns on sexual and gender minorities and sexual and gender minority rights

2.1.4 Target strategic health communication campaigns to increase awareness of high local rates of STIs (including symptoms, long-term consequences of asymptomatic infections, availability of testing and treatment) to promote safer sexual behaviours (condom use, partner reduction) and to increase healthcare-seeking behaviour

2.1.5 Undertake communication between the Secretaries of Education and Health to ensure continuation of in-school SRH education

2.1.6 Explore partnership arrangements among implementing partners toward the implementation of audience-appropriate comprehensive sexuality and reproductive health information and stigma reduction education in schools

2.1.7 Develop resources for the professional development of health education teachers

2.1.8 Conduct workshops for targeted teachers on effective ways to deliver SRH curriculum

2.1.9 Conduct comprehensive training in behaviour change communication strategies for targeted implementing agencies

2.1.10 Develop a comprehensive sexuality education (CSE) package including classroom video tools to be used in Cook Islands schools and the community

2.1.11 Conduct training of trainers to implement CSE package

2.1.12 Incorporate end of session evaluations as an essential component of the delivery of curricula

**Objective 2.2** Sexually active individuals report using condoms during risky sex

**Activities**

2.2.1 Redesign IEC materials on STI and HIV with a focus on STIs, VCCT and sexual health information

2.2.2 Conduct a media campaign and face-to-face sessions to increase knowledge about HIV and STIs, utilising special events and PH processes such as Tutaka (Health inspectors and relevant agencies quarterly door-to-door visits)

2.2.3 Conduct HIV/STI awareness campaign for groups such as sporting, cultural, and Tere-parties travelling into and out of the Cook Islands

2.2.4 Link HIV/STI interventions to CISNOC Stop AIDS campaigns targeting

athletes, sportspeople, coaches and supporters

2.2.5 Link HIV/STI awareness campaigns to tourism and entertainment industry events and meetings

2.2.6 Include migrant communities in education and awareness campaigns

2.2.7 Develop condom marketing campaign targeted at risk groups to encourage use of condom as fun and exciting

2.2.8 Maintain distribution of locally designed condom and lubrication packs

2.2.9 Increase condom dispensers around Rarotonga and explore the possibility of expanding these to outer islands

2.2.10 Supplement UNFPA condom and lubricant supplies

2.2.11 Conduct campaigns to promote community acceptance of condoms and dual benefits to condom use

**Objective 2.3** Reduce alcohol and other drug misuse, a contributing factor to risky sexual behaviour.

**Activities**

2.3.1 Expand implementation of peer education programs addressing behaviour change strategies to reduce ancillary risk-taking activities (e.g. alcohol and other drugs) in relation to STIs and HIV

2.3.2 Incorporate education sessions on smart drinking behaviour into comprehensive sexuality/peer education programs

2.3.3 Produce and disseminate media messages on alcohol and other drug misuse resulting in poor decision-making

2.3.4 Initiate a host responsibility campaign

**Objective 2.4** All forms of quality counselling and testing will be available with a focus on VCCT.

**Activities**

2.4.1 Review and implement recommendations of the national VCCT policies and guidelines

2.4.2 Monitor protocols and guidelines regarding confidentiality of personal information of VCCT clients to be observed by healthcare workers and service providers in public agencies, private practices and community based agencies

2.4.3 Determine baseline, map and review periodically VCCT services currently offered in the Cook Islands

2.4.4 Conduct counsellor training/re-training for healthcare practitioners and community service providers

2.4.5 Identify, select and furnish new VCCT sites based on Pacific Minimum Standards

2.4.6 Ensure clients receive STI and HIV results (including negatives) through post-test counselling

2.4.7 Maintain and/or strengthen laboratory services to support VCCT

2.4.8 Formalise and disseminate referral systems and processes to promote access to VCCT services

2.4.9 Establish a professional support system for VCCT counsellors

2.4.10 Conduct campaigns (including use of media) using updated promotional material to raise community awareness about VCCT

**Goal 2B:** Provide a rights-based approach to sexual and reproductive health to girls and women, with a focus on eliminating complications of teenage pregnancy.

**Objective 2.5** Sexual and reproductive health of all women and their rights will be improved, with focus on the elimination of complications of teenage pregnancy

**Activities**

2.5.1 Conduct IBBS follow-up surveys with ANC clients

2.5.2 Provide training to improve skills of youths to say no to sex and/or negotiating safer sex

2.5.3 Conduct training for youth volunteers as sexual health educators and distributors of condoms and IEC materials

2.5.4 Promote early engagement and vigorous antenatal are for pregnant teenagers

2.5.5 Maintain and sustain voluntary STI and HIV testing with appropriate counselling for all pregnant women

2.5.6 Explore administration of prophylaxis for neonatal conjunctivitis at birth

**Objective 2.6** Women's sexual and reproduction rights are respected and promoted (linked

with GEWE Output 5.1)

**Activities** 2.6.1 Create and encourage community dialogue around research findings on forced-sex experiences of young people in the Cook Islands

2.6.2Identify, provide immediate support, and link victims of violence to appropriate support services in the community

2.6.3 Develop and conduct education programs for healthcare workers to reduce fear of infection and eliminate discrimination against people living with HIV

2.6.4 Disseminate information about women's sexual and reproductive rights

2.6.5 Intensify dissemination to information about responsible sexual behaviours of teenage girls and boys in order to reduce girls' pregnancy and the transmission of STIs

2.6.6 Network relevant agencies to improve the coordination of service providers, including policy, health and NGOs

**Priority Area 3: Program integration**

Individual health needs cannot be siloed or compartmentalised. Individuals are integrations of body, mind, spirit and community. Likewise services and programs must be integrations. The integration of all the various health care program responses is essential in order to maintain the health of individuals and communities. In order to achieve this, the following goals and objectives are established:

**Goal 3**: Links among HIV, STI TB, non-communicable diseases, men's health, sexual and reproductive health programs and disaster preparedness will be strengthened in order to achieve an integrated programmatic response to individuals and communities at risk

**Objective 3.1** The management and training of TB in relation to HIV (and vice versa) will be strengthened to reduce co-morbidities

**Activities** 3.1.1 Link HIV training, management and testing to TB management

**Objective 3.2** Linkages between men's and young men's SRH and men's Health NCD programs will be strengthened

**Activities** 3.2.1 Explore linkage to and enhanced leverage of the Men's Health Program with a focus on promoting the sexual health of men: this will include stocktake on men's SRH services; identify existing processes and existing structures in Te Kainga, religious resources; engage in capacity building activities in this area

3.2.2 Explore linkages with other men's health related processes such as Rotaianga

3.2.3 Link interventions to eliminate all forms of gender discrimination with a focus on physical and emotional gender violence, abuse forced sex and marital rape to the Men's Health Program

3.2.4 Evaluate collaborative data and information flow, and referral and follow-up between clinical care and public health processes and partners to promote holistic care and support of men and their partners

**Objective 3.3** Linkages between SRH and Disaster Preparedness and Response, and MOH Emergency Response Plan will be clarified, with a focus minimizing SRH issues following disruptions and displacement transportation and sheltering during disasters

**Activity** 3.3.1 Link Sexual and Reproductive Health to the existing Disaster Preparedness and Response Plan, and implement the plan as required

**Priority Area 4: Comprehensive management of STIs**

Priority Area 3 (Program integration) is focused on the integration of services and programs, while Priority Area 4 focuses on the integration of programs to deliver comprehensive STI services to individuals. Implementation of this Priority Area will ensure that all STI services, blood donations, occupational exposure, laboratory services and the continuum of HIV-related care are seamlessly integrated.

**Goal 4A:** All STI and HIV services will be seamlessly integrated to ensure an appropriate and compassionate continuum of care for all persons at risk.

**Objective 4.1** Community access to high quality comprehensive STI management and support services (see Annex 2)will be maintained with a focus on strengthening access in outer Islands

**Activities** 4.1.1 Roll out the June 2013 National Comprehensive STI Management and the HIV Continuum of Care Guidelines to targeted healthcare workers and implementing entities

4.1.2 Conduct training of trainers (TOT) workshops on STI Comprehensive Management and HIV Continuum of Care

4.1.3 Conduct integrated STI Comprehensive STI Management and HIV Continuum of Care training/retraining for targeted healthcare workers facilitated by trained trainers

4.1.4 Monitor by peer review the provision of quality comprehensive management for both symptomatic and asymptomatic STIs, including partner management

4.1.5 Develop and implement strategies to overcome identified barriers in accessing STI care and services

4.1.6 Strengthen forecasting and supply for STI and HIV related drugs, lab test kits, reagents and other consumables to outer islands and implementing partners

**Objective 4.2** Network of HIV treatment, continuum of care (CoC) and support sustained.

**Activities** 4.2.1 Update policies and protocols to monitor treatment and continuum of care for PLHIV based on regional guidelines

4.2.2 Ensure availability and access to ARVs and HIV=specific tests and commodities

4.2.3 Maintain communication networks between local clinicians and international HIV/AIDS specialist care

4.2.4 Provide access to education and support services for people affected by and caring for people living with HIV

4.2.5 Conduct training with different sectors including church groups on the care and support needs of people living with HIV and their families

**Objective 4.3** All individuals living with HIV will be placed on ART if eligible, with focus on antenatal patients and infants born to mothers living with HIV

**Activities** 4.3.1 Produce and distribute information on PPTC transmission of HIV to pregnant women and partners

4.3.2 Adapt UNICEF regional policy on PPTCT of HIV

4.3.3 Conduct training/retraining of healthcare workers on PPTCT and the Cook Islands policy and protocols

4.3.4 Ensure access to ART drugs for pregnant mothers with HIV

**Goal 4B:** Appropriate protocols and procedures will be sustained to ensure the safety of the national blood supply and staff who may be occupationally exposed to HIV. Appropriate and robust laboratory surveillance mechanisms will be in place.

**Objective 4.4** All donated blood will come from voluntary non-remunerated blood donations (VNRBD) in a quality assured manner

**Activities** 4.4.1Maintain and monitor policy and guidelines for the clinical use of blood and blood products

4.4.2 Promote continuous recruitment of voluntary non-remunerated blood donors

4.4.3 Ensure continuous pre- and post-donation counselling for all blood donors

4.4.4 Ensure continuous testing of all donated blood for HIV and STIs

4.4.5 Ensure continuous biannual internal audits of blood bank services

**Objective 4.5** Infection control and occupational post-exposure prophylaxis (PEP) services are sustained for individuals at risk

**Activities**

4.5.1 Revise applicable policies and monitor the registration and regular inspection of premises and tattooists, skin piercers, and beauty therapists to assure compliance with universal precautions

4.5.2 Conduct awareness programs on universal precautions for all needle users (including diabetics, tattooists and skin-piercers, etc.)

4.5.3 Conduct annual training for health personnel in infection control and management

4.5.4 Ensure hepatitis B immunization is available for all healthcare workers exposed to biohazard materials

4.5.5 Ensure adequate supply of sterile and safe disposal of contaminated equipment and materials (e.g., gloves, needles, etc.)

4.5.6 Procure and install a new incinerator for safe disposal of biomedical waste and blood products

4.5.7 Monitor and evaluate procedures and protocols regarding disposal of blood, blood products and contaminated equipment

4.5.8 Display universal precaution signs at all times in all healthcare facilities and public services such as police, fire, prisons, etc.

4.5.9Maintain and monitor procedures and guidelines and single point of contact for post (occupational)-exposure management (PEM) with reference to regional guidelines

4.5.10 Train/Retrain healthcare workers and relevant agencies in assessment, counselling and procedures regarding PEM for HIV, HBV and standard precautions

**Objective 4.6** Strengthen LQMS including laboratory based surveillance mechanisms

**Activities**

4.6.1 Conduct six-monthly internal quality audits on testing systems for HIV, STI and TB

4.6.2 Conduct external quality audits of LQMS

4.6.3Integrate Laboratory Information System (LIS) with Health Information System

4.6.4 Train/Retrain staff on HIS

4.6.5 Maintain quality standard of procurement for STI and HIV consumables and turnaround time for results

4.6.6 Explore the feasibility of HPV screening and other special tests (e.g. urine gonorrhoea testing) in-country

4.6.7 Continue to maintain laboratory capacity for STI testing

**Priority Area 5: Family planning, reproductive health and gender based violence**

It has been noted that sexual and reproductive health care needs of women and men are different. Women of course are in a key role in making decisions about pregnancy, and are also more likely to be victims of gender-based violence and abuse. This theme recognises the specific needs of women and girls in making sexual and reproductive health decisions, and the importance of directing education and interventions to them. This theme also recognises that antenatal clinics are key places to access women and girls. It also recognises the importance of coordinating with other key service interventions, including those provided by the Police, Justice, civil society and maternal health providers. It also recognises that the distribution of these services and interventions may not be equitable, and directs specific attention to the outer islands.

**Goal 5A:** Ensure that women and girls have appropriate access to the array of sexual and reproductive health education and services and live in a safe and secure environment.

**Objective 5.1** The complete physical, mental and social well-being of women and men will be promoted, with focus on sexual health

**Activities**

5.1.1 Maintain Well Women's Clinic package of services and expand the model to Aitutaki and Atiu

5.1.2 Promote the services of the Well Women's Clinic

5.1.3 Improve gynaecological and sexual health services for women with a focus on young girls from onset of menstruation (in collaboration with the paediatrician where relevant) and women

5.1.4 Strengthen the use of HPV vaccine to young girls to prevent cervical cancer

5.1.5 Improve screening systems and responses to breast and cervical cancers, STI and HIV (linked to GEWE) by promoting increased awareness of the services

**Objective 5.2** Girls, women, and couples will be informed on their right to make free and informed choices on the number and timing of children, and avoid unwanted pregnancies

**Activities** 5.2.1 Strengthen national networks with regional collaborations on reproductive health commodities and interventions

5.2.2 Conduct comprehensive sexuality education, including community based distribution

5.2.3 Increase community awareness on the various forms of family planning and referral processes in collaboration with community based distribution activities

5.2.4 Increase access to contraceptives particularly for teenage girls (link to GEWE Output 5.2)

**Objective 5.3** Establish nationwide access to high quality ANC and RH services strengthened with focus on outer Islands mothers to maintain zero maternal mortality, reduce maternal morbidity, and peri-natal mortality

**Activities** 5.3.1 Roll out updated reproductive health policies and guidelines

5.3.2 Train/Retrain targeted healthcare workers on antenatal care, delivery and maternal care

5.3.3 Create incentives to retain skilled staff

5.3.4 Strengthen referrals systems for outer islands mothers in antenatal care who have complicated pregnancies

5.3.5 Train Sexual and Reproductive Health providers on special needs of people with disabilities and their families

**Goal 5B:** Agreed protocols and procedures for service delivery, reporting and referral are in place for cases of gender based violence

**Objective 5.4** Services for victims of gender-based violence into the sexual and reproductive health will be fully integrated.

**Activities** 5.4.1 Increase and awareness and adherence to agreed norms and protocols for case management, reporting and data collection in partnership with other implementing partners and agencies

5.4.2 Train targeted healthcare workers on identification, screening and care of victims of gender-based violence

**Objective 5.5** The process of documenting and reporting gender-based violence will be monitored through inter-sectoral collaborations between the health sector, police, justice civil society organisations and partner agencies (GEWE 6.1: Legal frameworks, law enforcement and justice system are strengthened).

**Activities**

5.5.1 Support the development, review, and amendment of policies and relevant legislation (e.g. Family Law Bill, Crimes Act 1969) to mitigate the issue of gender-based violence and stigma

5.5.2 Conduct workshops on eliminating gender based violence for leaders and key opinion-shapers at all levels, including traditional, political, community, church and government

5.5.3 Develop appropriate templates for data collection and reporting, and identify data collection points and key staff in all relevant implementing gender violence elimination agencies

5.5.4 Improve services and resources for support of gender based violence, in consultation with gender-based violence survivors and implementing agencies

5.5.5 Explore appropriate interventions such as parenting programs for young parents to prevent and/or reduce violence to children and young people

## SECTION 3: MONTORING AND EVALUATION FRAMEWORK

The Monitoring and Evaluation (M&E) Framework is intended to provide guidance on progress toward the goals, objectives and activities set out in the previous chapter (see Annex 4). Both process and outcome measures are included in this framework. Each activity in the strategic plan is linked to a specific measure, timeframe and responsible person, agency or organisation. This M&E framework is indicative, and is linked to an overall monitoring plan that measures progress of the NSP; this plan is maintained by Te Marae Ora in the Office of the HIV/STI Coordinator. The HIV/STI Coordinator or successors is responsible for monitoring the overall progress towards goals and objectives.

Abbreviations used in these tables:

| | |
|---|---|
| BTC | National Blood Transfusion Committee |
| CHS | MOH Community Health Services |
| CHS-HPU | MOH Community Health Services Health Promotion Unit |
| CIFWA | CI Family Welfare Association |
| CINDC | CI National Disability Council |
| CINYC | CI National Youth Council |
| CIRC | CI Red Cross Society |
| CINCW | CI National Council of Women |
| CSO | Civil Society Organisations |
| EMCI | Emergency Management Cook Islands |
| HHS | Hospital Health Services |
| HPU | Health Promotion Unit |
| INTAFF | CI Ministry of Internal Affairs |
| INTAFF-Gender | Gender Division |
| INTAFF-Youth | Youth Division |
| MOC | CI Ministry of Culture |
| MOE | CI Ministry of Education |
| MFEM-NSO | CI Ministry of Finance and Economic Management- National Statistics Office |
| MOJ | CI Ministry of Justice |
| M&E Team | Monitoring and Evaluation Team of the NHSTC (includes HIV/STI Coordinator) |
| MOH | Te Marae Ora Cook Islands Ministry of Health |
| PLPG | Pacific Legislatures for Population and Governance, Inc. |
| RAC | Religious Advisory Council |
| TA | Technical Advisor |
| Tourism | CI Tourism Corporation |

**Priority Area 1: Leadership and Policies**

| Index number | Activity | Measure | By when | By whom |
|---|---|---|---|---|
| 1.1.1 | Conduct awareness activities for leaders | Updates completed | Annually by 30 Jun 2014-18 | MOH |
| 1.1.2 | Enact appropriate legislation and policies, advocate for sustainable sector budget | Review annually post-election | 30 Sep2014 30 Sep 2018 | PLPG, OPM |
| 1.1.3 | Review relevant laws and policies; these should include protections of confidentiality | Review annually | Annual review by 30 Sept. 2014-18 | PLPG, OPM |
| 1.1.4 | Orient key stakeholders and public to key legislation | Annual orientation held | Completed by 1 Sep 2014-2018 | MOH |
| 1.2.1 | Rollout new NSP and M&E | NSP completed | 30 Jun 2014 | NHSTC |
| 1.2.2 | Review NHSTC functions, operations and processes | Review completed | 30 Dec 2014; reviewed 30 Sept 2016, 2018 | NHSTC with external TA |
| 1.2.3 | Assist MOH to resource NSP | Sustainable resources identified | 30 Sep 2014; reviewed annually | MOH Finance, NHSTC |
| 1.2.4 | Disseminate NSP and related policy decisions to stakeholders | Evidence of stakeholders briefed and regular information sharing | 30 Sep 2014 | NHSTC |
| 1.3.1 | Develop costed action plan for NSP | NSP and costing plan in place | 30 Jun 2014 | M&E Team; MOH Finance; MFEM |
| 1.3.2 | Identify focal staff to implement M&E activities | Staff identified | 30 Jul 2014 | NHSTC, MOH |
| 1.3.3 | Develop standardised data collection tools and protocols | Tools in place | 30 Aug 2014 | M&E Team |
| 1.3.4 | Incorporate M&E and surveillance to assess impact of NSP | Links established, systems in place | 30 Sep 2014 | M&E Team |
| 1.3.5 | Conduct M&E trainings with relevant staff | Trainings conducted | 30 Dec 2014 | M&E Team |
| 1.3.6 | Monitor implementation of NSP | Monthly reports completed | Monthly from 30 Jul 2014-30 Dec 2018 | M&E Team |
| 1.3.7 | Submit period program progress and quality reports to NHSTC, MOH and Donors | 6-monthly progress reports completed and submitted | 30 Dec 2014-30 Jun 2018 | M&E Team Leader |
| 1.3.8 | Conduct MTR and ETR of NSP | Reviews completed | MTR 30 Jun 2016 ETR 30 Jun 2018 | M&E Team |

**Priority Area 2: Prevention and Gender Rights**

| Index number | Activity | Measure | By when | By whom |
|---|---|---|---|---|
| 2.1.1 | Undertake study of vulnerable populations using existing data | Study completed | 30 Jun 2016 | MOH |
| 2.1.2 | Identify and implement initial activities to reduce HIV/STI to vulnerable populations | Number of activities | Review annually by 30 Dec | Te Tiare, CHS, CSO and INTAFF-Youth |
| 2.1.3 | Conduct sensitization and anti-stigma campaigns on sexual/gender minorities | Campaign in place and implemented, activity reports | 6-monthly reports from 30 Dec 2014 | CHS, CSO INTAFF-Gender |
| 2.1.4 | Target strategic health communication campaign for awareness of high rates of STI | Campaigns in place and implemented | Monthly 2014-2018 | CHS-HPU |
| 2.1.5 | Undertake communication between MOH and MOE to continue in-school activities | Meetings in place | Annually by 30 Mar | MOH, MOE |
| 2.1.6 | Explore partnerships for SRH in schools | Number of partnerships identified | 30 Sep 2016 | CIFWA |
| 2.1.7 | Develop resources for health education teachers | Resources developed | 30 Jun 2015 | MOE-MOH |
| 2.1.8 | Conduct workshops for teachers on SRH | Number of workshops completed | 30 Dec 2015 | MOE |
| 2.1.9 | Conduct training in behaviour change strategies | Number of trainings completed | 30 Dec 2014<br>30 Mar 2016<br>30 Mar 2018 | CIFWA, CHS |
| 2.1.10 | Develop CSE package | Package completed | 30 Jun 2017 | MOE |
| 2.1.11 | Conduct training of trainers to implement CSE | Number of trainings completed | 30 Sep 2017 | MOE |
| 2.1.12 | Incorporate end of sessions evaluations of CSE | Tool completed and implemented | 30 Sep 2017 | MOE |
| 2.2.1 | Redesign IEC materials on STI and HIV | Materials completed | 30 Jun 2016 | CHS, CIRC, CIFWA, CSO |
| 2.2.2 | Conduct media campaign to increase knowledge about HIV/STIs utilising special events | Campaign in place and impact assessed | Monthly from 30 Jul 2014 | CHS, CIRC, CIFWA, CSO |
| 2.2.3 | Conduct HIV/STI awareness campaigns for travelling groups | Campaign in place | Monthly from 30 Jul 2014 | CHS, CIRC, CIFWA, CSO, CISNOC |

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| 2.2.4 | Link HIV/STI interventions to CISNOC Stop AIDS campaigns | Documentation of link in place | 30 Mar 2015 | CHS, CSNOC |
| 2.2.5 | Link HIV/STI interventions to tourism and entertainment events | Documentation of link in place | 30 Mar 2015 | CHS, Tourism, MOC |
| 2.2.6 | Include migrant communities in awareness campaigns | Number of activities targeting migrant workers | 30 Mar 2015 | CHS, CSO, communities |
| 2.2.7 | Develop condom marketing campaign for at-risk groups | Number of campaigns conducted | 30 Mar 2016 | CIRC, CIFWA, CSO |
| 2.2.8 | Maintain distribution of local condom packs | Number of packs distributed | Monthly from 1 Jul 2014 | CIRC, CIFWA, CSO |
| 2.2.9 | Increase condom dispensers around Rarotonga and expanding to pa enua | Review locations, add 10 additional sites | 30 Sep 2014 | MOH |
| 2.2.10 | Supplement UNFPA condom and lubricants | Number of additional condoms available | 30 Dec 2014, 2016, 30 Mar 2018 | MOH-Pharmacy |
| 2.2.11 | Conduct campaigns to promote dual benefits to condom use | Pct people age 10-24 with access to male and female condoms | Evaluated 30 Dec 2014-2017, 30 Mar 2018 | CHS, CIRC, CIFWA, CSO |
| 2.3.1 | Expand peer education programs to reduce ancillary risk activities such as AOD | AOD issues included in peer education programs | 30 Jun 2015 | CIFWA Youth, MOH |
| 2.3.2 | Incorporate smart drinking education into peer education programs | Smart drinking education included in peer education programs | 30 Jun 2015 | CIFWA Youth, MOH |
| 2.3.3 | Produce and disseminate media messages on AOD and decision-making | Number of media messages | 30 Dec 2015 | CIFWA Youth, MOH |
| 2.3.4 | Initiate host responsibility campaign | Campaign developed | 30 Jun 2016 | CIFWA Youth, MOH |
| 2.4.1 | Review and implement recommendations about VCCT | Any changes implemented | 30 Dec 2014, 2016 | MOH |
| 2.4.2 | Monitor protocols and guidelines regarding confidentiality by HCW | Disseminate patient/client rights material, identify confidentiality complaint officer; number of complaints received | 30 Mar 2015 | MOH |
| 2.4.3 | Determine baseline, map and review VCCT service | VCCT locations reviewed | 30 Dec 2014, 2016 | MOH |

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|---|---|---|---|---|
| | locations | | | |
| 2.4.4 | Conduct VCCT counsellor (re)training | Number of counsellors retrained | 30 Jun 2017 | MOH |
| 2.4.5 | Identify, select and furnish new VCCT sites | New sites identified and furnished | 30 Jun 2015, 2017 | MOH |
| 2.4.6 | Ensure clients receive STI and HIV test results through counselling | Number of clients lost to follow up | Reported annually 30 Dec 2014-2018 | MOH |
| 2.4.7 | Maintain/strengthen laboratory services to promote access to VCCT | Lab services reviewed, problems identified and actioned | 30 June 2015, 2017 | MOH, HHS |
| 2.4.8 | Formalise and disseminate referral systems to VCCT | Referral system in place | 30 Jun 2016 | MOH, CSO |
| 2.4.9 | Establish professional support for VCCT counsellors | Support system developed and implemented | 30 Sep 2015 | MOH |
| 2.4.10 | Conduct VCCT awareness campaigns | Number of awareness campaigns | Reported annually 30 Dec 2014-2018 | MOH |
| 2.5.1 | Conduct IBBS surveys | 1 survey conducted | 30 Jun 2018 | CHS, HHS |
| 2.5.2 | Provide training to improve youth sex negotiating skills | 4 trainings conducted | 30 Dec 2014<br>30 Dec 2015<br>30 Dec 2016<br>30 Dec 2017 | CIRC, CIFWA, INTAFF-Youth, CINYC |
| 2.5.3 | Conduct training for youth as sexual health educators | 4 trainings conducted | 30 Mar 2015<br>30 Mar 2016<br>30 Mar 2017<br>30 Mar 2018 | CIRC, CIFWA, INTAFF-Youth, CINYC |
| 2.5.4 | Promote early engagement for pregnant teenagers | Number of pregnant teenagers linked to services | Report monthly from 1 Jul 2014 | HHS, CHS |
| 2.5.5 | Maintain voluntary STI and HIV testing for pregnant women | Number of tests conducted on pregnant women | Report monthly from 1 Jul 2014 | HHS, CHS |
| 2.5.6 | Explore prophylaxis for neonatal conjunctivitis | Number of newborns treated | Report 6-monthly from 30 Dec 2014 | HHS |
| 2.6.1 | Create community dialogue about research findings on forced-sex | Develop a plan | Plan developed by 30 Mar 2015 | CIFWA |
| 2.6.2 | Identify, provide immediate support and link victims of violence to appropriate community services | Number of victims linked to services | Assess 6-monthly from 30 Dec 2014 | Punganga Tauturu |
| 2.6.3 | Develop and conduct education for HCW to reduce fear/discrimination | 3 trainings completed | 30 Sep 2014<br>30 Mar 2015<br>30 Mar 2018 | CHS, HHS |

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|---|---|---|---|---|
| | of HIV | | | |
| 2.6.4 | Disseminate information about women's SHR | 5 distributions | 30 Dec 2014<br>30 Dec 2015<br>30 Dec 2016<br>30 Mar 2017<br>30 Mar 2018 | INTAFF-Gender, MOH |
| 2.6.5 | Intensify dissemination about women's SHR | 5 disseminations | 30 Jul 2014<br>30 Mar 2015<br>30 Mar 2016<br>30 Mar 2017<br>30 Mar 2018 | MOH, CIFWA |
| 2.6.6 | Network relevant agencies to improve coordination of services, and policy | MOUs in place | 30 Dec 2014 | NHSTC |

**Priority Area 3**

| Index number | Activity | Measure | By when | By whom |
|---|---|---|---|---|
| 3.1.1 | Link HIV management and testing to TB | HIV/TB training modules integrated | Dec 2014 | HHS, NHSTC, TB Coordinator |
| 3.2.1 | Explore links to Men's Health Program: identify and integrate existing resources | Number of skilled male SRH providers | Dec 2014; reassess in Dec 2016 | MOH, RAC, Te Kainga |
| 3.2.2 | Explore links with other men's health related processes | Directory of men's health services; Consider MOUs | Oct 2014 | CHS, CSO |
| 3.2.3 | Link interventions to eliminate all forms of gender discrimination | Number of men trained | Dec 2018 | Police, MOJ, INTAFF, CHS, Punga Tauturu |
| 3.2.4 | Evaluate collaborative data and information flow, referral and follow up for care of men and partners | Number attending Men's Health Program and pct referred for further care | Report quarterly from 30 Sep 2014 | CHS, HHS, CIFWA, CIRC, CINCW, Rotaianga |
| 3.3.1 | Link SRH and Disaster preparedness and response, implement | Plan in place; Monitor implementation | 30 Sep 2015; reassess post-disaster | MOH , EMCI |

**Priority Area 4**

| Index number | Activity | Measure | By when | By whom |
|---|---|---|---|---|
| 4.1.1 | Roll out June 2013 STI Management and HIV Continuum of Care guidelines | Number of clinics implementing STI guidelines | 30 Sep 2014 | HHS |
| 4.1.2 | Conduct TOT workshops on STI management and HIV continuum of care | Number of trainers trained, by designation and location | 30 Sep 2014 | WHO, MOH |
| 4.1.3 | Conduct integrated HIV/STI training for HCW by trained trainers | Number of HCW trained, by designation and location | 30 Sep 2015 | WHO, MOH |
| 4.1.4 | Peer review provision of quality management for STIs including partner management | Data entry of STI cases completed per month | Assess annually 30 Dec 2014-2018 | MOH |
| 4.1.5 | Develop and implement strategies to overcome barriers to accessing STI services | Number of STI testing sites | 30 June 2016 | MOH |
| 4.1.6 | Strengthen forecasting and supply for STI related drugs lab test kits etc. | Plan in place | 30 Dec 2015 | HHS Pharmacy, HHS Lab |
| 4.2.1 | Update policies to ensure continuum of care | Review completed | 30 Jun 2015 | HHS OB-GYN, CHS |
| 4.2.2 | Ensure access to ARVs | Stock in place | 30 Jun 2015 | HHS Pharmacy |
| 4.2.3 | Maintain links between local clinicians and international HIV/AIDS specialist care | Links in place | 30 Jun 2014 | HHS |
| 4.2.4 | Provide education and support for caregivers of PLWHIV | Plan in place | 30 Sep 2015; earlier if required | CHS, HHS, INTAFF |
| 4.2.5 | Conduct training with different sectors, including church | Number of participants trained by sector, designation, age gender and location | 30 Jun 2016 | CHS, INTAFF |
| 4.3.1 | Produce/distribute information on PPTCT of HIV to pregnant women and partners | Number of leaflets distributed | 30 Jun 2015 | CHS, HHS |
| 4.3.2 | Adapt UNICEF regional policy on PPTCT of HIV | Policy adopted | 30 Sep 2014 | NHSTC |
| 4.3.3 | Conduct training of HCW on PPTCT and CI policies and protocols | Number of trained HCW | 30 Jan 2018 | MOH |

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|---|---|---|---|---|
| 4.3.4 | Ensure access to ART for pregnant mothers with HIV | Number of women and proportion eligible for ART | 30 Jan 2018 | MOH |
| 4.4.1 | Maintain policy and guidelines for clinical use of blood/products | Policy reviewed | 30 Sep 2017 | HHS Lab |
| 4.4.2 | Promote continuous recruitment of voluntary blood donors | Number of blood donors recruited | Reported annually 30 Dec 2014-2018 | CIRC, HHS Lab |
| 4.4.3 | Ensure continuous pre- and post-donation counselling for all blood donors | Number of blood donors counselled | Ongoing | CIRC, HHS Lab |
| 4.4.4 | Ensure continuous testing of all donated blood for HIV and STIs | Number of units tested | Reported annually 30 Dec 2014-2018 | HHS Lab |
| 4.4.5 | Ensure biannual internal and annual external audits of blood bank services | Audits completed | 30 Dec 2016, 2018 | HHS Lab, BTC |
| 4.5.1 | Revise applicable policies and monitor registration and inspection of risky occupational premises | Policies in place; inspections completed | Reported annually 30 Dec 2014-2018 | CHS |
| 4.5.2 | Conduct awareness programs on universal precautions for all occupational needle users | Trainings completed | Reported annually 30 Dec 2014-2018 | CHS |
| 4.5.3 | Conduct training for HCW on infection control | Number of trainings and number of HCW | Reported annually 30 Dec 2014-2018 | HHS |
| 4.5.4 | Ensure HBV immunization is available for HCW | Number of staff vaccinated | Reported annually 2014-2018 | CHS |
| 4.5.5 | Ensure adequate supply of sterile equipment and disposal of contaminated equipment | Problems identified | Problem log reported annually 30 Dec 2014-2018 | HHS |
| 4.5.6 | Procure and install a new incinerator for disposal of biomedical waste | Incinerator in place | 30 Dec 2015 | MOH and HHS |
| 4.5.7 | M&E procedures and protocols regarding disposal of blood/blood products and contaminated equipment | Schedule of M&E signed by Chief Medical Officer | 30 Jun 2015 | HHS Quality Control |
| 4.5.8 | Update and display universal precaution signs in all HC and public services facilities | Number signs updated at inspections | Reported annually 30 Dec 2014-2018 | HHS, CHS |
| 4.5.9 | Maintain procedures and guidelines for post-occupational exposure management (PEM) | Number of exposures reported and actioned | Reported annually 30 Dec 2014-2018 | HHS, CHS |
| 4.5.10 | (Re)Train HCW and relevant agencies on standard | Number of trainings completed | Reported annually 30 Dec 2014-2018 | HHS, CHS |

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| | precautions and PEM procedures | | | |
| 4.5.11 | Conduct 6-monthly internal quality audits on testing systems for HIV, STI, TB | Audits completed | Annually by 30 Jun and 30 Dec 2014-2018 | HHS Lab |
| 4.6.1 | Conduct external quality audits of LQMS | Audits completed | 30 Dec 2015<br>30 Dec 2017 | HHS Lab |
| 4.6.2 | Review data collection processes of patient information and results | Pct patients not receiving results in a timely way | Reported annually<br>30 Dec 2014-2018 | HHS Lab |
| 4.6.3 | Integrate HIS and LIS | HIS and LIS integrated | 30 Jun 2016 | HHS Lab |
| 4.6.4 | (Re)Train staff on HIS | Number of trainings completed | Reported annually<br>30 Dec 2014-2018 | HHS Lab |
| 4.6.5 | Maintain quality standard of procurement for STI/HIV consumables | Stockouts reported | Reported annually<br>30 Dec 2014-2018 | HHS Lab |
| 4.6.6 | Explore feasibility screening for HPV and other tests in-country | Feasibility review completed | 30 Dec 2014 | HHS Lab |
| 4.6.7 | Maintain laboratory capacity for STI testing | Number of laboratory staff trained or upskilled | Reported annually<br>30 Dec 2014-2018 | HHS Lab |

**Priority Area 5**

| Index number | Activity | Measure | By when | By whom |
|---|---|---|---|---|
| 5.1.1 | Promote complete physical mental and social wellbeing of women and men with a focus on sexual health in Aitutaki and Atiu | Number of clients seen; 2 visits/year by OB-GYN specialist | Report annually 30 Dec 2014-2018 | HHS OB-GYN |
| 5.1.2 | Promote services of Well Women's Clinic | Number of initiatives and women reached | Report annually 30 Dec 2014-2018 | HHS OB-GYN |
| 5.1.3 | Improve GYN and SRH for women | Report number and demographics of women attending services; estimate non-attenders | Reported annually 30 Dec 2014-2018 | HHS OB-GYN |
| 5.1.4 | Strengthen use of HPV in girls | Number of girls vaccinated | Reported annually 30 Dec 2014-2018 | CHS |
| 5.1.5 | Improve screening for breast and cervical cancers, STI and HIV | Report number and demographics of women attending services; estimate non-attenders | Reported annually 30 Dec 2014-2018 | HHS OB-GYN, CHS, HPU |
| 5.2.1 | Strengthen national networks and regional collaborations | Number of collaborations and MOUs in place | 30 Dec 2015 | HHS Pharmacy |
| 5.2.2 | Conduct comprehensive sexuality education | Number of workshop participants | Reported annually 30 Dec 2014-2018 | CIFWA |
| 5.2.3 | Increase community awareness on family planning and referral | Number people accessing non-prescription contraceptives | Reported annually 30 Dec 2014-2018 | CHS, HPU, CIFWA, CIRC |
| 5.2.4 | Increase access to contraceptives | Number of contraceptives distributed | Reported annually 30 Dec 2014-2018 | HHS OB-GYN, CHS, HPU, CIFWA, CIRC, INTAFF |
| 5.3.1 | Roll out updated reproductive health policies and guidelines | Annual audits | 2-yearly 30 Dec 2014-2018 | HHS OB-GYN, CHS |
| 5.3.2 | Train HCW on ANC, delivery and maternal care | Number of HCW trained | Annually reported 30 Dec 2014-2018 | MOH |
| 5.3.3 | Create incentives to retain skilled staff | Incentives in place | 30 June 2016 | MOH |
| 5.3.4 | Strengthen referral systems for outer island mothers | Systems in place; number of mothers referred | 30 Jun 2015 | MOH |
| 5.35 | Train HCW on needs of clients with disabilities | Number of HCW staff trained | 30 Dec 2015 | CINDC |
| 5.4.1 | Increase awareness of adherence to protocols for case | Plan in place | 30 Jun 2015 | MOH |

| | | | | |
|---|---|---|---|---|
| | management, reporting and data collection | | | |
| 5.4.2 | Train HCW on identification and care of victims of gender-based violence | Number of HCW trained | Assess 6-monthly from 30 Sep 2015 | INTAFF-Gender, Te Tiare |
| 5.5.1 | Support development and review of policies and relevant legislation | Policies reviewed | 2-yearly reporting beginning 30 Jun 2015 | INTAFF-Gender, Te Tiare |
| 5.5.2 | Conduct workshops on eliminating gender based violence | Number of workshops held | Annual reporting by 30 Dec 2014-2018 | INTAFF-Gender, Te Tiare |
| 5.5.3 | Develop appropriate reporting frameworks | Templates developed | 30 Dec 2015 | INTAFF-Gender |
| 5.5.4 | Resources for gender based violence support services | Number of resources identified | 30 Dec 2017 | INTAFF-Gender |
| 5.5.5 | Explore options to prevent/reduce violence to children and young people | Directory of resources identified and | 30 Dec 2017 | INTAFF-Gender |

## ANNEX 1
## NSP 2008-2013 End Term Review

1.0 End term review process

In early June 2013 Te Marae Ora and the peak coordinating body, the National HIV, STI and TB Committee (NHSTC), led the end term review of the Cook Islands STI and HIV National Strategic Plan (NSP) 2008 – 2013, with technical assistance and support from team of Technical Advisers from the Public Health Division of the Secretariat of the Pacific Community (SPC). A team of multi-sectoral stakeholders reviewed both the STI and HIV response using both qualitative and quantitative methods and tools, against priority areas set out in the NSP. The information obtained from the review was utilised to guide the strategic directions of the next national strategic plan.

**End term review findings**

Priority Area 1: Prevention of transmission of HIV and other STIs

Stakeholders felt that the Cook Islands has made great steps towards preventing transmission of HIV and other STIs over the past five years. Steps have been taken to identify key populations at higher risk of STIs. In 2009, a baseline study was conducted identifying sexual behaviour of the Akavaine transgender community; in 2012 a further sentinel surveillance survey was conducted amongst the youth population. The results were utilised to develop targeted prevention programmes. Stakeholders reported there is still room for improvement in identifying at risk populations and delivering targeted prevention programmes, particularly in hard to reach areas such as the Northern Islands Group.

Sexual health is a component of the high school curriculum; however stakeholders expressed resistance from teachers and education personnel to implement this component of the curriculum. One explanation given was that teachers do not feel comfortable discussing sexual health issues as such discussions are not common place in the Cook Islands culture. It was felt there needs to be greater involvement of the Ministry of Education in delivering the sexual health response. One success story, is the pilot of providing a nurse in one of the main schools for half a day a week, this is to be replicated across schools. Cook Islands Red Cross (CIRC) currently conducts a peer education programme within schools which is noted as a success and there is a sexual and reproductive health programme for out of school youth aged 16 to 24 years.

The Ministry of Health, CIFWA and CIRC regularly conduct STI and HIV prevention programmes. It was felt that information is widely disbursed and condoms easily accessible for free. Condom dispensers are placed around the islands and maps are provided advising on locations. Condoms are currently being provided by UNFPA. A number of complaints have been received about the quality of the condoms which reports of condoms tearing. Stakeholders also raised the concern that whilst information is widely available they are unsure whether it is 'being heard' and whether it results in behaviour change. The stepping stones programme is currently being implemented in Rarotonga, however it is deemed expensive and stakeholders questioned whether it should be continued within the next NSP period.

There are on average 100,000 visitors to the Cook Islands per year and a large number of migrant workers. It was felt that risks presented by these visitors could be managed by existing strategies which focus on Cook Island residents. Migrant workers can also be managed through existing strategies.

A national VCCT policy has been developed, and VCCT is available in all 12 populated islands. Greater awareness about the existence of VCCT is required. A number of health care workers have been trained in PPTCT however the Cook Islands is considering setting up an e-training programme to reach communities in the outer islands and those who cannot be reached by clinical services. There have been no

cases of HIV positive pregnant women to through the end of 2013. Prophylaxis is available in Rarotonga should there be identified cases in the future.

Priority Area 2: Comprehensive management of STIs

Te Marae Ora have incorporated the Comprehensive STI Management Guidelines (SPC, 2012) in all health centres. It is reported that approximately 80% of facilities comply with the STI management guidelines. All pregnant women are tested for HIV, HBV, syphilis, chlamydia, and gonorrhoea and treated accordingly. It was felt that challenges still remain with regards to contact tracing. Stakeholders reported that there is a need to continue to up-skill staff in STI management and ensure the correct staff are trained.

In 2011 the Cook Islands undertook a chlamydia mass treatment campaign. The campaign covered all islands and reached 62% of the total Cook Islands population. A reduction in the national prevalence of chlamydia from 22% to 11% was attributed to the success of the campaign. The campaign is now being used as a model for other Pacific Island Countries and Territories.

STI information and data is available through MEDTECH using the STI investigation template and analysis is done at the highest level of responsibility. There is a need to strengthen the data feedback mechanism.

Priority Area 3: Blood safety and infection control

Stakeholders felt they exceeded in achieving blood safety and infection control objectives. The National Blood Policy was endorsed by Te Marae Ora in February 2013, and is currently being followed. The Cook Islands Red Cross conducts blood drives in which donated blood is tested for HIV and other STIs before transfusion. Internal audits of blood services require strengthening.

At present tattooists are requested to register with Te Marae Ora. The Ministry conduct regular checks on registered tattooists to ensure blood safety policies are being followed. Currently four tattooists are registered. Training in blood safety has been conducted with both registered and unregistered tattooists. Registration and training should be further expanded and monitored.

There has been no exposure to HIV amongst health professional to date. Universal precautions are currently in place and being followed. Post exposure prophylaxis is available at the Rarotonga Hospital in preparation for such cases. There is room for improvement in training health care workers, community groups and organisations on universal precautions and the management of any exposure. Stakeholders raised the issue of a short supply of sharp containers in clinics due to logistical difficulties and felt that supply chain management could be further improved. There has been no stock out of STI including HIV testing kits and other consumables to date. However there has been a reported stock out of condoms. A quality manager is in place at Te Marae Ora to attend to these issues.

Priority Area 4: Treatment, care and support for people living with HIV

A training of health care workers was conducted in 2009 to establish a national continuum of care system. In late 2010 a resident of Cook Islands was diagnosed as HIV positive. This case received wide publicity. The resident has since returned to their country of origin. Stakeholders reviewed the reaction to this event, and have identified ways to improve the national response. Currently there are no HIV positive cases in Cook Islands, and therefore no cases are enrolled in HIV care. Stakeholders reported they felt prepared to sufficiently manage any HIV cases that may present.

Legislation which creates an enabling and supportive environment for PLWHIV is currently being prepared for consideration by Cook Islands Parliament

When asked about the likeliness of the community accepting and supporting PLWHIV stakeholder response was mixed. It was felt that education and greater sensitivity of communities will be required in order to reduce and prevent stigma and discrimination.

Priority Area 5: Management, advocacy and coordination

In 1993 the National AIDS Committee was established. In November 2010 the successor body, the National HIV, STI and TB Committee (NHSTC) was established. The NHSTC meets on a quarterly basis to oversee and monitor the implementation of the NSP. An STI and HIV Programme Manager also sits within Te Marae Ora. It was agreed that there is a need to review and revise membership of the NHSTC to ensure an appropriate representation from multiple sectors and enhance participation. It is felt that commitment from members requires strengthening, and an 'e-voting' system is being considered, as a quorum is not always reached for meetings.

There is also a need to strengthen communication among stakeholders. At present each organisation has an annual workplan. The NHSTC would like to develop national annual work plans linked to the NSP so as to identify gaps and avoid duplication of activities. A quarterly reporting system using a simple template will be established to enhance cross stakeholder communication, knowledge sharing, and collaboration.

One area of strength of the NHSTC is in assisting members and organisations to obtain funding through supporting proposal writing and identifying funding sources. The Pacific Response Fund is due to end in 2013 and there is uncertainty regarding the extension of the Global Fund multi-country grant. Currently the Cook Islands government provide 40% of counterpart funding for STIs including HIV. The NHSTC plan to approach potential donors for funding of the new strategy.

A number of stakeholders were trained in monitoring and evaluation in 2012 and received further refresher training in 2013. A monitoring and evaluation framework will be developed in accordance with the new national strategy.

**Strengths, Behaviours, Barriers and Gaps**

Strengths

Stakeholders reported the main strengths of the previous response to STIs as strong coordination and governance provided by the NHSTC and Te Marae Ora. This was critical to achieving the successful implementation of awareness and educations programmes including programmes targeting at key at higher risk populations and hard to reach populations such as youth and the sexual and gender minority communities (these latter communities remain technically illegal at this writing, although a legislative revision to the Crimes Act is pending.) Further contributions to a strong response included training in monitoring, evaluation and surveillance, which has enabled stakeholders to critically monitor, evaluate and plan activities.

Behaviours

There were a number of key contributing factors associated to the transmission of STIs. Alcohol and other substance misuse was identified as the number one factor leading to inconsistent condom use and risky behaviours. This factor was closely followed with low perceived risk, together with perceived high rates of multiple partners within relatively small communities.

Barriers and gaps

Stigma and discrimination, lack of confidentiality, religion, social and cultural norms were identified as leading barriers to accessing sexual health services.

In order to strengthen the STI response stakeholders reported a need for greater commitment from NHSTC members. It was also felt that working with parents and teachers to gain further buy-in and raise awareness of risk and stigma amongst youth is required to implement a more effective response.

A number of organisations were identified as needing increased engagement so as to improve their responses. The key organisations identified include: Ministry of Education; sports associations; churches and religious groups; uniformed groups (such as the Scouts and Guides); Parliamentarians; the House of Ariki; and the Tourist Board.

Stakeholders also identified key populations who needed to be further reached through STI interventions. These included: sport groups; migrant communities; year 9 and year 13 students; and the adult population over 30.

**Conclusion of the end term review**

Whilst stakeholders consistently rated their achievements against the objectives in the NSP as either a four- or five- out of five, implying objectives had been largely or completely achieved, they also expressed a desire for a strengthened and more comprehensive response. A number of areas were identified as requiring a greater focus such as sexual health education in schools, reaching key at higher risk populations, and the expansion of programmes to outer islands. Overall there is still a concern amongst stakeholders that sufficient risk factors exist which could result in an increase in STI rates in Cook Islands.

**ANNEX 2**

**Description of the National HIV, STI and TB Committee (NHSTC)**

The functions of the National HIV, STI and TB Council shall be:

(1) (a) to be the single national coordinating mechanism in the Cook Islands for the targeted conditions and to oversee the progress of the national response to them; and

(b) to endorse and approve the goals and objectives for the national response to the targeted conditions set by the implementing agencies providing response programmes to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of the targeted conditions and related opportunistic infections; and

(c) to make application for, secure, mobilise, disburse and monitor resources, including financial resources, to contribute to the national response to the targeted conditions; and

(d) to procure sufficient personnel for its work and control and monitor their use; and

(e) to, subject to paragraph(b),—

(i) ensure the development, regular review, updating and publishing of national strategic plans to respond to the targeted conditions and that a consistent and effective framework of programmes, activities and measures exist to implement such plans; and

(ii) ensure the formulation, facilitation, implemention, monitoring, evaluation and review of human rights-based policies, guidelines, programmes and activities for the response to the targeted conditions and management of their impacts; and

(iii) provide support for programmes designed to increase awareness of and protective measures against the targeted conditions; and

(iv) promote research, awareness materials and information sharing on the targeted conditions and relevant human rights; and

(v) promote advocacy and lobby to the highest level of Government for the provision of education on prevention, management and control of the targeted conditions; and

(vi) facilitate access to sustained, appropriate and affordable means of prevention of infection and treatment for persons living with or affected by the targeted conditions;

(vii) ensure the promotion and protection of the rights of persons living with or affected by the targeted conditions; and

(viii) give advice on any matter concerning the national response to the targeted conditions to the Prime Minister and any Ministry, body, coalition, commission, committee, foundation, mechanism, person, association or organisation participating in the national response;

(f) foster national, regional and international networks among all stakeholders engaging in the national and international response to the targeted conditions; and

(g) include in the annual report required under section 10 an assessment of the continued appropriateness and effectiveness of this Act and its regulations and propose, at any time, any changes or modifications, as may be deemed necessary; and

(h) approve, adopt and issue accreditation requirements, codes of conduct, frameworks, guidelines, information papers, operational and other policies, plans, standard operating procedures and standards of practice and such other instruments as are necessary or convenient to be done for or in connection with the performance of its functions under this Act.

(2) The Council may perform any of its functions in co-operation with any association, body, coalition, commission, committee, foundation, mechanism, office, organisation or person, whether situated in the Cook Islands Islands or elsewhere

**ANNEX 3**

# IMPLEMENTATION GUIDELINES FOR COMPREHENSIVE STI INCLUDING HIV MANAGEMENT

# RAROTONGA,

# COOK ISLANDS,

# JUNE 2013

**Foreword**

To ensure that national and regional programmes are equipped to address the high prevalence of sexually transmitted infections, the Sexually Transmitted Infections Working Group for the Pacific (STIWG) was established in late 2006. The STIWG is a technical working group comprised of representatives from the Secretariat of the Pacific Community (SPC), World Health Organization (WHO), United Nations Population Fund (UNFPA), U.S. Centers for Disease Control and Prevention (CDC), United Nations Children's Fund (UNICEF) and Oceania Society for Sexual Health and HIV Medicine (OSSHHM).

The recommendations contained herein are the result of a consensus of representatives from the STIWG. Cook Islands has endorsed and began implementation the recommendations in 2011, and has revised them in May 2013.

This document is intended as a policy guideline for public health staff, STI program managers, laboratory and clinical staff.

This document should be read in conjunction with the following documents:

1. Improving national sexually transmitted infections surveillance in Pacific Island countries and territories: Sexually transmitted infections case definitions and minimum data set. STIWGP May 2008, http://www.spc.int/hiv/index.php?option=com_docman&task=cat_view&gid=126&Itemid=148 and
2. Comprehensive STI Case Management Guidelines, 2012 (SPC web site)
3. BD screening and treatment Guidelines (SPC website)
4. National STI Treatment Guidelines
5. SHC Guidelines

## Abbreviations

| | |
|---|---|
| ANC | Antenatal Clinic |
| Epi-Tx | Epidemiological Treatment |
| EML | Essential Medicines List |
| GASP | Gonoccocal Antimicrobial Surveillance Programme |
| HIV | Human immunodeficiency virus |
| HRG | High risk groups |
| IEC | Information, Education, Communication |
| M&E | Monitoring and Evaluation |
| MSM | Men who have sex with men |
| PTCT | Parent to child transmission |
| NAAT | Nucleic acid amplification tests |
| NGO | Non Government Organisation |
| OSSHHM | Oceania Society for Sexual Health and HIV Medicine |
| PICT | Pacific Island Countries and Territories |
| PHC | Primary health care |
| PNG | Papua New Guinea |
| RPR | Rapid Plasma Reagin |
| RTI | Reproductive Tract Infection |

| | |
|---|---|
| sDOT | Single dose direct observed treatment |
| SGS | Second Generation Surveillance |
| SHC | Strategic Health Communication |
| SPC | Secretariat of the pacific Community |
| STI | Sexually transmitted infection |
| STIWG | STI Working Group |
| UNICEF | United Nations Children's' Fund |
| UNFPA | United Nations Population Fund |
| WHO | World Health Organisation |

## Recommendations for Enhanced STIs including HIV Control

**Recommendation 1:** Targeted Strategic Health Communication (SHC) campaigns to increase awareness of high local rates of STIs (symptoms, long term consequences of asymptomatic infections, availability of testing and treatment), to promote safe sexual behaviours (condom use, partner reduction) and to increase health care seeking behaviour.

**Recommendation 2**: Provide quality comprehensive syndromic management for symptomatic STIs.

**Recommendation 3**: Counselling, testing and treatment for asymptomatic STIs, including proactive screening for Chlamydia, syphilis and HIV among vulnerable and most at risk groups.

**Recommendation 4**: Improved partner management.

**Recommendation 5**: Epidemiologic (presumptive) treatment for chlamydia in antenatal women and their partners and implementation of mass treatment for target population

**Recommendation 6**: Prophylaxis for neonatal conjunctivitis at birth.

**Recommendation 7**: Effective drugs for the treatment of STIs, available free of charge and administered at all levels of the health care system.

**Recommendation 8**: Framework for monitoring prevalence and long term consequences of STIs and evaluation of the impact of the STI strategy.

**Strategic Health Communication (SHC)**

**Recommendation 1**: Targeted Strategic Health Communication campaigns to increase awareness of high local rates of STIs (symptoms, long term consequences of asymptomatic infections, availability of testing and treatment), to promote safe sexual behaviours (condom use, partner reduction) and to increase health care seeking behaviour (Strategic Intervention 2.1.3).

**Aimed at:** general population, antenatal women & their partners, young people, high risk groups, health care workers

**Time frame:** mass media immediately building on existing HIV campaigns and develop targeted SHC

Public mobilisation would allow linkages to existing HIV/AIDS prevention messages through the following activities:

- Increase awareness and understanding about STI and the high rates of STI in Cook Islands which are often asymptomatic, like HIV, and their consequences if they remain untreated, including the increased risk for HIV transmission.
- Enhance primary and secondary prevention to reduce STI transmission
- Promote testing and epidemiological/mass treatment
- Promote diagnostic and health care seeking behaviour – recognition of STI symptoms and the need to seek services
- Educate parents to obtain buy in, so as to remove barriers to treatment. Need to design some information for parents. These activities can be integrated with immunisation programme in terms of awareness raising and places where parents go out such as housie (bingo), restaurants, etc.

**What needs to be in place:**

Set up the media campaign (TV, radio, social media) for both languages, community notices/Job Description re-orientation (through community & political, NGOs networks), and develop/revise the IEC Materials

**Responsible organizations:**

MOH/NGOs/MPs/CIRC/role models/Ambassador/INTAFF/MOE/MOC

**Starting time:**

Design information should start soon as possible. The message on the epidemiological/ mass treatment should get out to the community one month prior to the epidemiological/ mass treatment start.

**Possible challenges and solutions:**

| **Possible challenges** | **Solution** |
|---|---|
| Financial constraints | Include this activity as part of the NSP, and seek for funds from government and various donor |
| Timeframe and HR | Collaboration with all the implementers/stakeholders<br>Linkages this activity with other prevention program |
| Access | All IEC materials need to be made available in appropriate formats |
| Religious | Involve religious leaders in the planning and implementation of the activities |

**Resource need:**

Financial resources are needed to support the coordination and meeting to discuss on the development of the key messages and EIC materials.

**<u>Comprehensive syndromic management of STI symptoms</u>**

> **Recommendation 2**: Provision of quality comprehensive syndromic management for symptomatic STIs (Strategic Intervention 4.1.4)
> **Aimed at:** population at high risk of exposure with a focus on youth, men having sex with men, and other high risk groups; primary health care providers in public and private settings from primary health care setting to tertiary referral level.
> **Time frame:** training for health care providers immediate implementation dependent on availability of effective STI drugs

Comprehensive STI management should be provided at all levels and throughout all sectors of the health care system, including Primary Health Care (PHC) Centres. Health care providers from private, public and NGO institutions should be trained to provide comprehensive syndromic diagnosis of STI and have the capacity and authority to dispense STI drugs at the point of care, for patients and their sex partners who are asymptomatic carriers. Private and NGO health care providers need to be included in comprehensive syndromic management training and implementation to ensure harmonization of best practice across all sectors.

National Comprehensive STI Management Guidelines should be available to all service providers.

**What need to be in place:** All Policy & guidelines need to be made available in all health sectors.

**Responsible organization:** MOH (PHN)/CIRC/CIFWA

**Starting time:** Ongoing activity

**Possible challenges and solution:**

| Possible challenges | Solution |
|---|---|
| Lack of counsellors - provide CPD/CME, | Re-enforce all health care workers are provide counselling as part of comprehensive STI case management to all clients<br>Training for more counsellors |
| geographic locations - Location | Strengthening forecasting and supply for drugs and other consumable to outer islands |

**Resource need:** Technical assistance train counsellors, and financial support for capacity building of the staff

**Expanded testing for asymptomatic chlamydia and other STI**

> **Recommendation 3**: Counselling, testing and treatment for asymptomatic STIs, including proactive screening for chlamydia, syphilis and HIV among vulnerable and most at risk groups (Strategic Interventions 2.5.5 and 4.1.4)
> **Aimed at:** Pregnant women, population at high risk of exposure, and sexually active young people.

**Access to STI testing**

a) STI testing for all pregnant women and their partners

As part of the pre-natal care, all pregnant women should be screened for the following STIs: chlamydia, gonorrhoea, syphilis, hepatitis B, and HIV.

b) STI testing for the population at high risk of exposure

population at high risk of exposure, including men who have sex with men (MSM), seafarers, sex workers and males with high risk behaviour (e.g. multiple partners) are difficult to reach with routine clinical services and may be under-diagnosed for asymptomatic STI. These populations should be encouraged to adopt health care seeking behaviour by expanding and promoting access to quality health care. Behaviour change, with significantly increased condom use is simultaneously required to obtain sustained decreased STI prevalence in these populations (WHO, 2008).

**What need to be in place:** All VCCT Clinics/site, need to be accredited and able to provide/refer for STI/HIV testing and treatment**.**
**Responsible organization:** MOH/CIRC/CIFWA
**Starting time:** This is an on-going activity. However, the implementation teams need to be prepared to ensure all drugs and another necessary equipment are available prior to the mass treatment start.

**Possible challenges and solution:**

| Possible challenges | Solution |
|---|---|
| Confidentiality issues | Improve patient coding system, re-enforce code of practice for all service providers |

| | |
|---|---|
| High wastage of resources for laboratory (specimens collection from outer islands may not reach laboratory on time). | - Strengthen laboratory quality assurance (specimens collection, transportation, and testing procedure).<br>- Standard operation procedure for all stages for laboratory quality assurance needs to be in place. |
| Missing information during the mass treatment | Proper recording mechanisms during implementation of the epidemiological/mass treatment. |

**Resource need:** Portable testing kits available to support STI testing for outer islands.

**Improved partner management**

> **Recommendation 4**: Improved partner management (strategic intervention 4.1.4)
> **Aimed at:** sexual partners of all patients treated syndromically, epidemiologically or testing positive for an STI need presumptive DOTs.
> **Time frame:** immediately

Every effort should be made to ensure sexual partners receive presumptive treatment, so patients who receive treatment are not re-infected. This is particularly important for partners of pregnant women, where reinfection can have serious consequences for the outcome of the pregnancy.
Patient initiated partner notification should be promoted, including patient delivered treatment, information and condom supply.
Provider initiated partner notification should only be undertaken at the request of the patient (respecting confidentiality. Important issues such as partner violence need to be considered).
**What needs to be in place:** Contact tracing card, and Improve referral system among service providers.
**Responsible organization:** MOH/CIRC
**Starting time:** This is an on-going activity
**Possible challenges and solution:**

| **Possible challenges** | **Solution** |
|---|---|
| Client non-compliance, patient's honesty, stigma related to STIs | - Improve counselling and client education,<br>- More trained counsellors<br>- Availability of help line (phone, email) to provide information to public |

**<u>Epidemiological (Presumptive) treatment for chlamydia</u>**

> **Recommendation 5**: Epidemiologic (presumptive) treatment for Chlamydia in antenatal women and their partners, and periodic mass for all population age between 15 to 34 years old (two episodes of mass treatment only) (Strategic Intervention 2.1.5)
> **Aimed at:** pregnant women and their partners andall population age between 15 to 34 years old
> **Time frame:** On going for antenatal women and their partner, and the second time of mass treatment aim to administrate in October, 2013.

Epidemiological or presumptive treatment (Epi-Tx) is an aggressive short term strategy to rapidly reduce the chlamydia rate in particular populations (Wi, Ramos, Steen, Esguerra et al., 2006; Mayaud & Maybe, 2004).

All pregnant women and their partner(s) should receive treatment for chlamydia at first antenatal visit. This treatment needs to be repeated at subsequent antenatal visit if the partner was not treated at first visit. Intensive counselling to ensure partner will present for treatment, or take the patient-delivered treatment should be done. Treatment should be with oral single dose directly observed treatment (sDOT).

Mass treatment for Chlamydia is also recommended for everyone age between 15 to 35 years. The intervention should be started in October 2013, for 2 months period, and should not be repeated after this intervention.

Epi-Tx for chlamydia provides treatment based on the increased risk of STI and does not depend on presence of symptoms or laboratory results.

This strategy should also produce a decrease in STI in the population which must be sustained through other measures such as behaviour change, including increased condom use and access for all to comprehensive STI services. Implementation of Epi-Tx will require locally developed guidelines and also a framework and mechanisms for monitoring.

**Benefits of Epi-Tx of pregnant women and their partners and mass treatment, in combination with other measures:**

- Significantly cheaper than testing and treating positives.
- No requirement for intensive pre/post test counselling, as SHC prepares the population.
- Ensures all chlamydia infections in antenatal women are treated, reducing long term consequences for women and improving pregnancy outcomes.
- Will free up laboratory capacity to expand testing to other population groups and will allow STI data on youth and HRG to be collected, including development of sentinel surveillance.
- Informs and educates the population about sexual and reproductive health issues and methods to prevent reproductive health problems and promotes long term reduction of STI.
- Fast reduction of epidemic in the country

**Considerations**

- Epidemiological treatment of antenatal women and their partners and mass treatment can only be considered IF it can be guaranteed of drug availability for nationwide.
- It requires detailed planning prior to implementation to ensure the new approach is communicated to all healthcare practitioners and non-government organization (NGO) personnel affected by the changes, drug forecasting is in place, drug supply is secure and drugs can be dispensed at every level of the health service.
- Preparation of population through SHC, as there needs to be strong community awareness and acceptance of the need for the treatment.
- SHC needs to continue during and after the intervention to facilitate adoption of safer sexual behaviour and sustain a reduction in chlamydia prevalence.
- Focus and action required to ensure concurrent partner compliance (sDOT)
- Treatment (single dose Azithromycin) can be dispensed at the point of care at all levels of the health system (this may require Standing Orders to allow nurses to dispense)

- Epi-Tx would result in a large number of people without chlamydia infection receiving treatment and a small number of gonorrhoea infections not being identified and treated.
- Approximately 95% of gonorrhoea infections will be effectively treated with 1g Azithromycin. The very small risk of increased gonorrhoea resistance to this antibiotic should be monitored carefully through sensitivity testing or GASP. The sensitivity to the currently recommended first line treatment will not be affected.
- Monitoring of STI rate in antenatal women will not be possible from routine surveillance data so annual surveys of limited number of antenatal women must be planned for in this population.

**What need to be in place:** Coordination and planning, implementation guideline, material for campaign.
**Responsible organization:** MOH/CIFWA
**Starting time:** Epidemiological treatment for ANC and partner is on-going, and will continue until December 2013. Mass treatment should start on first week of October and complete by end of November 2013.

**Possible challenges and solution:**

| Possible challenges | Solution |
|---|---|
| Human resource (PH Staff) to go out to community | Collaboration with all key implementers<br>Mobilization community leader and church group |
| Fund to support campaign | Anticipated source from GF that supported initial round |

**Universal prophylaxis forneonatal conjunctivitis**

**Recommendation 6**: Prophylaxis for neonatal conjunctivitis should be administered at birth (Strategic Intervention 2.4.6)
**Aimed at:** Universal treatment for newborns in all new born babies
**Time frame:** Immediate implementation recommended.

In the absence of prophylaxis, 30-50% of infants born to mothers with untreated gonorrhea or chlamydia will develop a serious eye infection. This can lead to permanent eye damage and blindness (WHO, n.d.).

Providing prophylaxis for neonatal conjunctivitis to all newborns is a long standing recommendation of WHO which needs to be reinstituted and reinforced in Cook Islands with immediate effect to reduce avoidable morbidity.
**What need to be in place:** Memorandum of understanding on the implementation should be sent to all service providers. Recommendation drugs should be available to all service deliveries.
**Responsible organization:** MOH
**Starting time:** Immediately

**Effective Drugs**

**Recommendation 7**: Effective drugs for the treatment of STI, in line with appropriate National Guidelines, should be available free of charge and administered at all levels of the health care system (Strategic Interventions 2.2.3)

**Aimed at:** Ministries of Health, National Pharmacies

All guidelines and training materials used in a country should be harmonised accordingly. If necessary, Standing Orders should give nurses authority (Nurse Practitioners) to dispense STI drugs, and procedures should be in place to ensure drugs for the treatment of STI are available free of charge in all health care settings, including NGO reproductive health clinics.

National STI programs need to actively involve pharmacists to ensure the appropriate quantification and coordination of drug requirements and distribution.

Gonococcal antibiotic sensitivity should be monitored through regular culturing and sensitivity testing, and EMLs and STI Treatment Guidelines need updating accordingly.

**Responsible organization:** MOH

**Starting time:** Immediately

**Monitoring and Evaluation**

**Recommendation 8**: Framework for monitoring prevalence and long term consequences of STI and for evaluating the impact of the STI strategy.

**Aimed at**: Programme managers, MOH partners, donors

**Time frame:** Immediate development and implementation to obtain baseline data before implementation of Epi-Tx. Will permit measuring impact of STI control strategy.

It is important to develop and implement a monitoring strategy while developing the Epi-Tx strategy in order to obtain baseline and progress data. The monitoring framework will allow measurement on a longer term to determine whether the interventions are effective in achieving the short term and longer term objectives, whether the interventions need to be changed or whether there are unintended consequences. This Monitoring & Evaluation framework needs to be developed to cover the different components of the strategy and the overall framework should address the stated objectives.

1. Reduce chlamydia prevalence in antenatal women
2. Eliminate neonatal consequences of parental STI, including congenital syphilis
3. Reduce the long term consequences of STI, including pelvic inflammatory disease, ectopic pregnancies, miscarriages and infertility

**Summary of STI services for specific target populations**

| Target population for increased services | Service required | Possible delivery areas |
|---|---|---|
| Whole population | Awareness of STIs – symptomatic and asymptomatic, long term consequences including neonatal<br>Primary prevention education | Country specific SHC interventions reaching sexually active population groups |
| Pregnant women and their partners, sexually active youth, high risk groups | Availability of testing and treatment services (including Epi-Tx when appropriate) | PHC services, NGOs and private health care services<br>Targeted SHC interventions |
| Pregnant women and their partners | Epi-Tx at first ANC visit for chlamydia screening and treatment (if testing positive) at first ANC visit<br>Syphilis and HIV screening and treatment(if testing positive) at first visit;<br>Counselling, condom, presumptive partner treatment (if pregnant women screening test is positive) | Public and private clinics managing ANC<br>Promote involvement of men in ANC<br>Optional: treatment of partners in linked PHC services, when male involvement in ANC is not accepted, ensuring further counselling on Epi-Tx. |
| People with symptoms of STIs | Access to syndromic management of STI at all PHC, risk assessment, counselling, condom promotion and distribution, provider initiated screening for HIV | PHC clinics, selected private doctors and NGO clinics, medical services in the work place, family planning/ gynaecology/reproductive health clinics, YFH services |
| Sexually active youth and adolescents (15 – 29 years) | Adolescent-adapted-information on STIs, HIV, sexuality; chlamydia screening, counselling; treatment for STIs; condom | Youth friendly health(YFH) services; school HIV Program; high school/college health services; NGO clinics for out of school youth; selected private doctors |
| Sex workers & high risk men: men with multiple partners including clients and regular partners of sex workers, MSM | Improve access to services for comprehensive syndromic management and promote routine STI/HIV check-ups including periodic screening, counselling, provision of condom and lubricant, partner treatment. | Targeted SHC interventions; dedicated clinics (opening hours, clinicians, counsellors) in and around 'hot spots', clinics developed for migrant workers, seafarers, taxi drivers, uniformed services; PHC centres with exceptionally well performing staff, NGO clinics, mobile clinics, satellite clinics, private doctors |
| Spouses and regular partners of high risk men | Improve access and quality of services for syndromic management<br>Improve access to screening for STI/HIV, counselling, condom promotion and distribution | PHC clinics, selected private doctors and NGO clinics, medical services of the work places, family planning/ gynaecology/reproductive health clinics |
| Non-pregnant women at low risk | Screening and treatment for STIs on request; counselling; condom promotion | PHC clinics, family planning/ gynaecology/ reproductive health clinics |

## ANNEX 4

## Costing Estimates for the Cook Islands INSP-SRH 20014-2018 by Priority Areas and Objectives

| **Priority Area 1** | **$84,500** |
|---|---|
| Objective 1.1 | $8,500 |
| Objective 1.2 | $4,000 |
| Objective 1.3 | $72,000 |

| **Priority Area 2** | **$400,000** |
|---|---|
| Objective 2.1 | $132,000 |
| Objective 2.2 | $100,000 |
| Objective 2.3 | $21,000 |
| Objective 2.4 | $89,000 |
| Objective 2.5 | $39,000 |
| Objective 2.6 | $19,000 |

| **Priority Area 3** | **$16,500** |
|---|---|
| Objective 3.1 | $0 |
| Objective 3.2 | $15,000 |
| Objective 3.3 | $1,500 |

| **Priority Area 4** | **$153,000** |
|---|---|
| Objective 4.1 | $19,000 |
| Objective 4.2 | $15,000 |
| Objective 4.3 | $19,000 |
| Objective 4.4 | $7,000 |
| Objective 4.5 | $49,000 |
| Objective 4.6 | $44,000 |

| **Priority Area 5** | **$208,000** |
|---|---|
| Objective 5.1 | $39,500 |
| Objective 5.2 | $117,000 |
| Objective 5.3 | $11,000 |
| Objective 5.4 | $12,500 |
| Objective 5.5 | $28,000 |

| **Total Cost** | **$862,000** |
|---|---|

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