KIRIBATI FAMILY HEALTH ASSOCIATION
(KFHA)

Universal Periodic Review

Joint Stakeholder Submission for the 3rd Cycle Review of Kiribati

A joint submission by:

KFHA—Kiribati Family Health Association
KSCCSN – Kiribati School & Center for children with Special Needs
KSA – Kiribati Scouts Association
KRCS – Kiribati Red Cross Society
KANGO – Kiribati Association of Non-Government Organizations
K-WIMA – Kiribati Women in Maritime Association
RAK – Reitan Aine ni Kamatu
AMAK – Aia Mwaea Ainen Kiribati
IREKENRAO-(Women Association)
AOG – Assemblies of God
KGGA – Kiribati Girl Guides Association
TTM- Te Toa Matoa (Disability Group)
AAFR – Alcohol Awareness Family Recovery
HEMO- Healthy Eita Maeao Organisation
SDA DORCAS- Seventh Day Adventist Dorcas (Church Women Fellowship)

The **Kiribati Family Health Association** (KFHA), established in 1985, is a locally owned, globally connected, leading NGO service provider working to promote sexual and reproductive health and rights (SRHR) for all people in Kiribati. KFHA works in close collaboration with local, national and international partners in addressing HIV & AIDs, STI and sexual and reproductive health (SRH) including family planning issues. KFHA has been registered under the *Incorporated Society Act 2006* since 2011, and was accredited as a full member of the International Planned Parenthood Federation (IPPF) in 2016.

KFHA works towards an environment where all people have control over their own bodies and are able to make the right choices for their own lives. The overall objective of KFHA is to ensure that people of Kiribati are well informed through public awareness programs and training modules about their own bodies, to enable them to control and master their own choices and destinies in the pursuit of good health for themselves.

International and Regional Commitments of Kiribati

1. The Republic of Kiribati is a small island developing state in the equatorial Pacific Ocean made up of 32 coral atolls and two coral islands spread over an area of 3.5 million square kilometers. It has a young population (57% of the population is under 25 years of age) of 103,058, with 49% of the population living in South Tarawa, the primary urban center.[1]

2. The Government of Kiribati is a signatory to a number of global and regional human rights conventions, including the Convention on the Elimination of all forms of Discrimination Against Women (ratified 2004), the Convention on the Rights of the Child (ratified 1995) and both Optional Protocols (ratified 2015), and the Convention on the Rights of Persons with Disabilities (ratified 2013), as well as development strategy frameworks developed and carefully designed to form broad guidelines for countries in trying to address the emerging social, economic, health, and development issues, including the 2030 Agenda for Sustainable Development, International Conference on Population and Development, the Beijing Platform for Action as well as the UNFPA International Conference on Population and Development (ICPD) beyond 2014 Review for the Pacific Region. Although the country is party to these obligations, the Government's efforts to address them are firstly fragmented under the different portfolios of relevant Government Ministries and secondly poorly coordinated, resulting in acute under-reporting of the extent of the actual issues and problems in play across the country.

3. In previous UPR cycles, Kiribati has received recommendations on gender-based violence, including domestic and sexual violence, and discrimination against women, and one recommendation to "Continue its efforts to reduce the maternal and infant mortality rates" (Indonesia, 2nd cycle, accepted). However, it has never received recommendations on sexual and reproductive health or rights (SRHR), or ensuring access to sexual and reproductive services information or education. We therefore believe it is highly relevant and urgent to highlight the following issues during this Third Cycle of the Universal Periodic Review for Kiribati.

Sexual and Reproductive Health Services

4. Under SDG 3.7, SDG 5.6 and CEDAW Article 12, as well as the International Conference on Population and Development and the Beijing Platform for Action and their regional conferences, the state of Kiribati has the duty to ensure the provision of a high standard of sexual reproductive health and rights (SRHR), services, information and awareness programmes, and to ensure healthy lives and promote well-being for all at all ages. This is crucial as Kiribati has some of the worst SRHR indicators in the Pacific, which are particularly alarming for the population in terms of adolescent fertility, total fertility, unplanned pregnancy, unmet need for contraception, maternal and infant

[1] Family Planning in South Tarawa, Kiribati-Usage and Barriers (2016) p. 6, https://www.familyplanning.org.nz/media/302832/south-tarawa-kiribati-usage-and-barriers.pdf

morbidity/mortality, STI/HIV rates, and rates of gender based violence including sexual violence.[2] These indicators include:

- An infant mortality rate of 40/1000[3]
- An adolescent fertility rate (teenage pregnancy) of 49/1000[4]
- A total fertility rate of 3.8 children per women[5]
- A modern contraceptive prevalence rate of 18%[6]
- An unmet need for contraception of 28%[7]
- A chlamydia prevalence rate of 9.3%[8]
- A total number of HIV and AIDS cases of 63[9]
- A rate of women (15-49) who have experienced physical and/or sexual violence of 68%.[10]

5. Sexual and reproductive health and rights indicators directly contribute to, or cause, a wide range of socio-economic development challenges.[11] Many of these challenges are now present in Kiribati, particularly on South Tarawa, the capital and primary urban area of Kiribati, including poor maternal and infant morbidity and mortality, reduced productivity, rapid population growth, high unemployment, poverty, environmental damage, household crowding and increased government spending.

6. Sexual reproductive health and rights are not only important to improve health and well-being outcomes, but because they also play a significant role and impact on other key aspects of national developments. For example, the population growth rate (PGR) in Kiribati is 2.4%, which is one of the highest PGR among the Pacific countries. If the Government of Kiribati ignores such an increase in its population, this will have a direct impact in increasing public expenditure on the health and education sectors.

7. In its development plan, the Government of Kiribati has recognised the importance of addressing SRHR, particularly the SRHR of women and adolescents.[12] However, the Kiribati health system lacks the capacity to provide quality and comprehensive sexual and reproductive health services for its current population, let alone the projected increase. In as far as sexual and reproductive health programs are concerned, current Government health programmes and budgets focus more on reactive curative measures rather than

[2] Secretariat of the Pacific Community (2009) 'Kiribati Demographic and Health Survey', Noumea, New Caledonia, and; Secretariat of the Pacific Community (2008) 'Kiribati Family Health and Support Study', Noumea, New Caledonia.

[3] Kiribati Tracking Progress in Maternal and Child Survival, July 2013 https://www.unicef.org/pacificislands/14-02-2014_Kiribati_Case_Study_For_Delivery_to_UNICEF_8-29-2013_conversion.pdf

[4] ibid

[5] ibid

[6] ibid

[7] ibid

[8] WHO, Western Pacific Region 2018; 'Prevalence of HIV and sexually transmitted infections among young women engaged in sex work aboard foreign fishing vessels in Kiribati'

[9] ibid

[10] Secretariat of the Pacific Community (2009) 'Kiribati Demographic and Health Survey', Noumea, New Caledonia, and; Secretariat of the Pacific Community (2008) 'Kiribati Second Generation Surveillance of Antenatal Women, Seafarers, Policemen and Youth', Noumea, New Caledonia, and; Secretariat of the Pacific Community (2010) 'Kiribati Family Health and Support Study', Noumea, New Caledonia, and; WHO (2010) 'Kiribati Country Health Information Profiles'

[11] Asia Pacific Alliance (2008) 'Intimate Relations: Sex, Lives and Poverty', Wellington, New Zealand

[12] Government of Kiribati (2008) 'Kiribati Development Plan 2008-2011', Tarawa, Kiribati.

proactive preventive measures. For example, about 2,000 women typically attend cervical screening services provided by KFHA clinical services each year, whilst the Ministry of Health, with 4 main hospitals and 79 clinics, typically serve only about 200 to 300 women clients a year.

8. The Kiribati health system remains largely dependent on external donor assistance to maintain its current health systems and to date, foreign donors have focused their SRHR assistance on midwifery training and HIV and STI awareness, testing and treatment. This has resulted in clinical services that are predominantly focused on midwifery, HIV and STIs, neglecting key sexual and reproductive health interventions, such as;
    - The Kiribati National Cervical Cancer Prevention Policy was developed in 2017, based on the survey conducted by KFHA with a view to improve the management of cervical cancer cases in Kiribati, had never been approved for implementation. The proposed draft policy was submitted to the Ministry of Health towards end of 2017. (annex 1)
    - Effective implementation of the 'island development plan (IDP)' is an important attempt in improving some of the worst SRHR indicators, eg; family planning updates, high prevalence rate of teenage pregnancy, and so forth, in Kiribati. The IDP is the initiative of local authorities supported by KFHA in mobilising their people to ensure good health and well-being of all. *Health* is one of the key priority areas of the IDP and requires commitment and support of medical staff on the island. Currently, KFHA with only 5 medical staffs are providing outreach programmes to the islands to ensure effective implementation of the IDPs and to try and achieve the annual health set targets. The results of this programme could have been better if the Government had been more committed and supportive to it, in terms of human resources and funding supports.

    A cost benefit analysis based on a 2014 survey report on 'Reducing unmet need for family planning in Kiribati,' showed that for every $1 that Government will spend on family planning to reduce unmet needs by 2020, a net sum of $25 would be saved in health and education costs.[13] The Government urgently needs to prioritize national programmes to ensure appropriate strategies and policies are developed and implemented to address them, and ensure that these programs are assigned adequate budget to address the inequalities and service gaps for which they are designed.

Comprehensive Sexuality Education:

9. In addition to insufficient access to sexual and reproductive health services, another key challenge is the ineffective provision on comprehensive sexuality education (CSE) programmes in the country for young people. CSE provides basic, fundamental sexual and reproductive health and rights information that is essential for young people to fully comprehend their bodies, feelings, and sexuality, in order to enable them make well informed choices, but also goes beyond biological information to include values creation around gender equality by providing children and young people with age-appropriate and phased education based on human rights, gender equality, relationships, reproduction,

[13] A cost benefit analysis, Family Planning New Zealand-Investment in Family Planning in Kiribati, 2014

sexual behaviors, risks and prevention of ill health, and emphasizes values such as respect, inclusion, non-discrimination, equality, empathy, responsibility and reciprocity.[14]

10. There is an urgent need for CSE in Kiribati. Teenage pregnancy is high, with an adolescent fertility rate of 49%, or 1 in 20,[15] on the rise from the 1990 rate of under 40%.[16] The UNFPA ICPD beyond 2014 Review reports an unchanged contraceptive prevalence rate of 19% from 1990 to 2011, with an unmet need of 28%, and adolescent girls aged 15-19 represent those with the highest unmet need (36.5%).[17] Sexual and gender-based intimate partner violence is extremely high, with almost 70% of women experiencing physical or sexual violence from a partner in their lifetime.[18] Young people also face high rates of sexually transmitted infections. UNICEF reports from 2009 and 2013 both confirm that young people in Kiribati are highly vulnerable to HIV and STIs infections.[19] Kiribati has one of the highest rates of HIV and AIDS in the Pacific, with youth ages 15-24 representing about half all new HIV infections.[20] Despite these high and rising indicators, there is no form of sex education within formal education programs.[21]

11. Strong socio-cultural and religious taboos around sex, sexuality and gender, have made it difficult for government health services to provide comprehensive sexuality education and clinical services. Culturally, sexuality is a highly sensitive issue in Kiribati, preventing it from being openly discussed between parents and their children or in schools between teachers and their students. As a result, sexuality topics within school curricula are either non-existent or, where they are attempted, are invariably fragmented and incomplete, generalized under different subjects. Comprehensive sexual and reproductive educational services are, therefore, extremely limited and not prioritized. In particular, high quality, rights-based family planning educational and clinical services have largely been neglected.[22]

12. This has directly contributed to Kiribati having the second poorest aggregate SRHR indicators in the Pacific.[23] As alluded to above, specific concerns include high adolescent fertility, high total fertility, high unintended pregnancy, high unmet need for

[14] UNESCO, INTERNATIONAL TECHNICAL GUIDANCE ON SEXUALITY EDUCATION 16 (2018).
[15] Pacific Regional ICPD Review: Review of the Implementation of the International Conference on Population and Development Programme of Action Beyond 2014 (2013) p. 15, https://pacific.unfpa.org/sites/default/files/pub-pdf/PacificICPDreport-AZAugust9_PQ%282%29.pdf
[16] UNFPA Pacific Sub-Regional Office, *I am not a lost cause! Young Women's Empowerment and Teenage Pregnancy in the Pacific*, p. 6, https://pacific.unfpa.org/sites/default/files/pub-pdf/UNFPASWOPPacificSupplementIamNotaLostCauseLR5final.pdf
[17] Pacific Regional ICPD Review, p. 21-22
[18] Pacific Regional ICPD Review, p.42.
[19] I Feel I Can Never Get Infected; Understanding HIV and AIDS Risk and Vulnerability Among Kiribati Youth. UNICEF Pacific Offices and The Government of Kiribati; Kiribati: Tracking Progress in Maternal and Child Survival, A case study report, UNICEF, 2013.
[20] I Feel I Can Never Get Infected; Understanding HIV and AIDS Risk and Vulnerability Among Kiribati Youth. UNICEF Pacific Regional Offices p.10.
[21] Pacific Regional ICPD Review, p.81.
[22] Secretariat of the Pacific Community (2009) 'Kiribati Demographic and Health Survey', Noumea, New Caledonia, and; WHO (2010) 'Kiribati Country Health Inforamtion Profiles' http://www.wpro.int/countries/kir/2010/chips.htm, visited on, 21/July/2011, and; UNFPA (2006) 'Adolescent Sexual and Reproductive health Situational Analysis for Kiribati', UNFPA Office for the Pacific, Suva, Fiji
[23] Family Planning International (2009) 'A measure of the Future: Women's Sexual and Reproductive Risk Index for the Pacific', Wellington, New Zealand

contraception, high maternal and infant morbidity/mortality, high STI/HIV rates, and high rates of gender based violence, including sexual violence, most acutely felt by the communities in Kiribati, particularly on South Tarawa.[24]

Recommendations:

13. In light of the above challenges and barriers hindering effective implementation and delivery of SRHR services in Kiribati, the following recommendations will provide guidelines to appropriate government agencies and key stakeholders;

    i) The Government of Kiribati should ensure that appropriate SRHR programs, including family planning programs that are accessible to all, are integrated into the next National Development Plan for 2021 – 2025 and accordingly allocate a sufficient annual budget to ensure effective delivery.

    ii) The Government should develop a CSE curriculum in accordance with the UNESCO technical guidelines and integrate CSE into all school curriculums both in Junior and Senior high schools.

[24] Asia Pacific Alliance (2008) 'Intimate Relations: Sex, Lives and Poverty', Wellington, New Zealand

Annex Lists

Annex 1: Kiribati National Cervical Cancer Prevention Policy 2017:

Kiribati National Cervical Cancer Prevention Policy 2017

Contents

1 Background 9
1.1 Introduction 9
1.2 Key Issues 9
1.3 Rationale 10
2 Policy Statements 11
2.1 Policy Goal 11
2.2 Objectives 11
2.3 Policy Statement 11
3 Policy 12
3.1 Leadership/Governance 12
3.2 Medical Products/Technology 12
3.2.1 Primary Prevention – HPV Immunisation 12
3.2.2 Secondary Prevention – Cervical Screening 14
3.2.3 Tertiary Prevention – Referrals and Treatment 15
3.3 Cervical Cancer Prevention Workforce 15
3.3.1 Secondary Prevention – Cervical Screening 15
3.3.2 Tertiary Prevention – Referrals and Treatment 16
3.4 Service Delivery 17
3.4.1 Health Promotion and Education 13
3.4.2 Cervical Screening Pathway 17
3.4.3 Overseas referrals 17
3.5 Monitoring and Evaluation 17
3.5.1 Effectiveness of programme 17
3.5.2 Clinical processes/performance 18
3.6 National Register 18
3.7 Quality Assurance 19
3.7.1 Smear-taking 19
3.7.2 Laboratory process 19
3.7.3 Colposcopy, biopsy and treatment 19
4 Annexes 20
4.1 Annex 1: Summary of the WHO Position Paper on Vaccines against Human Papillomavirus (HPV), May 2017 20

1 Background

1.1 Introduction

Cervical cancer is a major public health issue in Kiribati, and a significant cause of morbidity and mortality. It is one of the leading causes of cancer death amongst I-Kiribati women[25]. This persists despite the existence of effective prevention tools which have led to cervical cancer being viewed as a preventable disease[26].

Cervical screening is an effective tool for reducing cervical cancer morbidity and mortality, alongside early and effective treatment and other prevention strategies such as HPV immunisation. Regular cervical screening enables any cell changes on the cervix, which might later develop into cancer, to be detected earlier, so they can be monitored and treated before cancer develops.

Cervical cancer prevention is best approached with a combination of primary prevention, such as human papillomavirus (HPV) immunisation, secondary prevention through cervical screening, and early and effective treatment for high grade pre-cancerous cell changes which are at risk of developing into cancer.

1.2 Key Issues

A needs analysis was conducted to identify current issues with cervical cancer prevention services in Kiribati, including community surveys and focus groups, and interviews with key stakeholders.

The key issues that need to be addressed to improve cervical cancer prevention in Kiribati are:

- Lack of primary prevention of cervical cancer through the availability of HPV immunization;
- No organised National Cervical Cancer Prevention Programme;
- Limited awareness of cervical cancer among the population, health providers and policy makers;
- Limited workforce capacity to deliver services, including smeartakers, cytologists and specialists;
- Conventional pap smears are being phased out in many countries as new screening methods such as liquid-based cytology/ThinPrep and HPV testing are rolled out;
- Lack of infrastructure and medical technology including equipment to perform smears, analyse results, conduct further testing and perform treatment;

[25] Ministry of Health and Medical Services. (2016). *Kiribati Annual Health Bulletin.* South Tarawa, Kiribati: Author.

[26] World Health Organisation. (2014). *Comprehensive cancer control: A guide to essential practice* (2nd Edition ed.). Geneva, Switzerland: Author.

- No national policy or clinical guidelines to inform service delivery;
- No centralised recall and referral system or cervical cancer register;
- Insufficient monitoring and evaluation systems;
- Lack of coordination and cooperation between health professionals and other concerned non-government agencies.

1.3 Rationale

Development of a successful cervical cancer prevention approach demands multilevel input from the government to the community level. It must address all components of cervical cancer prevention, including community education, social mobilization, HPV vaccination, cervical screening, and treatment to palliative care. It must also be nationally organised, well-funded and effective.

This cervical cancer policy demonstrates the Kiribati Government's commitment towards cervical cancer prevention and is aligned with the Kiribati Development Plan (KDP), the Ministry of Health and Medical Services' Strategic Plan, the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child (CRC). It also provides a framework through which a successful cervical cancer prevention programme will function to reduce unnecessary cervical cancer death and improve the health of I-Kiribati women and their families.

2 Policy Statements

2.1 Policy Goal

To provide a comprehensive, nationally coordinated cervical cancer prevention and control programme which is subject to rigorous monitoring and ongoing improvement.

To provide and promote routine cervical screening every three years to all I-Kiribati women aged 25 to 65 who have ever been sexually active, in line with clinical guidelines.

To provide effective and timely treatment for women with abnormal cytology.

2.2 Objectives

All eligible women (aged 25 to 65) will have at least one cervical cancer screening test in their lifetime.

80% of eligible women will have a cervical cancer screening test over a three-year year period.

The incidence rate of cervical cancer in Kiribati will fall over a 10 year period.

The mortality rate of cervical cancer in Kiribati will fall over a 10 year period.

All screening and treatment will be delivered in line with agreed clinical guidelines.

2.3 Policy Statement

All women in Kiribati will have access to quality cervical screening and cancer care through a comprehensive cervical cancer prevention and control programme.

Strategic Area 1	Provide a nationally coordinated cervical cancer prevention and control program across Kiribati.
Strategic Area 2	Promote access to the program by providing accurate health information to all women and men.
Strategic Area 3	Ensure a highly trained, well supported, up-to-date, sensitive, and effective workforce.
Strategic Area 4	Ensure cervical cancer prevention and screening supplies and commodities are distributed equitably across Kiribati.
Strategic Area 5	Provide high quality cervical cancer prevention, screening, diagnosis, and treatment to eligible women in the community.
Strategic Area 6	Ensure the cervical cancer prevention and control program is implemented in a manner to reduce the morbidity and mortality of cervical cancer in Kiribati.

3 Policy

3.1 Leadership/Governance

The Kiribati Cervical Cancer Prevention Programme will be coordinated at a national level by the Cervical Cancer Prevention Programme Manager. This role is additional to existing Ministry of Health and Medical Services staff.

A Cervical Cancer Prevention Committee will be sustained and will meet quarterly. They will work in partnership with the Programme Manager in an advisory role. The Committee will comprise both clinical and non-clinical experts.

The Cervical Cancer Prevention Programme will be managed within a strong clinical governance framework. The Programme Manager will report to the Director of Public Health and will ensure that:

- Indicators of the success and effectiveness of the Cervical Cancer Prevention Programme are collected and reported to the Director of Public Health monthly and to the Cervical Cancer Prevention Committee quarterly;
- Any areas where the Programme is not performing effectively are addressed promptly, including through retraining of staff or recruiting new staff as needed, provision of new equipment, and developing new systems;
- Regular training is provided to clinical and non-clinical staff to maintain their skills;
- A comprehensive health promotion approach is developed and implemented by all providers, and that regular health promotion and education is delivered to the community;
- The National Cervical Cancer Register is developed and maintained, and that providers are submitting data regularly;
- Policy and guidelines are reviewed periodically and in response to new evidence or technology being made available;
- Advocacy for resources and activities required to strengthen the performance of the Programme are conducted on a national level.

3.2 Medical Products/Technology

3.2.1 Primary Prevention

3.2.1.1 HPV Immunisation

Persistent HPV infection is responsible for almost all cases of cervical cancer worldwide. Immunisation against HPV has been established in many countries as a tool to reduce the incidence of cervical cancer.

HPV immunizations should be administered to girls aged 9-14 in both school and community settings by trained health professionals. A 2-dose schedule is sufficient in individuals under 15. An organized national HPV immunization programme which is sustained for several years will over time reduce

the incidence of cervical cancer. An HPV immunization programme requires investment, but by reducing the incidence of cervical cancer the costs of treatment will fall over time. Immunization does not protect against all strands of HPV, and so cervical screening will continue to be needed.

The Ministry of Health and Medical Services, Cervical Cancer Prevention Committee and the Programme Manager will explore funding sources in order to develop and implement an HPV immunization programme.

For more information on HPV immunization, see the Summary of the WHO Position Paper on Vaccines against Human Papillomavirus (HPV) in Annex 1.

3.2.1.2 Health Promotion and Education

Health promotion, including education and counselling of women and men, is an integral part of the cervical cancer control programme. All categories of health care providers, in whatever setting they work must be provided with correct information on cervical cancer so that they can provide correct and consistent information to women (and men) on cervical cancer. A coordinated approach to health promotion will be led by the Ministry of Health and Medical Services to ensure consistent, high-quality information is disseminated and adequate funding will be allocated for this to be achieved.

The cervical cancer subdivision of the NCD is responsible for providing up to date information on cervical cancer to all (Public and Curative) nurses and to relevant officers of Health Promotion Unit, as well as to community providers such as KFHA.

The Health Promotion Unit is responsible for promoting health at the community levels, by helping people to understand and reduce their personal risks, and to participate in regular cervical screening (or support their family members to). This will be achieved through:

- Development of key messages to be used consistently across all information, education and communication (IEC) materials;
- A regular (quarterly) release of public information and education campaign aimed at changing behavior. This shall be done via radio communications;
- The production of pamphlets and posters that contain (up to date) health education messages about cervical cancer and which are distributed to health providers and community settings;
- Exploring the role of new technologies to promote cervical screening, including social media and text messaging;
- The inclusion of cervical screening education and messaging in routine health promotion activities, particularly around sexual and reproductive health and non-communicable diseases;
- Delivery of community health education and promotion sessions to reach individuals and communities. These sessions will be used to disseminate information on cervical cancer and the role of HPV, cervical screening's role in prevention, and risk factors for cervical cancer;
- Inclusion of male partners and family members in health promotion activities;
- Training of community leaders, church leaders, women's groups and other key stakeholders to build their capacity to promote cervical screening in the community.

Kiribati Family Health Association (KFHA) and community nurses will also incorporate cervical screening promotion into their work, including through delivery of clinical services, peer education

and community consultations. The Health Promotion Unit will ensure that they are appropriately trained and equipped with necessary supplies to deliver this health promotion.

3.2.2 Secondary Prevention – Cervical Screening

3.2.2.1 Screening Methods

Screening Methods

Cervical screening aims to detect abnormal cell changes which risk developing into cancer. There are three main methods of cervical screening: visual inspection, particularly visual inspection with acetic acid (VIA); cytology, either with conventional pap smears or liquid-based cytology; and HPV testing.

Currently, conventional pap smears are the main method of cervical screening available in Kiribati. Conventional pap smears are a well-established screening method, with good sensitivity and specificity. However, it is not possible to give an instantaneous result with a conventional pap smear and unsatisfactory samples (where a result cannot be determined) are possible.

Visual inspection with acetic acid (VIA), is a low-technology screening method that is being utilized in low-resource settings. VIA involves placing a few drops of acetic acid onto the cervix, and observing any acetowhite lesions, which are a sign of infection. VIA has good sensitivity, but its specificity is lower than other screening methods, meaning there are higher false positive rates. VIA is able to give an instant result when performed, and treatment can then be performed immediately if needed, beneficial for areas where women are unlikely to return for a second visit. VIA may be well-suited for outer-island settings, where there is no laboratory service available, and is an affordable option for Kiribati. However, the cost savings with VIA, which involves some over-treatment, may be offset by the referral and investigation of a higher proportion of women.

HPV DNA testing is a relatively new screening method that is being introduced in many countries. HPV testing is considered a superior screening test to conventional pap smears and cytology, and allows for a longer interval between screening. HPV testing is currently an expensive screening test, but the cost may be offset by less frequent screening and by savings on treatment costs by preventing more cases of cervical cancer.

Conventional pap smears will continue to be used as the primary screening test. VIA will be performed on outer islands where cytology is not available by trained and qualified health practitioners. The Ministry of Health, Cervical Cancer Prevention Committee and the Programme Manager will review the feasibility of a change in the primary cervical screening test to HPV DNA testing.

3.2.2.2 Technology and Equipment

Cervical screening services must be well-equipped with sufficient high-quality and functioning material. Supplies must be increased as demand for services increase, and maintained at a sufficient stock level. Request for equipment/repairs should be made to the Programme Manager. The Ministry of Health and Medical Services must ensure there is funding available to maintain adequate technology and equipment.

3.2.3 Tertiary Prevention – Referrals and Treatment

3.2.3.1 Methods

Upon referral, women with abnormal cytology will undergo colposcopy to assess abnormal cell changes, and a biopsy may be taken in line with clinical guidelines. Biopsies are sent to an overseas laboratory for histology.

Treatment for pre-cancerous cell changes is performed at the Tungaru Central Hospital in South Tarawa through cryotherapy, loop electro-excisional procedure (LEEP) or large loop excision of the transformation zone (LLETZ), and cone biopsy. Early-stage invasive cancer may be treated by hysterectomy, and later-stage invasive cancer by radiotherapy.

Cryotherapy will be performed locally following a positive VIA result in areas where cytology is unavailable.

3.2.3.1 Technology and Equipment

Referral services must be well-equipped with sufficient high-quality and functioning material. Supplies must be increased as demand for services increase, and maintained at a sufficient stock level. Request for equipment/repairs should be made to the Programme Manager. The Ministry of Health and Medical Services must ensure there is funding available to maintain adequate technology and equipment.

3.3 Cervical Cancer Prevention Workforce

3.3.1 Secondary Prevention – Cervical Screening

There are two key sectors of the cervical screening clinical workforce, smear takers and laboratory staff.

The smear taker is responsible for:

- Ensuring that smears performed are of a consistently high quality (low rate of unsatisfactory results);
- Keeping records of smears performed and entering them in the National Cervical Cancer Register;
- Timely referring of smears collected to the laboratory staff for evaluation of the smears;
- Following up with the laboratory for results;
- Ensuring that smears are properly packed and comply with airline's regulations (if any) on transportation of Diagnostic 'category B' specimens;
- Informing the women of the results of the smear and arranging further testing or treatment of any abnormality detected.
- Following up with women who do not attend to receive their smear results;
- Recalling women for routine smears, or where results were unsatisfactory, in line with clinical guidelines;
- Keeping records of attempts to recall women.

The laboratory is responsible for:

- Ensuring that its services (Microscopic evaluation of PAP smears) are of a consistently high technical quality and sustainable over time and that results are accurate and reliable;
- Timely referral of abnormal smears for confirmation at an identified overseas Pathology Laboratory;
- Ensuring that results are available and are released to smear takers within the agreed turn-around time;
- Keeping records of all smear results and entering them in the National Cervical Cancer Register.

The cervical screening workforce will be of an adequate size and suitably trained and skilled. All nurses will be trained to perform conventional smears, and the Ministry of Health and Medical Services and Kiribati Family Health Association will nominate nurses to be trained and perform VIA. Laboratory services will have suitably trained and qualified professionals.

The Ministry of Health and Medical Services is responsible for ensuring recruitment and retention of a capable workforce, and this will be overseen by the Programme Manager. Training and refresher training will be provided for all clinical staff, both routinely and in response to need identified through monitoring and evaluation processes.

3.3.2 Tertiary Prevention – Referrals and Treatment

There are three key sectors of the tertiary prevention clinical workforce, smear takers, laboratory staff and treatment providers.

The smear taker is responsible for:

- Informing the women of the results of the smear and arranging treatment of any abnormality detected;
- Following up with women with abnormal results who do not present for further tests or treatment;
- Keeping records of attempts to follow up with women.

The laboratory is responsible for:

- Ensuring that any biopsies performed are properly packed and comply with airline's regulations (if any) on transportation of Diagnostic 'category B' specimens;
- Timely referral of biopsies to an identified overseas Pathology Laboratory;
- Ensuring that results of biopsies are available and are released to treatment providers within the agreed turn-around time;
- Accurate staging of cancers with histology;
- Keeping records of all biopsy results and entering them in the National Cervical Cancer Register;
- Reviewing cytology where results on colposcopy or biopsy are normal.

The treatment providers are responsible for:

- Ensuring that further tests and treatments are performed to a consistently high standard and are appropriate for the type of abnormality;
- Ensuring that biopsies when taken are properly labeled and sent to the lab in a timely manner so they can be sent for overseas assessment;

- Accurate staging of cervical cancers;
- Ensuring women return for results and treatment, and advising smear-takers to follow up with those who do not return;
- Keeping records of treatment provided, outcomes of treatment, recommendations for follow up, and date for next smear test, and entering them in the National Cervical Cancer Register.

The cervical cancer prevention workforce must be of an adequate size and suitably trained and skilled. The Ministry of Health and Medical Services will have at least two specialists trained and qualified to perform colposcopy, loop excision, cone biopsy and cryotherapy. Kiribati Family Health Association will have at least one specialist trained to perform cryotherapy in sites where VIA and cryotherapy is performed.

The Ministry of Health and Medical Services is responsible for ensuring recruitment and retention of a capable workforce. Training and refresher training must be provided for all clinical staff, both routinely and in response to need identified through monitoring and evaluation processes.

3.4 Service Delivery

3.4.1 Cervical Screening Pathway

All women who have ever had sexual intercourse should be offered a three-yearly cervical smear test from age 25 to age 65.

If this is the first ever smear, or more than 5 years have passed since the previous smear, a second smear is recommended one year after the first, with three-yearly smears thereafter.

Screening procedure, including screening age and interval, as well as referral and recall procedures, will be in line with the Clinical Guidelines. The Ministry of Health and Medical Services will develop clinical guidelines which follow best practice recommendations and are informed by clinical evidence and expertise. In the absence of Kiribati Clinical Guidelines, service providers will follow the Guidelines for Cervical Cancer Prevention in New Zealand.

3.4.3 Overseas referrals

A cervical screening programme will inevitably find new cases of cervical cancer, and adequate referral systems and services must be in place for these women. In cases of invasive cancer, overseas treatment may be required. All early stage cancers will be referred and treated overseas as necessary. This will be funded by the Ministry of Health and Medical Services. The Ministry of Health and Medical Services will seek additional funding for referral of late stage cervical cancers for overseas treatment. Where overseas treatment is not possible, palliative care will be provided.

3.5 Monitoring and Evaluation

Monitoring and evaluating the cervical screening programme will ensure that processes and systems are implemented and functioning effectively. The National Cervical Cancer Register will be used to monitor the success of the programme, and the effectiveness of clinical processes. Areas to be monitored include:

3.5.1 Effectiveness of programme

- Number of smears performed;
- Numbers of abnormal results (including grade of results);

- Number of referrals made;
- Number of women with abnormal results who receive treatment;
- Number of women who DNA for follow-up appointments (including receiving results, further tests, treatment, and recall for future routine smears);
- Results of colposcopies;
- Number of confirmed cases of cervical cancer;
- Treatments provided;
- Treatment outcomes (including number of deaths).

3.5.2 Clinical processes/performance

- Number of unsatisfactory smears (total number and by provider);
- Length of time between smear being taken and results being available;
- Length of time between woman receiving her results and being seen at the hospital;
- Number of colposcopy results that differ from cytology results;
- Number of cytology results that differ from histology result;
- Length of time between biopsy being taken and results being available

The Cervical Cancer Prevention Committee will review these indicators at quarterly meetings to evaluate the success of the programme and identify where improvement is needed. The Programme Manager will be responsible for ensuring that any areas where the Programme is not performing adequately are addressed quickly and effectively.

With the introduction of an organized screening programme, it is likely that the incidence of abnormal results and cervical cancer will initially increase as more target women are screened. Within approximately 10 years, improvements in cervical cancer incidence and mortality should be observed.

3.6 National Register

A National Cervical Cancer Register (NCCR) is an essential component of an organized screening programme. It will be developed and its maintenance overseen by the Programme Manager. The register will store data and provide information for all cervical screening services in Kiribati (including from hospital services, NGO/community providers and outer island clinics) so that it can be ensured that women are:

- Informed of an abnormal smear result
- Recalled regularly
- Referred for treatment where appropriate.

The National Cervical Cancer Register will monitor the quality of the smears taken and provide statistical information (that doesn't identify individual women) that can be used to measure the effectiveness of the Programme. It will also identify areas where improvements are needed.

The information that will be required and stored will include:

- Personal details to correctly identify and contact women;
- Information on cervical smears including when performed, who the smear-taker was, results, and due date for next smear;

- Information on referrals for abnormal cytology, including what tests were performed and when, results of colposcopy and biopsy, and recommendations for treatment;
- Information on what treatment was performed, treatment outcomes, and recommendations for follow-up.

The Ministry of Health and Medical Services (and or Donor Agencies) will support the development and implementation of the National Cervical Cancer Register and will ensure its sustainability. The Programme Manager will ensure it is kept updated and that it is used effectively to evaluate the effectiveness of the Programme.

3.7 Quality Assurance

Processes and systems will be implemented to ensure ongoing quality assurance. This will be done at each stage of the pathway. The Programme manager and senior staff for each provider will ensure that these processes are followed, and that supportive supervision is in place for all clinical staff. The Programme will link in with international external quality assurance programmes.

3.7.1 Smear-taking

Standard operating procedures will be available and utilized by every provider. Clinical guidelines will be followed. Records of unsatisfactory smears will be reported monthly to management to identify where refresher training is needed.

3.7.2 Laboratory process

Standard operating procedures will be available and utilized by every provider. Clinical guidelines will be followed. Reviews of cytology will be conducted monthly by MHMS and KFHA laboratory staff on a random sample of smears, as well as on all high-grade results. Reports of monthly cytology review meetings will be provided to the Programme Manager to identify where refresher training is needed.

3.7.3 Colposcopy, biopsy and treatment

Clinical guidelines will be followed. Records of treatment outcomes will be recorded on the National Register and reviewed by the Programme Manager for any areas where refresher training is needed.

4 Annexes

4.1 Annex 1: Summary of the WHO Position Paper on Vaccines against Human Papillomavirus (HPV), May 2017

This position paper published in May 2017 replaces the corresponding document published in October 2014. It incorporates recent developments concerning HPV vaccines, including the licensure of a nonavalent (9-valent) vaccine and recent data on vaccine effectiveness, and provides guidance on the choice of vaccine. New recommendations are proposed regarding vaccination strategies targeting girls only or both girls and boys, and vaccination of multiple birth cohorts.

Epidemiology and Virology
Persistent infection by oncogenic HPV types is a prerequisite for the development of cervical cancer, which each year hits about 528000 women and causes 266000 deaths worldwide. The viral types 16 and 18 HPV are the most common types in invasive cervical cancer, accounting for about 70% of all cervical cancers. In total, 85% of cervical cancer cases occur in the less developed regions and mortality rates vary as much as 18-fold between industrialized and developing countries. Other manifestations of HPV infection include vaginal, vulvar, penile, oropharyngeal and anal cancers. In addition, HPV types 6 and 11 cause anogenital warts and recurrent respiratory papillomatosis. HPV is mainly transmitted sexually. Cervical cancer occurs only in a small fraction of those infected and takes a decade or more to develop. Properly implemented screening and treatment programmes contribute to the low mortality observed in some countries.

Vaccines
Three prophylactic HPV vaccines, directed against high-risk HPV types, are currently available and marketed in many countries worldwide for the prevention of HPV-related disease: the quadrivalent vaccine was first licensed in 2006, the bivalent vaccine in 2007 and the nonavalent vaccine in 2014. The bivalent vaccine contains non-infectious protein antigens for HPV 16 and 18, the qudrivalent against non-infectious protein antigens for HPV 6, 11, 16, and 18 and the nonavlent non-infectious protein antigens for HPV 6, 11, 16, 18, 31, 33, 45, 52 and 58.

Current evidence suggests that from the public health perspective the bivalent, quadrivalent and nonavalent vaccines offer comparable immunogenicity, efficacy and effectiveness for the prevention of cervical cancer, which is mainly caused by HPV types 16 and 18. All three HPV vaccines have an excellent safety profiles.

By 31 March 2017, globally 71 countries (37%) had introduced HPV vaccine in their national immunization programme for girls, and 11 countries (6%) also for boys.

Recommendations
Recognizing the importance of cervical cancer and other HPV-related diseases as global health problems, WHO recommends that routine HPV vaccination should be included in national immunization programmes.

For the prevention of cervical cancer, the WHO-recommended primary target population for HPV vaccination is girls aged 9–14 years, prior to becoming sexually active.

The current evidence supports the recommendation for a 2-dose schedule with adequate spacing between the first and second dose (min. 6-month interval) in those aged 9–14 years. An interval no greater than 12–15 months is suggested in order to complete the schedule promptly and before becoming sexually active. If the interval between doses is shorter than 5 months, a third dose should

be given at least 6 months after the first dose. Individuals older than ≥15 years and older and HIV infected/immunocompromised should receive a 3-dose schedule (0, 1–2, 6 months).

Current evidence suggests that from the public health perspective the bivalent, quadrivalent and nonavalent vaccines offer comparable immunogenicity, efficacy and effectiveness for the prevention of cervical cancer, which is mainly caused by HPV types 16 and 18.

The choice of HPV vaccine should be based on:

- assessment of locally relevant data;
- the scale of the prevailing HPV-associated public health problem (cervical cancer, other anogenital cancers, or anogenital warts);
- the population for which the vaccine has been approved;
- unique product characteristics, such as price, supply, and programmatic considerations.

The initial vaccination of multiple cohorts of girls aged 9–14 years is recommended when the vaccine is first introduced. Vaccination targeting multiple age cohorts of girls aged between 9 and 18 years together at time of HPV vaccine introduction would result in faster and greater population impact than vaccination of single age cohorts, due to the estimated increase in direct protection and herd immunity.

Vaccination of secondary target populations e.g. females aged ≥15 years or males, is only recommended if feasible, affordable, cost-effective and does not divert resources from vaccinating primary target population or from effective cervical cancer screening programmes.

HPV vaccines should be introduced as part of a coordinated and comprehensive strategy to prevent cervical cancer and other diseases caused by HPV. The introduction of HPV vaccine should not undermine or divert funding from developing or maintaining effective screening programmes for cervical cancer. Opportunities should be sought to link the introduction of HPV vaccination to other vaccinations carried out at this age (e.g. diphtheria and tetanus vaccination) and programmes targeting young people.

HPV vaccine can be co-administered with other non-live and live vaccines using separate syringes and different injection sites. Efforts should be made to administer the same vaccine for all doses. However, if the vaccine used for prior dose(s) is unknown or unavailable, either of the HPV vaccines can be administered to complete the recommended schedule

HPV vaccine can be administered safely to immunocompromised and/or HIV-infected individuals. HPV vaccination of pregnant women should be avoided due to lack of data, though no adverse effects in mother or offspring have been observed. If a young female becomes pregnant after initiating the vaccination series, the remaining dose(s) should be delayed until after the pregnancy is completed. Breastfeeding is not a contraindication for HPV vaccination.