Federated States of Micronesia

Global AIDS Response Progress Report 2015

Submission date: 8th April 2016

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Forward

It is our pleasure to present to your attention the 2016 Report of the Federated States of Micronesia in honouring our commitment to the Political Declaration of 2011: Intensifying our efforts to eliminate HIV and AIDS.

The Federated States of Micronesia is a country of many islands with a low prevalence of HIV. However, the fact that regional trends indicate continuous increase of HIV infection especially among most at-risk populations is rather worrying. For this reason the National response in country is focused on prevention of HIV infection with the aim to timely and efficiently prevents a possible HIV epidemic that always has broader health, social and economic impacts on the individual and community level. Regional and sub-regional aspects and conditions are always considered in our national activities.

As one of the countries that signed the Declaration on Commitments for HIV/AIDS, FSM undertaken the necessary steps in defining the strategic HIV/AIDS priorities, implementing concrete activities, building sustainable systems and mobilization of financial resources according to their availability.

The HIV program supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria and Communicable Disease & Control (CDC), enabled our country to successfully implement the aims and activities in defined in the National AIDS Strategy 2013-2017. Moreover, this program contributed to the capacity building of the governmental and non-governmental sector for planning and implementation of activities targeting HIV/AIDS prevention.

This GARPR for 2016 demonstrates and summarizes the overall national efforts undertaken in development of relevant policies and progress in programme implementation and their contribution to the overall response to AIDS, as well as further challenges underlying that need to be addressed to halt the spread of HIV/AIDS in our country. This report also reflects the challenges in securing sustainable funding for prevention, treatment, care and support of HIV/AIDS by the Government due to the influence of the economic crisis.

With this report, we hope to increase our commitment in reducing stigma and discrimination towards people living with HIV/AIDS and to reduce gender-based violence, issues that lie beyond HIV infection that influences negatively the well-being of the population of our country.

Though FSM is a low HIV/AIDS prevalence country we reinforce our intention to ensure that our national response to AIDS is strong enough to maintain the low level of concentration and to ensure an AIDS free generation.

Yours sincerely,

Ms. Magdalena A. Walter, R.N., MSN
Secretary, Department of Health and Social Affairs

Date

Acknowledgements

This GARPR report developed by the Communicable Disease Section Team at the National Department of Health and Social Affairs and the report was approved by the Secretary of Health and Social Affairs on April 8, 2016. The technical support for the write up is provided from the UNAIDS Office in Suva, Fiji.

This report was coordinated by the national Team of HIV/AIDS Program Manager, Surveillance Program Officer and the Financial Management Specialist from the Department of Health and Social Affairs which is leading the HIV/AIDS program response in the Federated States of Micronesia. The data and commentary presented in this report was drawn from a diverse range of sources including (but not limited to): Four states Department of Health Services, Public Health Services, Hospital laboratories, 2006-2008 SGS survey for Pohnpei, Chuuk and Kosrae, 2011 sex worker survey in Chuuk and key informant interviews. Special Thanks for the input to: Ms. Takiko Ifamilik, National HIV/AIDS Program Financial Management Specialist, National Communicable Disease Surveillance Officer Ms. Nefertti David and Mr. Johnny Hebel, National HIV/AIDS Program Manager.

Contact person for the report:

Ms. Magdalena A. Walter, Secretary, Department of Health and Social Affairs – E-mail; mwalter@fsmhealth.fm

Dr. Mayleen Ekiek, Medical Director, Communicable Disease Section – E-mail; mekiek@fsmhealth.fm

Mr. Johnny Hebel, National HIV Program Manager, DHSA – E-mail; jhebel@fsmhealth.fm

I. Status at a glance

a) Inclusiveness of the stakeholders in the report writing process

The process for compiling the report was initiated end of February to early March 2016 when UNAIDS (Suva) informed the FSM Focal Point to submit the Global AID Response Progress Report (GARPR). February 29 to March 4 2016 on site training workshop coordinated by UNAIDS and UNDP held in Nadi, Fiji. The training provides the Pacific focal person that attended the meeting guideline and new indicators for this year's report. Following the training in Fiji FSM team got organized and started the process of report writing and gathering of information. FSM Team was able to verify and collect information from the states HIV & STI program Coordinators. Some revised indicators found to be relevant but data is not available. This issue will address this year in order to report on in the next year report. In the process FSM Team continues to liaise with Ms. Gabriela Ionascu from UNAIDS Fiji for further assistance in the development of this report.

A work plan was then agreed between the UNAIDS Suva Team and the Focal Point by email communication. Following the Technical Assistance via email and skype calls with Ms. Gabriela Ionascu, a meeting was convened with a small working group consisting of the national HIV Manager, the national Surveillance officer and national finance Specialist to discuss the process and agreed on responsibilities for compiling the report.

Given the constraints of geography across the four states and timeline for completion of the report and competing program priorities, it was agreed that data would be collected by three key means:

1) Review of existing program reports and other documentation relevant to the 2015 reporting period
2) Review of the financial data available in relation to the key funders
3) Review of available surveillance and other data to compile the indicators

The National HIV Program Manager undertook responsibility for working with colleagues to source all relevant program reports and Survey, supported by the national Surveillance Officer. The Financial Specialist, working with colleagues at state and national level, sourced all relevant financial data. Together, all these sources of data were drawn upon to compile the response to the indicators and draft the narrative report.

Information in response to the indicators was discussed with the National Manager, Surveillance Officer and the Financial Specialist and up loaded. The information on the funding data was discussed with the Finance Specialist, prior to compilation, finalized and uploads online.

b) Status of the Epidemic

With 48 cases reported since the beginning of the HIV-AIDS epidemic in 1989, FSM is considered to have a low prevalence of HIV. There are 10+ HIV cases currently living in FSM. Heterosexual contact is the predominant mode of transmission although male-to-male-sex and mother-to-child transmission has been significant modes of transmission throughout the epidemic as well. Routine case surveillance in 2015 reported 2 new diagnosed HIV cases. The two new cases were on treatment but on and off at times. CD4 count was taken locally but no Viral Load. High rates of STIs continue, generating significant health issues as well as indicating that unprotected sexual activity continues to be an ongoing risk factor across the population. The occurrence of transactional and commercial sex, particularly for young women but also in relation to their clients, has been recognised. The likelihood of male-to-male sexual activity is beginning to be discussed as a concern to be addressed. Transgender issue also beginning to be discussed.

The most recent survey data, the Second Generation Surveys conducted in Pohnpei, Yap and Chuuk through 2006-2008, interviewed young men and women, police and pregnant women. Whilst results varied across these populations, the surveys identified low knowledge of HIV transmission and prevention (except in the police); limited utilisation of testing; low condom use (especially for young women); early onset of sexual activity and strong likelihood of multiple partners (particularly for young men); a strong association between use of alcohol or drugs and sexual activity; low levels of tolerance for positive people; and limited health seeking behaviour in relation to seeking treatment for STIs, despite symptoms. The reasons for not using condoms included lack of availability or a preference for 'skin to skin'. These surveys suggested that a significant number of people continue to place themselves at risk through unprotected sex with multiple partners, despite variations in knowledge of transmission and prevention and access to treatment.

A subsequent survey of sex workers in Chuuk, released in 2011, confirmed the vulnerability of the respondents - and young women in particular - due to their social and economic status. Apart from indications that most women in the survey engaged in transactional sex because of the incentive of money or goods, the survey also identified a high level of forced sex amongst respondents. It also confirmed low levels of knowledge of prevention and high risk sexual behaviours.

c) Policy and programmatic response

FSM's National Strategic Plan 2013-2017 endorsed towards end of 2013 and now in its fourthS year of implementation. The NSP identifies four priority areas: prevention, comprehensive management of HIV & STIs, governance and coordination, monitoring and evaluation. Key areas for strengthening the effectiveness of the response in each of these priorities include:

- In prevention – the Strategy will strengthen the quality of the innovative work to date in outreach and community education programs, particularly focus on identifying and

establishing programs with key risk groups, men who have sex with men and sex workers and their clients and cross-state programs (e.g. expansion of the Chuuk linkage program); enhance the peer education program across the country, especially the quality of current training and support; engage parents as peer educators to strengthen the knowledge, capacity and support in the adult community; and integrate with broader vulnerability issues, such as alcohol use and domestic violence, through established programs.

- In the management of HIV & STIs, the Strategy will strengthen the dissemination of policy and procedures in clinical care, drawing on current experience; broaden engagement and linkages with the private sector in each state; more rigorous surveillance (crossing over with M&E); and build links with broader vulnerability issues, such as domestic violence;

- In Governance: the Strategy will enhance the dissemination of policy and procedures; share lessons learnt in developing policy and procedures and legislation; confirm ongoing funding from current sources, such as the global fund, who fund as well as the US federal grants

- In monitoring and evaluation: the Strategy will establish systems for the collection, analysis and dissemination of data to assess the quality and effectiveness of the response; the development of an M&E framework and associated training in monitoring and evaluation are key components.

The National Health Sector Policy for Strengthening of HIV/AIDS and STI prevention, Care and Treatment expired December 2013 and the process of revising this policy had already underway. The workshop in May 2014 by the National Communicable Disease team along with all coordinators from each of the four states with Technical Assistance from WHO to revisit the existing HIV policies and costed the NSP. The revised policies are still in progress to be completed in 2015 as targeted, unfortunately more time is needed due to additional policies are to be incorporated in to the new policy.

d) Indicator Overview Table

		Indicators	*Value*	*Source*	*Comments*
HIV Prevention among general population		1.1 Young People: Knowledge about HIV Prevention*	N/A	N/A	No new national survey conducted this reporting period.
		1.2 Young people: sex before the age of 15	N/A	N/A	Same as the above comment
		1.3 Multiple sexual partnerships	N/A	N/A	Same as above
		1.4 Condom use at last sex among people with multiple sexual partnerships	N/A	N/A	Same as above
		1.5 People living with HIV who know their status	10	DHSA CD Annual Report	Data collected in 2015 from DH&SA annual report for ages 0-35 + years
		1.6 HIV prevalence from antenatal clinics, by age group	1	DHSA CD annual Report	Only two new cases reported in 2015 and one was detected at the antenatal clinics
		1.20 HIV incidence rate	2	DH&SA HIV/STI QR	Reported in the DH&SA HIV/STI communicable Disease annual report for 2015
		1.22 Male circumcision, prevalence	0	N/A	No data collected for this indicator
		1.23 Annual number of men voluntarily circumcised	0	N/A	No data collected for this indicator this reporting period
Key populations	*Sex Workers*	2.1 Size estimations for key populations	N/A	N/A	Same as above
		2.2 Sex workers: Condom Use	relevant	relevant	Data not collected for this indicator this reporting period.
		2.3 HIV Testing in sex workers	relevant	relevant	Not recorded for this specific group
		2.4 HIV prevalence in sex workers	relevant	Relevant	Not collected this period.
	Men who have sex with men	2.5 Men who have sex with men: condom use	Relevant	Relevant	No data collected per this indicator this period
		2.6 HIV testing in men who have sex with men	relevant	relevant	Testing is done in the general population inclusive of the MSM but no record for specific to MSM.

		2.7 HIV prevalence in men who have sex with men	relevant	relevant	Testing done in the general population but not to this specific indicator per CD reporting form
	People who inject drugs	2.8 Needles and syringes per person who inject drugs	Relevant	Relevant	Data not available on this indicator this reporting period
		2.9 People who inject drugs: condom use	Relevant	Relevant	Date not available on this indicator
		2.10 People who inject drugs: safe injecting practice	Relevant	Relevant	Data not available on this indicator
		2.11 HIV testing in people who inject drugs	relevant	Relevant	Same as above
		2.12 HIV prevalence in people who inject drugs	Relevant	Relevant	Same as above
		2.13 Opioid substitution therapy (OST coverage	Relevant	Relevant	Same as above
	Prisoners	2.14 HIV prevalence in inmates/detainees	0	DH&SA	CD annual HIV/STI reporting template for DH&SA in Appendix I
	Transgender people	2.15 HIV prevalence in transgender people	Relevant	Relevant	No data collected per this indicator this period
Prevention of mother-to-child transmission (PMTCT)		3.1 Prevention of Mother-to-Child Transmission	1	DH&SA	Only one case reported in 2015
		3.2 Early Infant Diagnosis	relevant	relevant	C-section performed on pregnant mother and baby died (neonatal death).
		3.3 Mother-to-Child transmission of HIV	1	DH&SA QR	Was reported per QR by DH&SA of one pregnant mother with HIV + in 2015
		3.3 a Program-level mother-to-child transmission of HIV	1	DH&SA QR	This was reported in 2015 with C-section and new born died shortly after birth.
		3.4 PMTCT testing coverage	100%	DHS QR	State program coordinator reported that all pregnant women tested for HIV received their result
		3.5 Testing coverage of pregnant women's partners	relevant	relevant	No data collected on this indicator but there is data collected on # of pregnant women tested for HIV at the ANC but not including all their partners.
		3.7 Coverage of infant ARV prophylaxis	100%	DH&SA	Only one pregnant woman was positive this period and she had her CD4 test. ARV prepare for the baby,

				unfortunately baby died after birth.
	3.9 Co-trimoxasole (CTX) prophylaxis coverage	0	DH&SA QR	Reported by state programs
Treatment	4.1 HIV treatment: antiretroviral therapy (ART)	2	DH/SA	2 new cases reported in 2015 and both started on ARV.
	4.2 Twelve-month retention on antiretroviral therapy	0	Pt. Summary report	Reported that cases are not fully in compliance to their treatment. On and off none of them retain of treatment for the 12 months period
	4.2a Twenty-four-month retention on antiretroviral therapy	1	Pt. Summary report	This one transfer in from US and is on ARV regularly
	4.2b Sixty-months retention on antiretroviral therapy	1	Pt. Summary report	Same as above
	4.3 HIV care coverage	10	Pt. Summary report	From the10 patient total currently living only one refused to be on treatment, one on ART regularly and 8 are kind of on and off.
	4.4 Antiretroviral medicines (ARVs) stock-outs	0	Stock out report	All four states have not encounter stock outs of ART. ARVs are received at the National for all states except for Yap. Order comes in a 6mothly patches and monitor closely by National office and the Regional Pharmacy in Suva.
	4.5 Late HIV diagnoses	0	Pt. Summary report	FSM is now following the WHO and CDC treatment guideline, which is test and treat.
	4.6 Viral load suppression	0	Pt. Summary report	State HIV program report on the six month VL and CD4 follow up and this reporting period and the 2 pt. Reported have not rechecked for their VL.
	4.7 AIDS-related deaths	0	Pt. Summary	No report on death for the two cases reported in 2015.

				report	
AIDS spending		6.1 AIDS spending	4	DH&SA	There are four major funding sources that support the HIV program in FSM, CDC, HRSA, GF and WHO.
Gender		7.1 Prevalence of recent intimate partner violence	Relevant	Relevant	No data collected per this indicator although it is important.
Stigma and discrimination		8.1 Discriminatory attitudes towards people living with HIV	Relevant	Relevant	States HIV program continues to report of some discriminatory attitudes toward HIV + but is lessen then 2-4 year ago.
Health systems integration		10.2 External economic support to the poorest households	Relevant	Relevant	
HIV and other diseases	Tuberculosis	11.1 Co-Management of Tuberculosis and HIV Treatment	0	DH&SA QR	No TB and HIV co-infection reported this period.
		11.2 Proportion of people living with HIV newly enrolled in HIV care with active tuberculosis disease	0	DH&SA QR	No report on active TB cases with HIV this period.
		11.3 Proportion of people living with HIV newly enrolled in HIV care with active tuberculosis disease	0	DH&SA QR	No new case reported with active TB this period.
	Hepatitis	11.4 Hepatitis B testing	6634	DH&SA	This is reported in the HIV/STI Annual report for 2015
		11.5 Proportion of HIV-HBV co-infected persons currently on combined treatment	0	DH&SA QR	No co-infection case reported this period
		11.6 Hepatitis C testing	1478	PCSI report	Only two states doing the Heb. C testing (Pohnpei and Yap state)
		11.7 Proportion of persons diagnosed with HIV-HCV infection started on HCV treatment during a specified time frame (e.g. 12 months)	0	PCSI report	No co infection for HIV-HCV this period
	Sexually transmitted infections	11.8 Syphilis testing in pregnant women	581	HIV/STI QR	FSM developed a HIV/STI quarterly report to capture data that is used for populating this report. For one state only (Pohnpei State)
		11.9 Syphilis rates among antenatal care attendees	76%	HIV/STI QR	Same as above
		11.10 Syphilis treatment coverage among syphilis positive antenatal care attendees	84%	HIV/STI QR	Same as above

		11.11 Number of reported congenital syphilis cases (live births and still birth) in the past 12 months.	15	HIV/STI QR	Same as above
		11.12 Men with urethral discharge	relevant	relevant	No data collected per this indicator this period. Will address this in the reporting form for next year.
		11.13 Genital ulcer disease in adults	relevant	relevant	Same as above

II. Overview of the AIDS epidemic

Country context

The Federated States of Micronesia contains 607 volcanic islands and atolls scattered over 1 million square miles of the Pacific Ocean. The land area totals 704.6 square kilometres, with 7192 square kilometres of lagoon area. The Federated States of Micronesia is a constitutional federation of four states: Chuuk, Kosrae, Pohnpei and Yap.

The capital is located in Palikir, Pohnpei. The constitution provides for three separate branches of government at the national level: executive, legislative and judicial. It has a Declaration of Rights, similar to the Bill of Rights of the United States of America, specifying basic human rights standards consistent with international norms.

The Congress is unicameral and has 14 senators, one from each state, elected for a four-year term, and 10 who serve two-year terms, whose seats are apportioned by population. There are no formal political parties. The President and Vice-President are elected to four-year terms by the Congress.

The National HIV & STI Programs are part of the Department of Health and Social Affairs. The Secretary of the Department of Health and Social Affairs is a cabinet-level position, nominated by the President and requiring congressional confirmation.

Economic activity consists primarily of subsistence farming and fishing. Primary farm products include black pepper, tropical fruits and vegetables, coconuts, cassava, betel nuts, sweet potatoes, pigs, chickens and cava for the state of Pohnpei. The islands have few mineral deposits worth exploiting, except for high-grade phosphate. The potential for a tourist industry exists, but the remote location, lack of adequate facilities and limited air connections hinder development.

Under the current compact of Free Association, through which Micronesia receives ongoing US financial and technical assistance, FSM receives approximately US$92 million a year until 2023, including contributions to a jointly managed trust fund. Additional funding from the United States totalled US$ 57 million.

Employment declined from 16,119 in 2000 to 15,897 in 2005. Pohnpei had the highest number of employed, at 7060, and Kosrae had the lowest, at 1366. The three largest employers were the private sector, state government, and government agencies. Around 43% were in the public sector, 19.8% in wholesale trade and repair and 7% in education. The unemployment rate is 16% and the average real wage is US$ 6037. The number of people participating in the labour force increased by 25% between 1994 and 2000. Wage salary jobs,

however, declined by 11% between FY 1995 and FY 2009. This resulted in rapid growth in the subsistence sector as well as growth in the ranks of the unemployed.[1]

The country has reported significant trade deficit over the last decade[2]. In 2005, total imports were valued at US$117.5 million and exports were valued at only US$1.3 million. The tourism sector is small, with only 13,415 tourists reported for 2005. Private remittances are also limited, especially compared with other Pacific island countries. The gross domestic product (GDP) for 2008 was estimated to be US$ 304 million, with nominal GDP per capita estimated to be US$2223. The country's economic outlook is reported as fragile, due, in part to the continuing reduction in assistance from the United States of America and also to the slow growth of the private sector. Geographical isolation and a poorly developed infrastructure remain major impediments to long-term growth. In recent times, telecommunication costs have fallen and internet access is now available through broadband and could improve access to education and trade.[3]

Population

Based on the preliminary results of the 2010 Census, the Federated States of Micronesia has a population of 102 624. Of this population, 35.7% is below 15 years old and 3.3%is 65 years and over. The average age of the population is estimated to be 21.5 years. For every 100 females, there are about 103 males. There has been a decrease in the population of approximately 4,400 due to substantial outmigration over the past decade (since 2000[4]) – most particularly in Chuuk and Kosrae, where the economy has declined/experienced financial difficulties. Approximately 49% of the population lives in Chuuk, 32% in Pohnpei, 11% in Yap and 8% in Kosrae, with almost 23% living in urban areas.

Table 1A. Age and Sex Distribution, FSM: 2010

5 Year Age-group	Total	Male	Female	Sex ratio
All ages	102,624	52,055	50,569	102.9
0-4	12,042	6,129	5,913	103.7
5-9	11,933	6,138	5,795	105.9
10-14	12,675	6,521	6,154	106.0
15-19	11,878	6,172	5,706	108.2
20-24	9,292	4,865	4,427	109.9

[1]Taken from the 2000 census data – quoted by MDG 2011 report which advises that updated figures will be available in mid-2011 when the 2010 census data is analysed.

[2]More recent data was not available.

[3]WHO materials, WHO Fact Sheet, FSM WHO Country Office, accessed 01032012

[4]This decline resulted in an average annual growth rate of -0.42% for period 2000-2010, as compared to 0.25% for period 1994-2000.

25-29	7,610	3,822	3,788	100.9
30-34	6,592	3,404	3,188	106.8
35-39	5,896	2,899	2,997	96.7
40-44	5,567	2,703	2,864	94.4
45-49	5,204	2,648	2,556	103.6
50-54	4,638	2,306	2,332	98.9
55-59	3,568	1,856	1,712	108.4
60-64	2,313	1,176	1,137	103.4
65-69	1,208	542	666	81.4
70-74	951	397	554	71.7
75+	1,257	477	780	61.2
Median age	21.5	21.1	21.9	…

Note: Excludes persons residing outside FSM

Source: Preliminary counts, 2010 FSM Census

About 36% of the total population were aged 0-14 years, 21% were aged 15-24 years, 38% were aged 25-59 and 6% 60 years and above. The median age is 21.5 years. This is based on the latest census in 2010.

The health care system

Responsibility for National office is to coordinate health activities, establish baseline policies, monitor health implementation, planning and delivering health services are shared between national and state agencies in the FSM. At the national level, the Department of Health and Social Affairs (FSM-DHSA) has responsibility to provide technical assistance to the state program and to assist with mobilizing financial and other resources to support improved medical and public health services in the states. The departments of Health Services of the states have primary responsibility for planning and deliver services including those programs and activities directed at prevention and control of HIV AIDS and STI.[5]

The national Department of Health and Social Affairs does not have a direct role in the provision of health services. The Secretary of the Department of Health and Social Affairs is responsible for overseeing all health programmes and ensuring compliance with all laws and executive directives. Major mandates are coordination, monitoring, technical assistance and capacity-building.

Each state government maintains its own health services. The Department of Health Services in each state has primary responsibility for curative, preventive and public health services.

[5]National Health Sector Policy for Strengthening HIV/AIDS, STI Prevention Care and Treatment, Department of Health and Social Affairs, 2009

This responsibility includes the main hospital, peripheral health centres, and dispensaries. Each state maintains a centrally located hospital that provides a minimum range of primary- and secondary-level services, both preventive and curative. Only residents of urban centres have direct access to the main hospital in each state. Transportation issues between islands often prevent residents who live on the outer islands from accessing these hospitals.

Dispensaries (similar to health clinics) are located in municipalities and outlying islands and are part of the state health departments. Their location is based on population, need and political affiliations. The mayors and the dispensary supervisors are responsible for day-to-day operations. Diagnosis and treatment of common ailments are the primary services provided, with more advanced cases being referred to central hospitals.

Health services are highly subsidized by the state governments, except in the private clinics. There are eight private health clinics in the country and one private hospital.

A. Private Health Facilities

Type of Facility	FSM	Yap	Chuuk	Pohnpei	Kosrae
Private Health Facility	7	-	2	5	-
Private Hospital	1	-	-	1	-
- Licensed Bed	36	-	-	36	-
- Operating Bed	36	-	-	36	-
Private Health Clinics	3	-	-	3	-
Private Pharmacies	5	-	2	3	-
Private Dental Clinics	5	-	1	4	-

Source: FSM DHSA/HIS

B. Government Health Facilities

Facility Type	FSM	Yap	Chuuk	Pohnpei	Kosrae
Gov't Owned	115	26	66	12	7
Hospital	4	1	1	1	1
Licensed Beds	341	50	130	116	45
Operating Beds	294	42	125	92	35
Occupancy Rate	66	59	58	62	83
CHC	5	4	-	1	0
Dispensaries	96	19	68	9	-
Dental Clinics	4	1	1	1	1
Aid Posts	6	1	-	-	5

Source: FSM DHSA/HIS

At the State level, the Chief of Public Health supervises the posts relevant to sexual and reproductive health services: these include the HIV and STI coordinator/s in Chuuk, Kosrae, Pohnpei, and Yap; the Family planning coordinators in all states, the MCH coordinators and, in two states (Chuuk and Pohnpei) the Adolescent health coordinators.

Most of these posts are staffed by nurses who, in addition to coordinating and managing programs, also clinically manage patients and clients. The coordinators link with the community through the Community Health Centers (CHC)[6] which is usually managed by nurses or health assistants. The CHCs provides general clinical and public health services including the provision of contraceptives, screening tests for pregnancy, cervical cancer and

[6]These are called Community Health Centres in Yap and Pohnpei, and dispensaries in Kosrae and Chuuk

STIs including HIV, syphilis, gonorrhea and Chlamydia and treatment of STIs. Where necessary, they refer to their counterparts in the Public Health Unit for more specific support relating to specific areas of expertise, by each of the Coordinators.

Each state's HIV & STI Programs also has to a greater degree, strong collaborative networks with community based NGOs and FBOs, and is supported at by the state level Community Planning Groups (in Kosrae this is called the State AIDS committee). At national level, the newly-formed National Advisory Committee for HIV, and Other STIs (NACHOST), a mix of government and community representatives (including members from the State Community Planning Groups), provides oversight of the national strategic directions in response to HIV & STIs.

III. National response to AIDS epidemic

National Policy

The National Health Sector Policy for Strengthening of HIV /AIDS and STI Prevention Care and Treatment was adopted in February 2009. It aims to establish coherence between the national and state provision of activities to strength services in HIV & STI prevention care and treatment by focusing resources and activities on:

1) Counseling and testing for those at risk of HIV and STI
2) Early initiation of medical, emotional and social care for HIV &STI-infected individuals
3) Combating stigma and discrimination
4) Supporting human rights (right to health, confidentiality and voluntary care)
5) Collaborating with communities
6) Strengthening national reporting systems (including the HIV & AIDS case reports, and HIV/STI Data Quarterly Report form. This new form is in its second year of implementation. The states use this form to collect STI/HIV data and submit to national office every quarter.

National HIV & STI Strategy

The National Strategic Plan (2013-2017) has been developed to assist and guide implementation of the response on HIV and STI in the country. In December 2015 the states program coordinators and national team attended the 2015 NHPC in Atlanta Georgia and during this meeting the PIJs met with the CDC Project Officers and Capacity Builder to and revisit the issue of At-risk group and was cleared that the At-risk groups are;

1. Men who have Sex with Men (MSM)
2. Sex workers and
3. Injection Drug Users (IDU) and
4. Transgender

FSM commit to begin in 2016 to collect the data for these populations and set base line for 2016.

The NSP identifies four priority areas: prevention, comprehensive management of HIV & STIs, governance and coordination, monitoring and evaluation. Key areas for strengthening the effectiveness of the response in each of these priorities include:

- Prevention: the Strategy will strengthen the quality of the innovative work to date in outreach and community education programs, particularly focus on identifying and establishing programs with key risk groups, men who have sex with men and sex workers and their clients and cross-state programs (e.g. expansion of the Chuuk linkage program); enhance the peer education program across the country, especially the quality of current training and support; engage parents as peer educators to strengthen the knowledge, capacity and support in the adult community; and integrate with broader vulnerability issues, such as alcohol use and domestic violence, through established programs.

- Management of HIV & STIs: the Strategy will strengthen the dissemination of policy and procedures in clinical care, drawing on current experience; broaden engagement and linkages with the private sector in each state; more rigorous surveillance (crossing over with M&E); and build links with broader vulnerability issues, such as domestic violence;
- Governance: the Strategy will enhance the dissemination of policy and procedures; share lessons learnt in developing policy and procedures and legislation; confirm ongoing funding from current sources, such as the response fund and global fund, as well as the US federal grants, or identifying alternate funding sources to replace the Global funds should they dissolve in 2017.
- Monitoring and evaluation: the Strategy will establish systems for the collection, analysis and dissemination of data to assess the quality and effectiveness of the response; the development of an M&E framework and associated training in monitoring and evaluation are key components.

The commitment under two key funders – the Global Fund and the WHO Fund – will continue to provide assistance to assist the implementation of the National Strategic Plan in collaboration with the main funding sources CDC that are federally funded programs and Human Resource Services Administration HRSA.

National Coordination

The FSM National Advisory Committee on HIV, Other STIs and TB (NACHOST) was established in 2009 by the authority of the Secretary of Health and Social Affairs. Articles of incorporation were endorsed in August 2010. The NACHOST was established to support to National HIV, STI and TB Coordinators in the following areas: [7]

- Review of planning, coordination and monitoring of HIV, other STIs and TB activities to ensure maximum impact and effective management/use of funds.
- Review of external donor support and technical assistance to the FSM to assess impact, relevancy to FSM context and alignment to FSM national strategies and priorities;

- Compilation and review of national reports such as the UNGASS and MDG Progress Reports; and of HIV, other STIs and TB national and state strategic plans;
- Review national and state grant proposals and work plans to ensure alignment with national and state priorities and grant compliance, including technical input when requested;
- Ensure open communication and dialogue between national and state coordinators; and
- Ensure appropriate engagement and input of non-government sector (i.e. NGOs, Community Planning Groups (CPGs), and private sector) in the overall planning, implementation and monitoring of national and state activities.

The NAC HOST is expected to advocate with traditional, community and political leaders; share information about the response to HIV (and STIS and TB) and enhance implementation across all areas of the response through generating dialogue and understanding. It has a specific role in reflecting on the effectiveness, priorities and resources necessary for a strong response.

The NACHOST has formally met three times since its establishment in August 2010. Members of the NACHOST were engaged in the workshops to develop the National Strategic Plan. NACHOST did not meet in 2015 due to funding reasons and plan to have one meeting in 2016 to get reorganize.

IV. Best practices

The GARPR review 2015 identified a range of 'best practices' in FSM national response. These include:

- Decrease in STI screening across the country; this is due to targeted testing intervention.
- An increase in locations for counselling and testing – with staff and peer educators available to support clients;
- An increase in the number of sites where health education information can be accessed through a health professional or peer educator, and as base for outreach work;
- An increase in condom distribution sites; as a result 31,299 condoms were distributed in 2015 respectively.
- An increased laboratory capacity, with more efficient testing of chlamydia and gonorrhoea arising from the purchase of the Probe-Tec machine in central location of Pohnpei. These laboratory services were also accessed from Kosrae and Chuuk. Additional laboratory staff had been recruited and systems for air freight and delivery established between each state and nearby Guam and Hawaii.

The perception of stakeholders during this review is that these practices have been maintained overall, although with some ongoing challenges.

During the discussions to compile the Global AIDS Progress Report, and to develop the National Strategic Plan, it emerged that one of the real strengths demonstrated in the response to HIV & STIs in FSM was the stronger focus on the approach to working with vulnerable populations.

In 2015, FSM has a much clearer idea about the populations who are at risk or vulnerable to HIV and STIs and how to ensure their access to services. It was developing programs to address these groups. This section will highlight some of these as best practice:

- Extension of work hours by Community Health Centers (CHC) from 5 to 7pm Monday to Friday and 8-12 noon on Saturdays. The extended clinic hours increases service provider option of Provider Initiative Counseling and testing to the clients on HIV and STIs.
- In Chuuk, a behavioral survey was undertaken to explore the nature of transactional sex work and the behaviors and motivations associated with the exchange of goods and services for sex.
- In Pohnpei, a program targeting commercial sex workers and their clients is evolving.
- Improved access to services for positive people through collaboration between prevention and clinical care in Pohnpei
- The roll-out of the presumptive treatment campaign in Chuuk.
- Capacity in performing CD4 count locally, which enable the program to be able to monitor CD4 count as required and know the patient status toward prescribed regimen.

Scaling up Prevention understanding and engaging vulnerable populations:

Example: Knowing your situation - Chuuk Survey on women who exchange sex for goods and money

In Chuuk, a growing awareness of the existence of a group of women who engaged in sex for the exchange of goods or money emerged through the work of the Youth Resource Centre. As a result, in 2009 the Chuuk Resource Centre began a behavioural survey which was completed in 2011. The behavioural survey is a starting point for developing appropriate services.

The survey of identified a population of 70 women who exchange sex for goods and money in Chuuk. The survey confirms that sex work in return for money or goods does occur in Chuuk – particularly among young single women. Their clients are most often young single men, government workers and business men. This sexual activity involved high risk behaviours: including multiple sexual partners, low condom use and low health seeking behaviours regarding testing and treatment for all STIs. There is also significant experience of other high risk sexual activity such as anal sex and forced sex – the latter more often perpetrated by neighbours or an intimate partner, such as a boyfriend. There is a discrepancy between high knowledge of protective behaviours (such as high levels of knowledge about

condoms etc.) and yet low use of condoms (often, the women reported, because the condoms were not easily available).

The report confirmed the need to strengthen the link between knowledge of HIV transmission and prevention to behaviour change; to create opportunities for these women to access health services free from stigma and discrimination and which maintain confidentiality. Most women who provide sex in exchange for money or other goods have no other form of income. Introduce alternative options for income generation.

The report recommended a range of strategies: establish a support network for transactional sex workers to discuss their experiences and strength advocacy on social and economic determinants; increase access and use of condoms – through review of peer educators approach and training, perhaps drawing on the Stepping stones problem solving approach; increase knowledge of all STIs and their symptoms to encourage early access to treatment.

This is another example where research into an identified risk group will be used to inform program development.

Scale up of treatment care and support: working in collaboration to improve access to treatment and care:

Example: MRC and Pohnpei State HIV & STI Program working together to conduct education and outreach while the HIV & STI Program visits clients.

MRC and DHSA have identified a collaborative approach to respecting the confidentiality of those living with HIV while also addressing stigma and discrimination in the communities in which these people live.

Stigma and discrimination is a continuing barrier to access to treatment and care services in FSM. Although small changes have been reported, it remains an ongoing challenge. One step in addressing stigma and discrimination is the collaborative approach development by MRC and DHSA to respecting the confidentiality of those living with HIV while also addressing stigma and discrimination in the communities in which these people live.

When three people in Pohnpei state were diagnosed with HIV, they asked the Pohnpei DHSA to respect their confidentiality and privacy. It was known, however that community members believe that someone was HIV positive because of the many visits by the DHSA staff to the community.

Knowing the people with HV and the community would need support, the DHSA public health unit contacted the MRC HIV coordinate to discuss an approach. They agreed that MRC would slowly start an HIV awareness campaign in the surrounding communities, focusing on minimizing stigma and discrimination in 2009, six outreach activities were conducted in these specific community, with follow up activities concentrating on STI and HIV screening.

The MRC established an informal support structure through a youth peer educator from the same community. This peer educator stays in contact with the people living with HIV and talks to the MRC HIV coordinator, when support is needed. The MRC then liaise with DHSA who in turn provide counselling access to ART, other clinical and pharmaceutical requirements.

The work by the MRC and DHSA in these communities is said to have led to a change in the way people interact and a reduction in fear. The trust and credibility established between the PLWH and the peer educator, alongside the collaborative relationship between the DHSA and the MRC Coordinator, are clear contributing factors in generating this change.

Scale up of treatment and care: addressing the link between HIV &STIs

Example: the roll-out of Chlamydia presumptive treatment in Chuuk to show link between STI as a risk factor.

The Chuuk State HIV & STI Program initiated the Chlamydia presumptive treatment campaign in September 2011. The Chuuk AHDP reported that the HIV & STI program initiated education and awareness outreach about the campaign to a wide-ranging group of stakeholders, including: high school students, community women; the Chuuk Women's Council; women church groups; ANC clients; the Chuuk Breastfeeding Association; local sex workers; young people at the Chuuk high school; and the state Government administration officers.

Training for health assistants and clinical nurses on the approach and procedures for the campaign was conducted. Brochures discussing the campaign, including a description of the rate of Chlamydia and fact sheets on Chlamydia, translated into Chuukese, were distributed, with support from SPC.

As noted earlier, the campaign has generated contact with significantly higher numbers of men and women than Chuuk has previously contacted through its syndromic approach to treatment of Chlamydia. However, it has not been with challenges. Some of the issues identified by the Chuuk HIV & STI Program include:

- delays in accessing funds to support the campaign, including funds for transport and fuel and volunteer time;
- difficulty in gaining the acceptance and credibility of clinicians, who were worried that some clients would resist medications without a test;
- and delays in getting results from the laboratory in Pohnpei.

As noted earlier, the other States are yet to fully implement the campaign. Chuuk's earlier roll-out of the Chlamydia presumptive treatment campaign provides an opportunity for other states to learn from Chuuk's implementation.

V. Major challenges and remedial actions

a) Progress made on key challenges reported in the 2013 Country Progress Report

Followings are some of the Challenges reported in 2013:

- Separation of responsibilities for funding, policy and service delivery between national and state levels makes coordination difficult
  - From lesson learned the program management has resolved this issue to some degree. Activities that are in the cylo or cross cutting activities for the New Funding Announcement for CDC the programs can picky bag each other to allow activities to be implemented without delay or interruption.

- Broader public health system with limited capacity.
  - Capacity building trainings attended annually by program staff in previous years have improved staff skills in the implementation of the program activities.
- Pay and working conditions makes it hard to recruit and retain skilled staff. Missing or poor quality data influences the quality of reporting
  - Program will continue to face this because salaries a in the legislation and have not change for many years. Pay scales are varied from state to state base on legislation and policy.
- Lack dedicated staff to collect data due to funding issues
  - Program expects to continue with this challenge as funding remain the same every year. This year the Sub Recipient (SR) position for the Global Fund under the NFM has moved to Department of Health and Social Affairs. For the national salaries since the program staff at the national is already paid by other source will recommend hiring two data clerks from GF for the two states without a data clerk.
- New Challenge encountered in 2015, the FSM law that mandating Federal and Foreign grants to be approved by resolution before grants fund can be utilized.

b) Challenges faced throughout the reporting period (-2015) that hindered the national response and the progress towards achieving targets.

Lesson learned from the development of Global AIDS Response Progress Report (GARPR) is that some indicators are relevant but, there is no data collected because the program is not aware of the indicator. This is one area that can be included in the GARPR Training provided by UNAIDS. Jurisdiction that responsible to write the report should know in advance all the indicators to report on in order to collect the data so it can be reported. The plan is to include in the reporting template for HIV/STI beginning of this year in order to be able to report in 2017. Another strategy is to do site visit to all states prior to report write up.

c) Remedial action plans to achieve agreed targets

Plan is to hire data person for the state program as mentioned above with the GF funding that do not have a data clerk. Train the staff on the GARPR indictors and have them collect the data and submit on a quarterly basis using HIV/STI reporting form. A M&E visit to be conducted before the GARPR development is also an option to validate and do verification of data in the states.

VI. Support from the country's development partners

FSM draws on extensive technical advice, with the support of CDC, WHO, HRSA and UNDP as well as the broader range of regional partners. The key areas of technical advice and capacity strengthening over the last two years included:

Prevention:

- CT training and accreditation(PCSS)
- Family Planning Guidelines (UNFPA)
- AHD Capacity Development
- Reproductive Health Commodities Training (UNFPA)
- Stepping Stones (Media) (SPC)
- BCC (SPC)
- 2015 GARPR Training (UNAIDS)
- Program Coordinators Training (DHSA)
- All Grantee Clinical Training and Workshop (CDC and HRSA)
- Annual Training for state program and HIV/STI physician (HAETC)

Governance:

- Training and Workshop on Governances (UNDP)
- PIRMCCM Annual Meeting (UNDP)
- Development of the National Strategic Plan (Burnet)
- Transformational Leadership and Development (UNAIDS)
- Women's Human Rights – CEDAW and Climate Change and Violence Against Women legislation (RRRT)
- Parliamentary Leadership on gender, climate change and HIV & AIDS (PLPG) (PPAPD)
- Financial management (UNDP)
- Financial Training (APIPA)
- Advocacy on Involvement of HIV+ people/reducing stigma and discrimination (CDC)

Surveillance, research and monitoring and evaluation

- Development of a new standardized data collection form for STI program (UNDP & CDC)
- Strengthen Laboratory based Surveillance (UNDP)
- Monitoring & Evaluation Capacity Building (UNDP)
- Global Fund Monitoring (UNDP)

The advent of the Pacific HIV & STI Response Fund, Global Fund, WHO, CDC, HRSA and UNAIDS has been a key platform for supporting ongoing capacity building over the last two years. With the prospect of RF and GF each fund expired in 2013 and FG in 2015, it is important to find out what will replace RF and for GF to communicate clearly and consistently with the national program to clarify the potential impact of this, particularly on capacity strengthening activities.

VII. Monitoring and Evaluation Environment

a) An overview of the monitoring and evaluation (M&E) system

The national HIV & STI Policy confirms that FSM-DHSA is charged with responsibility to collect, organise and analyse the HIV and AIDS case reports, the HIV Data quarterly report forma and the STI data Quarterly Report form and other information from the states on the status of HIV, AID and STI infections and disease[8]. DHSA carries responsibility to use this information and analysis to;

- Inform government leaders, the public and relevant international partners of progress in addressing HIV & STIs within FSM
- Identify need for additional technical or financial support
- Mobilize technical and financial support
- Repot on progress to external funders.

b) Challenges faced in implementing a comprehensive M&E system

There is no national legislated agreement on data sharing with the major funders, although the HIV/STI program is now using a common format for data collection developed and agreed with CDC, HRSA and UNDP. At state level only Pohnpei has legislation defining surveillance obligations. No other states have legislation in relation to data collection and reporting.

Program staff at the state level has limited or no knowledge, and skills in conducting M&E due to lack of training and staff turnover.

c) Remedial actions planned to overcome the challenges

In view of these challenges, there is need to create more legislation and policies on the reportable diseases and unified reporting. Training on M&E activity in the states to different key staff is needed.

There are currently two key sources of data available to assist in analysis of the effectiveness of national response.

In the first instance, the National HIV & ST Program maintains a routine case surveillance system for the collection and analysis of HIV and STI data collected by the

[8]Insert reference to policy.....

state HIV & STI programs. This information is collected quarterly. The quality of the data varies across the States.

Secondly, the National HIV & STI Programs routinely submit program reports to the key funders, in compliance with funding requirements. These reports are usually required on a six monthly basis. Given the current range of grants, this can mean up to 12 reports in a year.

d) Highlight, where relevant, the need to M&E technical assistance and capacity-building.

The Mid-Term Review conducted in 2010 identified that the national response would be strengthened by building capacity at national and state level to plan, monitoring and evaluate. As part of this, it recommended that the national program should review current systems for monitoring and evaluation to:

- Identify what data is currently collected and reported;
- Identify any gaps in data collection;
- Identify how data is currently analyzed, for what purpose;
- Identify reporting requirements – at national and state levels, amongst donors;
- Streamline current systems for collection, analysis and reporting;
- Review and adjust programs in response to analysis of the data.

FSM support the outcome of this mid-term finding and recommendation and push forward for action in the future.

During 2013, the National HIV and STI program adopted a revised reporting template.

In 2013, the National Program established a new position for surveillance officer to collect, compile and report on data for all five programs under the Program, Collaboration, Service Integration (PCSI) and monitoring and evaluation of the response on HIV and STIs.

ANNEXES

Annex 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the 2011 Declaration of Commitment on HIV/AIDS

The process for compiling the report was initiated in early February 2016 when UNAIDS (Suva) invited the FSM Focal Point to submit the Global AID Response Progress Report (GARPR). February 29 to March 4 2016 a Training was conducted by UNAIDS in Nadi, Fiji to inform countries of the new Guideline and Indicators to be reported covering January to December 2015. Later that month Focal Point was inform of the due date extension to April 8, 2016. Following the training the Focal Point, Surveillance Officer and The HIV/AIDS Program Specialist got organize and agreed to write the report.

A work plan was then agreed between the UNAIDS office and the Focal Point by email communication. Following the consultant's arrival, a one day meeting was convened with a small working group consisting of the national manager, the national surveillance officer and national finance specialist to discuss the process and agree on responsibilities for compiling the report.

Given the constraints of geography across the four states and timeline for completion of the report and competing program priorities, it was agreed that data would be collected by four key means:

1) Review of existing program reports and other documentation relevant to the 2014 reporting period
2) Review of the financial data available in relation to the key funders
3) Review of the GARPR indicators
4) Review of available surveillance and other data to compile the indicators

The National HIV Program Manager undertook responsibility for working with colleagues to source all relevant program reports and supported by the national Surveillance Officer who task to upload the on line indicators. The HIV Program Financial Specialist, working with colleagues at state and national level, sourced all relevant financial data. The FSM team reviewed the most recent review of the response, the Mid-Term Review in 2010-2011, and data for the recent strategic planning workshops in 2013. Together, all these sources of data were drawn upon to compile the response to the indicators to develop the narrative report.

Information in response to the indicators was discussed with the National Manager and uploaded. Information for the funding data was discussed with the Finance Specialist, prior to compilation and the final draft forwarded to the Finance Manager for endorsement prior to upload. During the process the team comes across a problem where the financial report cannot be uploaded. The team consulted the UNAIDS office and advised to submit the electronic copy to UNAIDS office who took the liberty on behalf of FSM team and upload. The upload was successful. Lastly, the draft narrative report was circulated to the Secretary of Health and Social Affairs, National Director for Communicable Disease Programs and, State Coordinators for HIV and STI Programs for their review and comment.

Annex 2: Indicator 6.1 AIDS spending – at aidsspending@unaids.org or refer to page 28 on this report.

HIV/AIDS PROGRAMS 2015 SPENDING DETAIL										
INTERNATIONAL FUNDING SOURCES										
Program/Target Indicators		%centage	Total per Indicator	Bilateral			Multilateral			
				HIV PREVENTION	HIV SURVEILLANCE	RYAN WHITE PART B SUPPLEMENTAL GRANT	GLOBAL FUND/MHRDC	WHO	SPC/REGIONAL PHARMACIST	
1	Prevention (Sexual Transmission of HIV)	6.40%	$ 22,047.45	$ 22,047.45	$ -	$ -	$ -	$ -	$ -	
1.1	Behaviour change Programmes			2,722.45		-	-	-	-	
1.2	Condom Promotion			-		-	-	-	-	
1.1	Community Mobilization			19,325.00		-	-	-	-	
2	Prevention of IDU	0.00%	$ -	-	-	-	-	-	-	
3	Prevention MTCT	0.03%	$ 87.20	-	-	-	-	-	87.20	
4	Universal Access to Treatment	14.32%	$ 49,307.01	2,786.00	-	34,055.31	-	-	12,465.70	
4.1	HIV Testing/Test Kits			2,786.00	-	-	-	-	10,737.00	
4.3	Adult antiretroviralTreatment/Meds			-	-	26,213.62	-	-	1,728.70	
4.4	Support & Retention(Fuel/food-RWHAP Part B)			-	-	7,841.69	-	-	-	
5	Tuberculosis	0%	$ -	-	-	-	-	-	-	
6	Governance & Sustainability	79%	$ 272,827.42	202,843.19	17,152.00	13,054.12	39,778.11	-	-	
6.2	Planning & Coordination			127,086.19	17,152.00	7,059.00	35,897.07	-	-	
6.3	Procurement & Logistics			21,904.79	-	633.12	1,131.04	-	-	
6.4	Health Systems Stengthening			53,852.21	-	5,362.00	2,750.00	-	-	
7	Critical Enablers	0%	-	-	-	-	-	-	-	
8	Synergies with Development Sector	0%	-	-	-	-	-	-	-	
TOTAL per Program		100.00%	$ 344,269.08	$ 227,676.64	$ 17,152.00	$ 47,109.43	$ 39,778.11	$ -	$ 12,552.90	