GLOBAL AIDS MONITORING REPORT FOR THE FEDERATED STATES OF MICRONESIA

Department of Health Services 2017

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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.

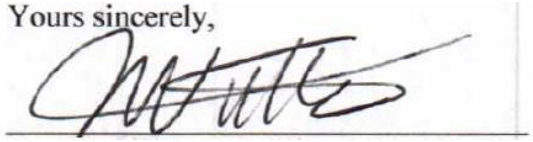
The HIV program supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria and Communicable Disease & Control (CDC), enabled our country to successfully implement the aims and activities in defined in the National AIDS Strategy 2013-2017. Moreover, this program contributed to the capacity building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

This GAM for 2017 demonstrates and summarizes the overall national efforts undertaken in the 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.

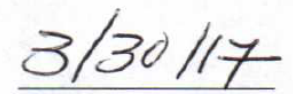
With this report, we hope to increase our commitment in reducing stigma and discrimination towards people living with HIV/AIDS and to reduce gender-based violence, issues that lie beyond HIV infection that influences negatively the well-being of the population of our country.

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 GAM 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 March 30th, 2017. The technical support for the write up is provided from the UNAIDS Office in Suva, Fiji.

This report was coordinated by the national Team, Medical Director, 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, 2016 Pacific Multi-Country Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations held in Chuuk and Pohnpei, 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.

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I. Status at a glance

a) Inclus*iveness* of the stakeholders in the report writing process

The process for compiling the report was initiated early January to March 2017 when UNAIDS (Suva) informed the FSM Focal Point to submit the Global AID Monitoring (GAM) report for 2017. The training provides the Pacific focal person and the Surveillance Officer that attended the meeting in Suva on the Regional HIV and STI. Following the training in Fiji FSM team got organized and started the process of report writing and data gathering from all four states in the FSM. 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.

After several email and skype calls with Ms. Gabriela Ionascu, the focal point person 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:

Review of existing program reports and other documentation relevant to the 2016 reporting period

1) Review of the financial data available in relation to the key funders
2) 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 Surveys, 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) Policy and programmatic response

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

I. 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.

II. 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;

III. 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

IV. 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.

(a) Indicator data in an overview table (below).

LIST OF REPORTED INDICATORS

Indicators for Commitment 6 and 7 will be reported starting with 2018

Indicator	Value 2017	Source	Comments
COMMITMENT 1: Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020			
1.1 Percentage of people living with HIV who know their HIV status at the end of the reporting period	100%	PUDR	All 12 living cases new their status or at least informed of their HIV + status.
1.2 Percentage and number of adults and children on antiretroviral therapy among all adults and children living with HIV at the end of the reporting period	50%	PUDR	Only 6 + cases on ART among the 12 living cases.
1.3 Percentage of adults and children living with HIV known to be on antiretroviral therapy 12 months after starting	4	PUDR	Only 4 on ART after 12 months for the 12 cases living.
1.4 Percentage of people living with HIV who have suppressed viral loads at the end of the reporting period	0	Pt. code	No VL done yet. Now that the FSM have the capacity to do VL, it will be taken this year.
1.5 Percentages of people living with HIV with the initial CD4 cell count <200 cells/mm3 and <350 cells/mm3 during the reporting period	0	Pt. code	No CD4 done, with same explanation above
1.6 Percentage of treatment sites that had a stock-out of one or more required antiretroviral medicines during a defined period	0	HIV/STI QR	No stock out reported. If any it will be reported int he HIV/STI Quarterly Report.
1.7 Total number of people who have died from AIDS-related causes per 100 000 population	1	HIV/STI QR	1 reported death in 2016
COMMITMENT 2: Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018			
2.1 Percentage of infants born to women living with HIV receiving a virological test	0	HIV/STI	No pregnant women

for HIV within two months of birth		QR	reported
2.2 Estimated percentage of children newly infected with HIV from mother-to-child transmission among women living with HIV delivering in the past 12 months	0	HIV/STI QR	Same as above
2.3 Percentage of pregnant women living with HIV who received antiretroviral medicine to reduce the risk of mother-to-child transmission of HIV	0	HIV/STI QR	Same as above
2.4 Percentage of women accessing antenatal care services who were tested for syphilis, tested positive and treated	0	HIV/STI QR	Same as above
2.5 Percentage of reported congenital syphilis cases (live births and stillbirth)	0	HIV/STI QR	None reported this period.
COMMITMENT 3: Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations—gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners			
3.1 Number of people newly infected with HIV in the reporting period per 1000 uninfected population	0.0357	HIV/STI QR	2 new cases reported this pd.
3.2 Size estimations for key populations	630	UNSW	MSM/TG 340 +290 FSW from the study done by UNSW in 2016
3.3a Percentage of sex workers living with HIV	0	HIV/STI QR	Not reported per HIV/STI QR this period
3.3b Percentage of men who have sex with men who are living with HIV	1	Same	One from the two reported were is MSM.
3.3d HIV prevalence among transgender people	1	Case report form	One of the reported cases in 2016 was a TG per case report.
3.3e Percentage of prisoners/inmates/detainees who are living with HIV	0	HIV /STI QR	None of the two were from these categories.
3.4a Percentage of sex workers who know their HIV status	0	Same	None of the two reported from this group
3.4b Percentage of men who have sex with men who know their HIV status	9.1	Case report	The one reported with

			MSM know his status
3.4d Percentage of transgender people who know their HIV status	100%	Case report	This one with TG know his status
3.5a Percentage of sex workers living with HIV receiving antiretroviral therapy in the past 12 months	0	HIV/STI QR	No re port on this group this period.
3.5b Percentage of men who have sex with men living with HIV receiving antiretroviral therapy in the past 12 months	0	HIV/STI QR and case report	The MSM case reported in Sept. And so it not yet 12 mos.
3.5d Percentage of transgender people living with HIV receiving antiretroviral therapy in the past 12 months	0	Same	This is the same case with MSM above.
3.5e Percentage of prisoners living with HIV receiving antiretroviral therapy in the past 12 months	0	HIV/STI QR	None of the cases reported from this category.
3.6a Percentage of sex workers reporting using a condom with their most recent client	9.5	HIV/STI QR	The two cases reported were not SW
3.6b Percentage of men reporting using a condom the last time they had anal sex with a male partner	0	HIV/STI QR	No report made on this activity
3.6d Percentage of transgender people reporting using a condom during their most recent sexual intercourse or anal sex	36.4	Same	Not reported in the quarterly report
3.7a Percentage of sex workers reporting having received a combined set of HIV prevention interventions	7.1	Same	Not reported in the QR
3.7b Percentage of men who have sex with men reporting having received a combined set of HIV prevention interventions	0	Same	Not reported in the QR
3.11 Percentage of sex workers with active syphilis	0	Same	No report captured in the QR on this activity
3.12 Percentage of men who have sex with men with active syphilis	0	Same	No Report captured in the QR on this activity
3.13 HIV prevention and treatment programmes offered to prisoners while detained	0	Same	None of the HIV positive are in detention
3.14 Prevalence of hepatitis and coinfection with HIV among key populations	0	Same	Not reported in QR per activity mentioned
3.15 Number of people who received PrEP for the first time during the calendar year	0	Same	No one is on PrEP this reporting period

3.16 Percentage of men 15-49 that are circumcised	0	Same	No report made on this indicator
3.17 Annual number of males voluntarily circumcised	0	Same	No report made on this activity this period. If any it will show in the QR.
3.18 The percentage of respondents who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months.	0	HIV/STIQR	If any it will show in the QR. No report made.
COMMITMENT 4: Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020			
4.1 Percentage of women and men aged 15-49 who report discriminatory attitudes towards people living with HIV	0	N/A	No information collected on this indicator
4.2a Percentage of sex workers who avoided seeking HIV testing because of fear of stigma, fear or experienced violence, and/or fear or experienced police harassment or arrest	0	N/A	No information collected nor survey known on this indicator
4.2b Percentage of men who have sex with men who avoided seeking HIV testing because of fear of stigma, fear or experienced violence, and/or fear or experienced police harassment or arrest	0	N/A	Same as above
4.2d Percentage of transgender people who avoided seeking HIV testing because of fear of stigma, fear or experienced violence, and/or fear or experienced police harassment or arrest	0	N/A	Same as above
4.3 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	0		No information collected nor survey known to collect this indicator
COMMITMENT 5: Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100 000 per year			
5.1 Percentage of women and men 15-24 years old who correctly identify both ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission	0	N/A	Indicator is relevant but information collected per this indicator.

5.2 Percentage of women of reproductive age (15-49 years old) who have their demand for family planning satisfied with modern methods	0	Relevant	No information collected per this indicator
COMMITMENT 8: Ensure that HIV investments increase to US$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enable			
8.1 HIV expenditure - Annex	N/A	Relevant	Refer to counter finance report attached.
COMMITMENT 9: Empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violations of human rights			
9. National Commitments and Policy Instrument – Annex	N/A	Relevant	But no policy made yet to address this indicator
COMMITMENT 10: Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C			
10.1 Percentage of estimated HIV-positive incident tuberculosis (TB) cases that received treatment for both TB and HIV	0	PCSI report	No pt. That with both TB and HIV together.
10.2 Total number of people living with HIV with active TB expressed as a percentage of those who are newly enrolled in HIV care	0	HIV/STI QR	Indicate now HIV & TB co-infection in the report.
10.3 Number of patients started on treatment for latent TB infection, expressed as a percentage of the total number newly enrolled in HIV care during the reporting period	0	HIV/STI QR	In the HIV/STI report did not indicate and co-infection
10.4 Number of men reporting urethral discharge in the past 12 months	0	Relevant	Reported last year that will try to collect data on this indicator but still with no success yet.
10.5 Rate of laboratory-diagnosed gonorrhoea among men in countries with laboratory capacity for diagnosis	6%	HIV/STI QR	Reported 1082 get tested and 66 were positive.
10.6 Proportion of people starting antiretroviral therapy who were tested for hepatitis B	0	Same	No pt. On ART tested for Hep B.
10.7 Proportion of people coinfected with HIV and HBV receiving combined treatment	0	Same	No co infection of HIV and Hep B cases reported this period.

10.8 Proportion of people starting antiretroviral therapy who were tested for hepatitis C virus (HCV)	0	Same	No report made on this indicator.
10.9 Proportion of people coinfected with HIV and HCV starting HCV treatment	0	Same	Same
10.10 Proportion of women living with HIV 30−49 years old who report being screened for cervical cancer using any of the following methods: visual inspection with acetic acid or vinegar (VIA), Pap smear or human papillomavirus (HPV) test	0	Same	No co infection reported this reporting period per this indicator.

II. Overview of the AIDS Epidemic

a) Status of the Epidemic

With 50 cases reported since the beginning of the HIV-AIDS epidemic in 1989, FSM is considered to have a low prevalence of HIV. There are 12+ 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 2016 reported 2 new diagnosed HIV cases. The two new cases started on treatment immediately after they were confirm +. Both CD4 count and Viral Load test are now available locally since July 2016. Confirmation test is done locally with the algorithm. 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.

In 2016 University of South Welles conducted a study in FSM targeting two states, Chuuk and Pohnpei entitled Pacific Multi-Country Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations. The study reveals four areas of finding. First, The Federated States of Micronesia (FSM) has a low prevalence generalized HIV epidemic. This study collected data from two populations considered to be particularly vulnerable to infection: transgender/men who have sex with men (TG/MSM) and female sex workers (FSW). Second, It was estimated that there are 340 TG and MSM in the states of Chuuk and Pohnpei. This estimate includes men who have sex with men but who might identify as

heterosexual. Third, service providers and key informants estimated that there are 40 FSW in Pohnpei and at least 250 FSW in Weno and the outer islands of FSM. Fourth, this study captured the first ever behavioral survey and interview data from MSM and TG in FSM.

b) 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]

c) 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.

d) 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 locations are based on population size, 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

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

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 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 the 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
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. This commitment has been fulfilled and as a result

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:

1. 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.

2. 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;
3. 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.
4. 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. The idea of reconvening the NACHOST in 2016 did not happened due to funding reason. Instead, the National and State Program Coordinators met once and the National team trained the state coordinators and data clerks on program objectives, data collection and reporting. Emphasis on Quality reporting was provided to ensure completeness, accuracy and timely submission of report.

In 2016 FSM has scaled up the intervention on the following areas:

- Prevention – HIV testing the focus is to do targeted testing approach. The testing has changed from encourage testing and this is why the testing data has decreased from 9,000 + from previous years to 7,541 test in 2016. Targeted testing is made on outreach activities to test the Key Affected Populations, like MSM, SW, IDUs and Transgender populations.
- Treatment, Care and Support - Treatment has switch from useing CD4 count and Western blot confirmatory test to start on treatment, but test and treat and using confirmation with the algorithm approach. As a result of this approach, there is increase in number of HIV + cases that are placed on ARTs and start early.
- Knowledge and behaviour change – Community outreach activities to improve public awareness on HIV and STI prevention messages, condom distribution, and IEC materials distribution were increased to target high risk, remote and unreached areas

IV. COMMITMENT

COMMITMENT 1: Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020

At the end of 2016 there were twelve (12) HIV positive cases reported living and residing in FSM. Of the 12 cases 6 of them were on ART and 6 either started and quit or refused to be on treatment. This is one challenge that FSM faced with in the care and treatment support for the HIV program. FSM has gone as far as inviting AIDS ambassadors from Fiji to also join the program staff in explaining the importance of treatment and regardless of this support some of the cases still are not on treatment. FSM staff continues to counsel and motivate them to be on treatment. Early 2017 four of the cases resumed on treatment which made 10 currently on treatment except two. Of the 12 living, six are males and 6 are females. Of the ten cases that are on treatment, six are males and four are females.

Adherence is improved with success rate 8%. ART is provided by Global Fund mechanism and is distributed at the point of care which is the state health department where the cases are situated or located. Currently, 11 cases are from Ponpei State and only one is from the state of Chuuk. Chuuk State HIV positive client was detected in 2003, started on treatment, and quit the same year and refused to restart till now. The other that is not on treatment lost to follow up. FSM now have the capacity to run both CD4 and Viral Load as of July of 2016. The reported cases have not had the CD4 count test but staff has planned to have initial test done with both test. FSM is now using the WHO and CDC treatment guideline.

COMMITMENT 2: Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018

For this reporting period no case of PMTCT reported. FSM is following the WHO and CDC PMTCT guideline. When there is a case, mother should be on treatment and when the new born baby is born will follow the treatment guidelines, meaning child will be tested and treatment will be initiated. Treatment regimen will also follow the WHO and CDC guideline. ARVs are provide and available in country by GF.

Challenges that FSM anticipate to face would be how the baby is to be deliver. This could happens when the Physician decide to do C-section at later stage. The delivery package has to be ordered and staff that will perform the procedure will need to be on prophylaxis. The main challenge is when decision is made late.

COMMITMENT 3: Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations—gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners

In 2016, University of South Welles (UNSW) conducted a project called Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations in FSM. The study aims to:

- Understand the size of populations vulnerable to HIV in Chuuk and Pohnpei state.
- Undertake a contextualized and comprehensive HIV risk vulnerability analysis of these populations
- Critically evaluate current HIV prevention services for ky populations and access to them and
- Appraise existing structures/institutions providing support for HIV activities.

The project employed a variety of methods in a cross-sectoral (snapshots) design which includes the following activities:

- Population size estimation
- A behavioural survey to capture quantitative information form key populations about sexual behaviour, mobility, drugs and alcohol, STIs, and stigma and discrimination as well as access to and assessment of services.
- In-depth interviews with members of key populations. These in-depth interviews will collect qualitatively reach data, and are intended to identify and map a range of key populations circumstances and experience.
- Interviews with stakeholders to assess the capacity of service and other organisations to undertake HIV prevention services to reduce HIV risk vulnerability amongst MSMs, TG people and female sex workers, and to assess opportunities to scaling up service delivery.

Challenges

- The UN categories (MSM and TG, and FSW) do not easily translate in the realities of Pacific lives and work.
- Ways of doing research in large countries also do not translate easily to those in small islands states.
- The size and hidden nature of key populations meant it was very difficult to carry out a BSS and even to interview sex workers in particular (in one case, Palau, even this filed).
- In many of the islands there were at best only nascent MSM/TG organizations and no sex workers organizations such as SAN in Fiji.
- The short timeline (10 months from start to finish) meant that we had to make difficult decisions about where to focus attention.

The Benefits

- For the first time in many of these countries, we have data that can be used for UN reporting
    - HIV prevention (measure by knowing where to go for HIV testing; been given condoms in the last 12 months)
    - Condom use at last sex
    - HIV testing in the last 12 months

- This qualitative data has given us insights into the lives and experiences of those people most at risk of HIV, many of whom are marginalized and criminalized.
- We can show that the Pacific is diverse and that one size fits all IV prevention is problematic and not helpful.

Results

Data collected during this study			
Men who have Sex with Men and Transgender		**Female Sex Workers**	
Survey participants	Interviews	Survey participants	Interviews
375I	52	275	48

COMMITMENT 4: Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020

In March of 2009 a report released on HIV, Ethics and Human Rights as a result of a joint project of UNND Pacific Centre, Regional Rights Resource Team SPC and UNAIDS highlighted on the principal of Human Rights relevant to HIV include:

- The right to no-discrimination, equal protection and equality before the law
- The right to life
- The right to the highest attainable standard of physical and mental health
- The right to liberty and security of the person
- The right to freedom of movement
- The right to seek and enjoy asylum
- The right to privacy
- The right to freedom of opinion and expression and the right to freely receive and impart information
- The right to freedom of association
- The right to work
- The right to marry and found a family
- The right to equal access to education
- The right to an adequate standard of living
- The right to social security, assistance and welfare
- The right to share in scientific advancement and its benefits
- The right to participate in public and cultural life

- The right to be free from torture and cruel, inhuman or degrading treatment or punishment.

Since the first case was detected in 1989, FSM HIV Program under the Department of Health and Social Affairs has been working hard to develop policy that will address security and safety for people living with HIV and AIDS. In 2009 the first HIV/STI policy was developed. Since then Pohnpei State have passed a law on HIV/AIDS and this legislation is also address safety of HIV + clients.

The Pohnpei HIV Prevention and Care Act 2007 in many respects provides a model for a rights-based approach to HIV for the other states in FSM and the Pacific region. It could be improved by

- Making civil remedies available for HIV related discrimination as an alternative to a prosecution. This would mean that a lower standard of proof would be required than a prosecution and would ensure that people wronged by discrimination have access to compensation or other remedies such as reinstatement.
- Strengthening the requirements for contact tracing such that it may only occur where:
    - Counselling of the HIV-positive patient has failed to achieve appropriate behaviour change;
    - The HIV-positive patient has refused to notify or consent to notification of the partner;
    - a real risk of HIV transmission to the partner exists;
    - the identity of the HV-positive partner is concealed from the partner where this is possible;
    - necessary follow-up support is provided to those involved.

Federal Health Regulations were not available for analysis. If HIV and AIDS appear in the Health Regulations, public health legislation relating to isolation and quarantine is inappropriate for their management. This applies also to current policies regarding screening of groups such as food handlers and immigrant's workers.

To avoid ambiguity, it is recommended that legislation guarantee that Constitutional right to equality between men and women take precedes over customary law in relation to inheritance and property.

The offences in Chuuk and Pohnpei relating to prostitution involving consenting adults in private, and the lack of provision for an offence for marital rape contravene human rights and are harmful to the status of women. The offence of abortion in Chuuk, Kosrae and Pohnpei contravenes the rights of women and girls to make their own reproductive choices.

Introducing a no fault model of divorce and allowing for women's non-financial contributions to a marriage to be taken into account in property proceedings after separation would improve women's social and economic status, and reduce HIV vulnerability. Women may be reluctant or afraid to seek divorce if they are required to prove fault. De facto relationships including same sex partnerships should be recognised by law.

It would be beneficial to develop a Code of Practice on HIV and employment, drawing on the International Labor Organization Code of Practice on HIV/AIDS. A Code of Practice should be developed that promotes universal infection control procedures in health care settings, confidentiality and non-discrimination in workplaces.

Blood safety legislation similar with Pohnpei, is required in all states or nationally.

Legislation to ensure that condoms and HIV test kits comply with international quality standards is required. Condoms and HIV/STI prevention information should be available in prisons.

COMMITMENT 5: Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100 000 per year

Public awareness on HIV and STI prevention is one of the HIV prevention activities that is an ongoing activity implemented annually and is conducted by department of Health HIV prevention program staffs, Red Cross, College of Micronesia (COM) and Chuuk Women Council in the state of Chuuk. This activity is also done annually during the World AIDS Day December 1st. The condom distribution and proper condom used is also an ongoing activity conducted annually to target young people and most especially the Key Populations and pregnant women. Young people at age 13 do not need parenteral consent in some states by law. In some religion the only birth control that is acceptable is the rhythm birth control method. Culture does not accept taboo and this is a disgrace to the family if reported.

COMMITMENT 8: Ensure that HIV investments increase to US$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enable

FSM is receiving support fund from various agencies such as The U.S. Center for Disease Control (CDC), Human Resource and Service Administration (HRSA) and Global Fund. CDC annual support fund to the FSM includes the HIV/AIDS Prevention Program in the amount of $225,206.00, and HIV Surveillance Grant in the amount of $17,152.00 while HRSA, Part B Supplemental Grant in the amount of $50,000.00 and Global Fund in the amount of $430,753.00 support prevention, control and treatment. These amounts are allocated to Salaries and wages, Fringe Benefits, Travel, Equipment, Supplies and Materials, Consumables, and Contractual Services. Detail allocation and expenditure can be found in the financial report attached in this report. In-kind contribution which includes administrative assistance, office space from the FSM DHSA Secretary's Office is considered replacement of monetary support from the department. The FSM budget remains the same for the past five years and will remain the same until December 2017.

COMMITMENT 10: Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C

In 2013 a new FOA was release that is called New Integrated FOA. This is a five years project funded by CDC were all five communicable diseases are merged. The five programs are:

- HIV/AIDS Prevention
- HIV Surveillance
- Viral Hepatitis B
- Tuberculosis
- Sexually Transmitted Disease

These five programs are also named Program Collaboration and Service Integration (PCSI). The management of the PCSI is under the Overall Responsible Party (ORP). Reporting is less with one person responsible to do the report and to ensure all activities are implemented according to the cooperative agreement for the grants. The only thing that is now consolidate is the budget, what is for HIV must be used for HIV activities, but for cross cutting activities can be shared among the five programs. FSM follows the WHO and CDC treatment guidelines for all disease components.

V. The situation with human rights in relation to HIV

Human rights have great impact on the improvement of how people view HIV in Micronesia. Understanding of the transmission and availability of Treatment also have helped in decreasing the stigma and discrimination. More + HIV cases are now on treatment and they are eligible for food bank or nutritional supplement that RW program provides the HIV + are more visible and not hidden anymore. The come to clinic to receive not only treatment but to pick up their food bank support that provide by the RW Care.

VI. Best practices

The GARPR review 2016 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.

FSM now have the capacity to perform CD4 count and Viral Load test locally, which enable the program to be able to monitor CD4 count as required and know the patient status toward prescribed regimen. This new development allows early treatment and care to HIV + cases.

VII. Major challenges and remedial actions

Followings are some of the Challenges reported in 2016:

a) Progress made on key challenges reported in the 2016 Country Progress Report.

- Grant Award to be approved by resolution before funds can be used by program for implementing activities.
- Separation of responsibilities for funding, policy and service delivery between national and state level 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 (2016) 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.

VIII. 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)
- 2016 GARPR Training (UNAIDS)
- Program Coordinators Training (DHSA)
- All Grantee Clinical Training and Workshop (CDC and HRSA)

Governance:

- Training and Workshop on Governances (UNDP)
- PIRMCCM Annual Meeting (UNDP)
- Transformational Leadership and Development (UNAIDS)
- Parliamentary Leadership on gender, climate change and HIV & AIDS (PLPG) (PPAPD)
- Work Plan and Budget (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.

IX. 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 form and the STI data Quarterly Report form and other information from the states on the status of HIV, AID and STI infections and disease. 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 legislation 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 less knowledge, and skills in conducting M&E due to lack of training and staff turnover. The government complex structure, where there is national and state is a challenge in the implementation

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 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 evaluation. As part of this, it is 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 FTE position for surveillance officer to be responsible 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. This is a great accomplishment and data flow to national has improved in terms of quality data.

ANNEXES:

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 2017 when UNAIDS (Suva) informed the FSM Focal Point to submit the Global AID Response Progress Report (GARPR) which now changed to Global AIDS Monitoring GAM. November 2016 short Technical Assistance and process was conducted in Suva, Fiji to FSM Focal Point and the Surveillance Officer. Early 2017 the guideline and report write up was provided and FSM Team move on with the development of the GAM.

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