



Federated States of Micronesia

Global AIDS Response Progress Report 2012

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Table of Contents

- 1. Status at a glance**
- 2. Overview of the AIDS epidemic**
- 3. National response to the AIDS epidemic**
- 4. Best practices**
- 5. Major challenges and gaps**
- 6. Recommendations**
- 7. Support from the country's development partners (if applicable)**
- 8. Monitoring and evaluation environment**

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

ANNEX 2: National Commitments and Policy Instrument (NCPI)

ANNEX 3: National Funding Matrix

I. Status at a glance

(a) the report writing process and the inclusiveness of the stakeholders in this process

The process for compiling the report was initiated in December 2011 when UNAIDS (Suva) invited the FSM Focal Point to submit the Global AID Response Progress Report (GARP). Following negotiation of the dates for the consultants field visit, the Focal Point attended the GARP training workshop offered by UNAIDS and SPC in Fiji in January. Following the workshop, the focal point held a meeting of national and state programs, where he distributed the guidelines on the indicators and the NCPI survey.

A work plan was then agreed between the consultant and the Focal Point by email communication. Following the consultant's arrival, a meeting was convened with a small working group consisting of the national coordinator, the national M&E officer and national finance manager 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 2010-2011 reporting period
- 2) Distribution of a word version of the NCPI survey (Part A and B) to the relevant state coordinator for completion at the state level by a small group of key stakeholders including state government representatives and the local community planning groups
- 3) Review of the financial data available in relation to the key funders
- 4) Review of available surveillance and other data to compile the indicators

The National HIV Program Coordinator undertook responsibility for working with colleagues to source all relevant program reports and distribute the NCPI Survey, supported by the national M&E Officer. The Finance Officer, working with colleagues at state and national level, sourced all relevant financial data. The consultant reviewed the most recent review of the response, the Mid-Term Review in 2010-2011, and data from two recent strategic planning workshops over the 2011-2012. 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 Coordinator and uploaded, then reviewed by the Coordinator. 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. The NCPI Surveys were aggregated; and the final draft shared with the National Coordinator for endorsement and comment prior to upload. Lastly, the draft narrative report was circulated to the NACHOST - the governing committee which oversees the response across FSM - for their verification.

The final draft of the Report, with attachments, was revised by the consultant then returned to the National HIV Program Coordinator and his team for upload.

(b) the status of the epidemic

With 38 cases reported since the beginning of the HIV-AIDS epidemic in 1989, FSM is considered to have a low prevalence of HIV. There are currently 6 cases living with HIV in FSM. Heterosexual contact is the predominant mode of transmission although male-to-male-sex and mother-to-child transmission have been significant modes of transmission throughout the epidemic as well. Routine case surveillance through the last 2 years shows only one new case, despite an increase in overall numbers screened for HIV.

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.

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 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) the policy and programmatic response

FSM's National Strategic Plan 2007-2011 expired in the last year of this reporting period. Two workshops were held over the last three months to draft the next National Strategic Plan 2012-2017. The draft 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:

Country Progress Report - Federated States of Micronesia - 2012

- 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 response fund and global fund, as well as the US federal grants, or identifying alternate funding sources to replace the SPC/Global funds should they dissolve in 2013 as currently forecast, is critical.
- 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 draft Plan will be finalised and circulated for verification by the NAC-HOST by the end of April, 2012.

(d) indicator data in an overview table

Targets	No.	Indicator	Applicable ¹	Source	Status	Comment
Target 1: Reduce sexual transmission of HIV by 50% by 2015						
<i>General population</i>	1.1	% of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	Yes	SGS in FSM Survey 2006-2008: Behavioral Survey of Youth, Pohnpei 2008	26% of 275 young women and men aged 15-24years in Pohnpei FSM correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission	Data limited – best available
	1.2	% of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Yes	SGS in FSM Survey 2006-2008 - Behavioral Survey of Youth,	26.9% of 275 young women and men aged 15-24 have had sexual intercourse before the age of 15 years	Data limited – best available

¹ The indicator was deemed applicable if it is considered that the **topic** is relevant to the situation in FSM even if the required data to address the formula is either not available or unreliable for a range of reasons, including the absence of significant population estimates to provide meaningful responses or the absence of verifiable data relating to the reporting period.

Country Progress Report - Federated States of Micronesia - 2012

Targets	No.	Indicator	Applicable ¹	Source	Status	Comment
				Pohnpei 2008		
	1.3	% of adults aged 15-49 who had more than one sexual partner in the past 12 months	Yes	SGS in FSM Survey 2006-2008: STI Prevalence Survey of Prenatal Clinic Attendees in Pohnpei 2008; Behavioral Survey of Police, Pohnpei, 2007	15.3% of 248 prenatal women aged 15-49 had more than one sexual partner in the past 12 months 45.9% of 114 male police reported having multiple sex partners in the last 12 months	Data limited – best available
	1.4	% of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during last intercourse*	Yes	SGS in FSM Survey 2006-2008: STI Prevalence Survey of Prenatal Clinic Attendees in Pohnpei 2008; Behavioral Survey of Police, Pohnpei, 2007	50% of 248 prenatal women who reported sex with multiple partners <u>in their life time</u> reported never having used a condom. Of those police reporting casual sex in the last 12 months (30), none reported using a condom. Of those 26 police (n=114) reporting sex with both a live in and a casual partner in the past 12 months, 65.4% reported never using a condom with their live in partner and in the past 12 months and 76.9% reported never using a condom with their casual sex partner in the past 12 months.	Data limited – best available
	1.5	% of women and men aged 15-49 who received an HIV test in the last 12 months and know their results	Yes	SGS in FSM Survey 2006-2008: STI Prevalence Survey of Prenatal Clinic Attendees in Pohnpei 2008; Behavioral Survey of Police, Pohnpei, 2007	Of those 76 (30.6%) (n=248) prenatal women ever tested, 64% were tested in the last 12 months and another 3.9% tested in the last 3 months, 68.4% altogether. Of these, 88.2% had received the results of their test. 47 (41.2%) police surveyed (n=114) had ever been tested – and 26 of 31 (83.9%) police had been tested in the last 12 months and know their results	Data limited – best available
	1.6	% of young people aged 15-24 who are living with HIV*	Yes	SGS in FSM Survey 2006-2008: STI Prevalence Survey of Prenatal Clinic Attendees in Pohnpei 2008	The survey found no young women aged 15-24 who are living with HIV (n=275).	Data limited – best available DHS data shows no HIV+ diagnoses in this age group during 2010-2011. Cumulative incidence since 1989 shows total of 7 cases diagnosed in 13-24 age group.
Sex workers	1.7	% of sex workers reached with HIV prevention programs	Yes	Chuuk HIV & STI Behavioral Survey with Women who Exchange Sex for Money or Goods July 2011	73.5% [50] women who engage in transactional sex in Chuuk [n=68] know where to go to get an HIV test; and 58.5% [n=67-69] demonstrated correct knowledge of HIV prevention [i.e. answered questions correctly on use a condom, be faithful and get tested, abstinence]	
	1.8	% of sex workers reporting the use of a condom with their most recent client	Yes	Chuuk HIV & STI Behavioral Survey with Women who	29% or 16 women who engage in transactional sex in Chuuk who answered the question (n=55) reported the use of a	Of those who did not use a condom, 37 (n=39) or 94.9%, did not use

Country Progress Report - Federated States of Micronesia - 2012

Targets	No.	Indicator	Applicable ¹	Source	Status	Comment
				Exchange Sex for Money or Goods July 2011	condom with most recent client	a condom because none was readily available
	1.9	% of sex workers who have received an HIV test in the past 12 months and know the results	Yes	Chuuk HIV & STI Behavioral Survey with Women who Exchange Sex for Money or Goods July 2011	Only 8 (17%) women who engage in transactional sex in Chuuk and answered the questions [n= 47] had ever been tested prior to the survey. Most, 7, (87.5%) of the women who had been tested [n=8] said their last test had been conducted over 1 year ago. Of these women [n=8], only 37.5% (3) said they knew the result of their test.	Sixty-two percent said their test was voluntary, and 75% received VCCT.
	1.10	% of sex workers who are living with HIV	Yes	No data available		
<i>Men who have sex with men</i>	1.11	% of men who have sex with men reached with HIV prevention programs	Yes	No data available		
	1.12	% of men reporting the use of a condom the last time they had sex with a male partner	Yes	SGS in FSM Survey 2006-2008 - Behavioral Survey of Youth, Pohnpei, 2008	Pohnpei Youth Behavior survey: 7 (3.6%) of those males surveyed [n=135] reported ever having sexual contact with another man Of these 7, 2 youth (28.6%) reported condom use at last sex with a male partner.	Data limited – best available is
	1.13	% of men who have sex with men who have received an HIV test in the last 12 months and know their results	Yes	No data available		DHSA data did not report any clients screened for HIV who also reported MSM in the last 12 months as a risk factor.
	1.14	% of men who have sex with men who are living with HIV	Yes	DHSA 2010-2011 routine surveillance data	No current HIV+ case reporting male-male-sex as the risk factor.	DHSA case surveillance shows that 6/38 total cases of HIV+ reported MSM as a risk factor. All 6 diagnosed with HIV died within 24 months of diagnosis.
Target 2: Reduce transmission of HIV among people who inject drugs by 50% by 2015						
	2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programs	NA	na	na	There are no syringe programs in FSM. FSM is confident that there is no IDU in FSM, and challenge the validity of the survey data.
	2.2	% of people who inject drugs who report the use of a condom at last sexual intercourse	Yes	SGS in FSM Survey 2006-2008: Behavioral Survey of Youth, Pohnpei, 2008; Behavioral Survey of Youth, Yap, 2007	6 of the 9 (66.7%) females in Pohnpei who reported injecting drug use in the last 12 months and reported no condom use in the past month. 8 of 15 males (53.3%) in Pohnpei who reported injecting drug use in the last 12 months and reported no condom use in the past month. In Yap, 6% of all youth (n=173 with 91 males & 82females) reported IDU within last 12 months – and 50% of these	Pohnpei Youth Survey reported 9 females and 15 males indicating injecting drug use in the last 12 months.

Country Progress Report - Federated States of Micronesia - 2012

Targets	No.	Indicator	Applicable ¹	Source	Status	Comment
					youth reported not using a condom last time they had sex.	
	2.3	% of people who inject drugs who reported using sterile injecting equipment the last time they injected	Yes	SGS in FSM Survey 2006-2008: Behavioral Survey of Youth, Pohnpei, 2008; Behavioral Survey of Youth, Yap, 2007	Of the 21 Pohnpei youth reporting IDU, one reported knowingly using a needle that had been used by somebody else, while 3 others not knowing if they had injected with previously used needles. In Yap, 6% of all youth (n=173 with 91 males & 82females) reported IDU within last 12 months – 30% of these youth reported having ever shared a needle.	Limited data available
	2.4	% of people who inject drugs that have received an HIV test in the last 12 months and know the results	Yes	No data available		
	2.5	% of people who inject drugs who are living with HIV	Yes	DHSA Data 2010-11	One HIV+ case diagnosed with risk factor of IDU in 2003 remains on-island.	Ongoing IDU is not known. This client is mobile and compliance with ART varies.
Target 3: Eliminate mother to child transmission of HIV by 2015 and substantially reduce AIDS-related neonatal deaths						
	3.1	% of HIV-positive pregnant women who receive anti-retrovirals to reduce the risk of mother to child infection	Yes	DHSA 2010-2011	There was one woman who is HIV+ but zero pregnant women who are HIV+ in the last 12 months.	Epi analysis indicates 5 cases (13%) of mother to child transmission since HIV first identified in 1989.
	3.2	% of infants born to HIV-positive women receiving a virological test for HIV within two months of birth	Yes	DHSA 2010-2011	No data available	A female child was born to an HIV+ woman in 2010; a virological test in same year was taken at approximate age 6-8 months and was negative.
	3.3	Mother to child transmission of HIV (modeled)	Not applicable	NA		
Target 4: Have 15million people living with HIV on antiretroviral treatment by 2015						
	4.1	% of eligible adults and children currently receiving antiretroviral therapy*	Yes	DHSA 2010-2011	There was one male diagnosed with HIV+ in 2011. He is eligible for ART but is awaiting CD4 viral load count to determine start up for treatment.	
	4.2	% of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Yes	DHSA 2010-2011	There are no clients who are HIV+ and who <u>started</u> treatment <u>during</u> the reporting period ie 2010-2011.	There are 4 clients who HIV+ and are on ART and who started ART before the 12 months prior to the reporting period (of 2010-2011): they started in either 2007 or earlier. There was one more male person who was positive at the start of the reporting period who was diagnosed in 1998 and had been on ART since 2000. He died during the reporting period, in 2010. He was not compliant with his medication for

Country Progress Report - Federated States of Micronesia - 2012

Targets	No.	Indicator	Applicable ¹	Source	Status	Comment
						much of the 24months prior to his death.
Target 5: Reduce tuberculosis deaths in people living with HIV by 50% by 2015						
	5.1	% of HIV-positive incident TB cases that received treatment for both TB and HIV	Yes	DHSA 2010-2011	During the reporting period, there were no TB-HIV co-infections identified.	There were 521 TB cases screened in the FSMs TB clinics in 2010-2011 with zero reports of HIV. One male client with diagnosed TB and subsequently diagnosed positive for HIV died in 2004.
Target 6: Reach a significant level of annual global expenditure (US22-23billion) in low and middle income countries						
	6.1	Domestic and international AIDS spending by categories and financing sources	Yes	DHSA 2010-2011	See online report	na
Target 7: Critical enablers and synergies with development sectors						
	7.1	National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programs, stigma and discrimination, and monitoring & evaluation)	Yes	NCPI Surveys 2012	See online report	na
	7.2	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	Yes	Chuuk HIV & STI Behavioral Survey with Women who Exchange Sex for Money or Goods July 2011	Two-thirds 46 (66.7%) of women surveyed (n=69) said that they had been forced to have sex against their will at some stage in their life. 12 (n=46) (26%) of the women who had ever been forced to have sex said that it was neighbor who forced them, and another 11 (n=46) 24% said it was their partner. 9 (19.6% said it was a stranger and another 9 (19.6%) said it was another relative. 4(8.6%) said it was a client.	MDG 2010 reports the statistical data base is weak but there is overwhelming perception that intimate domestic violence (largely by men against women) is common.
	7.3	Current school attendance among orphan and non-orphans aged 10-14*	Not applicable.	Not applicable.	Not applicable.	MDG report advises this is not relevant in FSM. National HIV Program advises all children are provided for by extended family should both parents die.
	7.4	Proportion of the poorest households who received external economic support in the last 3 months	Yes	Household Income & Expenditure Survey 2005, referenced in FSM MDG tracking Report 2010	No data.	Best available data: MDG advises that HIES 2005 reported that for FSM, poverty rates increased (from 1998) although not dramatically. In 2005, across FSM, 1-4 households and 1-3 individuals lived below the basic needs poverty line. Households headed by women and persons with

Country Progress Report - Federated States of Micronesia - 2012

Targets	No.	Indicator	Applicable ¹	Source	Status	Comment
						low levels of education were at heightened risk of poverty. 78% of poor households had at least one working member, a relatively high level of working poor, reflecting low wages and high living costs.

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. Elections were last held in 2011.

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 and chickens. 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 in 2004.

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 labor 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.²

The country has reported significant trade deficit over the last decade³. 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.⁴

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 2000⁵) – 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.

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
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

² 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.

³ More recent data was not available.

⁴ WHO materials, WHO Fact Sheet, FSM WHO Country Office, accessed 01032012

⁵ 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.

About 35.7% of the total population were aged 0-14 years, 58.7% were aged 15-59 years, and 5.6% were aged 60 years and above. The median age is 21.5 years, an increase of about 3 years since 2000, indicating the FSM population is ageing.⁶

The health care system

Responsibility for 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.⁷

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. The Department:

- provides overall supervision for the Division;
- sets priorities within financial, manpower and material constraints, as approved by the Secretary;
- conducts annual programme and staff performance audits and evaluations;
- enforces department and national policies;
- improves accountability within the Division of Health;
- implements national health strategies and the Strategic Development Plan in accordance with the Secretary's directives;
- works to increase external funding to support implementation of health strategies;
- develops and implements property inventory systems; and
- coordinates financial support and assistance to the states.

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. 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.

⁶ 2010 Census, Preliminary Report, FSM Department Statistics Website accessed 01032012

⁷ National Health Sector Policy for Strengthening HIV/AIDS, STI Prevention Care and Treatment, Department of Health and Social Affairs, 2009

Country Progress Report - Federated States of Micronesia - 2012

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 considerations. Local 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 six private health clinics in the country and one private hospital.⁸

Health facilities in the country, including private clinics and hospitals ⁹					
Type of facility	FSM	Kosrae	Pohnpei	Chuuk	Yap
Total health facilities in country	122	6	19	71	26
Hospitals	5	1	2	1	1
Community health centre	5	0	1	0	4
Dispensaries	92	0	9	64	19
Aid Posts	6	5	0	0	1
Health Clinics	6	0	3	3	0
Pharmacies	6	0	2	3	1
Dental clinics	2	0	2	0	0
Govt Owned Health Facilities					
Hospitals	4	1	1	1	1
Licensed beds	326	35	116	125	50
Operating beds	312	45	92	125	42
Occupancy rates	65.5	83	62	58	59
Health centre	5	0	1	0	4
Dispensary	92	0	9	64	19
Aid Posts	6	5	0	0	1
Privately owned facilities					
Hospitals	1	0	1	0	0
Licensed Bed	36	0	36	0	0
Operating Beds	36	0	36	0	0
Private Health Clinics	4	0	3	0	0
Private Pharmacies	6	0	2	3	1
Private Dental Clinics	5	0	2	3	0

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 Kosrae, Pohnpei, Chuuk and Yap; the Family Planning Coordinators in all states, the MCH coordinator and, in two states (Chuuk and Pohnpei) the Adolescent health coordinator.

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 Centres (CHC)¹⁰ which are 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 STIs including HIV, syphilis, gonorrhoea and Chlamydia and treatment of STIs. Where necessary, they refer to their counterparts in the Public Health Unit for more

⁸ Federated States of Micronesia, Country Health Information Profile, WHO, 2011

⁹ Federated States of Micronesia, Country Health Information Profile, WHO, 2011 – note errors cited in source document and unable to confirm prior to submission. This data seems to be sourced from the 2004 National Development Plan and was unable to be verified. Anecdotal reports of closures in some rural areas particularly suggest the actual figures may have changed since 2004.

¹⁰ These are called Community Health Centres in Yap and Pohnpei, and dispensaries in Kosrae and Chuuk

specific support relating to specific areas of expertise, as do each of the Coordinators.

Each state's HIV & STI Programs also has to a greater or lesser 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, Other STIS and TB (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.

Governance of the national response

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 & ATI 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, HIV Data Quarterly Report form, and the STI Data Quarterly report form).

National HIV & STI Strategy

The National Strategic Plan (2007-2011) which guided implementation of the response through 2010-2011 expired in 2011. A participatory mid-term review appraising the effectiveness of the implementation of the Plan was conducted in the last quarter of 2010.

Development of the National Strategic Plan 2012-2017 is currently in progress, with two workshops over the last three months identifying the four priority areas:

1. Governance and coordination of the response
2. Prevention of HIV & STIs
3. Comprehensive management and care of HIV & STIs
4. Monitoring, Evaluation, Surveillance and Research

The Strategy affirms the ongoing importance of focusing on young people and travellers, as well as identifying the need to consider an emerging risk group, men who have sex with men.

The draft 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 SPC/Global funds should they dissolve in 2013 as currently forecast, is critical.
- **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.

With two commitments under two key funders – the Global Fund and the Response Fund – due to expire in 2013, ongoing resources to facilitate implementation of the next National Strategic Plan is a key and pressing issue to be addressed. The forthcoming merger of CDC funds for HIV, STDs, and TB under one funding offer is also generating uncertainty, as well as interest.

National Coordination

The FSM National Advisory Committee on HIV, Other STIs and TB (NACHOST) was established in 2009 by the authority of the Director 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: ¹¹

¹¹ Articles of Incorporation, June 2010, endorsed at meeting of the NACHOST August 2010.

- 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 twice since its establishment in August 2010. Members of the NACHOST were engaged in the recent workshops to develop the National Strategic Plan.

Monitoring and Evaluation

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 disease¹². DHSA carries responsibility to use this information and analysis to

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

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

¹² Insert reference to policy.....

Country Progress Report - Federated States of Micronesia - 2012

A key challenge which FSM has repeatedly raised with their funders is the level and complexity of reporting compliance obligations. With multiple funders supporting the response, and limitations in the capacity of the information system supporting the collection and analysis of data, reporting is a demanding and constant task that could be simplified and refined to focus on program improvement as well as compliance.

National funding

In addition to Compact funding that supports most Government programs, external funding sources for the national response derive from the key areas:

- US Federal Funds through CDC and HRSA support HIV prevention, and surveillance, comprehensive care for STDs, and support those infected with HIV (under the Ryan White funds)
- The Pacific HIV & STI response fund and Global Fund, both managed by SPC, supporting additional programs and capacity strengthen in governance and program management and coordination, prevention and access to treatment and care
- A single but substantial grant allocation from UNFPA

National funding of HIV and AIDS prevention, treatment, care and support services and management of the response - estimated total allocations from external sources for 2010-2011 calendar years in US\$								
USD\$	US Federal Grants		SPC Fund ¹³ Response		SPC Global Fund		Other	Total
	2010	2011	2010	2011	2010	2011	2009-10	
Prevention ¹⁴ services	212866 ¹⁵	242361 ¹⁶	56,520	80,279 ¹⁷	24000	12000	300,000 ¹⁸	928026
Treatment Care and support HIV & STIs services	113,253 ¹⁹	86,645 ²⁰	19,000 ²¹	30,988	58800	58800	--	367486
Surveillance, M&E and research	18130 ²²	18130 ²³	24,000	12,494	11323	11323	--	95400
Program Management				49,251	44720	50720		144691
Other				500 ²⁴	69,536 ²⁵			70036
Total	344249	347136	99520	173512	208379	132843	300,000	1605639

¹³ NSP Stream 1 Grant allocated September 2009 and first tranche disbursed 2010; 2nd allocation and tranche disbursed July 2011-Dec 2011. Next tranche due July 2012. Grant allocation runs to end Dec 2013.

¹⁴ All personnel costs are attributed to the program areas in which they are incurred in budget proposals e.g. Chuuk YRC Coordinator is attributed under Prevention budget allocation

¹⁵ Operates on October-September fiscal year

¹⁶ Includes \$18795 carry-over from 2010 financial allocation

¹⁷ Includes two additional grants under Stream 5: \$27,256 Youth 4 Change; and \$21,650 Midnight Project.

¹⁸ Estimated allocation under the UNFPA grant in 2009-2010 to Chuuk to support the Men's Wellness Centre and Youth Resource Centre (including some support to the cross-regional Chuuk Linkages Program); this grant was withdrawn by UNFPA in 2010; actual data on the grant was not available at the time of report compilation.

¹⁹ Operates Jan-Dec calendar year

²⁰ HIV Care Grant runs October-September fiscal year rather than calendar year

²¹ Includes STI Presumptive treatment campaign materials and workshops inc IEC

²² Operates Jan-Dec calendar year

²³ Includes \$12227 carryover from 2010 financial year

²⁴ Administration costs not included in programming

²⁵ Technical assistance.

Country Progress Report - Federated States of Micronesia - 2012

Estimated expenditure by GARP categories by year in US\$ for external funds				
Source: GARP Funding Matrix – DHSA & Global Fund Finance Data				
Year	Prevention	Care and Treatment	Program Management ²⁶	Total
2009	142793	--	--	142793
2010	380556	110575	97264	388395
2011	321120	37914	84902	443936
Total	844469	148489	182166	975124

As the tables above indicate, grant allocations across the 2009-2011 calendar and years totaled US\$1605639. Estimated total expenditure across all grants for the same period was recorded as US\$975124 – indicating that an amount of US\$630515 was underutilized. While we note these are estimates, so some caution is advised, these figures suggest that just over half of the possible funds available to support the response in FSM were utilised. This analysis suggests that the key area where funds were available and possibly underutilized are the treatment and care areas of the program where under half of available funds were expensed.

It is noted that the data here is an estimated based on available information at the time of the report. It is recommended that a more rigorous analysis of expenditure such as national aids spending assessment be undertaken to clarify and confirm expenditure patterns prior to making any assessments of future program effectiveness and efficiencies.

In addition to the funds noted in the table, another SPC-managed grant of approximately \$150,000 over three years was also available for FSM. The Capacity Development grant supports civil society strengthening in relation to HIV & STI programming. FSM agreed with SPC that these funds be re-allocated to SPC to undertake this role, in lieu of identifying a local community based organization for the task.

Cumulative Incidence: HIV

During 2010-2011, 1 confirmed case of HIV was identified in early 2011. This case was a male from Pohnpei in the 25-29 age group, with the mode of transmission identified as heterosexual sexual activity.

Currently Living with HIV Source: DHSA HIV Register 2012															
Year	<15			15-19			20-24			25-49			50>		
	M	F	U	M	F	U	M	F	U	M	F	U	M	F	U
2010	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
2011	--	--	--	--	--	--	--	--	--	1	--	--	--	--	--
Total										1					

A total of 38 cases of HIV have been notified during 1989-2011 with

33/38 (87%) notified in the decade 1988-2007. Since 1989, 24 cases were reported amongst males (43%), 13 females (34%) and 1 not known reported (3%). Age ranges were 0-14yrs (5 cases) 15-24years (7 cases) 25-44 years (23 cases), 45+ (1 case) and unknown (2 cases). The causes of transmission included 24 heterosexual (63%) 6 male-to-male-sex (16%) 5 mother to child (13%) 2 IDU (5%) and 1 bisexual (3%). All states have reported cases: Chuuk 23 (61%) Pohnpei 9 (24%) Kosrae 4 (11%) and Yap 2 (5%).

²⁶ Includes surveillance and M&E.

The epidemiological curves suggests that there might have been two 'outbreaks' in Chuuk and in Pohnpei – it is known that at least some of these cases were linked. There have been a small number of infections reported to date and most have already died. All 6 known living cases are under medical management, although only one of those diagnosed and continuing to live in FSM is currently compliant with their ART regimen. All others are eligible for ART, with 2 yet to start (accept) treatment and the remaining three not compliant with their medication regimen. Another two cases diagnosed on-island are now off-island. There was one death of an AIDS client registered during the reporting period. He had not adhered to his ART regimen from some time preceding his death. There have only been two known deaths attributed to AIDS since access to medication was introduced in 2007, one of which was a co-infection case with TB.

Cases have been acquired overseas and locally – with small clusters of cases occurring after the return of overseas travelers. 9 cases in Chuuk had never been overseas, while 10 were diagnosed off-shore.

Most cases have been among those aged 25-44 years. Heterosexual transmission appears to be the predominant mode but small numbers of cases are attributed to male-male sex, intravenous drug use and vertical transmission.

Early in the epidemic, cases were usually diagnosed late in the course of illness. This was due to a mix of factors: limited knowledge and capacity to provide diagnostic and clinical care amongst the health care profession and limited access to and utilization of testing and care services by the broader community, alongside the stigma and discrimination associated with HIV. With the increase in community education, testing, diagnostic and clinical skills and capacity since access to ART was introduced in 2007, it is thought that this has changed. With so few cases diagnosed in the last two years, it is difficult to discuss any change in this trend. A specific evaluation of the changes in the quality of access to treatment and care over the last decade, based on a review of all cases, would be useful.

III. National response to the AIDS epidemic

3.1 Prevention

The Mid-Term Review identified some real strengths in the prevention programs across most states. There was evidence of innovative programming in response to analysis of the data. In Chuuk, for example, the Chuuk linkages program was established in collaboration with the Guam public health team to address the needs of the Chuukese community located in Guam. This program directly responded to the evidence that many of the early HIV cases in Chuuk arose while the clients were located in Guam, where, due to language and other cultural barriers, they did not access appropriate services promptly or effectively. Similarly, Chuuk established the Men's' wellness centre in early 2009, in response to the need to address men's sexual and reproductive health issues. The Men's wellness centre offered sexual and reproductive health education and clinical services. It was located adjacent to the Youth resource centre, will facilitated access and resource sharing. In Pohnpei, in addition to a broad range of peer education and other outreach services, the HIV & STI Program had begun to establish contact with local commercial sex workers and their clients in response to perceived needs that this group was reluctant to approach the general health services because of perceived stigma and discrimination.

Most states reported an increase in the level of general prevention activities during 2010-2011, noting an increase in the level of IEC materials distributed as well as the number of outreach and awareness activities delivered and an increase in numbers attending the HIV & STI clinic for HIV & STI tests as evidence of increased reach.

However, whilst there was strong evidence of innovative and responsive programming, there were also challenges:

- Funders were raising questions about the effective and efficient financial management and performance of some projects, which was jeopardising future funding for the programs.
- There was some evidence that prevention programs may have delivered mixed prevention messages, and limited evidence that knowledge was translating into changed, and safer, behaviors.
- There were gaps in targeting of some identified risk groups and related vulnerability factors, such as the relationship between alcohol and unsafe sexual activities.
- Funding for the Adolescent Health program was uncertain, generating confusion and concern amongst program staff and interrupting program delivery.

3.1.1 Prevention and the General Population

Under the previous National HIV & STI Strategy (2007-2011), prevention was a key priority in each state. In most of the states, prevention programs are delivered through collaborations across government and NGO organizations in formal and information settings. These included:

- Peer education, primarily targeting young people but also operating with women engaged in transactional sex in Chuuk
- Community outreach and education/awareness in villages and outer islands
- One-off education and awareness events, such as World AIDS Day events in the community
- Education and support services in informal settings for young people, such as youth resource or 'drop-in' centres, or through sporting organisations
- Education and awareness in formal settings, targeting school students with age-appropriate information through the national school curriculum
- The use of media, puppetry and drama groups, such as Youth for Change in Pohnpei
- Mother and daughter/father and son support groups for younger adolescents (10-13 years), sometimes associated with church or other youth groups such as scouts
- Youth friendly health services, in Pohnpei and Chuuk
- Condom distribution services, through clinics, bars, hotels and other community settings
- Access to VCCT counseling, testing and referral services targeting the general population, young people, sex workers and seafarers.

A number of these programs also provide direct linkages to secondary prevention services through access to counseling and testing, either on-site or by referral to the HIV & STI clinic in the local Public Health Program.

The key messages to address individual risk behaviours delivered by all prevention programs across FSM include a mix of:

- Abstinence (delay sex)
- Be faithful, get tested (and have one faithful partner)
- Use a condom for protection

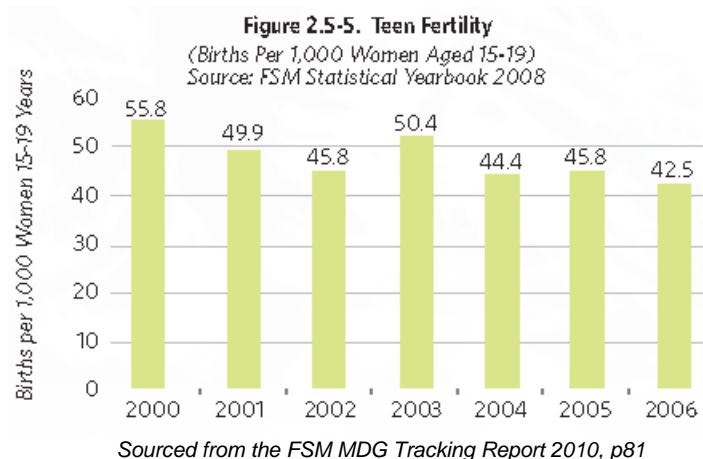
Some HIV & STI programs also reported that their prevention messages also address associated issues related to vulnerability, such as life-skills, family planning (particularly for young people); alcohol use and stigma and discrimination.

Key target audiences for prevention programs include: youth, (in-school and out of school); transactional and commercial sex workers and their clients, particularly seafarers; mothers & daughters, fathers and sons; church groups; and broad-based community groups including members of faith-based congregations.

3.1.2 Young people and prevention

As indicated in the preliminary report of the 2010 census, young people aged 13-25 years represent a substantial proportion of FSM's population. The MDG Tracking Report (2010) identified that the 2000 census confirmed that youth are a group in the population which is much more likely to be unemployed and

advised that one-in-three youth aged 15-24 years were unemployed in 2000²⁷. 28 FSM has experienced a steady decline in total fertility rates over the last decade, including for adolescents. The MDG report advises that FSM's Adolescent birth rate (births to women 15-19 years of age per 1,000 women 15-19 years of age) have also dropped from 90 in 1990 to 41.5 in 2008. The MDG Report attributes this trend to improved access to sexual and reproductive health services, including reproductive education, for adolescents over the last decade.



Despite the overall downward trend in fertility these rates are high in comparison to other parts of the world. With high unemployment amongst young people and high adolescent fertility, the FSM government and external donors have agreed that young people's sexual and reproductive health is a serious issue for concern in FSM and requires specific attention²⁹. High adolescent fertility tends to both increase and reflect the vulnerability of young people, especially young women, and contributes to dependency and poverty as household income is spread across more members. It can also reduce the opportunity for young mothers and parents to acquire or complete their education and develop independence.

Both the National HIV & STI Strategy (2007-2011) and the 2008 National Youth Policy³⁰ identified youth vulnerability and risk behaviors as serious issues. They advocate for increased awareness and advocacy on sexual and reproductive health issues, including the promotion of contraceptive and condom usage amongst young people.

Teenage pregnancies

Adolescent pregnancies are monitored through the National Family Planning Unit on the basis of data collected through the Family Planning and ANC

²⁷ The Millennium Development Goals and the Federated States of Micronesia, Status Report, 2010 FSM Office of Statistics, Budget and Economic Management, Overseas Development Assistance, and Compact Management in cooperation with the FSM Millennium Development Goals Task Force with Financial and Technical Support from the United Nations Development Program, Dec 2010

²⁸ The results of the 2010 Census which would identify the number of adolescents and youth who are out of school or unemployed was not available.

²⁹ UNFPA Reproductive Health, 2004; UNICEF 2004, The State of health behavior lifestyle of Pacific Youth, FSM Report

³⁰ FSM National Youth Policy 2004-2010, Department of Health Education and Social Affairs, 2004. The policy defines youth as ages 15-34 years. With the policy's expiry, a new policy is in development as this report was being written.

Country Progress Report - Federated States of Micronesia - 2012

programs at the state Public Health clinics. The table below lists the total number of pregnancies for all women. A breakdown by age was not available.

Number of pregnancies in FSM by State 2010-2011 Source National Family Planning Office FSM					
	Yap	Pohnpei	Kosrae	Chuuk	Total
2010	257	778	174	840	2049
2011	216	863	173	816	3147

Sexually Transmitted Infections in Young People

The 2006 SGS Surveys identified relatively high levels of Chlamydia (25.8%) in antenatal women in FSM generating concern for the level of STIs amongst the broader population. DHSA case surveillance on reported STIS for young people for 2010-2011 is noted in the tables below. Chlamydia continues to be present in a significant proportion of young people over the last two years.

Reported cases of STIs amongst males 0-24 years 2010 Source DHSA 2010-2011												
Years	Gonorrhea			Chlamydia			Syphilis			Hep b		
	Total tests	Detected	%	Total tests	Detected	%	Total tests	Detected	%	Total tests	confirmed	%
0-4	0						10	8	80	-	-	-
5-9	2	0	0	2	0	0	3	0	0	-	-	-
10-14	5	0	0	5	0	0	23	0	0	-	-	-
15-19	449	25	6	420	44	10	536	17	3	-	-	-
20-24	654	34	5	589	75	13	843	19	2	-	-	-
Total	1110	59		1016	119		1415	34				

Reported cases of STIs amongst females 0-24 years 2010 Source DHSA 2010-2011												
Years	Gonorrhea			Chlamydia			Syphilis			Hep b		
	Total tests	Detected	%	Total tests	Detected	%	Total tests	Detected	%	Total tests	confirmed	%
0-4	2	0	0	2	0	0	12	6	50	-	-	-
5-9	0	0	0	0	0	0	2	0	0	-	-	-
10-14	23	1	4	23	4	17	116	0	0	-	-	-
15-19	664	25	4	652	163	25	863	46	5	-	-	-
20-24	863	25	3	850	162	19	1083	48	4	-	-	-
Total	1512	51		1527	329		2076	100				

Reported cases of STIs amongst males 0-24 years 2011 Source DHSA 2010-2011												
Years	Gonorrhea			Chlamydia			Syphilis			Hep b		
	Total tests	Detected	%	Total tests	Detected	%	Total tests	Detected	%	Total tests	confirmed	%
0-4	4	0	0	1	0	0	24	2	8.3	9	0	0
5-9	2	0	0	2	0	0	6	0	0	4	0	0
10-14	32	2	6.25	32	4	12.5	46	0	0	21	0	0
15-19	384	19	4.9	370	57	15.4	367	5	1.36	231	2	0.86
20-24	356	32	8.9	345	79	22.89	536	7	1.30	339	8	2.35
Total	778	53		440	140		979	14		604	10	

Reported cases of STIs amongst females 0-24 years 2011 Source DHSA 2010-2011												
Years	Gonorrhea			Chlamydia			Syphilis			Hep b		
	Total tests	Detected	%	Total tests	Detected	%	Total tests	Detected	%	Total tests	confirmed	%
0-4	3	0	0	3	1	33.3	22	3	13.6	8	0	0
5-9	2	1	50	1	0	0	2	0	0	20	0	0
10-14	49	4	8.16	49	10	20.4	62	1	1.6	48	1	2.08

Country Progress Report - Federated States of Micronesia - 2012

15-19	699	29	4.14	664	175	26.35	719	8	1.11	475	8	1.68
20-24	819	35	4.27	764	151	19.76	936	11	1.17	670	22	3.28
Total	1572	69		1481	337		1741	23		1221	31	

Behavioral surveys conducted in Yap, Pohnpei and Chuuk with young people through 2006-2010³¹ confirm that sexual encounters amongst young people were often high risk activities. These included sex in exchange for goods and money, (some) male to male sexual contact, forced sex, having multiple partners and not using condoms³².

Young people and vulnerability

There has been no new data on adolescent and youth involvement in alcohol, drug and substance abuse since the SGS surveys conducted in Pohnpei and Yap in 2007 and 2008. The 2009 Youth Risk Behaviour Survey data for FSM was not available online.

Officers from the Pohnpei Public Health Program and the National HIV Program all challenged the reports of intravenous drug use noted in the 2007 Youth Risk Behaviour survey, stating that their professional view was that no intravenous drug use is present in Pohnpei. They explained the reports by suggesting that those surveyed may have misunderstood the question on intravenous drug use and perhaps referred simply to IV drug supply during the course of other medical treatments. The HIV & STI Program staff suggested that it would be useful to draw on their expertise to assist with the Youth Risk Behaviour Survey, suggesting that they would ensure that students understood the survey questions by conducting awareness and education sessions alongside the survey process.

Programs targeting young people

Most of the general prevention programs operating across FSM also conduct activities which specifically address young people's knowledge attitudes and behaviors in relation to HIV & STI transmission and prevention. At the beginning of 2010, some of the more prominent programs included:

- Prevention programs, using peer education, operated by Red Cross in Kosrae and Pohnpei;
- Youth 4 Change, peer education group (20 peer educators) located in Pohnpei are working with Public health HIV program youth across the state to conduct outreach, on the prevention of HIV & STIs teen pregnancy and discrimination, through skits;
- The Mural Group, a drama and mural group located in Pohnpei aiming to use creative arts to educate young people on HIV & STI prevention;
- The Youth Resource Centre in Chuuk, also drawing on peer educators to educate young people across the state on the prevention of HIV & STIs, teenage pregnancy and stigma and discrimination.

Youth Friendly Health Services

³¹ There have been two surveys in Chuuk, the 2006 Survey identified young people within a broader group on the Pattiw islands; the second identified young people within a broader group of women who engage in the exchange of sex for goods or money.

³² See the FSM 2006-2006 SGS, SPC, 2010

Despite some challenges with funding flows over the last two years, the Adolescent Health Development Program continues to operate in two locations in FSM: Chuuk and Pohnpei. In each state, the AHDP officer collaborate officers from the broader Family Planning and Reproductive Health and HIV & STI programs to support young people in and out of schools with education and prevention programs. A Youth Friendly Health Service operates in each state.

In Pohnpei, the AHDP re-initiated the Youth Friendly Health Service through a newly-funded activity called “the Before Midnight Clinic”. This service had been interrupted over the last two years, until the Pacific HIV & STI Response fund identified and approved support in late December 2011. This service will re-establish Pohnpei’s Youth Friendly health Service at the Youth Resource Centre. It will operate in collaboration with the peer education program also supported by the Pohnpei HIV & STI Program. With service interrupted over the last two years due to disruption to the funding flow, general youth friendly guidelines and minimum standards for service operations are yet to be developed.³³

Similarly, Chuuk also offers outreach education and access to clinical services through the linkage between the Adolescent Health program and the HIV & STI Program. The Youth Friendly Clinic continues to operate at the local Chuuk High School in Weno.

Until the end of 2010, young people in Chuuk were able to also access counseling and testing services at the Youth Resource Center and, if male, at the Men’s Wellness Centre in Weno. With shifts in the funding available, the Youth Resource Centre and the Men’s Wellness Centre have since closed. The VCCT service previously offered at the Youth Resource Centre has since re-located to the Chuuk Women’s Centre, where a VCCT-accredited counselor is available to take specimens and/or referrals.

Total number of health facilities in each state that provide access to HIV testing and counseling services for young people				
Source: FSM National HIV Program				
	Kosrae	Pohnpei	Chuuk	Yap
High School Clinics	--	3	--	--
Youth friendly Health services	--	1	1	--
HIV & STI Clinic (in the Public health Unit	1	1	1	1
College level services	--	1	--	--

Sexual and Reproductive Health in Schools

Young people in schools can also access the school clinics operated by the Family Planning and Reproductive health programs with the support of the ADHP in Chuuk at the one public high school in Weno, and Pohnpei in the three public high schools in Kolonia³⁴. These services offer over the counter medicines, family planning commodities, access (referrals) to testing for

³³ Midnight Project is currently operating, having started late December 2011. It was intended to start July 2011, but the funding did not arrive until December 2011. Funds are channeled through the state Finance. First activity report covering July to Dec is due Feb 2012, still to be submitted to SPC.

³⁴ Funded through the US federal funds – compact funding.

pregnancy, adolescent sexual and reproductive health issues, including STDs, and counseling. The school clinics take specimens and then refer clients to the local dispensary for follow-up management and treatment.

While the FSM national education curriculum does include modules on sexual and reproductive health, including HIV & STI transmission and prevention, the Pohnpei AHD Program advised that teachers are yet to be trained in the curriculum, so they do not feel confident to teach in the classrooms. Teachers in the public schools draw on the AHD Program and HIV & STI Program in Pohnpei state to teach sexual and reproductive health to students in the 13-19 year age group. One of the four private schools also invites the AHDP and HIV & STI program to talk to their students.

Young people also have access to the Public Health HIV & STI clinic, located opposite the hospital; and, if students of the College of Micronesia, to the peer counseling centre located at the College.

In Pohnpei, the Youth Resource Centre peer educators used to be able to support requests from the schools but with the shortfalls in funding, these peer educators are no longer available. This has resulted in increased pressure on the HIV & STI program staff who are cannot support all the additional awareness and education requests from schools. The national HIV Coordinator advises that a similar situation exists in the other states.

Micronesia Red Cross also provides awareness session to young people in elementary schools in the 13-19 year age group. Red Cross has a formal partnership with the Ministry of Education through the Gaining Early Awareness and Readiness for Undergraduate Programs GEAR UP targets 13-16 years old students who are most likely to drop-out of schools. The program was developed in response to concerns that these students may be most at risk of early teenage pregnancies. MRC draw on a pool of 8 peer educators to deliver these programs.

General outreach and awareness for young people

The AHD program also conducts outreach and general awareness sessions on request, either individually or in collaboration with the Red Cross or HIV & STI Program in Pohnpei, Chuuk and Kosrae.

In Kosrae and Pohnpei, Micronesia Red Cross provides a range of complementary services to the operations of the state HIV & STI program in relation to settings and technical input, sharing the workload based on expertise and networks. The HIV & STI program target bars and ports, MRC peer educators conduct community outreach and act as a focal point for young people in the community. MRC also complement the HIV & STI program clinical focus. While the State HIV & STI Program deliver screening programs, with MRC provide the outreach and peer education, and refer young people to the state team for VCCT services.

Program reach

Comprehensive data on the numbers of youth reached through prevention programs during 2010-2011 was not available. Red Cross data on the number of condoms distributed (as a proxy for reach) across 2008-2009-2010 in Pohnpei and Kosrae states showed a decrease of 15% because no condoms were available in the six months over the end of 2009 and beginning of 2010. The lack of condoms was attributed to a change in staff at the national DHSA office³⁵.

3.1.2 Prevention in sub-populations with higher risk of HIV exposure

Vulnerable Populations

The last two years have seen a growing recognition amongst service deliverers of the need to understand and address the situation for those women who engage in transactional or commercial sex in Chuuk and Pohnpei. Recent discussions raised at the National Strategic Planning workshops over the last three months also point to a growing recognition of the need to identify and address the 'hidden' population of men who have sex with men. However, most of those working in the HIV & STI program dispute the presence of intravenous drug use in FSM. No data is available distinguishing the number of SWs, MSM or IDUs tested for HIV and STIs or accessing general services.

Commercial and transactional sex work in Chuuk & Pohnpei

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 behavioral survey with these women. The survey was completed in 2011. The information identified in the behavioral survey is the starting point for the state HIV & STI program, in collaboration with the Youth Resource Centre, to develop appropriate services for this group. (*See best practices below for more discussion*)

In Pohnpei, a developing relationship with local commercial sex workers emerged when one or two members of this group began to access the mainstream HIV & STI clinic in Kolonia. Through an introduction by a peer educator, who established a relationship with some members of the group, in the last year, the National Adolescent Health Development Program and HIV & STI Program then initiated a community education and outreach program working with commercial sex workers and sailors. At first, the Pohnpei HIV & STI and AHDP team visited the sex workers in their shared household to offer testing and education services. Now, they also operate in the local bar where the sex workers operate most evenings. This is the only program providing services to sex workers and their clients. (*See best practices below for more discussion*)

Men who have sex with men

DHSA case surveillance shows that 6/38 total cases of HIV+ reported MSM as a risk factor. All 6 diagnosed with HIV died within 24 months of diagnosis. There are no current HIV+ cases reporting male-male-sex as the risk factor. DHSA

³⁵ Mid-term evaluation of the IFRC component of the GFTAM Round 7 Federated States of Micronesia Red Cross Society, Interim Report, Attachment Number 3, from the Mid-Term Review of HIV Vulnerability in Four Pacific Countries, Anne Mehaffey, Global Fund/SPC, 2011

data did not report any clients screened for HIV who also reported MSM in the last 12 months as a risk factor. Survey data from the Pohnpei Youth Behavior survey: 7 (3.6%) of those males surveyed [n=135] reported ever having sexual contact with another man. Of these 7, 2 youth (28.6%) reported condom use at last sex with a male partner. There is no specific data on the number of young people who also report 'mixed sex' partners. The police survey commented on reports of 'low levels' of MSM but provided no specific data.

During the recent discussions to develop the new National Strategic Plan, health care workers from a number of services and states agreed that although it is rarely discussed publicly or privately, it is commonly known that there are men who have sex with men in the population. There are no formal programs which directly target the safer sexual behaviours of this group, even though the risks may be identified in general prevention program awareness and outreach.

The Pohnpei HIV & STI Program said that, even though they identify the risks associated with some sexual behaviours for men who have sex with men as a risk group in their outreach education programs, the community ignores this information and it is never discussed publicly.

The Chuuk HIV & STI Program has initiated focus group discussions through the peer education network as a first step in considering the health needs of this group. The Chuuk HIV & STI Program advised that it is recognized that the community generally struggles to discuss or even accept the existence of men who have sex with men. As a result, services rarely provide for the specific needs of men who have sex with men.

The National Strategic Plan workshop agreed on the need to identify and provide services for the relatively hidden population of men who have sex with men. The size of the population of men who have sex with men in FSM is not known.

3.2 Treatment Care and Support

The midterm review identified some common themes in relation to access to quality treatment care and support services across FSM.

There are clear signs of improvement in some key areas of treatment care and support. Access to testing has improved as a result of strong collaborative efforts to educate the community of the benefits of knowing your status – combined with prompt and efficient communication of test results through the enhanced capacity of the local laboratory in Pohnpei to test. As a result, the credibility of the programs has improved and so, more people are willing to be screened and most STIs are more promptly managed.

Although there has been progress in addressing access treatment care and support for HIV positive people, improvements could still be made in some states in relation to:

- Confirmatory testing – particular with prompt and reliable transportation of specimens

- Contact tracing/partner notification, including the communication of confirmatory results
- Data recording
- Resources for supporting testing and diagnostic and treatment services in the more remote communities of the outer islands.

Improvements in the quality of testing and diagnosis would enhance the credibility of services and reassure positive clients that they can rely on local services: and thereby encourage positive people that they are accepted, reducing the potential for experiencing stigma and discrimination.

3.2.1 STI Diagnosis and management

The population of FSM is highly mobile. Guam Public Health data shows that FSM nationals living in Guam have rates of STIs more than 2.5times higher than the local (Guam) population. According to SPC data, pregnant women in FSM have the 2nd highest rate of Chlamydia in the Pacific.³⁶ The DHSA case reports for 2010-2011 for males and females combined are noted below. For the syphilis screening, FSM use RPR reagents; and if this is positive, the laboratory run a titer and then run the confirmation test locally using the Determine for confirmation.

STI Case Report 2010-2011 Total Male and Females combined												
Source: DHSA case surveillance												
Year	Gonorrhoea			chlamydia			Syphilis			Hep b		
	Total tests	Detected	%	Total tests	Detected	%	Total tests	Detected	%	Total tests	confirmed	%
2010	5995	198	3.3	5719	866	15.1	9732	250	2.6	--	--	--
2011	4811	176	3.6	4574	789	17.2	7869	165	2.09	5230	191	3.65

On the light of SPC & WHO analysis of effective strategies for addressing Chlamydia in higher prevalence settings, FSM agreed to introduce presumptive treatment for Chlamydia in 2011. Although scheduled to start across the whole country in August 2011, so far Chuuk is the only state to roll-out the program and has done so across the whole population. In the other states, Yap and Kosrae plan to roll-out the program only with pregnant women; and Pohnpei aims to address pregnant women and young people. The campaign is a rolling campaign, with the first six-month program of treatment followed by a rest phase, preliminary testing and analysis, then a second six-month phase of treatment. With the similar size populations between Chuuk and Pohnpei, it's interesting to compare their data thus far, with one having moved to presumptive treatment and the other continuing with a mix of syndromic and diagnostic confirmation and follow-up treatment. The data thus far shows that a total of 5983 persons have been reached since August 2011 in Chuuk, compared with 1170 for the similar period (quarters 3&4) in Pohnpei. It is interesting to see in the data that Chuuk has covered a far higher number of people under its presumptive treatment campaign than recorded in the same quarters for 2010.

³⁶, Mid-Term Review of the Response, Epidemiological Overview, Federated States of Micronesia, 2011, p1

Country Progress Report - Federated States of Micronesia - 2012

Chuuk	Chlamydia Cases – Presumptive treatment started Sept 2011								
	Source: DHSA STI Surveillance Data March 2012								
2010	Total nos	Detected	%	Treated	%	Female	Male	Total	
Qtr 1	228	34	15	--	--	216	12	na	
Qtr 2	236	32	14	--	--	208	28	na	
Qtr 3	302	44	14.5	33	75	233	69	na	
Qtr 4	225	31	13.7	31	100	169	56	na	
Total	991	141	14.2	64	45.3	826	165	na	
2011									
Qtr 1	43	6	14	--	--	34	9	na	
Qtr 2	18	5	27.7	--	--	16	2	na	
Qtr 3	45	4	9	3	75	1469	1492	2961	
Qtr 4	--	--	--	na	na	1564	1458	3022	
Total	106	15	14.1			3033	2950	5983	

Pohnpei	Chlamydia Cases							
	Source: DHSA STI Surveillance Data March 2012							
2010	Total nos	Detected	%	Treated	%	Female	Male	
Qtr 1	471	146	30.9	96	47.2	390	81	
Qtr 2	828	143	17.27	94	65.73	457	371	
Qtr 3	837	139	16.6	93	66.90	563	274	
Qtr 4	1062	41	3.86	31	75.7	474	588	
Total	3198	469	14.6	314	66.9	1884	1314	
2011								
Qtr 1	771	187	24	106	56.68	572	199	
Qtr 2	922	189	20.5	129	68.25	631	291	
Qtr 3	690	127	18	70	55.11	530	160	
Qtr 4	480	91	19	54	59.3	353	127	
Total	2863	594	20.7	359	60.43	2086	777	

The campaign has taken a slower start in Pohnpei. Pohnpei's HIV & STI Program explained that they although the ANC clinics have begun rolling out treatment (azythromycin) for pregnant women and their partners, they have not rolled out the IEC campaign across the wider community because they do not yet have the appropriate pamphlets. They explained that although the pamphlets have been translated, the data still reflects Chuuk data rather than Pohnpei data, which would be more appropriate. They advised that the ANC clinics are still testing the pregnant women for Chlamydia alongside handing out the presumptive treatment.

3.2.2 HIV testing and counseling services

HIV testing and counseling services were introduced in FSM in 2002 with support from CDC. There are now HIV testing and counseling services offered routinely through the HIV & STI clinics are each of the four state Public Health clinics, with referrals available through school clinics in most high schools and other community health clinics. Doctors operating in state hospital inpatient or outpatient services and the private clinics are also able to request HIV tests.

Health facilities that provide HIV testing and counseling services ³⁷						
Source: DHSA National HIV Program March 2012						
	Dispensaries	Super Dispensary/ community health clinic	Public Health Clinics	Hospital outpatients	Hospitals inpatients	Private clinic
Pohnpei	No	Refer to	1	Only on doctor	Only on doctor	Genesis

³⁷ Personal communication with the National HIV Program Coordinator, DHSA, March 2012

Country Progress Report - Federated States of Micronesia - 2012

		public health		request	request	
Chuuk	No	Refer to public health	1	Only on doctor request	Only on doctor request	1
Yap	No	Refer to public health	1	Only on doctor request	Only on doctor request	0
Kosrae	No	Refer to public health	1	Only on doctor request	Only on doctor request	0

The Public Health Unit houses the HIV & STI clinic in each state. These are the central point for HIV tests. The dispensaries and other clinics will refer to Public Health HIV & STI clinic which offers tests at no cost to the client. In addition, all doctors at both the public and private hospital (Genesis) are able to request an HIV test for a client.

The National HIV & STI Policy identifies four principal approaches for providing confidential counseling and testing:

- Client initiated voluntary, confidential counseling and testing (VCCT)
- Provider-initiated counseling and testing (PICT)
- Medically-initiated counseling and testing (MICT)
- Mandatory counseling and testing (MCT)

The same policy identifies the following groups for 'VCCT' screening:

- Women who receive antenatal care in health facilities
- Individuals who volunteer to donate tissues or organs for transplants or blood for transfusion
- Individuals requesting HIV testing as a condition of employment or as may be required for travel to other countries
- Sexual partners of HIV & STI infected individuals
- Persons receiving medical care who indicate high risk of exposure to HIV e.g. high scores on the risk assessment form, infected with an STI or TB or other 'opportunistic infection'; engage in high risk behaviors such as sex work, promiscuous sexual relations, men who have sex with men or injecting drug use.

FSM advised that they are guided by the testing algorithm for HIV recommended by OSSHHM as well as that recommended by CDC. Since the 2008 OSSHHM Guidelines were produced, however, a new HIV algorithm associated with a point of care rapid test has been introduced by SPC in 2010. This new algorithm is yet to be confirmed for use in FSM, and training is yet to occur.

In practice, state HIV & STI Program staff advised that procedure followed is that they use DETERMINE as the first screening test (at the Pohnpei laboratory); then, if the initial screening test is positive, they use the INSTI and UNI GOLD rapid tests on-site in Pohnpei for confirmation. If both these tests results are negative, then a negative result is agreed. However, if the initial screening and subsequent rapid tests all show positive, they then send the specimen to the DLS reference laboratory in Honolulu for the Western blot confirmation test. However, they also pointed out that the CDC advice is that even if both INSTI and UNI GOLD show a negative result, they should still send the specimen for Western blot confirmation at the reference laboratory – which they also follow, because they are obliged to agree with both SPC and CDC's guidelines if they are to continue to access funding. The state program reported that they were

Country Progress Report - Federated States of Micronesia - 2012

aware that there had been discussions initiated at the 2010 PIJAAG summit between SPC and CDC to reach agreement on a common algorithm, but the outcome of these discussions was not known.

The table below shows that a total number of 9870 and 9249 persons were tested for HIV in FSM in 2010 and 2011 respectively. Slightly more females than males were tested in each year.

Year	Number of females and males (age range: >13-50+) who received HIV testing in 2010 and 2011		
	Male	Female	Total
2010	4343	5527	9870
2011	4223	5026	9249

The table below shows the numbers tested for HIV by sex by each of the routine surveillance groups for 2010-2011. Blood donors, voluntary 'walk-ins' and prenatal represent the largest groups.

Clinic	Numbers tested for HIV by routine surveillance groups					
	Source: DHSA HIV Surveillance data March 2012					
	2010			2011		
	Male	Female	Total	Male	Female	Total
Prenatal	--	2214	2214	--	2136	2136
Postnatal	--	55	55	--	70	70
Pre-employment	381	232	613	501	216	717
Premarital	45	45	90	34	34	68
Student	421	463	884	464	503	967
Food handlers	272	547	819	275	445	720
STI clinic	175	139	314	123	104	227
STI contact	33	52	85	31	17	48
Blood donor	1740	453	2193	1966	329	2295
Blood recipient	219	191	410	100	153	253
TB	361	47	408	63	50	113
Voluntary	708	767	1475	698	928	1626
Others	0	0	0	0	0	0
Total	4355	5205	9560	4255	4985	9240

The table below shows the number of females and males who received HIV testing during 2010 and 2011 by age group. The highest numbers are captured across the 13-34 age group reflecting the predominant focus on young people as a priority risk group for the response across FSM.

Number of females and males who received HIV testing in 2010 and 2011 by age group																						
Source: DHSA HIV Surveillance data March 2012																						
Year	<13		13-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		unk		Total	
	m	f	m	f	m	f	m	f	m	f	m	f	m	f	m	f	m	f	m	f		
2010	6	15	577	943	841	1203	597	922	444	677	320	499	285	294	200	193	316	245	757	536	9870	
2011	13	13	509	903	735	1077	580	789	470	559	395	377	350	249	242	117	354	174	575	768	9249	

Only one person was diagnosed positive for HIV during the reporting period. The reported risk factor for this person was heterosexual activity.

Number of women and men aged 15 and older diagnosed HIV+ by risk factor in 2010 and 2011							
Source: DHSA HIV Surveillance data March 2012							
Risk factor	Msm	IDU	Female hetero	Male hetero	Transfusion	Perinatal	unknown
2010	0	0	0	0	0	0	0
2011	0	0	0	1	0	0	0

CDC has offered training in CTR regularly since 1999. In the last two years, the Pacific Counseling and Social Services, an organization funded by SPC's Pacific Response Fund, has also provided training to 16 staff from FSM in voluntary and confidential counseling. One staff member from Chuuk is now accredited through the PCSS Diploma program.

The National HIV Program advised that a total of 19119 people received testing across 2010-2011. The data on the level of pre- and post-test counseling accompanying those tests is show below. The discrepancy between the pre and post test numbers shows that follow up is an area where improvements could be made.

Numbers receive pre and post test counselling for 2010-2011 combined			
<i>Source: DHSA HIV Surveillance data March 2012</i>			
	Male	Female	Total
Pre-Test Counselling	8415	10438	18853
Post - Test Counselling	2843	5609	8452

3.2.3 ART treatment (prophylaxis), care and support

In general, FSM follows the Guidelines recommended by OSSHHM (and WHO) and CDC in relation to procedures and operational guidelines for the treatment management and care of people diagnosed with HIV. Pohnpei State HIV & STI Program has adapted these guidelines to produce their own Protocols and procedures manual, which has now been endorsed by the State Director for Health.

The state HIV & STI Programs provide ongoing support and monitoring to those who are diagnosed with HIV. This includes individual counseling and education on HIV prevention and transmission; home visits 1-2 times per month to discuss support; monitor compliance with treatment, including CD4 monitoring and access to medications at the pharmacy; provision of food; and transportation to hospital when necessary. There are challenges in providing support to positive clients: apart from one positive person in one state, no others have disclosed their status to their families. Confidentiality is maintained by the core team which provides support: the HIV & STI physician, the Program Coordinator; and the HIV nurse.

The four Government pharmacies located in each state is responsible for supplying ART medications under the guidance of the HIV & STI physician in each state. The ART medications are provided at no cost to the client. The supply of ART medications are subsidized through the Ryan White and Global Funds (through the regional Fiji-based Pharmaceutical program).

It is useful to remember that before 2007, people often left FSM because of the cost of care, so that they could access drugs at no personal cost in the US-

mainland. Similarly, treatment has only readily been available in FSM from 2007, with the support of Global Fund monies and clinical training for the HIV Core Care team provided by the Fiji-based HIV Advisor based in SPC, as well as CDC and the AIDS Education and Training Centre (AETC) based in Honolulu, Hawai'i. The Oceanic Society for Sexual Health and HIV Medicine provides ongoing support remotely from Suva Fiji. All HIV & STI physicians located in FSM are members of the OSSHHM.

The number of those people on ART by eligibility, enrollment and retention in FSM during 2010-2011 is noted in the table below. The table shows that one client died during 2010 but was replaced by a new diagnosis in 2011, retaining the total number of people living with HIV at 7. All are eligible for ART. There are 4 who have started ART. Of these, one has successfully maintained their treatment regimen for over 14 years; the remaining three vary in their compliance. Another two clients are eligible but are yet to start treatment, awaiting confirmation of their CD4 results³⁸ to determine the regimen. All are under the care of their state HIV & STI Physician. There are no known cases identified by the clinicians in the private sector.

Number of people on ART eligible, enrolled and retain on treatment 2010-2011			
Source: DHSA HIV Register March 2012			
	Total	Male	Female
Eligible for treatment	7	3	4
Enrolled on treatment	5	2	3
Retained on treatment	1	--	1

The level of non-compliance with treatment, particularly now that it is available in FSM, is a concern. The reasons for non-compliance have centred on family concerns that the side-effects of the ART make the HIV+ positive person more (visibly) sick. The person who refused treatment and subsequently died, early in 2010, had expressed concern about the side-effects of his treatment regimen for some time: despite efforts by his doctor to adjust the medication, they had been unable to successfully re-assess his CD4 levels, and so the patient lost confidence in the treatment offered. His partner, who is also positive, has refused to resume ART.

During the reporting period, there were no TB-HIV co-infections identified. There were 521 TB cases screened in the FSMs TB clinics in 2010-2011 with zero reports of HIV. In relation to previous clients, one male client with TB with subsequently diagnosed with HIV and subsequently died in 2004.

3.2.4 PMTCT services

FSM has experienced a steady decline in total fertility rates over the last decade, including for adolescents. Generally, the MDG report noted, most births are preceded by at least one antenatal visit, although only 60% achieve a score of 80% or higher on the Kotelchuk Index. Ninety percent of births take place in a health facility and 88% are attended by skilled health personnel³⁹.

³⁸ Pohnpei is now able to monitor CD4 levels on-island with the recent provision of the PIMA analyser with SPC support in 2010.

³⁹ 2011 MDG Tracking Report, FSM

Country Progress Report - Federated States of Micronesia - 2012

The number of health facilities providing access to ANC services is listed in the table below. Services and tests routinely offered to pregnant women through the ANC clinic include counseling/ information session; weight and height measurement; blood pressure measurement, urine testing; blood testing to detect anemia and routine screening for HIV and other STIs⁴⁰.

Number of health facilities providing ANC services				
	Public health	Hospital	Dispensary in outer islands and rural areas	Super clinics
Pohnpei	1	Genesis + 3 private clinics	<i>ANC services also provided in all dispensaries in the outer islands – a breakdown of the number of dispensaries in the outer islands is not known, but up to 92</i>	4 (inc Kolonia)
Chuuk	1	One private clinic		-
Yap	1	--		-
Kosrae	1	--		-

ANC services refer clients to the Public Health Unit's HIV & STI Program for HIV and STI testing, counselling and where necessary, treatment and care. All ANC clients are routinely offered an HIV test, in accord with the FSM National Policy on HIV testing. FSM follows the OSSHM and WHO guidelines for managing PMTC transmission of HIV, including the treatment regimen and breastfeeding policy. ART is available for pregnant women, although there is currently none who require ART prophylaxis.

During 2010-2011, there was one woman who was HIV+ but zero women who are HIV+ and pregnant in the last 12 months. There was one pregnancy related to an HIV+ woman was identified early in 2010⁴¹. She became pregnant in 2010 at 34 years. She received ART while she was pregnant. She was initially on *atrilpa* medications, and then moved to *combivir* when pregnant. The female child was born in 2010. The child was tested at approximately age 6-8 months and the test result was negative. A dry blood spot specimen was taken for PCR test in Australia.

Testing of infants on virological testing					
Source: DHSA HIV register – March 2012					
	2010	2011	Age	Virological test	Diagnosis
Infants >3yrs	1	0	1-2 yrs	Yes (NRL)	0

In relation to cases prior to 2010, there was only one other female who may have been positive when she became pregnant. The situation related to a family of three diagnosed in 2007 (a husband and wife and their son). All three clients were diagnosed at late stage. The female client may have been positive when she became pregnant as her son was subsequently diagnosed when 3 years old. It is suspected that the son became sick through the mum. This was in 2007 prior to treatment being available. DHSA do not have records.

The number of women who were tested for HIV in ANC clinics, as recorded in routine surveillance records, is noted in the table below.

⁴⁰ The National HIV Coordinator advises that the routine laboratory tests include US fro glucose and protein, haemoglobin blood grouping, Pap-trich and BV, RPR/HBsAg.

⁴¹ This woman is currently non-compliant with her ART medication. She was initially diagnosed off-island and re-confirmed as HIV+ when she returned in 2010 at age 34 yrs. When she came back from Hawaii she was already on medication. Although the State HIV & STI Program re-tested the client to confirm the diagnosis and re-assess recommended mediations, there were complications with confirmation due to transportation issues. In parallel to this, her husband, who was diagnosed positive in 1998, was also refusing to take the recommended ART medications. He subsequently died in early 2010.

Country Progress Report - Federated States of Micronesia - 2012

Number of pre and postnatal women tested for HIV in 2010 and 2011⁴²		
<i>Source: DHSA HIV Screening Data March 2012</i>		
	2010	2011
Prenatal	2214	2136
Postnatal	55	70
Total	2269	2206

There is no breakdown of data on the numbers (or proportion) of pregnant women who received counseling prior to testing for HIV and then received counseling when they received their test results. However, the DHSA has advised that the number of pregnancies for 2010-2011 (as noted earlier in this report) were reported as 5196 pregnancies for the period. This suggests that less than half the women who were pregnant in FSM during 2010-2011 may have received HIV counseling and testing services. It is noted that these figures were unable to be verified within the time constraints of this report. It is recommended that there be further exploration of the data to clarify this potential issue.

In relation to STIs diagnosed in ANC clinics, the table below provides data in relation to ANC diagnoses during 2010-2011. Total cases of syphilis amongst pregnant women reported by ANC clinics for 2010 were: 2185 with 64 detected and 44 treated; in 2011, 1926 with 32 detected and 23 treated.

Number of women tested and treated for STIs in ANC clinics^{43,44}												
<i>Source: DHSA STI Surveillance Data March 2012</i>												
	Gonorrhea			Chlamydia			Syphilis			trichomonas		
	Total tests	Detected %	Treated %	Total tests	Detected %	Treated %	Total tests	Detected %	Treated %	Total tests	Detected %	Treated %
2010	1650	1.6	67	1589	24.5	65	2185	2.9	40	1843	9.7	100
2011	1309	3.28	69.76	1211	23.53	69.82	1926	1.66	71.85	2265	10.02	77.09
Total	2950	--	--	2800	--	--	4111	--	--	4108	--	--

As noted above, further confirmation of the data is advised in order to draw any conclusions in relation to coverage.

3.3 Human rights

During the development of the National Strategic Planning workshops and the consultations to compile this report, stakeholders advised that it was difficult to engage positive people, or other vulnerable groups, because of the level of stigma and discrimination in the community. People living with HIV are reluctant to disclose their status, even to their families, because of the fear of stigma and discrimination.

There is no national legislation to protect the human rights of positive people in FSM from stigma and discrimination. FSM's Constitution provides protection for all citizens of FSM although it does not specify protection on the basis of HIV status, sexual orientation or gender.

⁴² Source: National HIV Registry 2011 Combined data (cf: STI Surveillance indicates alternate figs: 2104 screened in 2010 with zero positive cases;

⁴³ Source: National STD Program 2010 and 2011 Routine Case Surveillance: note: 2011 data not verified.

⁴⁴ In 2011, ANC data also tested for HBV with 54 positive in 1377 screened – no data on treatment available.

At state level, however, Pohnpei is the only state in the FSM which has passed legislation to protect the rights of those believed or known to be infected with HIV. Kosrae advises that it has had a draft bill to criminalise intentional transmission of HIV in progress before its state legislature since 2008.

The Pohnpei HIV Prevention and care Act of 2007⁴⁵, passed by the State of Pohnpei Legislature in October 2008, relates to the prevention and care of HIV in FSM. The legislation establishes a state-wide HIV information and educational program; a comprehensive HIV monitoring system; the Pohnpei HIV Council; and associated supporting programs.

The legislation protects the rights of those who are believed to be, or diagnosed, as HIV+. In particular, the legislation asserts that:

- compulsory HIV testing is unlawful;⁴⁶
- the right to privacy of individuals with HIV guaranteed;
- discrimination, in all its forms and subtleties against individuals with HIV or persons perceived or believed as having HIV shall be considered inimical to individual and state interest;
- provision of appropriate health and social services for individuals with HIV shall be assured;
- state shall promote utmost safety and standard precautions in practices and procedures that carry the risk of HIV transmission; and
- the state shall recognize the potential role of affected individuals in propagating vital information and educational messages about HIV and shall draw on their experience to inform the public about HIV, promote HIV testing, and encourage changes in behaviours.

The legislation emphasises the obligation of the government to provide all Pohnpeians with relevant information and resources (condoms) to prevent the transmission of HIV. This applies to communities and workplaces, as well as schools; and to those Pohnpeians travelling abroad, as well as tourists from elsewhere who visit Pohnpei.

The legislation asserts the prohibition of compulsory testing (6A.-131) as a precondition to employment, admission to educational institutions, the exercise of freedom of abode, entry or continued stay in the state, the right to travel, the provision of medical service or any other kind of service, or the continued enjoyment of said undertakings shall be deemed unlawful.

A review of FSM's legislative support for HIV and Human Rights in 2009⁴⁷ identified the Pohnpei Act as a model for human-rights based approach to HIV for other states and Pacific countries. Whilst suggesting improvements in relation to the way the legislation addressed stigma and discrimination – by providing for remedy through civil means as well as prosecution – and strengthening the

⁴⁵ Pohnpei HIV Prevention and Care Act of 2007, Amendment to the Pohnpei Code, 2007

⁴⁶ "Compulsory HIV testing" refers to HIV testing imposed upon a person, characterized by the lack of consent, use of physical force, intimidation or any form of compulsion

⁴⁷ HIV, Ethics and Human Rights, Review of legislation of Federated States of Micronesia, Joint project of UNDP Pacific Centre, Regional Rights Resources Team SPC and UNAIDS, March 2009

obligations to confidentiality in relation to partner contact tracing. However, the review expressed a number of concerns

- that assertion of traditional law and customs alongside the rights of the constitution might impede women's equality in relation to inheritance and family law;
- similarly, the offences of 'prostitution' when it relates to consenting acts between adults in private, and the lack of provision for an offences of marital rape, in Chuuk and Yap, were seen as also harmful to the status of women;
- that the provision of a no-fault model of divorce and allowing women's non-financial contribution to marriage would improve women's social and economic status and thereby reduce women's vulnerability to HIV
- the offence of abortion in Chuuk, Kosrae and Pohnpei infringe the rights of women and girls to make decisions about their own reproductive health
- The introduction of a code of practice on HIV and the workplace could assist reduce stigma and discrimination; and, in health care settings, could promote greater attention to universal precautions and confidentiality and assist the reduction of stigma and discrimination.
- Finally, legislation to ensure condoms and HIV test kits comply with international quality standards was required; and information and resources to support HIV & STI prevention in prisons should be available.

3.4 Knowledge and Behaviour Change

There is limited data available to identify the extent of knowledge and behaviour change over 2010-2011.

The mid-term review undertaken during 2010 reported an enhanced response. It confirmed the improvements in the services and programs in the delivery of the response, as identified in the last Country Progress Report submitted in early 2010. These improvements included:

- An increase in the level of education and awareness programs offered in the community;
- An increase in the level of counselling and testing services offered;
- An increase in the skills and capacity of health care workers to provide education and broader prevention services;
- An increase in the skills and capacity of health care workers to provide diagnostic, testing and clinical care services for STIs and HIV.

But in relation to changes in the level of knowledge and behaviours in FSM since 2008, there is little specific evaluation data available. The SGS surveys undertaken in 2006-2008 have not been replicated.

One behavioral survey of women who exchange sex for goods and services was undertaken in Chuuk in 2010. This survey is with a different target group from the previous SGS surveys, which means there are limitations on its comparative value. However, what it did utilize many of the same questions about sexual behaviors and knowledge related to HIV transmission and prevention which we can draw on for some comparison. The total number of women surveyed was

70. The average age of women surveyed was 20.4 years, and the majority of women (80%) were between 15-24 years of age, although the group ranged from 15-40 years of age. The survey showed that

- 73.5% women who engage in transactional sex in Chuuk know where to go to get an HIV test;
- 58.5% demonstrated correct knowledge of HIV prevention [i.e. answered questions correctly on use a condom, be faithful and get tested, abstinence].
- 29% women who engage in transactional sex in Chuuk reported the use of a condom with most recent client.
- Of those who did not use a condom, 94.9%, did not use a condom because none was readily available.
- Only 8 (17%) women who engage in transactional sex in Chuuk had ever been tested prior to the survey. Most, 7, (87.5%) of the women who had been tested said their last test had been conducted over 1 year ago. Of these women [n=8], only 37.5% (3) said they knew the result of their test. Sixty-two percent said their test was voluntary, and 75% received VCCT.

The average age of first sexual intercourse was 15.5 years, whilst the average age of first paid sexual encounter was 17.6 years. Over half had sex for the first over the age of 15 years, and more than two thirds were older than 15 years when they first had paid sex. The majority said they did sex work to make money (66%) or because they enjoyed it (23%). A small proportion (14.5%) said that they had other paid work. Nearly all women reported commercial sex work in the last 12 months, with the average number of partners on the last day of sex was 2 (although the responses range from 1-9).

With some qualifications about the validity of comparisons across risk groups⁴⁸, the survey does show higher levels of knowledge about transmission and prevention than demonstrated in any of the 2006 SGS surveys with other risk groups. However, the surveys also show a significant disconnect between levels of knowledge of prevention and the adoption of safer sexual behaviors, such as condom use or testing, as was also demonstrated by the risk groups surveyed in the earlier SGS Surveys.

Evaluation- the Red Cross Peer Education program

Only one program was able to present an evaluation of its work over the last two years. A mid-term evaluation of the peer education program offered by Micronesia Red Cross (MRC) in Pohnpei and Kosrae was also undertaken in 2011. The evaluation, by an independent evaluator, was positive overall, although improvements were recommended. The evaluation identified that

- MRC keeps accessible records of condom distribution.
- Condoms are distributed during community outreach, school session, and events, as well as available at the Red Cross office.
- Monitoring condom distribution had informed new approaches to education: for example, as the distribution of condoms was seen by some to encourage sexual activities (promiscuity), peer educators shifted their message to encourage young people to “give the condom to a friend you

⁴⁸ Given that the sample group is not the same with earlier surveys of young people.

know is at risk". This reinforced the care for others and awareness of others' risk behaviours, each of which is more likely to work in the community-oriented environment of FSM

- MRC ensure that cultural sensitivities are addressed by separating females and males in all education activities to encourage community acceptance of the discussion, and practice, of safer sexual behaviors.

Peer educators working for MRC reported an increase in their own skills and capacity arising from their work with MRC. These included the acquisition of new knowledge leading to new attitudes and practices, such as:

- More confident in themselves
- Know how to use condoms
- Know how to relay messages using the correct words
- Understand and can talk about the difference between HIV and STIs
- Are no afraid of people who are living with HIV & AIDS
- Understand that if you have HIV you can still live a happy life
- Are knowledgeable and can talk to peers and family (about HIV)
- Are confident to stand up in front of people and talk
- Enjoy working in the community and making new friends through their work
- Are personally more responsible, including being faithful to one partner.

Despite these positive approaches to the way MRC delivered its program, the evaluation identified data from the MRC Knowledge Attitudes and Practices (KAP) survey which demonstrated evidence that condoms continue to not be acceptable, nor used; and not used consistently.

The KAP survey of 1208 students in six schools in Pohnpei showed that 60% of students reported they were sexually active: of these, 20% had had sex without a condom and 9.3% never used a condom.

The survey also showed that stigma continues to be a significant issue among young people: 62% of 181 respondents state that a teacher who has HIV and is healthy should not be allowed to continue teaching.

In contrast to the KAP survey findings, however, DHSA and the MRC and peer educators all reported anecdotal evidence that overall tolerance towards people living with HIV has improved. Previously, people living with HIV were followed, or their family kicked them out of their homes. Now, people in the community do not appear to react in the same way.

Overall, the evaluation reflects a similar pattern to that identified in the mid-term review: an increase in the capacity to deliver a stronger program – but little evidence, yet, of changes in the behaviors in the target audience although there is some evidence of changes in program deliverers own behaviors, and in the shifts in attitudes of the target audience towards people who are positive.

3.5 Impact alleviation

In 2010, FSM demonstrated capacity to meet only five (of 25) performance indicators in relation to the core UNGASS impact & outcome indicators.

Although these indicators have since been modified, the current report's findings demonstrate the same issue which faced the NACHOST when it met to discuss the findings of the Country Progress Report in 2010: many of the indicators are premised on a degree of underlying health systems capacity and resources, as well as an HIV & S TI situation, that is not the case in FSM.

As a result of this, the NAC HOST in 2010 wanted to know 'what was happening' in the implementation of the response which could explain the relatively negative performance assessment arising from the 2010 UNGASS review and so the country could better position itself to identify and collect the information (evidence) relevant to assessing its progress in responding to HIV & STIs.

Staff at the National HIV & STI Programs, and their state counterparts, knew the level of effort and commitment demonstrated in their programs to addressing the HIV & STI situation. But the nature of evidence sought by the UNGASS indicators was outside the experience of their program.

Hence, the NACHOST directed that the Mid-term Review focus on verifying, or explaining, the last UNGASS Review's findings in relation to the effectiveness, relevance and appropriateness of the implementation of the response under the current national and state strategic plans. The indicators were insufficient to help them understand what was happening.

Overall, the Mid-term Review found that the response in FSM had some clear strengths, but would benefit from a number of steps for consideration in the development of its next national strategy. These steps were:

1. Clarify who is at risk of HIV through a case study of those diagnosed and/or living with HIV, to determine modes of transmissions, demographics and characteristics of known infections to reach conclusions on who is most at risk based on the current HIV epidemiological data and personal interviews
2. Review the STI data to consider how well programs are bridging the populations most at risk and others who are vulnerable, including identifying and analysing how well those tested from community awareness sessions meet known risk groups and how well those screened under mandatory requirements were shown to be infected with either STIs or HIV.
3. Consider how to give greater attention to the STI situation and its link to HIV as well as broader sexual and reproductive health.
4. Identify a process for the review and adapt prevention programs, particularly education and screening programs, in light of the findings of who is most at risk of infection of HIV and STIs

5. Strengthen access to reliable data through stronger, routine, monitoring and evaluation including the development of a standardized approach to collecting and reporting data which:
 - a. demonstrates the agreed risk groups;
 - b. identifies agreed results intended to be achieved;
 - c. measures the key changes the Plan wants to achieve; and
 - d. implements routine approaches to quality assurance.

6. Strengthen underlying organisational and management capacity through a review of performance management systems to identify and implement a revised approach to performance management.

Finally the review advised that FSM develop a national strategy which aimed to balance of prevention, treatment and the reduction of stigma and discrimination, with greater attention to:

- Strengthening the policy and legislative context and supporting programs – particularly to address stigma and discrimination.
- Strengthening the links between education, screening and testing and treatment and care.
- Strengthening monitoring and evaluation capacity so that the quality – including the scope and coverage - of program delivery can be more effectively monitored and evaluated
- Strengthening the integration of HIV and STIs as part of a broader sexual and reproductive health program. STIs result in substantial poor health outcomes in their own right if left untreated, as well as represent a risk factor for HIV

FSM is currently developing a strategic framework which aims to achieve this balance.

IV. Best practices

The UNGASS Review 2010 identified a range of 'best practices' in FSM national response. These included:

- An increase in STI screening across the country;
- 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;
- 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 2012, 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:

- The “Before Mid-night” project was re-established in Pohnpei to address young people.
- 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.

Scaling up Prevention” understanding and engaging vulnerable populations:

Example: The Before Midnight Project, Pohnpei - Youth Friendly Health Services

The AHD program was created 2001 at the Federated States of Micronesia, National level to address the high risk for teenage pregnancy, STI, and HIV among adolescents in Pohnpei, FSM. The program provides health education and prevention services targeted at young people, particularly through the peer-to-peer education program such as youth outreach services, radio spots and awareness, classroom education, theatrical drama shows, scripts and television, peer to peer approach, referral and youth networking for Y-Peer in Asian Pacific countries

In a 2007 study of qualitative and quantitative research on Adolescent utilization of AHD Clinical Services in Pohnpei State, it was found that despite the availability of Adolescent Health & Development (AHD) clinical services, teenage pregnancy from 2001-2004 remained high. Teenage girls may not be adequately accessing the clinical services for contraception. There was also evidence of inadequate awareness and support from the community for prevention of teenage pregnancy. Accelerated actions are needed to ensure access to Reproductive Health services for young people, to educate the

community and to create a supportive and enabling environment for adolescent health. There is an urgent need to continue and expand the AHD clinic models and peer education program in Pohnpei State.

A study on in 2006 on utilization of AHD services, the question of Health Care Providers' perceptions of the quality of services found that existing services did not meet the needs. So in order to address the problem, the program aimed to expand the clinical hours for adolescents from 5-9 PM in school clinics and multipurpose youth center (MYC) and increase mobile outreach clinic to twice a month through the establishment of the Before Midnight Project.

Established with funds from the Pacific HIV & STI Response Fund in late 2011, the Midnight clinic provides an after-hours youth clinical and education service to complement the youth 'drop-in' centre located in Kolonia township. The service operates in collaboration with the Youth Centre, operated by local peer educators, also supported by the AHDP program. Services at the Youth Centre/midnight clinic: computers with free internet access, search for information, karaoke, exercise equipment e.g. weight lifting, located in fitness gym; access to booklets and other educational pamphlets on issues for young people, such as teen pregnancy, STDs, family planning. There is a big screen TV for educational and recreational movies.

The Midnight Project aims to attract young people after schools hours, in recognition that they have limited opportunity for access to the Youth Centre or the Public Health HIV & STI clinic during school hours. The Midnight Project service is open to all young people between 13-25 years of age in Pohnpei, specifically targeting young people with evening opening hours. The estimated population in any one quarter is around 60 young people.

The service is staffed by Public Health clinical staff (one health assistant and one peer educator⁴⁹) and is open 5pm-8pm on weekends and 5-7pm on weekdays (Mon-Wed-Fri). It offers counseling and testing services, and specimen collections⁵⁰. Staff will also refer, if necessary, to the HIV & STI clinic located down near the hospital at the Public health clinic.

The Before Midnight Project is a pilot program, with expectations/hopes that the service will expand to 2 more locations in the rural areas. The Youth Resource Centre was selected due to its urban location, close to one of the three public high schools in Pohnpei. The expansion to a further two sites will encompass sites in rural areas.⁵¹

The "Before Midnight" Project is an excellent example of the move from local research and analysis to enhanced program delivery, which is to be encouraged.

⁴⁹ Both staff are paid; the peer educator rate is a stipend of \$10 per day.

⁵⁰ Staff will collect specimens and deliver to the local hospital laboratory for testing, after clinic closing hours, in accord with usual guidelines.

⁵¹ Personal communication with the AHDP coordinator, Mercedes Gilmete, Pohnpei, Department of Health

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 behavioral survey which was completed in 2011. The behavioral survey is a starting point for developing appropriate services.

The survey 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 behaviors: including multiple sexual partners, low condom use and low health seeking behaviors 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 neighbors 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 behavior 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.

Example: Pohnpei AHDP and HIV & STI Program - Developing programs for sex workers and their clients:

Over 2011, the Adolescent Health Development Program and HIV & STI Program in Pohnpei initiated a community education and outreach program working with commercial sex workers and sailors. This is the only program providing services to sex workers and their clients. The program includes three key strategies targeting each group:

- provision of information materials on the transmission and prevention of HIV & STIs;
- provision of condoms and lubricants accompanying the materials and in key locations such as hotels (in the rooms as well as at reception), port and security offices;
- referrals to testing.

The State HIV & STI Program in Pohnpei estimates that there are two groups, largely women, who engage in transactional or commercial sex work, with an approximate population of around 50-60. The HIV & STI program works with one group of around 25-30 women, whose ages range from 17-35 years, although many are still teenagers. Mostly, the women in this group are from Pohnpei, although some Chuukese who have lived in Pohnpei for some time are also part of the group. Whilst sex is usually exchanged for money, sometimes food or alcohol is also exchanged.

The sex workers' clients are primarily foreign seafarers, fishermen from Indonesia and other parts of Asia. The sex workers usually meet seafarers at a particularly bar which is also the hotel where some of the women also work as bar tenders and waitresses.

The main reason given by the women for doing sex work is to earn an income. They may start as waitresses, and then have the opportunity to earn some extra cash. Although some have partners, few have a long-term married spouse, and a number have children. It is not clear whether these partners benefit from the women's earnings.

The HIV & STI program was introduced to the group initially through one or two clients attending the Public Health clinic, then, through collaboration with peer educators, approached the sex workers in their home. Initially, the program visited the sex workers at their home, they share as a group, but now the program visits the hotel bar where the sex workers operate, usually in the evening prior to clients' arrival.

The Program workers visit key sites, such as the port, hotels, and sex workers' residences. To maintain confidentiality, they also offer to conduct testing on site at the workers residences for HIV & STIs.

The HIV & STI Program provides services on safer sexual behaviors, emphasizing the importance of safety and protection. They have introduced the sex workers to different condoms, condom kits, leaflets and counseling on STIs including HIV and testing. Health workers will take specimens on location for testing back at the laboratory because it is safer for the women and reduces the experience of stigma and discrimination.

Anecdotally, clients have reported positively on the services: they have told the health workers that they really need the HIV & STI services but have been afraid to go to the clinic because they don't want other people to look at them, knowing they are 'UHT' or 'a banana' as they are called in local slang.

The program relies on the police, port and security staff and hotels for support – and these groups also benefit from the materials distributed under the program.

A baseline of current sailors and sex workers knowledge and behaviors is yet to be determined. This is the next phase in the program's development. In discussion between the sex workers and the HIV & STI program, it has been identified that although most sailors were of Chinese or Indonesian backgrounds, the materials were largely in English with few pictures. Options for placing condoms on board ships had been explored but rejected by the shipping companies. And although the sex workers were offered information on preventing STIs, it remains unclear what the sex workers rely on to assist with contraception.

This program is an excellent example of building relationships and trust with a 'hidden' and stigmatized population in order to develop effective and appropriate services. As yet, it is an evolving program.

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 HIV 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 counseling 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 in the reason 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 without 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 gaps

The 2010 UNGASS Review identified a range of challenges in explanation of the shortcomings in FSM's capacity to meet the performance indicators. These included:

1. The separation of responsibilities for funding, policy and service delivery between national and state levels makes coordination difficult

2. The broader public health system has limited capacity
3. Pay and working conditions makes it hard to recruit & retain skilled staff
4. Missing or poor quality data influences the quality of reporting

Key areas of need identified to improve the quality and performance of the response included:

1. Need to identify and design interventions to focus on at risk populations, using existing SGS data
2. Need to strengthen inter-sectoral collaboration to address broader social and economic issues especially for youth
3. Need to reduce red tape & paperwork to streamline shipping & freight of ARTs and samples.
4. Health information systems need to be 'user friendly'
5. Need to encourage routine M&E systems which collect and analyses and uses data at program and services levels including a regularly scheduled M&E system; and ready access to, and use of, a standard suite of tools and checklists to support routine and systematic M&E processes

In the last two years, FSM has focused on the development of a national strategic framework which more accurately responds to its situation and prioritizes its programs accordingly, with the capacity to measure the intended results.

Whilst acknowledging some of the underlying challenges presented by the capacity of the supporting health systems, the FSM HIV and STI program has demonstrated a commitment to address some of these key issues identified in the last Country Progress report:

Prevention

There is a stronger focus on at risk populations, drawing from the concerns expressed in the SGS data analysed in 2008. As a result, there are emerging programs addressing commercial sex workers; and the development of approaches to engage men who have sex with men and transactional sex workers.

The Midnight Project is an example of a strong inter-sectoral collaboration between the state department of health, through the HIV & STI program and the Adolescent Health Development Program and the Youth Centre, to specifically target young people's sexual and reproductive health needs in a way which acknowledges the broader social and economic environment.

Monitoring & evaluation and Surveillance

A new tool for collecting and reporting STI data is now used: reflecting collaboration between donors/funders (CDC and SPC) as well as national and state programs. This is clearly a first step to developing routine monitoring and

evaluation systems which collect, analyze and share data at program and service levels using a standard suite of tools.

The Micronesia Red Cross Evaluation is an excellent contribution to the knowledge base for improving program delivery.

The Chuuk behavioral survey on women who exchange sex for money, goods and services is a valuable contribution to the knowledge base for future program development.

Program management and coordination

The development of the draft National Strategic Plan aims to bring all the states and national program together under the one umbrella to deliver the one national strategy: seeking to acknowledge but clarify the separation of responsibilities for funding, policy and service delivery between national and state levels which can make coordination difficult.

The establishment of the NAC HOST is an important first step to building a stronger and more representative stakeholder base for a more effective response across government and civil society.

However, there were also challenges that have made the delivery of the response difficult:

Consistency in technical advice:

The joint development of a common reporting template by SPC and CDC was cited by the National STI Program Manager as one of the most positive examples of collaboration between funders. However, this is not always a common experience for the country's implementers.

One state identified the roll-out of presumptive treatment as one more example of conflicting advice between the two major program funders, CDC and SPC that created challenges for their program delivery and for compliance with funding guidelines. Often, staff noted, they are forced to comply with two sometimes conflicting guidelines on treatment and care. In this instance, whilst SPC recommends presumptive treatment, CDC remains focused on encouraging testing. Furthermore, staff noted, at the community level, men have not responded favorably to the prospect of treatment, arguing instead that they would prefer that the women were tested to determine whether they need to take the medicine.

Despite assurances from each funding agency that the two agencies would reach agreement on the approach prior to the roll-out of the campaign, the State HIV & STI Program reported that they have not heard the outcome of discussions. In such situations, sometimes the response at country level is simply to wait.

Funding Flows

Funding flow has been an ongoing issue over the last two years for the AHD Program in Pohnpei. Although originally funded directly through the UNFPA via SPC, funds have been delayed for the last two years of the Program. As a result, the AHD Officer's salary has been subsidized by the Pohnpei State HIV Program for the last two years, pending clarification of the funding flow.

In addition, the peer educators previously supported by the AHD program stopped operating and have only been revived through the prospect of funding under the Midnight project. The Midnight Project was premised on the basis of AHD funds, so when funds were delayed, it became complicated: "We lost the backbone of AHD" is the way the AHD officer described it.

The UNFPA have recently advised that the funds are now directly channeled through the national government (through the MCH program), who have advised the AHDP officer that the MOU was to be signed in March 2012. The AHD Officer is yet to be advised of the status of funds.⁵²

Infrastructure

One state HIV & STI program reports that its office floods every time it rains. Delivering a program is challenging in such circumstances.

Treatment Care and Support: Improving Compliance with ART

Five of the current 6 people who are living with HIV are not compliant with their medications or are reluctant to start ART. This is a concern. A strategy needs to be put in place.

Financial management

Despite the innovation apparent in some state programs, one state has lost access to substantial funds for two key programs targeting prevention, screening and testing services for men and young people due to concerns about the integrity of the program's financial management. This is a serious issue. Steps must be taken to ensure that this does not happen again and that future innovative programs funded through either this donor or others are not jeopardized, on behalf of both the population of this state and for the country.

Reducing stigma and discrimination

Although Pohnpei has introduced model legislation, the review of HIV and Human Rights undertaken by RRRT has never been pursued to develop a stronger legislative and policy framework for the protection of the rights of those who are positive, or others, on the basis of sex, gender or status.

The current Strategy must address and promote a stronger legislative and policy framework to protect human rights and reduce stigma and discrimination – and encourage a more effective response through access to services and programs.

⁵² UNFPA says FSM national is the reason for the delay in funds due to submitting an inconsistent budget.

VI. Recommendations

Program Management, Policy and Coordination

During the development of the new National Strategic Plan, stakeholders noted that there were strong and positive relationships between federal and state levels. It was also agreed that communication and collaboration between the states and national programs could improve, particularly around reporting and policy development. The recently established NACHOST is one mechanism for improving and building on the existing positive networks and collaboration to develop and agree on common policy and protocols to guide aspects of program delivery. The more pressing of these include:

- The development of national legislation to protect positive people from stigma and discrimination;
- Agreement on data sharing arrangements and systems;
- Acknowledgment of existing lines of responsibility and authority;
- Planning and reporting protocols between states and federal areas.

Prevention, knowledge and behavior change

There remains a valid concern about the current prevention programs have yet to address the gap between knowledge and behaviour change. While there has been much work to develop and initiate new prevention programs, there are few evaluations of the effectiveness of current prevention initiatives, apart from the Red Cross evaluation and the earlier AHD program evaluations

More specific program evaluations to improve program performance, including financial management, are recommended. The capacity of stakeholders to monitor and evaluate needs strengthening to achieve this, so training and other support is also recommended.

Care treatment and support

The level of non-compliance amongst those currently living with HIV and eligible for ART is a concern. This needs exploration. It is recommended that the National HIV & STI Program institute a review to ascertain the reasons underlying non-compliance and develop an appropriate strategy.

Financing

The level of under-utilization of the allocated funds indicates that absorption capacity is the critical issue, rather than access to funds. However, this data is based on estimates and therefore is qualified. A thorough analysis of the relationship between current allocation and program expenditure and program outcomes (if possible) is recommended before any decisions about effectiveness and efficiency is made by funders.

Human resources

There has clearly been a strong and dedicated effort to address capacity strengthening, particularly through the resources provided under the Pacific HIV & STI response fund and the Global Fund. More than one stakeholder commented positively during the GAPR process on the level of support from SPC, particularly from the local office. The re-location of SPC staff to a local

office was a specific positive source of information on funding and other resources, including technical advice.

Discussions need to be initiated now to establish how the expiry of these funds may affect the capacity to deliver the response. Contingency strategies need to be developed. Thinking carefully about the mismatch between existing allocations and current expenditures may assist with this.

Monitoring and evaluation and surveillance

During the development of the National strategic plan, stakeholders were in agreement that monitoring and evaluation including surveillance data could be improved. Clearly, the development of a new template for reporting STIs is a positive first step, particularly as it reflects agreement between the key funders on the key data set to be maintained. This needs consolidation and systemic support. Stakeholders have already identified clear steps for doing this:

- Training in monitoring and evaluation for all staff - and particularly for the monitoring and evaluation officer.
- Development and implementation of a new data system to improve the reliability and use of data across FSM.
- Conduct program evaluations to inform program improvement
- Establish case reporting between the private and public health sector in all states.

VII. Support from the country's development partners (if applicable)

FSM draws on extensive technical advice, with the support of SPC and CDC 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:

- VCCT training and accreditation (PCSS)
- Family Planning Guidelines (UNFPA)
- AHD Capacity Development (SPC)
- Reproductive Health Commodities Training (UNFPA)
- Stepping Stones (Media) (SPC)
- BCC (SPC)

Governance:

- National Advisory Committee Governance Capacity Building (SPC)
- Conduct of the mid-term review (Burnet)
- 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 (SPC)
- Advocacy on Involvement of HIV+ people/reducing stigma and discrimination (PIAF)

Treatment Care and Support

- Clinical care in prevention of mother to child transmission (SPC)
- Clinical care in treatment, particularly in relation to HIV Rapid testing, ART for adults, and guidance on Mother to Child transmission during pregnancy and after (SPC)
- STI Chlamydia presumptive treatment campaign – rationale, effectiveness and approach to implementation (SPC & WHO)

Surveillance, research and monitoring and evaluation

- Development of a new standardized data collection form for STI program (SPC & CDC)
- Data collection, analysis and reporting of the Behavioral survey in Chuuk (SPC)
- Strengthen Laboratory based Surveillance (SPC)
- Child Protection Survey – baselines (UNICEF)
- Oceania Community Health Evaluation (OCH)
- Most Significant Change Evaluations (SPC)
- Monitoring & Evaluation Capacity Building (SPC)
- Global Fund Monitoring (SPC)

The advent of the Pacific HIV & STI Response Fund and the Global Fund has been a key platform for supporting ongoing capacity building over the last two years. With the prospect of each fund expiring in the next 18months, it is important the funders communicate clearly and consistently with the national program to clarify the potential impact of this, particularly on capacity strengthening activities.

VIII. Monitoring and evaluation environment

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 disease⁵³. DHSA carries responsibility to use this information and analysis to

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

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

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.

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 analysed, 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.

During 2010-2011, the National STI program adopted a revised reporting template

⁵³ Insert reference to policy.....

Country Progress Report - Federated States of Micronesia - 2012

In 2011, the National Program established a new position for monitoring and evaluation of the response, and appointed an officer to the role.

It is suggest that a starting place for the development of the monitoring and evaluation framework would be to revisit the recommendations of the assessment of the Surveillance Systems and Monitoring and Evaluation (MESS) Systems were undertaken by SPC and the Global Fund in 2008 and 2009.

SPC is scheduled to assist FSM national and state programs to develop a monitoring and evaluation framework during 2012 to guide monitoring and evaluation of the response for the next five years. This will provide a framework for the collection and analysis of additional data on the response, and build on the routine surveillance to strengthen the focus on the systematic collection and analysis of data to demonstrate capacity and program quality and improvement.

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 December 2011 when UNAIDS (Suva) invited the FSM Focal Point to submit the Global AID Response Progress Report (GARP). Following negotiation of the dates for the consultants field visit, the Focal Point attended the GARP training workshop offered by UNAIDS and SPC in Fiji in January. Following the workshop, the focal point held a meeting of national and state programs, where he distributed the guidelines on the indicators and the NCPI survey.

A work plan was then agreed between the consultant and the Focal Point by email communication. Following the consultant's arrival, a meeting was convened with a small working group consisting of the national coordinator, the national M&E officer and national finance manager 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 2010-2011 reporting period
- 2) Distribution of a word version of the NCPI survey (Part A and B) to the relevant state coordinator for completion at the state level by a small group of key stakeholders including state government representatives and the local community planning groups
- 3) Review of the financial data available in relation to the key funders
- 4) Review of available surveillance and other data to compile the indicators

The National HIV Program Coordinator undertook responsibility for working with colleagues to source all relevant program reports and distribute the NCPI Survey, supported by the national M&E Officer. The Finance Officer, working with colleagues at state and national level, sourced all relevant financial data. The consultant reviewed the most recent review of the response, the Mid-Term Review in 2010-2011, and data from two recent strategic planning workshops over the 2011-2012. 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 Coordinator and uploaded, then reviewed by the Coordinator. 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. The NCPI Surveys were aggregated; and the final draft shared with the National Coordinator for endorsement and comment prior to upload. Lastly, the draft narrative report was circulated to the NACHOST - the governing committee which oversees the response across FSM - for their verification.

Country Progress Report - Federated States of Micronesia - 2012

The final draft of the Report, with attachments, was revised by the consultant then returned to the National HIV Program Coordinator and his team for upload.

[ANNEX 2: National Commitments and Policy Instrument \(NCPI\)](#)

[See online report.](#)

[ANNEX 3: National Funding Matrix](#)

[See online report.](#)

