

UNGASS 2008 COUNTRY PROGRESS REPORT

Federated States of Micronesia

Reporting period: January 2006–December 2007



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Submission date: [fill in the date of the formal submission of the country report to UNAIDS by e-mail]

Acronyms and Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
CDC	Centers for Disease Control and Prevention
CNMI	Commonwealth of the Northern Mariana Islands
CPG	Community Planning Group
CHC	Community Health Center
FSM	Federated States of Micronesia
DHSA	Department of Health and Social Affairs
HIV	Human Immunodeficiency Virus
MCRS	Micronesian Red Cross Society
M&E	Monitoring and evaluation
MDG	Millennium Development Goal
MSM	Men who have sex with other men
NASA	National AIDS spending assessment
NCPI	National composite policy index
NCM	National coordinating mechanism
NDHSA	National Department of Health and Social Affairs
NGO	Non-governmental organisation
PLWH	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PRHP	Pacific Regional HIV/AIDS Project
TTPI	Trust Territory of the Pacific Islands
SGS	Second-generation surveillance
STIs	Sexually Transmitted Infections
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
VCCT	Voluntary confidential counselling and testing

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1. Status at a glance

1.1 The inclusiveness of the stakeholders in the report writing process

The process of UNGASS report preparation began in September 2007, when a series of meetings were held with stakeholders by the FSM National HIV/AIDS Coordinator, assisted by Program Officer, Monitoring and Evaluation, of the Pacific Regional HIV Program at the Secretariat of the Pacific Community.

NCPI workshops were held during December 2007 in Pohnpei and Chuuk States and involved both representatives of national and state governments and NGOs.

This report also drew heavily on a national situation report and strategic plan that was completed in December 2006 as a collaborative effort of the FSM HIV Program, the Pacific Regional HIV/AIDS Project (PRHP) and the Centre for Epidemiology and Population Health Research (CEPHR), Burnet Institute, Australia. This strategic plan involved very extensive consultation with government, NGOs and communities throughout all four states of FSM. Although further progress has been made in 2007, many of the findings of the national situation report remain current and pertinent today.

1.2 The status of the epidemic in the Pacific Region

HIV infections have now been reported in every country or territory in the Pacific island region, barring two of the smallest: Niue and Tokelau. Although the epidemics are still in their early stages in most places, preventative efforts need to be stepped up.¹

More than 90% of the 11,200 HIV infections reported across the 21 Pacific island countries and territories by mid-2004 were recorded in Papua New Guinea where an AIDS epidemic is now in full swing. Recorded HIV infection levels are low in the rest of the Pacific island region, and the total number of reported HIV cases exceeds 150 only in New Caledonia (246), Guam (173), French Polynesia (220) and Fiji (171). The data are based on limited HIV surveillance. The high levels of other sexually transmitted infections that have been recorded in some Pacific island countries, including FSM, show that significant risk behaviours exist along with the potential for the rapid spread of HIV throughout the Pacific island region.²

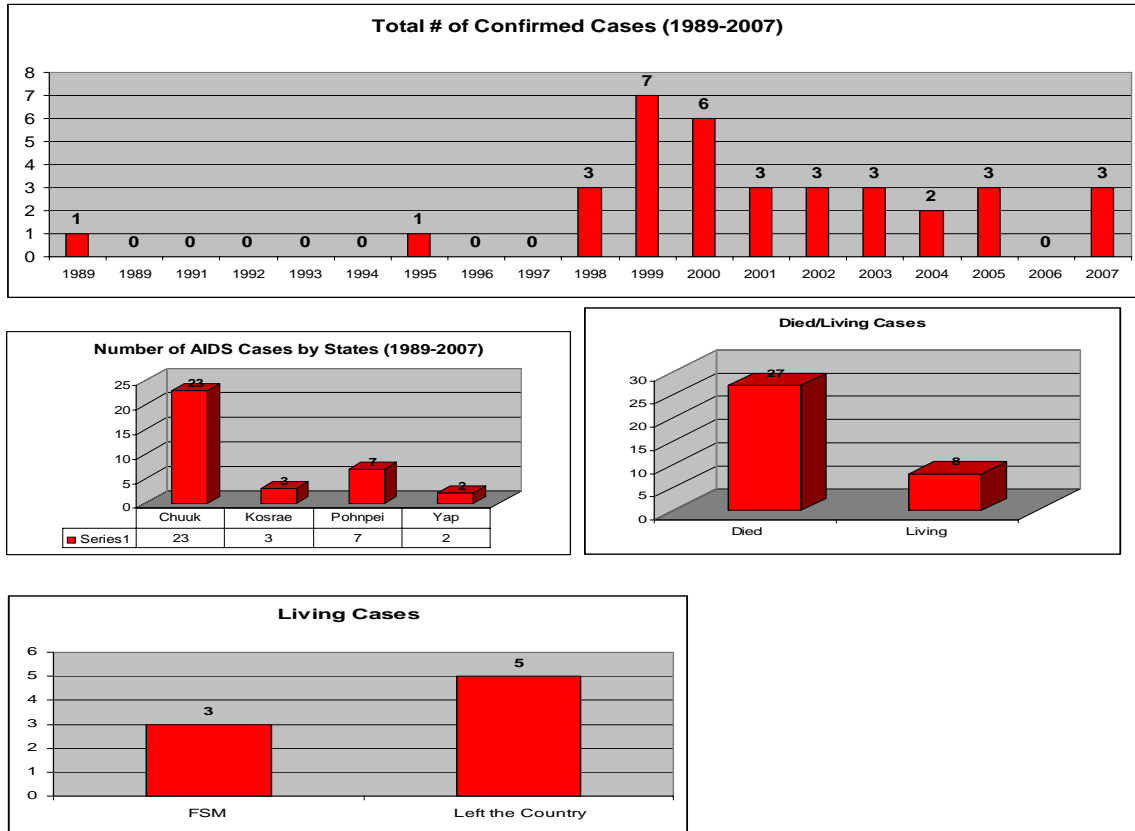
1.3 The status of the epidemic in Federated States of Micronesia (FSM)

Since the first case was detected in FSM in 1989, a total 35 cases of HIV and AIDS have been reported here. The number of confirmed cases of HIV has steadily mounted (

¹ UNAIDS website: www.unaids.org/en/Regions_Countries/Regions/Oceania.asp Dec 13, 2007.

² SPC website: www.spc.int Dec 13, 2007

Figure x). In 2007, 3 new cases of HIV were confirmed, and tests were continuing on another 9,010 people, involving altogether 3,746 men and 5,264 women. By the end of 2007, with the total of 35 confirmed cases in the FSM, 27 of these individuals had died from AIDS related illnesses and 5 had left the country. There are then 3 known PLWH in FSM.



1.4 The policy and programmatic response

HIV/AIDS programs operate in each of the four states of FSM: Pohnpei, Chuuk, Kosrae and Yap. The major source of funding for HIV/AIDS programs in FSM comes from the US Federal Government, through the Centre for Disease Control (CDC) and Human Resources and Services Administration (HRSA), and from GFATM and WHO.

Each state coordinates and implements its own HIV program. Although US and other donor funding has a strong influence on program design and implementation and thereby act to standardise the state programs and the availability of resources, the different cultures, political systems and geographical settings of the four states nevertheless maintain a strong local influence on program implementation and outcomes.

Nationally, improvements over the past two years include:

- i. **Wider availability and use of VCCT.** Many of the HIV tests conducted are mandatory under FSM or US law. These include all physical examinations conducted in government-run health facilities (there are only few privately

operated clinics); all people who join the US military forces, and all students going to study in the US. Since 2006, facilities for VCCT have expanded in all states, designed particularly for young people. The rising number of HIV tests conducted at voluntary request reflects the success of the program in encouraging testing (Table x).

- ii. **Availability of antiretroviral treatment in all states of FSM since August 2007.** Antiretroviral treatment is free through the public health system in FSM, funded through the Pacific regional HIV program that is implemented by the SPC. As mentioned above, however, PLWH who are FSM citizens are also eligible for free treatment and other benefits in the US. Several known PLWH left FSM this year to live in Hawaii.
- iii. **Implementation of community education programs** that emphasise prevention of HIV infection and counter negative community attitudes or stigmatisation of PLWH. These programs are being delivered by the national and state government HIV/STI programs, and by NGO groups such as the Micronesia Red Cross Society and the Adolescent Health Program. Other community groups have responded through their active participation in these activities.
- iv. **A stronger policy environment** with the development of state HIV/STI strategic plans and an inaugural FSM National Strategic Plan for HIV and other STIs 2007 – 2011 which were completed in early December, 2006. **As of December 2007, the FSM HIV/AIDS Bill is with the FSM Congress meanwhile, Pohnpei State has passed the Pohnpei HIV/AIDS Bill into law.**

Core Indicators for the Declaration of Commitment Implementation (UNGASS)

2008 reporting

Indicators	Data Available and Reported Yes or No	Method of Data Collection
National Commitment and Action		
Expenditures		
1. Domestic and international AIDS spending by categories and financing sources	No	National AIDS Spending Assessment Financial resource flows
Policy Development and Implementation Status		
2. National Composite Policy Index	No	Desk review and key informant interviews

Areas covered: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation		
National Programmes: blood safety, antiretroviral therapy coverage, prevention of mother-to-child transmission, co-management of TB and HIV treatment, HIV testing, prevention programmes, services for orphans and vulnerable children, and education.		
3. Percentage of donated blood units screened for HIV in a quality assured manner	Yes	Programme monitoring/special survey
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	No	Programme monitoring and estimates
5. Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	No	Programme monitoring and estimates
6. Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV	No	Programme monitoring
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results	Yes	Population-based survey
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results	Yes	Behavioural surveys
9. Percentage of most-at-risk populations reached with HIV/AIDS prevention programmes	Yes	Behavioural surveys
10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	No	Population-based survey
11. Percentage of schools that provided life-skills based HIV/AIDS education within the last academic year	Yes	School-based survey
Knowledge and Behaviour		
12. Current school attendance among orphans and among non-orphans aged 10–14*	No	Population-based survey
13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	Yes	Population-based survey
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	No	Behavioural surveys

15. Percentage of young women and men who have had sexual intercourse before the age of 15	Yes	Population-based survey
16. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	Yes	Population-based survey
17. Percentage 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 their last intercourse*	Yes	Population-based survey
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	No	Behavioural surveys
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	No	Behavioural surveys
20. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected	No	Special survey
21. Percentage of injecting drug users who report the use of a condom at last sexual intercourse	No	Special survey
Impact		
22. Percentage of young women and men aged 15–24 who are HIV infected*	Yes	HIV sentinel surveillance and population-based survey
23. Percentage of most-at-risk populations who are HIV infected	Yes	HIV sentinel surveillance
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	No	Programme monitoring
25. Percentage of infants born to HIV infected mothers who are infected	No	Treatment protocols and efficacy studies

STATE	LIVING	DEATHS	TOTAL
CHUUK	3	20	23
KOSRAE	1	2	3
POHNPEI	4	4	8

YAP	1	1	2
TOTAL:	9	27	36

Age Group	F	M	Total
0-14	2	3	5
15-24	3	4	7
25-44	7	15	22
45 +	0	1	1
Unk	0	1	1
Total:	12	24	36

Risk Factors	Male	Female	Total
Bi-Sexual	1	0	1
Heterosexual	12	10	22
IDU	2	0	2
MSM	6		6
MCT	3	2	5

Total	24	12	36
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HIV Screening and Testing from 2003 to 2007 by state per year.

STATES	2003	2004	2005	2006	2007
Pohnpei	2169	2494	2041	2335	2962
Chuuk	2285	1943	1505	4442	2849
Kosrae	707	771	601	737	660
Yap	348	520	214	1764	1277
Totals	5509	5728	4359	9278	9010

*Millennium Development Goals indicator

2. Overview of the AIDS epidemic

[Instructions: This section should talk about the HIV epidemic in your country. You can get this data from sentinel surveillance and specific studies (if any) from the UNGASS impact indicators (indicators 22-25). The source of information for all data provided should be included.]

2.1 The national setting

The Federated States of Micronesia (FSM) consists of four major island groups forming the states of Kosrae, Pohnpei, Chuuk and Yap. Together, these groups comprise of 607 islands – many uninhabited – spread across approximately a million square miles of the Western Pacific Ocean. The islands range from tiny coral atolls to large mountainous islands. Apart from Kosrae, each of the four states has lagoon and/or outer islands, most of which are only connected to the state urban centres by boat.² Half of the population of the FSM resides in the state of Chuuk. The wide dispersion of the population on many small islands makes the provision of health and other services expensive and difficult.

The population of FSM is mostly young and mobile, The national population was estimated at 110,000 in 2006, with a median age around 19 years. Fertility rates are moderately high, with an estimated TFR of 3.16 in 2006. Population growth between the two most recent national censuses in 1994 and 2000 nevertheless was low at an annual average of 0.3% , a dramatic decrease from earlier periods, largely because of out-migration to Guam, the Commonwealth of the Northern Mariana Islands (CNMI), Hawaii, and the United States mainland. (FSM citizens have full access to the United States and its territories.) By the end of 2005, an estimated 30,000 FSM citizens resided overseas,⁷ almost 12,000 of whom had emigrated in the period 1994-2000 alone.⁸

There is a high level of unemployment or under-employment, especially for young people. The economy is largely dependent on the fishing industry and licensing fees, migrant labour, and funds from the United States through the Compact of Free Association and other aid grants. Just of half of all people in paid jobs are employed in the public sector, which reflects the shortage of paid livelihoods. Household incomes are generally low, with a median of USD 4,662 per year, households are large with an average of 6.8 people, and there are few paid livelihood opportunities outside of the public sector.

Fertility rates in FSM remain relatively high, although the number of children born per woman has considerably declined over recent decades, from 8.2 in 1973, 4.7 in 1997, and 4.4 in 2001. The fertility decline has happened in the absence of economic development seen in other countries with similar declines. The decline is attributed to the high infant mortality rate of 21.8 (2001) per 1 000 live births, emigration, family planning, education of parents, employment of women, the new retirement program and job opportunities in the US where many men and especially women move to.³

³ Dept Health 2002.

2.2 Health infrastructure and services

The set-up of the health care system in the FSM mirrors the three-leveled structure of government, with national, state and municipal services. The national government does not implement or provide direct services but mainly provides policy direction for the four states. Each state coordinates and implements its own health programs, including for HIV. Although US and other donor funding has a strong influence on program design and implementation and thereby acts to standardise the state programs and the availability of resources, the different cultures, political systems and geographical settings of the four states nevertheless maintain a strong local influence on program implementation and outcomes.

The state health departments, through their government-run hospitals, provide all health care. Each of the FSM state has a public hospital that can provide primary and secondary care. Although everyone can receive health care at the hospitals, a nominal fee may be applied. The private health sector is small, operating a few primary health clinics with their own pharmacy. Their patients are mostly those who can afford to pay for services or are enrolled in an insurance program.

In the outlying islands, state government health dispensaries are supervised by the island mayors. Staffed by health assistants, these dispensaries mainly diagnose and treat common ailments and more advanced cases are referred to the central hospitals.

The major causes of morbidity and mortality In FSM are in the emerging epidemic category of non-communicable diseases such as heart disease, diabetes, hypertension, obesity, chronic lung disease, cancer, prematurity, complications of pregnancy and labour, and malnutrition. However, respiratory diseases, skin diseases, gastrointestinal diseases, otitis media and other infectious diseases—combined-- are the leading causes of the hospital admissions. Skin disease is highly prevalent, reflecting poor environmental conditions, particularly poor water supply. The prevalence rate of leprosy is among the highest in the Pacific (31.16 cases per 10 000 population), and the prevalence of tuberculosis is rising.⁴

Although health services receive a lot of funding, service delivery nevertheless faces difficulties. Compared to other Pacific island countries, health indicators in FSM are poor. FSM is second only to Kiribati in having the highest infant mortality rate in the region, largely due to preventable causes such as diarrhoea and acute respiratory infections.

⁴ Dept Health, 2002.

Table 2: Selected FSM population and health indicators 2000-2006 (various sources)

	FSM Census ²	World Health Organization ²⁴	US Department of State ¹³	FSM Health Statistics Office ²⁵	United Nations ²⁶	CIA world fact book ²⁷⁻ ₃₁
<i>Year of estimate</i>	2000	2002	2005	2005	2006	2006
Population	107,008	108,000	107,000	114,100	110,000	108,004
Population growth rate	0.3%	0.7%	3.0%	-	0.6%	-0.11%
Death Rate per 1,000	3.9*	-	-	2.8	-	4.75
Infant Mortality Rate per 1,000 births	40^	47	33.5	13.6	-	29.16
Total fertility rate	4.4	3.8	-	-	-	3.16
Life expectancy (years)						
Overall	67.0^	66.5	-	67.5		70.05
Males	-	64.9	66.7	-	68	68.24
Females	-	68.1	70.6	-	71	71.95

* When calculated using an indirect method, the crude death rate was 7

^ Calculated using indirect methods

3.2 The progress of the HIV epidemic in FSM

From 1989 – 2007, **thirty five (35) cases** of HIV infection were reported in FSM, following tests conducted locally and confirmed in Hawaii. By state, in December 2007 **there were two (2) people** living with HIV and AIDS in Pohnpei, **0 in Kosrae**, **one (1) in Yap** and 0 in Chuuk, from where the five (5) known HIV cases had recently moved to U.S. Of the people reported to be infected with HIV, **twenty seven (27) had died from AIDS related illnesses**. Most cases in FSM have been identified in Chuuk State, the most populous state.

The reported numbers of PLWH most likely under-count of the level of infection and do not fully reflect the risk of a widespread epidemic:

- The high ratio of deaths from AIDS to the known cases of HIV infection indicates that the prevalence of HIV in the FSM population remains under-reported. For example, of the 22 people ever reported as HIV-positive in Chuuk State, 19 have died. In the past, many tests for HIV were in response to clinical symptoms.
- Information is not shared between private health care providers and government health services, although there are plans to do so. Although there are few privately run health clinics in FSM, they do provide HIV testing. Some people would expect confidentiality to be higher in the private clinics. State HIV/STI programs have trained counsellors to deliver appropriate pre- and post- HIV test counselling and, despite community pressure in these small communities, have placed a strong emphasis on the confidentiality of testing.
- The population of FSM is very mobile. People frequently travel between FSM, Guam, CMNI, Hawaii and the US mainland, and this further limits local capacity to monitor the prevalence of HIV in the population. Anti-retroviral treatment only became available in FSM in August 2007. Although this is now free, FSM citizens

with HIV or AIDS are also eligible for free treatment in Hawaii, where they also can receive other benefits such as free housing. The three people in Chuuk State known to have HIV all left for Hawaii late in 2007 even though treatment was then available to them in Chuuk.

HIV testing is increasing as VCCT facilities have become more widely used. Most HIV tests are mandatory, being conducted during screening of blood donors, pregnant women, students, food handlers and prior to marriage (---% of all HIV tests in 2007). Screening of blood donors is the next major reason for HIV testing (---%), and testing of STI clients and their sexual contacts (---%). In 2007 voluntary requests accounted for ---% of testing in Chuuk, ---% in Kosrae, ---% in Pohnpei and ---% in Yap.

Clinic	2007		2006		2005		Totals
	Male	Female	Male	Female	Male	Female	
Prenatal		2283		2009		1582	5874
Post-natal		79		78		87	244
Pre-employment	324	284	266	233	136	95	1014
Premartial	46	47	61	57	69	62	296
Student	524	482	488	468	281	294	2013
Food Handlers	302	684	157	400	94	287	1622
STI Clinic	295	230	472	807	86	33	1628
STI Contact	58	72	37	57	21	33	220
Blood Donor	1580	309	1118	230	545	155	2357
Blood Recipient	80	147	341	241	Not Reported		729
TB	23	13	21	22	103	29	188
Voluntary	513	643	560	1316	223	270	3012
Sub-Totals	3745	5273	3521	5918	1558	2927	19197
Totals	9018		9439		4485		13924

Of reported cases of HIV infection, most appear to have occurred through unprotected sexual intercourse, principally heterosexual. The common practice of unprotected sexual intercourse is also apparent from the high incidence of other STIs.

Table 3 Reported risk factors in HIV transmission, FSM 2003-2007

Risk Factors			
Risk Factors	Male	Female	Total
Bi-Sexual	1	0	1
Hetrosexual	11	10	21
IDU	2	0	2
MSM	6		6
MCT	3	2	5
Total	23	12	35

Source: National Department of Health and Social Affairs, 2007

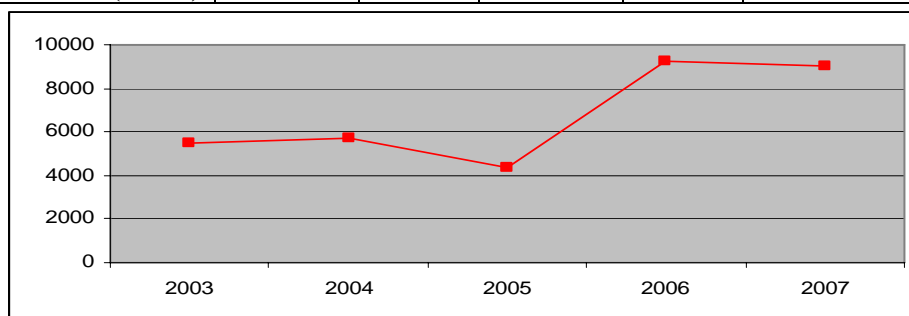
3. National response to the AIDS epidemic

[Instructions: This section should reflect the changes made in national commitment and programme implementation broken down by prevention, care, treatment and support, knowledge and behaviour change, and impact during the period January 2006–December 2007. What have you done in the past two years?]

3.1 Greater availability and use of VCCT

Table 4 Total number of HIV tests in FSM by state and year, 2003-2007

States	2003	2004	2005	2006	2007
Pohnpei	2169	2494	2039	2335	2962
Chuuk	2285	1943	1505	4442	2849
Kosrae	707	771	601	737	660
Yap	348	520	214	1764	2539
FSM(Totals)	5509	5728	4359	9278	9010



Community education

In some states, particularly Pohnpei and Chuuk, existing structures such as an HIV community planning group and an active HIV/STI program have facilitated extensive outreach education and awareness campaigns to all municipalities on both the main island and the outer islands.

Programs within Public Health – HIV, STDs, Family Planning, Maternal and Child Health – are responsible for most education and health promotion relating to HIV and other STIs. Each conducts sporadic education and awareness workshops to students attending schools and the college, as well as to the community, generally following a similar format of a lecture/presentation followed by a question and answer session. Rarely are workshops conducted in gender- and age- specific grouping and there appears to be little pooling of skills or resources – while sometimes programs deliver workshops together, often they work and travel as separate entities.

WHAT OTHER KINDS OF PROGRAMS OPERATE?

Availability of treatment

Antiretroviral treatment became available and free in FSM in August 2007. Since then, we have one (1) person currently on the antiretroviral treatment.

3.2 Stronger surveillance

Second- generation behavioural surveys were conducted in 2007.

- Pohnpei: HIV risk behaviour surveys conducted in youth and police, data now being analysed; STI Prevalence Survey- including testing for HIV & other STIs conducted in prenatal women, about to commence **March 2007. Same surveys were conducted and completed in Yap State and the data now being analysed.**
- Similar surveys have been proposed for both Chuuk and Kosrae State.

3.4 A stronger planning and policy environment

In 2005 the FSM National HIV/AIDS program requested assistance from the Pacific Regional HIV/AIDS project (PRHP) to develop a National Strategic Plan for HIV. Subsequently PRHP supported a technical advisor to assist in-country from August-December 2006 with the planning process. The first stage in the planning process was a situation and response analysis to assess the current situation of HIV and other sexually transmitted infections (STIs) in the FSM in 2006, and past and current responses to these infections. A summary situation and response analysis report was prepared for each state of the FSM to inform the development of state HIV/STI strategic plans for 2007-2011. These state plans assisted in the formation of the inaugural FSM National Strategic Plan for HIV and other STIs 2007 – 2011 which was completed by early December, 2006.

Indicator 1. National AIDS Spending Assessment

[Instructions: Briefly discuss national and international spending on HIV in your country. You will need to try to complete the National AIDS Spending Assessment (NASA) excel spreadsheet. This excel sheet is in your UNGASS package.]

The major source of funding for the FSM HIV/AIDS program is US federal funding grants, administered through the Center for Disease Control (CDC) and Human Resources and Services Administration (HRSA). Other support is provided by GFATM, through the Pacific regional program implemented by the Secretariat of the Pacific Community, and WHO.

Because of the heavy dependence on aid donor support, long-term financial support to the health system is uncertain. The support provided by the United States Government is subject to the Compact of Free Association between the FSM and United States Governments, and it is uncertain what will happen when the current agreement expires in **2020**. The financial situation is exacerbated by the large proportion of the health budget spent for such things as the large number of off-island medical referrals and costly health care for the relatively small number of patients who require treatment for degenerative diseases and.⁵

⁵ August 22, 2002, FSM National Government, Department of Health, Education and Social Affairs

Indicator 2. National Composite Policy Index

[Countries should specifically talk about the relationship between the existing policy, implementation of HIV programmes, proven behaviour change (from a survey) and HIV prevalence.

Countries should also use the National Composite Policy Index (NCPI) data to summarise progress made in policy/strategy development and implementation, and include a trend analysis on the key NCPI data since 2003 if possible. Countries are encouraged to report on additional data to support their analysis and interpretation of the UNGASS data.]

The political system

The FSM has three levels of government – national, state and local. The FSM National Government is located in Palikir, on the main island of Pohnpei. Each state of the FSM has its own legislature, with members representing a particular geographical area, and Governor and Lieutenant Governor, all of whom are elected by popular vote. The states all have their own constitution, and retain considerable power, especially in relation to the implementation of budgetary policies. States are further sub-divided into municipalities for local government.¹³

Traditional leadership, and their modern day role, varies between the FSM states, with the exception of Kosrae which no longer has traditional leaders. Both Pohnpei and Yap maintain a hierarchical system of traditional leadership, including a Council of Chiefs, while Chuuk has traditional leaders but no council that oversees the entire state. The traditional chiefs in Yap retain a considerable degree of influence over day-to-day living across the entire state, while the influence of chiefs in Pohnpei and Chuuk varies between individual villages and islands.

The Constitution of the FSM specifies which powers are delegated to the FSM national congress, and all powers not expressly delegated or of ‘indisputably national character’ are regarded as state powers.¹⁵ Some states still retain many laws from the days of the Trust Territory, while other states have enacted many of their own laws replacing and/or overriding the old laws of the Trust Territory.

While there is no formal age at which a person can have sex in the FSM, each state automatically considers sex under the age thirteen as sexual assault.¹⁶ Legal age of marriage is 18 years for males and 16 years for females, although females aged under 18 must have parental consent to be married. Apart from Kosrae, where marriages must be performed by an ordained minister, civil, religious and traditional marriages are recognised by state law. Divorces can be granted by courts in all states, however the legal grounds for divorce vary between states.¹⁶ According to interviews with the

Attorney Generals offices in each state, divorce cases very rarely appear before the courts.

Apart from Yap, abortion is illegal in all states, and is rarely (if ever) performed in the Yap State Hospital. Prostitution is illegal in Chuuk and Pohnpei but not in Yap and Kosrae. Homosexuality is not illegal in any state of the FSM.¹⁶ According to the FSM National Secretary of Justice, each state has been requested by the FSM National Government to pass a law regarding the “reckless transmission of HIV”; however no bills have yet been passed by the state legislature regarding this issue.

The FSM Constitution offers various protections to FSM citizens including

- Banning discrimination based on race, sex, language, religion, ancestry, national origin and social status;
- Rights to education, health care and legal services; and
- Freedom of expression, peaceable assembly and religion.¹⁵

The FSM is a party to the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against women, but is not party to any other major international human rights treaties such as the International Covenants on Economic, Social and Culture Rights and Civil and Political Rights.¹⁷

3.1 National Programme Indicators

Indicator 3. Percentage of donated blood units screened for HIV in a quality assured manner

i Description

This indicator assesses progress in ensuring a safe blood supply. Universal (100%) screening of donated blood for HIV and other transfusion-transmissible infections cannot be achieved without mechanisms to ensure quality and continuity in screening. In some countries, interruptions to supplies of test kits and reagents, or emergency situations, can result in the use of blood for transfusion without screening for transfusion-transmissible infections. The development of systems for reliable and regular supplies of low-cost, high-quality test kits and reagents and effective stock management are therefore essential to ensure universal quality screening of blood units.

Thus, it is crucial that all donated blood units be screened for HIV in a quality-assured manner. Two key components of quality assurance in screening are: 1) The use of documented and standardized procedures (standard operating procedures) for the screening of every blood unit; 2) Participation of the laboratories in an External Quality Assessment Scheme for HIV screening in which external assessment of the laboratory’s performance is conducted using samples of known, but undisclosed, content to assess its quality system and assist in improving standards of performance.

Indicator 4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy

i Description

This indicator assesses progress towards providing antiretroviral combination therapy to all people with advanced HIV infection. As the HIV pandemic matures, increasing numbers of people are reaching advanced stages of HIV infection. Antiretroviral therapy (ART) has been shown to reduce mortality among those infected and efforts are being made to make it more affordable within low- and middle-income countries. Antiretroviral combination therapy should always be provided in conjunction with broader care and support services including counseling for family caregivers.

ii Measurement Tool and method

INFORMATION NOT AVAILABLE

Indicator 5. Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission

i Description

This indicator assesses progress in preventing vertical transmission of HIV. In the absence of any preventative interventions, infants born to and breastfed by HIV-infected women have roughly a one-in-three chance of acquiring infection themselves. This can happen during pregnancy, during labour and delivery or after delivery through breastfeeding. The risk of mother-to-child transmission can be significantly reduced through the complementary approaches of antiretroviral prophylactic regimes for the mother with or without prophylaxis to the infant, implementation of safe delivery practices and use of safe alternatives to breastfeeding. Antiretroviral prophylaxis followed by exclusive breastfeeding may also reduce the risk of vertical transmission when breastfeeding is limited to the first six months.

ii Measurement Tool and method

INFORMATION NOT AVAILABLE

Indicator 6. Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV

i Description

This indicator assesses progress in detecting and treating TB in people living with HIV. Tuberculosis (TB) is one of the commonest causes of morbidity and mortality in people living with HIV, even those on antiretroviral therapy. Intensified TB case-finding and access to quality diagnosis and treatment of TB in accordance with international/national guidelines is essential for improving the quality and quantity of life for people living with HIV. A measure of the percentage of HIV-positive TB cases that access appropriate treatment for their TB and HIV is important.

ii Measurement Tool and method

INFORMATION NOT AVAILABLE

Indicator 7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results

i Description

This indicator assesses progress in implementing HIV testing and counseling. In order to protect themselves and to prevent infecting others, it is important for individuals to know their HIV status. Knowledge of one's status is also a critical factor in the decision to seek treatment.

ii Measurement Tool and method

INFORMATION NOT AVAILABLE

Indicator 8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results

i Description

This indicator assesses progress in implementing HIV testing and counselling among most-at-risk populations. In order to protect themselves and to prevent infecting others, it is important for most-at-risk populations to know their HIV status. Knowledge of one's status is also a critical factor in the decision to seek treatment. This indicator is calculated separately for each population that is considered most-at risk in a given country: sex workers, injecting drug users and men who have sex with men.

ii Measurement Tool and method

INFORMATION NOT AVAILABLE

Indicator 9. Percentage of most-at-risk populations reached with HIV/AIDS prevention programmes

i Description

This indicator assesses progress in implementing HIV prevention programmes for most-at-risk populations. Most-at-risk populations are often difficult to reach with HIV prevention programmes. However, in order to prevent the spread of HIV among these populations as well as into the general population, it is important that they access these services. This indicator should be calculated separately for each population that is considered most-at-risk in a given country: sex workers, injecting drug users, men who have sex with men.

INFORMATION NOT AVAILABLE

Indicator 10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child

i Description

This indicator assesses progress in providing support to households that are caring for orphaned and vulnerable children aged 0–17. As the number of orphaned and vulnerable children continues to grow, adequate support to families and communities needs to be assured. In practice, care and support for orphaned children comes from families and communities. As a foundation for this support, it is important that households are connected to additional support from external sources.

- Due to the islands' custom and cultures and the system of the “extended” families, orphans are not a major problem in the FSM.
- INFORMATION NOT AVAILABLE

Indicator 11. Percentage of schools that provided life-skills based HIV/AIDS education within the last academic year

i Description

This indicator assesses progress towards implementation of life skills-based HIV education in all schools. Life skills-based education is an effective methodology that uses participatory exercises to teach behaviors to young people that help them deal with the challenges and demands of everyday life. It can include decision-making and problem-solving skills, creative and critical thinking, self-awareness, communication and interpersonal relations. It can also teach young people how to cope with their emotions and causes of stress. When adapted specifically for HIV education in schools, a life skills-based approach helps young people understand and assess the individual, social and environmental factors that raise and lower the risk of HIV transmission. When properly implemented, it can have a positive effect on behaviors, including delay in sexual debut and reduction in number of sexual partners.

No data available for this indicator

3.3 Knowledge and Behaviour Indicators

Indicator 12. Current school attendance among orphans and among non-orphans aged 10–14*

i Description

This indicator assesses progress towards preventing relative disadvantage in school attendance among orphans versus non-orphans. AIDS is claiming ever-growing numbers of adults just at the time in their lives when they are forming families and bringing up children. As a result, orphan prevalence is rising steadily in many countries, while fewer relatives within the prime adult ages mean that orphaned children face an increasingly uncertain future. Orphan hood is frequently accompanied by prejudice and increased

poverty, factors that can further jeopardize children’s chances of completing school education and may lead to the adoption of survival strategies that increase vulnerability to HIV. It is important therefore to monitor the extent to which AIDS support programmes succeed in securing the educational opportunities of orphaned children.

ii Measurement Tool and method

INFORMATION NOT AVAILABLE

Indicator 13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*

i Description

This indicator assesses progress towards universal knowledge of the essential facts about HIV transmission. HIV epidemics are perpetuated through primarily sexual transmission of infection to successive generations of young people. Sound knowledge about HIV is an essential pre-requisite—albeit, often an insufficient condition—for adoption of behaviours that reduce the risk of HIV transmission.

ii Measurement tool and method

Youth surveys were conducted in Pohnpei and Chuuk states in 2007. To date, data are only available from the Pohnpei survey. The Pohnpei Youth Survey covered 300 respondents (143 males, 147 females, 9 refusals) aged 15-24 years. The survey instrument was a self- completed questionnaire, based on a haphazard (convenience) sample taken from seven sites in Pohnpei State over a three month period.

iii Definition of Indicator, the Data, Interpretation and Analysis

Table 5 Knowledge of HIV transmission: Results of the Pohnpei Youth Survey, 2007

	Males (n= 143)	Females (n= 147)
Having sex with only one faithful uninfected partner can reduce the chance of getting HIV?	58.3%	35.4%
Using condoms correctly can reduce the chance of getting HIV?	71.5%	57.8%
A healthy looking person can be infected with HIV?	68.1%	68.0%
A person can get HIV from mosquito bites?	67.4%	73.5%
A person can get HIV from sharing a meal with someone who is infected with HIV?	82.6%	83.7%
A mother can pass HIV to her baby during pregnancy, delivery and breast-feeding?	81.9%	83.7%

Pohnpei State Dept Health, unpublished data from 2007 Youth Survey

The results of the 2007 Pohnpei Youth Survey suggest that there is far from universal knowledge of the essential facts about HIV transmission about young people aged 15 to 24. Only just over half of young men and one third of young women knew one of the most fundamental ways to protect themselves from contracting HIV, namely that having sex with only one faithful uninfected partner can reduce the chance of getting HIV. High proportions of young men and women wrongly believed they could contract HIV from mosquitos or sharing meals. This suggests that public education programs have not yet been effective in transferring useful information about HIV transmission.

Indicator 14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

i Description

This indicator assesses progress in building knowledge of the essential facts about HIV transmission among most-at-risk populations. Concentrated epidemics are generally driven by sexual transmission or use of contaminated injecting equipment. Sound knowledge about HIV is an essential prerequisite if people are going to adopt behaviours that reduce their risk of infection. This indicator should be calculated separately for each population that is considered most-at-risk in a given country: sex workers, injecting drug users, men who have sex with men.

ii Measurement Tool and method

INFROMATIOIN NOT AVAILABLE

Indicator 15. Percentage of young women and men who have had sexual intercourse before the age of 15

i Description

This indicator assesses progress in increasing the age at which young women and men aged 15–24 first have sex. A major goal in many countries is to delay the age at which young people first have sex and discourage premarital sexual activity because it reduces their potential exposure to HIV. There is also evidence to suggest that first having sex at a later age reduces susceptibility to infection per act of sex, at least for women.

ii Measurement tool and method

Youth surveys were conducted in Pohnpei and Chuuk states in 2007. To date, data are only available from the Pohnpei survey. The Pohnpei Youth Survey covered 300 respondents (143 males, 147 females, 9 refusals) aged 15-24 years. The survey instrument was a self- completed questionnaire, based on a haphazard (convenience) sample taken from seven sites in Pohnpei State over a three month period.

Table 6 Sexual behaviour of young people aged 15-24: Pohnpei Youth Survey, 2007

	Males (n= 143)	Females (n= 147)
Percentage who have had sex	85.3%	55.8%
Age at first sex experience	14.5 yrs	16.5%

(mean)		
Age at first sex experience (range)	8-23 yrs	13-20 yrs
Condom use at first sex	12.3%	11%
Had ever used a condom	48.4%	30.5%
Condom use in last 12 mths	5% (always); 52% (sometimes); 43% (never)	1% (always); 28% (sometimes); 63% (never)
Condom use last time had sex	38%	17%
No of sex partners in last 12 mths (mean)	3.3	1.5
No of sex partners in last 12 mths (range)	0-17	0-6

Pohnpei State Dept Health, unpublished data from 2007 Youth Survey

iii Definition of Indicator, the Data, Interpretation and Analysis

Information needed here on PERCENTAGE WHO HAD SEXUAL INTERCOURSE BEFORE THE AGE OF 15 - Therefore, need further break-down of survey results from Pohnpei State Dept Health. Please include gender, age, numerator, denominator. What does the information mean?

Indicator 16. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months

i Description

This indicator assesses progress in reducing the percentage of people who have higher-risk sex. The spread of HIV largely depends upon unprotected sex among people with a high number of partnerships. Individuals who have multiple partners (concurrently or sequentially) have a higher risk of HIV transmission than individuals that do not link into a wider sexual network.

ii Measurement Tool and method

There are no data available that cover this age-group. The youth survey completed in 2007 for Pohnpei State (see Indicator 15, above) however provides information about people aged 15-24 years (Table x).

iii Definition of Indicator, the Data, Interpretation and Analysis

The Pohnpei Youth Survey, 2007, found that the mean number of sexual partners was 3.3 for young males and 1.5 for young females. The range in the number of sexual partners over the past 12 months was 0-17 for young males was 0-17 and 0-6 for young females.

Indicator 17. Percentage 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 their last intercourse*

i Description

This indicator assesses progress towards preventing exposure to HIV through unprotected sex with non-regular partners. Condom use is an important measure of protection against HIV, especially among people with multiple sexual partners.

ii Measurement Tool and method

There are no data available for FSM that cover this age-group. The youth survey completed in 2007 for Pohnpei State (see Indicator 15, above) provided information only about people aged 15-24 years (Table 6). Only 38% of young males and 17% of young females reported using a condom during their most recent sex experience.

Other indicators of condom use are also low (Table 6). Furthermore, alcohol and other substance use is associated with unsafe sexual activity among young people. A survey of alcohol and other drug consumption in 1997 in the FSM found alarmingly high consumption of alcohol, moderate use of marijuana but very low use of “harder” drugs. A 2006 survey of Kosrae High School students found that a quarter reported getting drunk at least monthly.³³ The police in Kosrae estimate that almost all incidents they attend are driven by alcohol use.⁶

Indicator 18. Percentage of female and male sex workers reporting the use of a condom with their most recent client

i Description

This indicator assesses progress in preventing exposure to HIV among sex workers through unprotected sex with clients. Various factors increase the risk of exposure to HIV among sex workers, including multiple, non-regular partners and more frequent sexual intercourse. However, sex workers can substantially reduce the risk of HIV transmission, both from clients and to clients, through consistent and correct condom use.

ii Measurement Tool and method

INFORMATION NOT AVAILABLE

iii Definition of Indicator, the Data, Interpretation and Analysis

While transactional sex occurs in FSM in an informal, disorganised way, only a very small number of people are at all identifiable as sex workers. A 2006 survey of stakeholders on Kosrae found that only one third (8 of 24) of the people interviewed were at all aware that sex work occurred on the island. Of those that knew of it, all but one estimated there were less than five local women involved in the trade, and that it was predominately younger women selling to visiting fishing crews, especially in the past when more boats came in. One of the female peer educators interviewed reported a much higher number of sex workers (10-50) and had heard that selling sex was “good and fast money”. No healthcare workers were aware of any of their patients being sex workers.⁷

⁶ Situation Report

⁷ Situational Report, 2006

Even more loosely defined transactional sex appears to be rare, at least on Pohnpei. The 2007 Pohnpei Youth Survey found that only 1.2% females reported having received money for sex, and only 5.1% males reported having given money or goods for sex.

Indicator 19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

i Description

This indicator assesses progress in preventing exposure to HIV among men who have unprotected anal sex with a male partner. Condoms can substantially reduce the risk of the sexual transmission of HIV. Consequently, consistent and correct condom use is important for men who have sex with men because of the high risk of HIV transmission during unprotected anal sex. In addition, men who have anal sex with other men may also have female partners, who could become infected as well. Condom use with their most recent male partner is considered a reliable indicator of longer-term behaviour. Countries like PNG with generalized epidemics may also have a concentrated sub-epidemic among men who have sex with men.

ii Measurement Tool and method

INFORMATION NOT AVAILABLE

Men who have sex with other men

Most stakeholders were aware of men who had sex with other men in Kosrae, although estimates of numbers were less than 20 and there was a generally feeling expressed by stakeholders that this practice is not acceptable to Kosraean culture and religion. No healthcare workers were aware of any of their patients being men who had sex with other men.

Indicator 20. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected

i Description

This indicator assesses progress in preventing sexual transmission of HIV. Safer injecting and sexual practices among injecting drug users are essential, even in countries where other modes of HIV transmission predominate, because: (i) the risk of HIV transmission from contaminated injecting equipment is extremely high; and (ii) injecting drug users can spread HIV (e.g. through sexual transmission) to the wider population.

ii Measurement Tool and method

INFORMATION NOT AVAILABLE

iii Definition of Indicator, the Data, Interpretation and Analysis

Injecting drug use appears to be rare, at least in some states of FSM. A 2006 survey on Kosrae found that not a single person interviewed, including the Chief of Police, was aware of anyone who injected drugs on the island. A few of the interviewees reported that they believed there were people in Kosrae who had injected drugs whilst off-island,

indicating that while the practice may not actually occur in Kosrae (probably due to a lack of supply), some of the population may have previously been involved in this activity. The Chief of Police reported that tattooing using improvised equipment is very common within the prison.⁸

The 2007 Pohnpei Youth Survey however reported that 6.1% of young females and 11.2% of young males reported having injected drugs in the previous 12 months.⁹ There was no information available as to whether the injecting equipment used was sterile or not. Given the illegal and socially unaccepted status of this activity, however, it is unlikely that young people would have good access to sterile equipment.

Indicator 21. Percentage of injecting drug users who report the use of a condom at last sexual intercourse

i Description

This indicator assesses progress in preventing injecting drug use-associated HIV Transmission. Safer injecting and sexual practices among injecting drug users are essential, even in countries where other modes of HIV transmission predominate, because: (i) the risk of HIV transmission from contaminated injecting equipment is extremely high; and (ii) injecting drug users can spread HIV (e.g. through sexual transmission) to the wider population.

ii Measurement Tool and method

INFORMATION NOT AVAILABLE

iii Definition of Indicator, the Data, Interpretation and Analysis

See Indicator 20 above.

3.4 Impact indicators

Indicator 22. Percentage of young women and men aged 15–24 who are HIV infected*

i Description

This indicator assesses progress towards reducing HIV infection. The goal in the response to HIV is to reduce HIV infection. As the highest rates of new HIV infections typically occur in young adults, more than 180 countries have committed themselves to achieving major reductions in HIV prevalence among young people—a 25% reduction in the most affected countries by 2005 and a 25% reduction globally by 2010.

ii Measurement Tool and method

⁸ Situation Report

⁹ Pohnpei Youth Survey

How information was collected and with what tool (e.g. a survey)]

iii Definition of Indicator, the Data, Interpretation and Analysis

[what is the data: please include gender, age, numerator, denominator and what does the information mean.

PLEASE tell us what the challenges with the data are, is there anything that you want to tell the reader that is unique about the data? Remember, the people reading this do not know anything about your country or your data]

Indicator 23. Percentage of most-at-risk populations who are HIV infected

i Description

This indicator assesses progress on reducing HIV prevalence among most-at-risk Populations. Most-at-risk populations typically have the highest HIV prevalence in countries with either concentrated or generalized epidemics. In many cases, prevalence among these populations can be more than double the prevalence among the general population. Reducing prevalence among most-at-risk populations is a critical measure of a national-level response to HIV. This indicator should be calculated separately for each population that is considered most-at-risk in a given country: sex workers, injecting drug users, men who have sex with men.

ii Measurement Tool and method

INFORMATION NOT AVAILABLE

Indicator 24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

i Description

This indicator assesses progress in increasing survival among infected adults and children by maintaining them on ART. One of the goals of any ART programme is to increase survival among infected individuals. As ART is scaled up in countries around the world, it is also important to understand why and how many people drop out of treatment programmes. These data can be used to demonstrate the effectiveness of those programmes and highlight obstacles to expanding and improving them.

ii Measurement Tool and method

INFORMATION NOT AVAILABLE

Indicator 25. Percentage of infants born to HIV infected mothers who are infected

i Description

This indicator assesses progress towards eliminating mother-to-child HIV Transmission. In low-income countries, significant difficulties exist in implementing these strategies due to constraints in accessing, affording and using voluntary counselling and testing

services, reproductive health, and maternal and child health services, which have integrated prevention of mother-to-child transmission (PMTCT) interventions, including breast milk substitute (where this is part of the country's policy on PMTCT). Nevertheless, substantial reductions in mother-to-child transmission can be achieved through approaches such as short-course antiretroviral prophylaxis.

ii Measurement Tool and method

INFORMATION NOT AVAILABLE

4. Best practices

Youth Issues and Challenges

Since the development of the National Youth Policy 2004-2010 and its ratification by National Congress in 2005, several components are address in its Family Life sector, including health and wellness, family life-skills, peer education training, prevention of HIV/AIDS, and alcohol awareness. In its development area, HIV/AIDS s has been the predominant discussion among the youth during the three National Youth Summits that follows, which to measure the effectiveness of the indicators provide in the policy, whereas to see whether or not the intended outcome has been successful and if there is any impact.

Under the matrix of Objective 6.2 Youth and Health in the National Youth Policy strategies 2, it indicated the need to have available counselling services to ARH, HIV and STIs and the measurable indicator is to target at 200-250 youth per year in increase awareness in-order to decrease incidence of HIV and STIs in the FSM.

On the basis of the policy objective, we are targeting campaign development and implementation. Therefore, the following recommendations are made, which is in line with the "Be Wise" campaign slogans. The development of behavioural change communication materials for the FSM Youth while developing the capacity of youth organizations is one of the effective ways of dealing with youth in this region and here are some of the recommendations:

1. There should be campaign at all stages: planning, development, implementation, monitoring and evaluation.
2. Campaigns should consider utilizing the extremely effective, peer-to-peer participatory approach. At bilingual event it is critical to ensure equal number of pee-to-peer advocates.
3. Select materials that participants wear or use make the campaign prominent, fashion etc., and provide key talking points.
4. Integrate the campaign into the event program.
5. Supply local "branded" condoms which are attractive to participants (flavoured and colour) as part of the campaign. It has to be provided in a subtle ways in recognition of remaining stigma in getting or carrying condoms (pockets or into bags, etc).
6. Ensure female condoms are included for distribution.

7. Ensure good communication/collaboration with partners so that any key promotional items arrive on time.
8. Opportunities for participants to speak to/listen to a person who is living with HIV or hearing young Pacific islanders stories on video programs, etc.
9. Support for vocational education training, and family Life Education in Schools.

Community Outreach:

1. The importance of having the 'Pocket-info' leaflets x 4 topics translated into the vernacular languages of the islands within the FSM, as a mass production to reach as many communities as possible to all communities with a campaign slogan of "Safe Sex".
2. The translation must be done by young people of the particular island and consultation must also be followed so it can be accepted by all the youth of the islands. The activities include the following:
3. The printed publication material from SPC is to be distributed to those islands that have the same languages in 2009-2010.
4. Free condoms would be available for distribution at this time.

ADVOCATING TO DECISION-MAKERS

Governing Structures:

- *target your efforts towards the right level of government.*

Partnerships for Youth Development

To strengthen partnership among Public Health, community-based stakeholders in supporting youth development through the national youth policies. Families, communities, churches, sports and media were identified to have strong influences on youth and right level of governments.

5. Major challenges and remedial actions

[Instructions: This section should focus on:

- (a) progress made on key challenges reported in the 2005 UNGASS Country Progress Report, if any;

(b) challenges faced throughout the reporting period (2006-2007) that slow the national response,

(c) give examples of what specific actions that are planned in your country to ensure achievement of the UNGASS targets]

6. Support from the country's development partners

[Instructions: This section should focus on

(a) key support received from your development partners (e.g. CDC, AusAID, NZAID etc...)

(b) actions that need to be taken by development partners to ensure achievement of the UNGASS targets.

This is your chance to express what you need. Do not just say money; what do you need to do with that money? What specific resources or skills does your country need?]

Health services in the FSM are funded mainly by the United States through compact funds, separate US Federal Programs state funds, user fees, insurance, and grants and loans from bilateral, multilateral and non-government donors.¹¹ Challenges facing the public healthcare system across the FSM include limited funding for personnel, inadequate supplies of medication, poor maintenance of facilities and other fixed assets and the need for expensive off-island referrals for tertiary healthcare.¹¹

Coordination of the national and state public healthcare systems is difficult. The National Department of Health controls most of the health budget, but the states are mandated to provide health services under the FSM constitution. Furthermore, while the states have control over the policy and planning of the delivery of health services, they are required to report to the national level on the management of US federal programs.⁹

Prevention and care services for HIV and other STIs are primarily funded through four grants from the US Centers for Disease Control (CDC):

- **HIV Prevention:** 5 year grant (*1st April 2004 till 31st December 2008*), approximately \$213,000 annually
- **HIV Surveillance:** 3 year grant (*1st April 2004 till 31st December 2007*), approximately \$17,0000 annually
- **HIV Care:** 6 year grant (*1st April 2001 till 31st March 2007*), \$50,000 annually
- **STD Prevention:** 18 year grant (*1st January 1990 – 31st of December 2008*), \$60,000 - \$70,000 annually

The HIV grants are administered by the FSM National HIV/AIDS program and the STI grant by the FSM National STI program. A fourth grant to the FSM National HIV/AIDS program is from PRHP who provide a three year, AUD \$150,000 (approximately USD

\$114,000) country allocation to conduct capacity building workshops and trainings and other activities as requested. In addition to external grants, national (and state) government revenue (primarily derived from compact monies) support some aspects of the HIV/AIDS and STI programs including salaries for various personnel at both national and state level and providing office space. Other preventive health FSM National programs, such as Maternal and Child Health and Family Planning also receive funding from external grants, and include some services relating to HIV and other STIs such as purchase of testing kits. Additional funding for activities relating to HIV have also previously been received from the Global Fund to fight AIDS, TB and Malaria and the World Health Organization.

7. Monitoring and evaluation environment

7.1 The current monitoring and evaluation (M&E) system

HIV programs in all four states are required to report quarterly to the FSM National HIV/AIDS program on the number of HIV tests performed, disaggregated by:

- Age
- Reason for testing
- Condom use (always/sometimes/never)
- Number of pre- and post-test HIV counselling sessions performed

If any HIV tests are determined to be reactive and confirmed positive via Western Blot testing the risk factor for the HIV infection, along with a case report, is also required to be reported to the national program. All data submitted by the states are collated by the FSM National HIV/AIDS program and submitted annually to the US Centres for Disease Control (CDC).

While some testing and case data are being collected, HIV passive sentinel surveillance, including collection, analysis and interpretation of data, is not currently occurring in FSM. Second generation behavioural surveys were conducted in 2007 in Pohnpei and Yap and been proposed in the other two States (Chuuk & Kosrae).

7.2 Challenges faced in the implementation of a comprehensive M&E system

DESCRIBE EXISTING PROBLEMS

7.3 Actions planned to overcome the challenges

The National Strategic Plan 2006-2010 sets out a series of tasks and a timeline by which to complete them:

Task	Target date	Achieved
A. SURVEILLANCE AND		

RESEARCH

To <u>standardize the HIV counseling, testing and referral form</u> for the four states to collect uniform data	Form to be developed and in use by Jun 07	90% Achieved
To improve surveillance data by <u>strengthening communication between state HIV/STI programs and private clinics</u> (e.g. facilitating the sharing of test kits, collection of testing data)	Data from private clinics to be included by Dec 07	Not yet in all states
To <u>develop a database</u> for collecting data relating to HIV and other sexually transmitted infections including automated reporting	Database to be developed by Dec 07	Not yet
To <u>train</u> key national and state HIV/STI program staff and private clinics in the HIV/STI database	Trained staff and database to be in use Mar 08	Not yet
To <u>analyze and report on data</u> collected from the states	Data to be reported and analyzed each quarter	80% Achieved
To <u>strengthen systems for external transport of specimens</u> including ensuring IATA certified packers in all state laboratories and facilities for advance payment for shipment	Reactive specimens to undergo confirmatory testing within three weeks of collection	100% Achieved
To support the four states to conduct, analyze and report on <u>behavioral surveillance surveys</u>	Surveys to be conducted in all states by 2011	30% Achieved

B. MONITORING AND EVALUATION

Develop a <u>standardized form for conducting site visits</u> to state HIV/STI programs	To be finalized March 2007	Not yet
In collaboration with the four states, develop a <u>standardized evaluation form</u> for education workshops, presentations, training etc for translation	To be finalized June 2007	Not yet
Conduct <u>yearly site visits</u> to monitor programmatic and financial aspects of the state HIV/STI programs	To be complete during 2nd half of each year	On-giong
Prepare and submit a <u>yearly Financial Status Reports</u> to US federal agencies and financial reports to other funders	To be complete by April 1st each year	On-going
In collaboration with the four states, develop <u>standardized quarterly activity reporting form</u> including items such as success, challenges (<i>including human resources needs, workload</i>), needs, performance indicators, description of people reached (<i>number, age, gender</i>), financial information, progress in implementation of state strategic plans, quality assurance activities	Form to be completed Dec 07, and in use by Mar 08	Achieved/On-going
Evaluate the <u>usefulness</u> of the activity reporting form and evaluation forms and revise as necessary	Revise 1st quarter 09; revised form in use Jun 09	Not yet
<u>Analyze and compile a quarterly summary report</u> of state and national activity, financial and data reports	Form completed Dec 07; In use Mar 08	90% Achieved

C. FACILITATE POLICY DEVELOPMENT

To collect and evaluate <u>existing policies</u> in the four states	Completed 1st Quarter 2007	Not yet
To collaborate with the four states to develop consistent policy on <u>counseling and testing</u> for HIV and other STIs including laboratory testing, confirmatory testing, counseling standards and timeliness	Begin 1st Quarter 2007 Complete 4th Quarter 2007	Achieved
To collaborate with the four states to develop consistent policy on <u>HIV treatment, care and support</u> including anti-retroviral	Begin 1st Quarter 2007 Complete 4th Quarter 2007	Achieved

medication and opportunistic infections

To collaborate with the four states to develop consistent policy and lobby for legislation on stigma and discrimination issues including employment discrimination, right to education and healthcare and access to public services

Begin 2nd Quarter 2007 Complete 1st Quarter 2008

30% Achieved

To collaborate with the four states to develop policies on confidentiality issues especially in the healthcare setting

Begin 2nd Quarter 2007 Complete 1st Quarter 2008

Not yet

To collaborate with the four states to develop consistent policy for prevention activities including assurance of quality

Begin 4th Quarter 2007 Complete 3rd Quarter 2008

Not yet

To collaborate with the four states to develop consistent policy for the management of people who knowingly transmit HIV

Begin 4th Quarter 2007 Complete 3rd Quarter 2008

25% Achieved

To collaborate with the four states HIV/STI program to develop consistent policy on procurement for HIV and STI related products including condoms, test kits and medication

Begin 2nd Quarter 2008 Complete 1st Quarter 2009

Not yet

To collaborate with the four states to develop consistent policy on data management and consistent and standardized reporting

Begin 2nd Quarter 2008 Complete 1st Quarter 2009

Achieved

To collaborate with the four states to develop consistent policy for the prevention of mother to child transmission

Begin 2nd Quarter 2008 Complete 1st Quarter 2009

Not yet

To collaborate with the four states to develop consistent policy for involvement of people living with and affected by HIV in all aspects of the response to HIV (*planning, policy making, prevention activities, treatment, care and support, monitoring and evaluation*)

Begin 4th Quarter 2008 Complete 3rd Quarter 2009

Not yet

To collaborate with the four states to develop consistent policy for partner counseling and referral services (contact tracing) in relation to HIV and other sexually transmitted infections

Begin 4th Quarter 2008 Complete 3rd Quarter 2009

Achieved

To collaborate with the four states to develop consistent policy on roles and responsibilities of community members voluntarily involved in the response to HIV

Begin 4th Quarter 2008 Complete 3rd Quarter 2009

Achieved

and other sexually transmitted infections

7.4 The further need for M&E technical assistance and capacity-building.

Since the development of the FSM National and States' HIV/AIDS-STD Comprehensive Strategic Plans, Only Chuuk has gotten the full support and endorsement of her plan by the Political leaders. The remaining States and the National are still seeking the support and the endorsement from their political leaders. Still without the support and endorsement of the plans, the National and States' program continue to implement and carry out most of the activities in their plans as required by the funding agencies.

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ANNEXES

ANNEX 1: Consultation and Preparation Process

Consultation/preparation process for the Country Progress Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

Which institutions/entities were responsible for filling out the indicator forms?

a) NAC or equivalent	Yes	No
b) NAP	Yes	No
c) Others (please specify)	Yes	No

With inputs from

Ministries:

Education	Yes	No
Health	Yes	No
Labour	Yes	No
Foreign Affairs	Yes	No
Others (please specify)	Yes	No
Civil society organizations	Yes	No
People living with HIV	Yes	No
Private sector	Yes	No
United Nations organizations	Yes	No

Bilaterals	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
International NGOs	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Others	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

(please specify)

Was the report discussed in a large forum? Yes No

Are the survey results stored centrally? Yes No

Are data available for public consultation? Yes No

Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?

Name / title: Dr. Vita A. Skilling, Secretary, FSM, Dept. of Health & Social Affairs

Date: _____

Signature: _____

Address: P.O. Box PS-70, Palikir, Pohnpei, FSM 96941

Email: vskilling@fsmhealth.fm Telephone: (691) 320-2619

Annex 2: National Composite Policy Index 2007

COUNTRY: Federated States of Micronesia

Name of the National AIDS Committee Officer in charge: Dr. Vita A. Skilling

Signed: _____

Postal address:

Tel:

Fax:

E-mail:

Date of submission:

ANNEX 2: National Composite Policy Index

[INSERT NCPI document after you have had a meeting with civil society and government for their feedback]

ANNEX 3: National AIDS Spending Assessment

[Insert NASA document]