FOCUSED COUNTRY EVALUATIONS

MULTI-COUNTRY WESTERN PACIFIC HIV EVALUATION

REGIONAL PROGRAM

March 2020

Introduction

The eleven countries included in this Multi-country Western Pacific (MWP) regional program are the Cook Islands, Federated States of Micronesia, Republic of the Marshall Islands, Nauru, Niue, Palau, Samoa, Kingdom of Tonga, Tuvalu and Vanuatu. These countries are governed independently, small in population size, defined as low income by the World Bank and spread across a diverse region of hundreds of islands equaling 15% of the globe's surface. These countries are varied, small in land mass and population density, have narrowly based economies and are extremely vulnerable to natural disasters. Sustainability requires long term cooperation between governments, international development partners, national and regional organizations (World Bank 2019).

Across the MWP countries, human immunodeficiency virus (HIV) prevalence is low and estimated to be less than 0.1%. The cumulative number of people diagnosed with HIV from the beginning of HIV testing to the end of 2017 is only 234 (UNDP 2017). The high rate of untreated sexually transmitted infections (STIs), low HIV and STIs knowledge, high mobility and migration, complex sexual networks, transactional sex and intimate partner violence means vulnerability to HIV is high (UNDP 2018a). The HIV program has been supported by the Global Fund since July 2003 and the current grant period covers January 2018 to December 2020. The MWP program is neither approaching funding transition nor has a transition date.

This is an evaluation of relevant components in the national disease program, with an emphasis on the Global Fund investments. The Global Fund Country Team identified the following priorities for this evaluation:

- Evaluate progress against objectives;
- Determine the extent to which the health information system (HIS) has been strengthened and how the linkages are between the community and health information system
    - Review the progress around building case-based surveillance system
    - Review the progress of sentinel surveillance;
- Review legal barriers and the extent to which the environment is blocking access to services for key populations, and what progress has been made to reduce barriers;
- Evaluate the extent to which service delivery systems (health facility and community) deliver quality services; and
- Assess the possibility of refocusing the grant potentially for the next allocation towards youth/women and girls.

As the timeframe and resources for the evaluation did not permit in-country visits to all eleven countries, Samoa, Tonga and Vanuatu were selected in consultation with the Global Fund Country Team and the Principal Recipient (PR) for in-country visits.

The in-country visits took place from 18-29 November 2019 and included:

- Country visits to the capitals of three implementation countries (Samoa, Tonga and Vanuatu, approximately three days were spent in each country);

- Key informant interviews with 42 individuals from each country's National HIV Program, Ministry of Health (MoH) staff including managers, clinicians and laboratory technicians, United Nations agencies, non-government organizations NGOs) and community-based organizations (CBO);
- Interviews in Sydney with the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM), with Dr. Catherine O'Connor (the current independent consultant provider of clinical mentoring) and with a representative of the Oceanic Society for Sexual Health and HIV Medicine (OSSHHM);
- Site visit observations at the main hospital in each country, the family health associations, and community-based organizations (or programs within broader NGOs) providing information, advocacy and outreach to transgender people (including Leiti in Tonga and Fa'afafine in Samoa, and to gay men and other men who have sex with men (MSM);
- Inception meetings in Samoa and Tonga with the MoH HIV program staff and key program partners. An inception meeting was not possible in Vanuatu, but a briefing was held with the MoH National HIV Co-ordinator in Vanuatu. Debriefs were held in each country with the MoH HIV coordinator;
- Consultation and discussion with senior staff of the PR (UNDP) in Fiji;
- Consultation with regional partners in Fiji included the Fiji Positive People's Network (FJN+), UNAIDS sub-regional office, International Planned Parenthood Federation (IPPF) Pacific Sexual and Gender Diversities Network (PSGN) and the United National Population Fund (UNFPA);
- Consultation with seven representatives from across the MWP Technical Working Group (TWG), MWP oversight group and regional members of the Pacific Islands Regional Multi-Country Coordinating Mechanism (PIRMCCM).

The evaluation was complex because of its regional focus, the distances between the four countries visited and the time limitation in each of the countries visited meant consultations outside the capital were not possible. A serious measles outbreak in Samoa and lesser outbreaks in Tonga and Vanuatu at the time of the evaluation also impacted on the availability of MoH personnel.

More detailed information on the evaluation methodology and agenda are available in the Supplementary Information Document.

Findings

This evaluation is part of a broader set of evaluations by the Global Fund of Focus Country programs. The majority of these are single country program evaluations and the template being used for these includes tables at the end of Objective that rates the country program in terms of a set of agreed indictors. This is the first regional program to be evaluated under this system. Rating was not possible in this case as it would have required verification visits to all eleven countries under the regional program.

Objective 1. To evaluate the extent to which – and how – the Global Fund grants have helped enable countries to achieve a) the goals and objectives described in their national disease strategic plans and overall health sector strategy, and b) the goals and objectives agreed in the grant agreements.

Domain 1.1. Strategic information, planning and investment

In 2016, a set of mapping exercises of HIV and STI Risk Vulnerability among Key Populations (KP) were carried out in all eleven countries. These included population size estimation (PSE) for key populations, and these PSE were used to determine targets for prevention outreach and HIV testing among KP. These studies and the summary data from them, provide an important baseline of behaviour and programmatic reach for these KP across the region.

Inputs: The Ministries of Health of the Cook Islands, the Federated State of Micronesia, Kiribati, Niue, the Republic of Marshall Islands, Tonga and Tuvalu requested technical support in 2018 to update their HIV National Strategic Plans (NSP) and this is being conducted by an independent consultant through Oxford Policy Management. Guidelines on key population definitions and recommended service delivery packages were rolled-out to the 11 countries. A regional workshop on Strengthening HIV Strategic Information and Reporting was conducted in 2018. Strategic information gaps on linkage to care and treatment adherence were addressed through a regional HIV workshop in October 2018 that brought together PLHIV and their nominated key health workers to discuss how to engage and strengthen treatment adherence and care services (The Global Fund & FJN+ 2018). Countries also received individual support from the regional PR team, and from their nominated sub-regional Program Analyst on maintaining national data systems and timely and accurate reporting.

Some countries receive support for a position in the MoH for a public health epidemiologist. In Samoa, it was clear that this had contributed to a significant strengthening of the strategic information available to the program.

Outputs: At the time of the evaluation, draft revised HIV NSP had been completed for Cook Islands, Federated States of Micronesia, Kiribati, Niue, Republic of Marshall Islands, Tonga and Tuvalu.

Outcomes: The strategic information generated through the mapping studies conducted in 2016 provided the evidence for a shift in programming towards a greater focus on key and vulnerable populations. This meant resulted in a shift in resources from sub-recipients (SRs) working primarily with the general population to those working to reach people from key and vulnerable populations. The standard definition of key populations appeared to be in use in the three countries visited, though there were some practice issues identified – there was some confusion between the use of KP definitions for reporting and the use of KP definitions in outreach practice as descriptors of identity. This is covered in more detail under Objective 2.

Each of the NSP reviews and revisions involved country-level consultations, providing an opportunity for HIV response stakeholders to gather and review progress.

This round of NSP included STIs along with HIV – an important outcome in the Pacific where STI levels in the general and key populations are much higher than HIV and national and regional responses to STIs are much less coordinated.

There were some issues with KP populations size estimates, particularly the combined estimate for MSM and TG in Samoa, which is widely thought to be a significant overestimate and has led to the setting of some unrealistic targets for outreach and testing. This is covered in Domain 2.1.

Domain 1.2. Resilient and sustainable systems for health

Inputs: In partnership with WHO, countries had been supported to finalise, endorse and disseminate national HIV and STI treatment guidelines (UNDP 2018a).

A regional training workshop was conducting in July 2018, involving National and States HIV/STI and TB Programme Coordinators, Lab technicians, supply chain officers and stock control nurses on the use of mSupply for day-to-day electronic inventory management to improve health procurement, inventory and supply management system. The training also included modules on safe and effective supply storage, inventory management and distribution practice, and quantification and forecasting of health products. National laboratories were strengthened through training of staff in GeneXpert instruments and portable X-Ray machines, and external quality assessment and direct laboratory support to eight program countries through the Pacific Laboratory Initiative (PATLAB).

In 2018 (and in previous years) the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) was contracted to work with the Oceanic Society for Sexual Health and HIV Medicine (OSSHHM) to establish and maintain a set of regional clinical practice mentors, primarily for HIV but also for STI (and to some extent viral hepatitis). Funds for this input were significantly reduced in 2019 (by just over 50 percent) and the input was transferred to a single independent consultant, based in Sydney. This initiative aims to build the cadre of health workers competent in HIV and STI clinical management and to broaden the regional cadre of clinical mentors.

Outputs: Revised national HIV and STI treatment and practice guidelines were in place in the three countries visited and there were plans for dissemination to remote health services. Telemedicine clinical support (by Skype and e-mail and visits to some of the program countries) remains in place. Clinicians interviewed in the three countries visited reported using the clinical support mechanism from time to time and having received training and mentoring under the program.

Outcomes: Clinicians interviewed reported that the updating of clinical guidelines has been very helpful – particularly in relation to establishing the use of the newer ART combination (DTG) and for more consistent STI clinical practice. The reduction in resources has significantly reduced the availability of on-the-job mentoring for clinical practice. In-country training still takes place in some countries. The lack of funds to include and strengthen regional mentors through OSSHHM (mostly experienced HIV physicians from Fiji) ceased in 2019 and so the strengthening of OSSHHM as a regional health system resource in on hold. The current provider of clinical mentoring services reported that she receives regular calls from clinicians managing complex HIV presentations (particularly late presentations), and that when providing training in several countries, she has been asked to spend significant time on updating STI treatment.

> *"There are success stories from the training and clinical mentoring. By the end I saw the quality of care improve for patients. One doctor in particular became more engaged in the quality of care for patients – even her case notes were clear and well documented"* -- Clinical Trainer, Mentor, OSSHHM.

Domain 1.3. Supportive and sustainable legal, policy and financial environments

Inputs: The Fiji Network of PLHIV (FJN+) is a subrecipient provided with funds to support the development of networks of PLHIV (where possible), to advocate on behalf of PLHIV and to provide

national-level training to healthcare workers to reduce stigma and discrimination and establish a more supportive care environment for PLHIV and their families. The Network also conducted an HIV Stigma Index Study in 2018 in the Federated States of Micronesia, the Republic of Marshall Islands, Samoa, Palau, Kiribati, Tonga and Vanuatu. Results of the study were disseminated in the region and in the participating countries in 2019. In Vanuatu, a national meeting was held to address capacity development healthcare workers, stigma and discrimination and strategies to respond to gender-based violence.

The Pacific Sexual and Gender Diversities Network (PSGDN) also receives a small grant under the Program to provide support to Fa'afafine, Leiti and other transgender groups and programs and to services/CBOs providing outreach to gay men and other men who have sex with men.

Outputs: The Stigma Index Study has been distributed and dissemination workshops held in several of the participating countries. This has also led to healthcare worker training by FJN+ in collaboration with clinical mentors.

Outcomes: It is not clear yet what the outcomes of this work have been. Training workshops have received positive participant feedback, but there have been no studies to measure changes in health worker behaviour. In the three countries visited, there are cadres of healthcare workers and national Ministry of Health (MoH) coordinators in place to monitor and respond to issues regarding stigma and discrimination. The CBOs (or projects within NGOs) working with KP are also in a position to monitor practice and are included in national decision-making groups where they are able to raise concerns.

Objective 2. To evaluate the extent to which service delivery systems (health facility and community) deliver quality services.

Although the Evaluation Framework focusses on HIV prevention, treatment, care and support, given the link between HIV and other STIs, and the high prevalence of many STIs across the Pacific, this report also touches on STI issues. It is important to note that the program countries were all signatories to the Pacific Sexual Health and Well-being Agenda 2015 – 2019. There was little evidence of a systematic approach or appropriate resources available to implement this Agenda in the countries visited, nor in the publications provided. As one of the few providers of development assistance in sexual health in the region, this should be an important consideration for Global Fund in the next round of funding.

One issue that affects all implementation is the quarterly reporting and funding cycle that is in place. There are issues in relation to getting financial reports through the respective Ministries of Health each quarter. Delays in financial reporting cause implementation delays as funds are not made available until reports are submitted and approved.

Four sub-regional Program Analysts are employed by the Principal Recipient to support three to four countries each. They provide technical assistance, coordination, support for quality assurance and timely reporting, but there are still some reporting (and therefore onward funding) delays that occur and that result in activities being pushed towards the end of the next quarter once funds arrive. This has an impact on quality of the interventions delivered.

This issue also raises the question of the effectiveness of the vertical programming approach – funding relatively separate HIV and TB programs in each country. There is scope for greater integration here by providing support for a communicable diseases team, rather than two or three vertical programs. This would provide the national MoH with greater flexibility to respond to the exact nature and extent of the communicable diseases it is managing and also manage the risk of poor performance on one program area by spreading responsibility for coordination of the disease areas across more staff.

Domain 2.1. Prevention

Inputs: There was a significant shift in the 2018 allocation away from organisations providing general population prevention services towards the delivery of prevention services (including assistance with access to HIV and STI testing) to key populations. UNDP signed agreements with seven civil society organizations (CSOs) in 2018 to conduct interventions with KP and community advocacy to reduce stigma and discrimination. Condoms and lubricant are budgeted for key populations. Funds are also provided to Ministries of Health and used in some countries to enhance primary care services and to support and build the capacity of primary care workers in remote areas through outreach visits. Some countries were assisted to conduct information campaigns in the media (radio spots, text blasts, distribution of IEC materials).

Outputs: This outreach takes different forms depending on the size of the KP and the available peer workforce. In some countries, this is delivered by KP CSOs as a part of their work in their communities. In other countries where these organisations do not exist, the outreach is conducted by KP peers as a project within another CSO or NGO, like the Family Health Association. There are few (if any) organised groups of sex workers in the program countries, so the outreach to female sex workers and other women engaged in transactional sex happens mostly through Family Health Associations. Transgender and MSM groups also reach out to transgender people and gay men and other MSM who are engaged in sex work of transactional sex.

There was little evidence in the countries visited (nor in reports) of other primary prevention activities such as information and awareness campaigns for HIV and STI prevention, broad community condom promotion and distribution. Some public health officials spoke about the need for a program of STI awareness and prevention, particularly tied to community or cultural celebrations and festivals that brought people together in large numbers for days at a time and were known to contributing to increased STI risk in particular. Given the high prevalence of STI among the adult (and adolescent) populations in most of the program countries, general health promotion and STI prevention activities need to be in place to provide an important complement to more targeted interventions.

Outcomes: The Global Fund program defines 'reached with a package of prevention services' as reached by a volunteer, paid peer outreach worker or clinic worker, and provided with condoms, information materials on safer sex, involved in a discussion about their risk and provided with a referral for HIV and STI testing.

The program's 2018 outcomes for reach (and for HIV testing) are summarized below. Although testing is covered in Domain 2.2 below, the combined Domain 2.1 and 2.2 data is presented here to indicate some issues with reporting.

Table 1. 2018 Key population reach with prevention and testing

Country	MSM		Transgender		Sex workers	
	Individuals Reached/Target	Individuals Tested/Target	Individuals Reached/Target	Individuals Tested/Target	Individuals Reached/Target	Individuals Tested/Target
Cook Islands	3/12	3/5	23/28	23/20	0/4	0/4
Federated States of Micronesia	21/12	22/5	24/23	20/17	144/30	139/29
Kiribati	128/9	128/4	75/16	75/12	131/8	128/8
Nauru	0/0	0/0	3/0	3/0	3/0	3/0
Niue	4/0	0/0	0/0	0/0	0/0	0/0
Palau	13/10	13/4	19/12	10/9	14/5	2/5
Republic of the Marshall Islands	22/3	22/3	7/5	7/4	6/15	6/14
Samoa	355/600	254/258*	678/1200	678/876	20/14	26/14
Tonga	91/30	91/13	73/60	73/44	319/72	319/69
Tuvalu	3/2	3/2	5/3	5/3	2/2	2/2
Vanuatu	25/25	25/11	43/50	43/37	142/48	142/46
Regional	**665/693**	**561/305**	**950/1397**	**937/1022**	**781/208**	**767/877**

*This appears as 358 in the 2018 Annual Report, but as 258 in the PUDR

Table 2. 2019 (January – September inclusive) Key population reach with prevention and testing

Country	MSM		Transgender		Sex workers	
	Individuals Reached/Target	Individuals Tested/Target	Individuals Reached/Target	Individuals Tested/Target	Individuals Reached/Target	Individuals Tested/Target
Cook Islands	17/77	17/34	25/155	25/115	10/6	10/6
Federated States of Micronesia	38/49	38/21	70/97	69/72	55/32	54/29
Kiribati	232/18	232/8	100/36	100/27	555/13	555/12
Nauru	-	-	-	-	-	-
Niue	-	-	-	-	-	-
Palau	6/31	6/13	3/62	3/46	6/6	6/6
Republic of the Marshall Islands	24/15	24/6	19/31	19/23	29/25	29/24
Samoa	846/865	569/382	982/1730	982/1280	28/22	28/21
Tonga	74/30	84/13	180/60	180/44	338/72	338/69
Tuvalu	5/3	3/3	15/6	15/6	11/5	11/3
Vanuatu	100/93	54/40	174/186	67/138	259/223	259/212
Regional	**1318/1181**	**1027/520**	**1568/2363**	**1460/1751**	**1291/374**	**1290/382**

Targets were increased significantly in 2018 (as a way to improve focus on KP). Taking MSM as an example, the regional targets for reaching and for testing MSM doubled. It does not appear however that the modification of targets took into account the capacity of the programme in each country to reach KP. For example, in Kiribati, 2018 targets were relatively low (9 for reach; 4 for testing) yet programme results were high (128 for each). Despite this, 2019 targets for Kiribati MSM programme

remained low (only doubling to 18 for reach and 8 for testing). For Samoa, targets appear to have been better matched to capacity to deliver – there was significant progress to meeting them in 2018 and more progress in 2019. Vanuatu targets were increased significantly in 2019 (by a higher proportion than most other countries) and these have largely been achieved. In Tonga, the programme significantly exceeded its sex worker reach and testing targets in 2018, yet these were not adjusted in 2019.

Key informants reported that part of the shift in targets in 2019 was to adjust the 'unreasonably high' targets for Samoa that resulted from the over-estimated KP PSE. Other countries reported that they received larger increases in targets to 'take up some of the reductions in Samoa' and maintain a significant increase across the region.

It is clear that more work is required in 2020 to adjust PSE and set targets that a reasonable and achievable within the resources allocated to the programmes and based upon more accurate population size estimates.

Other issues that emerge from this data:

- There is great variation between countries in the size, nature and accessibility of key populations. This points to the need for greater differentiation in approaches. This data (and the 2016 risk mapping studies) would suggest that the KP approach is only really feasible in a subset of countries (Kiribati, Samoa and Vanuatu) and a different approach is required in the other countries.
- Some countries are greatly exceeding their targets (e.g. Kiribati). Targets should be aspirational and therefore set to encourage programs to continue the pace of implementation throughout the year. This also points to the need to broaden the focus of the encounter between CSOs and beneficiaries beyond testing, as the Kiribati numbers indicate that all encounters are related to testing. In a low HIV yield environment, this is not necessary, and broader encounters with beneficiaries around sexual health and wellbeing would be more beneficial.
- Some countries report exactly the same number for 'reached with a package of prevention services' and 'tested for HIV'. This suggests that the model they are using is narrow – focussed entirely on testing and not on reaching people with condoms and lube, behaviour change communication and information materials. This was verified in site visits, as some CSOs reported that all (or most) of their testing took place at large events, and that they only counted as 'reached' those people who tested.
- Projects visited report that they only count people once per year for reach and testing and that they know that they are not double counting as they know all of their beneficiaries. None appear to be using unique identifier coding systems. As numbers increase and it will be more difficult to ensure that there is no double-counting.
- Positive yield from this testing effort is almost zero, probably due to the very low HIV prevalence in these countries. This raises the question of the appropriateness/public health effectiveness of a model that is almost entirely focussed on HIV testing. A model of this kind is better suited to populations with large numbers of undiagnosed PLHIV. This does not seem to be the case in these countries. If it were, there would be significant numbers of people presenting at hospitals with late-stage HIV illness. This only happens very occasionally.

- These figures represent what was possible in a single implementation year (or 9 months in the 2019 data), but WHO 2019 Guidelines recommend annual HIV testing for sexually active people in high burden settings (and more frequent (3-6 month) testing for people at higher risk) (WHO, 2019). It is not clear how the program will deal with this – to what extent outreach programs are supposed to re-test the same people each year (and count them as part of achieving their target) or find new people to test.
- Some of the projects visited appeared to be at, or close to, the maximum reach that they can achieve with the resources they have and the models they are using. Although there is a small allocation for PSGDN to provide technical assistance to the MSM and transgender groups and projects doing outreach, it is not clear that PSGDN has the specific capacity required , or the resources, to work with these groups on organisational strengthening and appropriate peer-based models for the Pacific context.

Domain 2.2. Screening/testing and diagnosis/knowledge of status

Issues of HIV testing referrals conducted under outreach models by KP groups are covered in Domain 2.1 above.

Inputs: The Bioline HIV/Syphilis (SD Duo) test was rolled out across the region, except for Niue, following a five-country pilot. The GeneXpert instrument was supplied to ten countries for TB and HIV diagnostics. Outreach teams have received training in focussing their outreach attention on HIV testing. In some countries, teams from the MoH conduct routine HIV testing in specific settings, like prisons. Support is also provided in some countries for KP peers to accompany integrated health visits to remote settings. In this way they are able to specifically target people from key populations who may be reluctant to participate in the community primary health care events that are taking place. Support is also provided for Chlamydia testing cartridges for GeneXpert. These are meant to be targeted towards KP. Significant laboratory support has also been provided. Collaboration between HIV and TB programs has been generally good, and rates of HIV testing of people diagnosed with TB are high.

Outputs: In 2018 over 39,500 SD Duo test kits were supplied to 17 implementing partners including MoH, CSOs and NGOs, and over 200 health care workers received training on their use. Financial incentives are used by some service providers to engage female sex workers in testing. In most of the program countries, testing can only be performed by registered health care workers, despite the fact that the Duo test is easy to perform as a screening test and is used successfully by peer workers in KP programs across Asia and in other parts of the Pacific. This will need to be addressed if testing reach among KP is to be increased.

Outcomes: The Duo test is useful, not only because it tests for both HIV and Syphilis, but also because it allows the health worker or peer to approach the client from the perspective of STIs rather than HIV. This is often more relevant (and more acceptable) to people from KP. Testing levels among key populations have certainly increased since the change of program focus, but at the current level of resourcing, the proportion reached out of the estimated key populations will remain low. Among other populations, testing levels at ANC are high, but this does not generally include women who are not pregnant, nor men in general, unless they are targeted in MSM programs. Given the very low positive

yield and the human resources pressures on health ministries and services, the benefits of regular testing of easy-to-reach populations like prisoners needs to be reviewed.

Domain 2.3 Linkage to treatment and care

Inputs: Diagnosis with HIV is a rare event in all of these countries due to the low HIV prevalence. There are protocols in place and there has been training for health workers and CSO staff and volunteers in referral of people who test HIV positive in screening to have confirmation testing. The co-location of key population CBOs with established SR NGOs such as Wan SmolBag Theatre in Vanuatu and the Family Health Association in Samoa enables support for referrals, clinical interventions and follow-up.

Outputs: Collaborative formal and informal referral pathways appear to be well used by CSOs and NGOs. There appear to be good referral pathways for STI screening and for syndromic management in the absence of screening.

> *"I know the community and find I can get people to come to activities and there we can deliver testing"* -- MSM/TG SR Co-ordinator

Outcomes: Initial linkage of newly diagnosed PLHIV to confirmation testing and clinical assessment and treatment appears to be working well.

Domain 2.4 Treatment, clinical care and monitoring

Inputs: Clinical HIV, STI and PMTCT guidelines have been updated in almost all countries under this program. Clinical care capacity has until 2019 been strengthened through the ASHM-OSSHHM clinical training and mentoring program. (Refer to outcome Domain 2.4 below). This included assistance the identification of treatment failure and in changing to new regimens when managing complex HIV cases. (ASHM 2019). Resources for this input have steadily decreased (from around US$500,000 in 2017, to US$175,000 in 2018 to US$80,000 in 2019 (ASHM 2019). Mentoring and telemedicine support for HIV clinical management is now conducted by an independent consultant based in Sydney. A Pacific Forum (held in collaboration with FJN+) involving PLHIV from across the region along with their nominated primary health care worker was held in Fiji in 2018.

Outputs: Outreach has increased. The low PLHIV case load means PLHIV are generally well-known by the health services. Whilst program funding was available for more intensive support to PLHIV who require it (such as travel to isolated areas to assist primary health carers deliver consistent support to PLHIV experiencing problems, there appeared to be some unnecessary delays in providing this (particularly in Vanuatu) but his may have been an isolated issue.

Outcomes: The 2018 PUDR reports that in 2018, there were 61 reported cases of PLHIV across the program countries. Out of these PLHIV, 53 (87%) were on treatment. (The GF Performance Framework denominator is used as the estimated number of PLHIV currently in the countries). This is highest reported rate since 2015 and is attributed in the most part to the effectiveness of the PLHIV forum conducted in 2018.[1] The ASHM and OSSHHM partnership developed clinical capacity across the region in TG health through workshops, the development of communities of practice and on-going clinical

[1] Country breakdown of known PLHIV on treatment: CK=0/0, FSM=9/11, KI=10/10, MH=7/8 , NU=0 cases, NR=0 cases, PW=5/7, WS=13/13, TO=5/6, TV=0/0, VU=4/6.

mentoring one-to-one or via webinars. This program also built the mentoring skills of the seven clinical mentors based in Fiji enabling them to better share knowledge and support better patient care. The scaled-down model currently in use, while effective in providing tele back-up to clinicians managing complex presentations and some training and coaching on site (including in STI treatment and management), is unlikely to build regional capacity to take this role on in the future.

> *"The ASHM and OSSHHM partnership enabled access to 3rd line medication for one PLHIV who was the first to have this treatment and has done well clinically."* -- Clinical Trainer, Mentor, OSSHHM

There were issues identified during the field visits in relation to coordinated case management for PLHIV in isolated areas. With such small numbers of PLHIV in each country, it was possible for national-level program workers to know reasonably accurately who was on treatment and who was not. There was however little evidence of case management plans in place to assist those not on treatment to regularly review their decision not to be treated. There was also little expressed understanding by program staff of the reasons behind their decisions not to be treated. There also did not appear to be a plan in place to support these PLHIV to minimise HIV transmission to others. There is a need to develop some flexible and Pacific-relevant case management models and guidance materials, and for training of key staff to manage these complex issues.

Domain 2.5 Approach and methods for quality assurance

Inputs: Technical and staffing support for data-collection and analysis and financial reporting has been provided. Regional workshops and regional assistance were provided to increase the quality of HIV testing. Sub-regional Program Analysts employed under the program played a key role in Quality Assurance. Quality assessment and direct laboratory support was provided to eight program countries. A regional workshop on Strengthening HIV Strategic Information and Reporting was conducted in 2018.

Outputs: Updated HIV and STI guidelines were in place with implementation training in health services. Stakeholder meetings in two of the countries visited demonstrated good communication and coordination between government, civil society and health service sectors.

Outcomes: It was not possible to assess these across the eleven countries but in the countries visited there was generally good attention to the need for quality assurance, and specific strategies in place to manage quality. There were difficulties identified by several key informants in relation to coordination of the HIV program in one of the countries visited. These were raised specifically with the Principal Recipient in the de-briefing session in Suva. Senior staff were aware of these concerns and there are plans in place to address them.

Objective 3. To evaluate the extent to which country data systems generate, report and use quality data.

Domain 3.1 Epidemiology, surveillance and context data

Inputs: Regional technical support was provided across the 11 countries to improve the quality and timeliness of data input and analysis. Positions were funded in several Ministries of Health for data-

collection, analysis and program co-ordination. Risk and vulnerability mapping studies in 2016 for the 11 countries included PSE for KP. Technical support was provided for new NSP in seven countries.

Outputs: There was evidence in the in-country visits of up-to-date data on all areas of programming. This included PLHIV patient databases. There were some concerns expressed in one country about the whether there was sufficient data collected in the HIV register to properly plan a response for people not on ART. The on-line Excel register in this country was also not password protected – this was addressed.

Outcomes: Given the low number of PLHIV in each country, maintaining accurate records of their health and treatment status is relatively straightforward and registers appeared to be well-maintained. What was not obvious was the mechanisms in place (like a multi-sectoral case management committee) for coordinated case management of PLHIV requiring additional support, particularly in the area of commencing or maintaining HIV treatment.

The population size estimates for key populations developed during the 2016 Risk Mapping exercises were also reported as problematic in some countries. The most obvious example is Samoa, where the combined PSE for MSM and transgender people is given as 25,000 to 35,000. This figure seems to have come from this sentence in the Risk Mapping study: "We would conservatively estimate that around approximately 25–30% of adult men have had sex with another man in their lifetime – in total, around 25,000 men (2011 census). This does not mean that these men regularly have sex with men; this may occur only in their youth." (UNDP, UNCEF 2016a). A man having ever (or once) had any kind of sex with another man is not an accurate predictor of risk of HIV from male to male sex over a lifetime.

The population of Samoa is just under 200,000. If 50% of these people are men, and around 37% are under 15 years of age (World Population Review 2019), then the total male population 15 years and above is around 64,000. This means that the current PSE suggests that between 40% and 55% of the male population 15 years and above in Samoa are men who have sex with men or are transgender. This is clearly incorrect and probably inflated by a factor of around ten. This PSE is still in use for target setting and other reporting, as it is the only 'official' one available. It should not be used, and a new and more realistic estimate should be developed as a matter of urgency. The mapping report also provides a PSE of 9,000 for Fa'afafine in Samoa (assuming 7-9% of the male population 15 years and over), but this is also problematic (and seems to be incorrect) as 7%-9% of 64,000 would only be only 4,480 - 5,760. These figures need to be adjusted in the denominators for reporting.

The new draft NSP review the implementation results of the HIV response and consider what action is needed to prevent HIV and STIs for the 2020-2025 period. Each plan contains contextual data and a results framework (Draft NSP available: Cook Islands, Federated States of Micronesia, Kiribati, Niue, Republic of Marshall Islands, Tonga, Tuvalu, 2019).

These countries do not have in place accurate estimates for the total number of PLHIV in the country. This makes it difficult to track the first 90 (percentage of PLHIV who know their status) in the 90:90:90 cascade. Results frameworks in the revised NSP that were available for review at the time of this evaluation aim for zero HIV transmission by 2025, 100% of diagnosed PLHIV on treatment and 100% viral suppression for PLHIV on treatment. Following on from the regional technical support provided in 2019 to improve the timeliness and quality of data input and analysis, countries will require follow-

up technical support and coaching in this area as a high priority. In the countries visited for the assessments, capacity and resources within the national health departments to design and conduct surveillance and to ensure accurate reporting of HIV diagnosis varied significantly. Although there was limited time to do a thorough assessment in any of the three countries, data analysis, reporting and follow-up of PLHIV appeared to be particularly strong elements of the Samoan and Tongan programmes.

Beyond the 2016 risk mapping studies and the 2013 sex worker study conducted in, Federated States of Micronesia, Fiji, Kiribati and Vanuatu (SPC 2013), there is very little data and information available on the context and risk of HIV (and STIs) in the Pacific and in the different contexts across the Pacific. This makes it difficult to suggest changes to programming, or to tailor services and interventions to local need. Even in resource-limited environments, it is possible to develop a modest reach and mapping agenda to provide programs with more information about changes that need to be made.

Domain 3.2 Service use and program data and reporting

Inputs: There has been technical assistance, training and coaching to introduce or strengthen HIV case-based surveillance systems from diagnosis in order to track service use and loss to follow-up. Assistance in electronic inventory and supply management of health products through mSupply was provided with UNDP training on-site.

Outputs: Reporting on supply management to the PR. Evidence of strengthened data systems.

Outcomes: Data is routinely collected and reported with the technical support of the PR and often with reminders about timeliness. The quality and comprehensiveness of data systems in the prevention services varied. Sub-recipients had client registers so that they could avoid double-counting of KP reached. No unique identifier code (UIC) system was in place and time constraints prevented the evaluation team from having an opportunity to examine how the SRs with a large number of beneficiaries was managing data and recording. This area will require further technical assistance and monitoring in 2020. The risk and occurrence of stockouts and wastage had been reduced with countries being able to better quantify and forecast procurement quantities. However, stockouts do occur when supplies procured for key populations are used for the general population. Some health service managers reported rolling stockouts of STI test kits and medicines. National pharmacy staff in two countries reported difficulties in procuring medicines and supplies ad their calls for tender were too small to be of interest to suppliers. They requested assistance to develop a regional procurement system, so that orders would be larger, more economical and more likely to attract suppliers. (Refer to Domain 2.2).

Domain 3.3 Using data to drive service design and practice

Inputs: Technical support from the PR for data collection and reporting, and analysis or results.

Outputs: Draft NSP in five countries, patient databases.

Outcomes: It was not possible to evaluate this across the eleven countries, though there was evidence that UNDP as Principal Recipient periodically reviews the data it receives and makes changes to programming where possible. There was also evidence in two of the countries visited of good stakeholder engagement in program data review and reflection. There are some practical/funding

issues here though. The mortality and morbidity caused by Hepatitis B (HBV), and the availability of a relatively inexpensive treatment provides an opportunity to discuss the integration to HBV into communicable diseases programming. Several countries have identified this and beginning to collect data to make a case for support and intervention, but there is currently no scope under existing Global Fund guidelines to respond to this. There is also a persistently high prevalence of STIs across the region, causing morbidity including infertility, but no clear resource partway to increase the reach and effectiveness of prevention and treatment.

There is an opportunity to use community mapping processes to better understand where key populations are and potential hotspots. Evidence of an increase in STIs after large public events - such as the Pacific Island Games or the King's birthday celebrations in Tonga – can be used to plan BCC and health promotion interventions, rather than the 'one size fits all' approach of programming for World AIDS Day. Each of the revised NSP include a results matrix and indicative costings. These NSP show a commitment to sustainability through greater utilization of primary health care staff and a shift away from development partner support towards national financing.

Analysis

Impact

The most significant and visible impact of the Global Fund investments in these eleven countries has been the regional engagement with PLHIV and their nominated primary health care workers, and subsequent follow-up in countries, that has demonstrated a significant increase in the proportion of PLHIV in the region on ART and regular clinical management. There is work to be done to build on this, particularly by improving case management models and by implementing the recommendations for the 2018 HIV Summit, particularly in relation to treatments literacy and adherence (UNAIDS 2018).

In terms of equitable access to the benefits brought about by the program, there are some groups that require more attention. The first of these is young people, particularly young people at higher risk. Whilst there are some 'youth-friendly' clinics in some countries, there needs to be comprehensive attention paid to specific prevention and care programming for young people. People providing health services in isolated geographical areas also require greater attention if the gains of the program are to be equitably shared. Providing additional resources for clinical coaching and mentoring and developing clear case management models and resources to assist primary health care workers in geographically isolated areas to support PLHIV would make these gains more widely accessible.

Effective Strategic Investment

Findings from Objective 1 of this evaluation show that there has been significant progress in almost all of the program countries in updating National HIV Strategies and linking them to STIs and sexual health. Support is provided to national Ministries of Health for coordination of the National HIV program. In some countries, this includes funding for a national HIV coordinator in the MoH, in others, this position is funded domestically and includes STI coordination or another program area such as viral hepatitis. In some of the countries visited there was clear cooperation and collaboration between program areas (HIV and TB in particular). In others this was not evident.

The next challenge will be to turn the national HIV and STI national strategies into a set of integrated implementation plans to ensure consistent access across isolated areas to a package of HIV and STI prevention, treatment and care services. Due to the very low HIV prevalence across the region, this will be more of a challenge in HIV and STI prevention and in STI treatment. Good evidence-based HIV and STI treatment guidelines are also now in place, but there appear to be very limited financial and human resources to turn these into consistent good practice in remote health care settings.

There is scope to focus the allocations made to MoH under the Global Fund program to be more tightly focused on these challenges.

Findings from Objective 2 of this evaluation show a significant shift towards more targeted approaches to HIV prevention. These approaches have increased HIV testing access (and so, knowledge of HIV status) for increased numbers of people from KP. There is a developing competence among KP individuals, CSOs and health-oriented NGOs to work within KP on issues relating to HIV and sexual health. The programme's investment in this component has been modest despite the ambitious HIV testing targets and high levels of accountability imposed on these small projects. Many of these are located within existing services (Family Health, other health-oriented NGOs) and this is an appropriate

model in countries where the size of the KP makes models like drop-in centres and KP-specific CBOs impractical. The exception to this is that there are existing and successful fa'afafine CBOs that can add this to their work. The allocation of technical support to these projects has also been modest leaving individuals and projects to face significant challenges as they grow. The geographical reach of these projects is also limited by resources and by the (currently unmet) need for assistance to develop innovative models that integrate KP-specific outreach with primary care outreach in isolated communities. The employment of people from KP in national health departments and in health services also increases the visibility and acceptability of KP and reduces barriers to service access by indicating that services are more KP-friendly. There were examples of this in all three countries visited.

There are gaps in the delivery of a full package of HIV and STI prevention services, brought about to some extent by the funding model that focuses on HIV testing targets. For example, to meet ambitious HIV testing targets one transgender CSO holds mass events like pageants to bring together as many people from the community as possible. HIV testing is offered at these events and can meet its Global Fund HIV testing targets in this way. Meanwhile, staff are aware that women, men and transgender women regularly trade sex for money and goods in the evenings in a particular back street of the main town, quite close to their office. Despite this, they do not have an outreach team that regularly visits this street at night to distribute condoms, lubricant, sexual health materials, support for violence and information. Given the low yield from the testing that is carried out at KP community events, the organisation would benefit from technical assistance and regular coaching in local risk mapping and the development and implementation of models more attuned to the broad and long-term health needs of its community.

In another example, the Global Fund allocation is used in many of the eleven countries to purchase chlamydia test cartridges for GeneXpert machine. It is stipulated in the grant that these are for chlamydia testing for KP. In the absence of any other allocation for these kits (from national MoH or another development partner) the laboratory uses these kits to test all chlamydia requests that come into the laboratory, and the allocation of kits regularly runs out before all samples can be tested. On the surface of it, testing for chlamydia makes sense given the high prevalence in this region, but to provide test cartridges in limited numbers for KP, without additional kits available for the remain population is problematic. It is also problematic that this investment in diagnosing (and treating) chlamydia is taking place without any other elements of a comprehensive STI prevention program in place (mass education, general populations condom promotion and distribution, partner notification and testing for example). Without these other elements in place, people who test positive and are treated for chlamydia are likely to be reinfected by their sexual partners relatively quickly, reducing the cost-effectiveness and health benefit of the test kit investment. This issue needs to be addressed.

The evaluation team identified some issues in the way that some KP services are interpreting the key population classifications. These are reporting classifications. They are meant to ensure that reporting of reach is consistent across the program. They are not identities that can be assigned by the programs to people in communities. Some of the services visited appeared to be confused about this and seemed to want to assist beneficiaries to understand that they were now part of this population. This is problematic, particularly because these broad categories (sex worker, man who has sex with men, transgender person) do not take account of the complexities of life and the varying contexts that exist in the Pacific (as in many other places). For some, these are just activities in their lives (engaging in transactional sex, having sex with another man), for others they represent complex identity issues

(gender diversity) that are not summed up in a simple externally applied term like transgender person. There is a need to assist KP services across the program to understand that these reporting categories are important, but that they are not meant to be used to label people in health promotion practice. There is ample evidence across the Pacific for example, that many women engaging in regular transactional sex do not see themselves as sex workers (Kelly 2011; McCallum 2018). The role of the KP outreach services is to assist people to maximise their health and wellbeing, working from within the reality of their lives. Whilst it is currently important for reporting and funding purposes to categorise this activity as 'reaching sex workers', this activity could also reasonably include working with women who would not (and do not need to) use that label to describe themselves. There was some evidence in the key informant interviews that outreach workers and their managers saw their role partly as "helping these women to understand that they were sex workers". This issue emerges in KP practice in many settings. There are clear benefits for some people from key populations to take on an identity as gay man, transgender, sex worker and so on, and to gather into support groups to provide services to and advocate on behalf of their community. At the same time, there are also people from KP who can (and should) be supported to maximise their health in relation to the behaviours that place them at risk without doing this. There is a need to strengthen coaching and mentoring to these programs to ensure maximum effectiveness and quality from the outreach effort.

Programming rigidly within the KP categories (and the pressure to meet targets in relation to only sex workers, MSM and transgender people) also does not take account of the fluidity of risk in many of the settings found in the Pacific. Programming does not provide space (or an incentive in reporting terms) for targeting the sexual partners of people engaging in transactional sex. In many of the main towns there are gathering spots where people meet to drink, party and meet partners for sex. Some of this is transactional in the strict sense (an exchange for money or goods) but much of it is not, and people involved in 'non-transactional' sex may be at a similar risk in terms of STIs and HIV as those involved in transactions (Kelly et al, 2011) . In some countries, taking more an 'environments of risk' approach has proven more successful (McCallum et al 2018). Under this approach, KP organisations map their environment and identify sites for outreach and engagement. They then provide the elements of the package of prevention services within those environments without using the strict KP categories (sex worker, MSM, TG). They are still able to code their encounters with people for reporting purposes (with the addition of some coding categories like 'mobile men'). In this way they are still reaching people at considerable STI and HIV risk without having to focus their attention on trying to distinguish between those involved in transactions and those not.

There is evidence that increased support to PLHIV, and to their primary health care providers, has increased the level of ART coverage across the eleven countries. There was evidence during the in-country visits, of good case monitoring of PLHIV, though the notifications database and through a relationship between the MoH officials and ART prescribers. There were some issues identified in relation to case management. For example, in one country, while it was clear that some of the PLHIV were not currently on treatment, and even potentially placing others in the community at risk, there was no agreed case management plan in place to provide additional and regular support to these PLHIV. There are ample resources available within the Global Fund MoH allocation for technical assistance to build local health care providers capacity to work with the PLHIV in their area. However, there appeared to be an issue in coordinating and maintaining a supportive engagement with these

PLHIV. These is also scope for assistance in the development of case management models for health care workers supporting PLHIV in isolated islands and areas within these countries.

Findings from Objective 3 of this evaluation show that countries have received assistance to strengthen their data systems, particularly for HIV management. On the in-country visits it was clear that HIV notification databases were in place and being used, though in some cases these were not password protected on the MoH server, so requires attention in relation to privacy. There were also concerns expressed that the data systems were not being used effectively for case monitoring and management. There are lessons to be learned from the use of TB registers and patient databases in countries in the region. While the countries visited had timely and reasonably accurate quantitative data available on HIV and STIs, there was little information available on context of risk and vulnerability. The national-level risk mapping exercises conducted in 2016 provide good information and a snapshot of the context of risk and vulnerability for particular populations. There is a need to work with each national MoH on the development of a manageable HIV/STI monitoring and research agenda that will provide the country with data to assist in tailoring interventions to changing needs. A particular priority in this area is young people. There appears to be very little information available on the changing context of HIV and STI risk and vulnerability for young people, yet for many of these countries, young people compromise up to 50% of the population. There is also very little available on innovative ways to reach and provide services for young people in Pacific contexts.

Sustainability

Findings from Objective 4 of this evaluation show that there is an urgent need to develop strategies to embed effective responses to HIV and STIs into national programs and local health services in a sustainable way. Within Ministries of Health, the donor-funded vertical program model requires particular attention. Under this model, low capacity and poor performance by an individual can threaten outcomes in an entire health area. Ministries also need to be supported to develop options for more effective management of communicable diseases at the national level.

Given the high rates of STIs among particular populations, and the stigma and discrimination faced by some populations when they try to access general health services, there will continue to be value in working through population-based CSOs, particular for TG and MSM and also for other populations such as young people. Whilst some of the eleven governments in the program have a history of providing funding to CBOs (even KP CBOs in some cases), presently there is a significant (almost total) reliance on development partners for this part of the response. This reliance will need to shift over time, with support to remove any legal or policy barriers that exist. In order to prepare for this, the stronger KP CBOs (and KP projects within broader NGOs) will require resources and technical assistance to build their capacity to plan, manage, implement and report on the work that they do in their populations. They will also need assistance to build the case that demonstrates to their governments the very real HIV and sexual health outcomes that can efficiently be gained through community engagement models.

Analysis relative to the Global Fund's Blueprint for Country Portfolio Priorities Analysis (v1.0) is provided below.

Table 3. Global Fund's Blueprint for Country Portfolio Priorities Analysis

Dimension	Critical Activities
Find and effectively treat more cases	– The shift towards funding of KP CBOs or KP positions/projects within NGOs has resulted in increased access to HIV testing for key populations – HIV treatment coverage has increased following specific support to PLHIV and their primary health care workers – There are indications of more systematic case monitoring, but there is scope for more sophisticated/active case management
Prevention of new cases	– Prevention is problematic. The singular focus on HIV testing alone means that there is limited funding/human resources for other prevention activities (follow-up, behavior change communication, condom promotion) – There is a need to approach HIV prevention through STI prevention to make it more relevant to KP and others – There is a need for greater specific focus on young people in prevention (YKP and other young people at risk) – The strict application the KP model for prevention needs to be reviewed in favour of a model that includes more people at risk
Increase funding available for HIV	– Political commitment varies from country to country across the eleven program countries – These is little evidence of commitment of government funding for HIV (beyond the funding of mainstream primary care services) – The bigger gap is funding for STIs (which would have HIV prevention benefits as the health promotion messages are linked)
Reduce cost of fighting HIV	– There has been some work done to assist in improving PSM efficiency and cost effectiveness. – Countries still complain however that they are required to approach the market as a single purchaser (usually due to their government procurement policies and laws) and find it difficult to procure some medicines/supplies. There is scope for a single purchaser model for the region

Recommendations

#	Major Recommendations	Priority	Who to implement?	By when?	Implications for Global Fund funding
1	**Strengthen the Key Populations approach in appropriate countries through increased technical support and resources**				
	For the current grant period: • Discontinue using the current Samoa PSE (MSM & Fa'afafine combined; Fa'afafine) immediately. Develop more accurate PSE (one for MSM, one for TG)	High	UNDP/Samoa MoH	June 2020	None
	• Work with KP outreach SRs to develop a clearer understanding of the difference between 'reached with prevention package' and 'tested' and to record their activity accurately in this area	High	UNDP/SRs	June 2020	None
	• Review 2020 targets against the 2019 achievements to improve the balance of outreach for testing and targeted outreach for STI/HIV prevention.	High	UNAIDS/UNDP/SRs	June 2020	None
	• Record and analyse key population testing by age to monitor access by young people.	Medium	UNDP/SRs/MoH	June 2020	None
	• Work with technical partners (FJN+ and PSDN) to identify options to increase the	High	UNDP/ FJN+/PSGDN	June 2020	Will require some reprogramming of resources

	size of the key population workforce to increase reach. • Document and promote successes and lessons learned. • Produce clear guidance materials on working with KP in the Pacific settings (including guidance on local risk mapping and addressing issues of 'behaviour versus identity').	Medium Medium	UNDP/MoH/SRs/technical partners UNDP/MoH/SRs/technical partners	September 2020 September 2020	None None
	For the next grant period: • Increase the allocation to CBOs by increasing the grant envelope or reducing the level of funding to the Ministries of Health. • Balance HIV testing targets with achievements in other evidence-based prevention activity areas. • Ensure that whilst outreach and KP-engagement practice remains focussed on KP, it is designed in response to local context and environments of risk, and to the needs of people at greater risk of, or most affected by HIV.	High	UNDP/Global Fund	June 2020	Include resources in the next proposal
2	**Strengthen the STI outcomes under the program by developing a single implementation strategy and approach**				
	For the current grant period: • Review the appropriateness of providing chlamydia test cartridges. A return to	High	UNDP/technical partners	June 2020	None

	syndromic management or presumptive treatment at risk may be more effective. • Develop a clear STI and Sexual Health Plan for the MWP based on a mapping of other national, regional and donor inputs and implement as part of the new allocation in 2021. • Increase attention to STIs in CBO implementation.				
	For the next grant period: • Increase STI prevention program focus and support through government, private sector and CBOs.	High	UNDP/PIRCCM/GF	June 2020	Include resources in the next proposal
3	**Make sustainability a key focus of the next grant period**				
	For the next grant period: • Improve the effectiveness of the resource support to national health departments by setting regional standards for case surveillance and reporting and providing in-country technical support and coaching to meet these • Improve HIV case management guidelines, particularly for primary care workers in isolated settings. • Restore the clinical training and mentoring model across the region.	High	UNDP/PIRCCM /Global Fund	June 2020	Include resources in the next proposal

	• Balance resource allocation to CBOs between HIV and broader STI/HIV prevention, including supports for capacity development. • Provide the Program Analysts with the support and supervision to develop their role to support the capacity development of CBOs and government. • Discontinue interventions that are unlikely to be continued after the grant (such as chlamydia testing) for interventions more likely to be sustained. • Provide the regional partners (JFN+ and PSGN) with technical assistance and support to strengthen their role in the capacity development of key populations and PLHIV groups.				
4	**Establish stronger integration systems and processes between HIV/TB and other communicable disease areas**				
	For the current grant period: • Document and promote successful integration activities. • Include key population outreach as part of general population outreach particularly in remote areas.	High	UNDP/MoH/SRs	2020 Implementation year	None
	For the next grant period: • Support the Ministries of Health in the countries to move towards more	High	UNDP/PIRCCM /Global Fund	June 2020	Include resources in the next proposal

	integrated and less vertical programming towards a communicable diseases program support allocation covering HIV, STI, TB and Viral Hepatitis.				

References

ASHM international, Oceania Society for Sexual Health and HIV Medicine. (2109). The Pacific Sexual Health Workforce Capacity Building Program. End of Program Report.

ASHM international. (2018). Evaluation of the ASHM International Clinical Mentoring Model (ICMM). Independent Evaluation by Darren Leitch. November 2018.

ASHM international, Oceania Society for Sexual Health and HIV Medicine. (2018). The Pacific Sexual Health Workforce Capacity Building Program. End of Program Report.

Communicable Disease Section, Ministry of Health Tonga. (2019). National Guideline on Prevention of Mother-to-Child Transmission of HIV, Syphilis, Hepatitis B and C. 2018.

Communicable Disease Section, Ministry of Health Tonga. (2019). National Guideline on HIV Testing Services. 2018.

Communicable Disease Section, Ministry of Health Tonga. (2019). National Guideline on the Use of Antiretroviral Drug for Treating and Preventing HIV Prevention 2018.

Cook Islands Ministry of Health. (2018). Global AIDS Monitoring Report, Palau.

Kelly, A., Kupul, M., Man, W.Y.N., Nosi, S., Lote, N., Rawstorne, P., Halim, G., Ryan, C. & Worth, H. (2011). Askim na save (Ask and understand): People who sell and/or exchange sex in Port Moresby. Key Quantitative Findings. Papua New Guinea Institute of Medical Research and the University of New South Wales: Sydney, Australia.

Kingdom of Tonga, Ministry of Health. (2017). Global AIDS Monitoring 2017. Reporting Period January – December 2016.

McCallum, L., Perez, S., Parsons, D., Burrows, D. & Falkenberry, H. (2018) Regional Summary: Assessment of HIV Service Packages for Key Populations in Asia and the Pacific. APMG Health, Washington, DC.

Ministry of Health of Palau. (2017). Global AIDS Monitoring Report, Republic of Palau.

Ministry of Health Samoa. (2018). GAM (Global Aids Monitoring) Report 2018.

Ministry of Health Tuvalu. (2015). Global AIDS Progress Report, Tuvalu. 2015.

Ministry of Health of Vanuatu. (2018). Country Progress Report – Vanuatu. Global AIDS Monitoring 2018.

Ministry of Health of Vanuatu. (2015). Global AIDS Progress Report, Vanuatu.

National Department of Health and Social Affairs, Federated States of Micronesia. (2016). Global AIDS Response. Progress Report 2015.

Secretariat of the Pacific Community (SPC). (2013) Sex work and HIV/STI prevention in the Pacific region, including analysis of the needs of, and lessons learnt from, programs in four selected countries.

Secretariat of the Pacific Community (SPC). (2014). Pacific Sexual Heath & Well-Being. Shared Agenda 2015-2019.

The Fiji Network for People Living with HIV (FJN+). (2018). The People Living with HIV Stigma Index. Overview Report of the People Living with HIV Stigma Index Study in Seven Countries in the Pacific. Retrieved from https://www.stigmaindex.org/wp-content/uploads/2019/11/Pacific-Regional-SI-Report-2018.pdf

The Global Fund. (2019). Global Fund's Investments in the Pacific Region. Regional Impact Report. Retrieved from https://www.theglobalfund.org/media/8544/publication_pacificregionimpact_report_en.pdf?u=636960342150000000

The Global Fund (2018a). MWP: Progress Update and Disbursement Request (PUDR).

The Global Fund. (2017b). Program Continuation Request Cover Letter. CCM Chair, PDSN. FJN+.

The Global Fund. (2018). Sub Recipient Grant Agreement. Execution Version. Samoa (2017), Tonga.

The Global Fund, (2019). Regional Impact Report. Global Fund's Investments in the Pacific Region.

The World Bank. (2019). The World Bank in Pacific Islands. Retrieved from https://www.worldbank.org/en/country/pacificislands/overview

UNAIDS. (2018) UNAIDS Data 2018. Retrieved from https://www.unaids.org/sites/default/files/media_asset/unaids-data-2018_en.pdf

UNAIDS, Fiji Network Plus (FNJ+). (2018). Regional HIV Forum for the Pacific Island Countries and Territories 2018

UNDP. (2019 a). Annual Results Report 2018. Multi-Country Western Pacific Integrated HIV/TB Program.

UNDP. (2019 b). Programme Brief. Multi-Country Western Pacific Integrated HIV/TB Programme. Retrieved from https://www.undp.org/content/dam/fiji/docs/GlobalFund-programme-brief-integrated-hiv-tb.pdf

UNDP. (2018 a). Key populations definitions and recommended service delivery packages within the Multi-Country Western Pacific Integrated HIV/TB Programme (2018-2020).

UNDP. (May 2018). Results Report 2015-2017. Multi-Country Western Pacific Integrated HIV/TB Program.

UNDP. (2018 b). Sub Recipient Agreement between the United Nations Development Programme and (Country Ministry of Health) for a Project Funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

UNDP, UNICEF, UNFPA, UNSW, ASHM. (2016). Pacific Multi-Country Mapping and Behaviour Study: HIV and STI Risk Vulnerability Among Key Populations. Key Findings.

UNDP, UNICEF, UNFPA, UNSW, ASHM. (2016a). Pacific Multi-Country Mapping and Behaviour Study: HIV and STI Risk Vulnerability Among Key Populations. Samoa.

UNDP, UNSW, ASHM. (2016b). Pacific Multi-Country Mapping and Behaviour Study: HIV and STI Risk Vulnerability Among Key Populations. Tonga.

UNDP, UNICEF, UNFPA, UNSW, ASHM. (2016c). Pacific Multi-Country Mapping and Behaviour Study: HIV and STI Risk Vulnerability Among Key Populations. Vanuatu.

UNDP. (2017). Multi-Country Western Pacific TB and HIV/STI M&E Plan 2018-2020.

UNDP. (2017a) Sub-Recipient Agreement Between the United Nations Development Programme and the Samoa Ministry of Health for a Project funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

UNDP. (2018) Sub-Recipient Agreement Between the United Nations Development Programme and the Tonga Ministry of Health for a Project funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

UNDP. (2017b) Sub-Recipient Agreement Between the United Nations Development Programme and the Vanuatu Ministry of Health for a Project funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

UNDP. (2017c) Sub-Recipient Agreement Between the United Nations Development Programme and the Vanuatu Ministry of Health for a Project funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

World Bank. (2018). Samoan Population 2016. Retrieved from https://www.google.com.au/publicdata/explore?ds=d5bncppjof8f9_&met_y=sp_pop_totl&idim=country:WSM:TON:VUT&hl=en&dl=en

World Health Organization (WHO). 2019. Consolidated Guidelines on HIV Testing Services for a Changing Epidemic: Policy Brief. November 2019.

World Health Organization Western Pacific Region (WPRO). 2019. Retrieved from https://www.who.int/westernpacific/health-topics/hiv-aids

World Population Review Samoa (2019). Retrieved from http://worldpopulationreview.com/countries/samoa-population/

Supplemental Information

Please see the following document for information regarding additional project background, specific methodology, and limitations of this evaluation.