Global AIDS Progress Report 2010-2011

Republic of the Marshall Islands

Submission date: 31st March 2012


Marshall Islands
Taongi
Pacific Ocean
Bikar
Rongerik
Bikini
Rongelap
Utirik
Ratak Chain
Enewetak
Ailinginae
Taka
Ailuk
Jemo
Mejit
Wotho
Ralik Chain
Ujelang
Likiep
Watje
Erikub
Ujae
Lae
Maloelap
Kwajalein Atoll
Lib
Aur
Namu
Jabwot
Majuro
Arno
Ailinglapalap
Majuro
250 mi
250 km
Jaluit
Mili
Knox
Namorik
Kili
Ebon

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1. Status at a glance

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

The Focal Point for RMI attended a UNAIDS/SPC training workshop in Nadi in late January to discuss the purpose of the GAPR. Subsequently the consultant agreed on a workplan for data collection, analysis and submission of the report with the Focal Points from Government and the NGO sector. A small working group was nominated, and key contact points identified.

Four key processes for data collection were agreed:

- A review of program reports, including any evaluations or other assessments on the response.
- Completion of the survey by government and NGO stakeholders representative of the response
- Review of all surveillance data for inclusion in the indicators table
- Collation and analysis of financial data for inclusion in the Funding matrix

The focal point for government and the NGO sector liaise with a range of stakeholders to collect and forward program reports to the consultant for review.

Meetings were held with three key groups of stakeholders from the NGO Sector, Government, and those from the NGO and Government and private sectors who might be able to contribute to completion of the survey or the indicators. The Focal points chaired these meetings.

The survey instrument was trialed with each group; and minor amendments made to improve its accessibility in the Marshallese context. The Survey instruments were then distributed widely across each stakeholder group. The focal point from Government and NGO sector then monitored completion and submission of the surveys over a three-week period, encouraging stakeholders to respond to the Survey. Surveys were submitted either electronically or in hard copy. The Consultant reviewed the surveys and aggregated the data for presentation at the Validation meeting as discussed below.

All Ministries, civil society organizations and private sector individuals who were involved in the meetings or other communications to discuss the purpose of the Global AIDS Progress Report, assist with the data collection process, or to whom a survey was distributed, or who responded to the surveys, was invited to the Validation meeting. Prior notice of the meeting had been advised during the preparation meetings.

A soft copy of the aggregated final draft survey Part A and Part B was distributed by email prior to the meeting. A hard copy of the aggregated final draft survey, together with the draft indicators matrix, was available at the meeting.

The consultant presented the key ratings and responses in relation to each category in the surveys, i.e. categories I-VI in Part A and categories I-V in Part B, identifying the achievements and challenges noted for each effectiveness rating;

and briefly discussing key issues raised throughout the response to the Category. The group discussed each rating and the associated achievements and challenges to confirm, explain and verify the information. The ratings were then endorsed by group agreement. When necessary, representatives from the Ministry of Health translated questions and comments to encourage discussion in Marshallese. The final aggregated survey was completed following the meeting and forwarded to the focal points for endorsement by the Ministry of health and upload.

In parallel with this process, the Focal points collated the financial data for discussion and aggregation into the funding matrix. The draft funding matrix was circulated and endorsed by the Ministry and uploaded.

Finally, the report was drafted and circulated to the Focal Points and the Secretary of Health for review prior to endorsement and upload.

At each point in the process, communication was maintained through face to face meeting, or, where location did not permit, skype and email.

(b) the status of the epidemic

RMI is considered to be a low prevalence setting for HIV. The number of people reported to be living with HIV in the Marshall Islands remains low. At the end of 2011, the cumulative incidence of HIV in the Republic of the Marshall Islands was 25 cases, since the first case was identified in 1984.

Only one new case was identified during the 2010-2011; this client also presented as a co-infection with TB. There are currently 8 people living with HIV in RMI. Of these, seven are currently on ARV treatment; the eighth has decided to stop ART due to the side effects. All are living in Majuro. Three are male and five are female. The age range of those currently living with HIV on-island is between 21-40 years, with the biggest cluster of four in the 26-30 year age range.

Of the 25 cases, heterosexual transmission appears to be the dominant mode in the 23 cases. Mother to child transmission is the next most common mode of transmission. Ten cases have died since diagnosed, and another seven cases have left the island, leaving eight currently living and receiving medical care.

Low levels of knowledge and unprotected sexual activity, particularly among young people, is thought to be the most significant risk factors, but there has been little new data since the 2007 Demographic Health Survey was conducted, so any shifts in behaviors or risk factors are not well-documented. Alcohol use associated with unprotected sexual behaviors, particularly amongst young people, was identified as a significant risk in the 2009 Youth Risk Behaviors survey, one of the few recent behavioral surveys recently documented. The preliminary results of an epi-analysis of 2009-2010 case surveillance in Ebeye found that the highest risk category for males and females is high-risk heterosexual contact – defined as sex without a condom, with a person who is

HIV positive, in exchange for drugs money or gifts, while using alcohol or drugs pr while diagnosed with an STD.

During the recent development of the National Strategic Plan, stakeholders confirmed mobile people (including local and expatriate travelers), young people, sex workers, seafarers and prisoners as key risk groups.

Most STIs continue to be a concern, although the MOH data for 2008-2010 indicates a decrease in case positivity (and assumed prevalence rate) for Chlamydia, syphilis and hepatitis, with only gonorrhea showing an increase. It is not clear from the data whether this reflects a more rigorous picture of the situation due to increase testing reported by Ebeye and Majuro public health programs or an actual decrease in level of STIs present in the population.[1]

(c) the policy and programmatic response

With the expiry of the last National Strategy in 2009, the National Advisory Committee on STDs, HIV & TB (NAC) and MOH are currently in the process of developing the National Strategic Plan 2012-2017.

The NAC identified that one of the key barriers to effectively addressing HIV in the Marshall Islands is the stigma and discrimination surrounding HIV. The NAC identified that it would draw on both the strengths and address the challenges represented by culture to effectively address HIV in RMI. The development of vigorous and transparent partnerships across government and civil society is intended to be the foundation for a strong response. The membership of the new NAC, drawn from government, community NGOs and the private sector and learning institutions, is the first step in developing strong and effective collaborative partnerships.

The Strategy aims to establish a coordination national response against HIV & STIs that promotes sexual and reproductive health; encourage respect among all individuals, families and the community; and acknowledge the strength of culture.

The main components of the Draft Strategic Plan include

1) strong governance and coordination at local and regional levels, with a particular focus on promoting a strong policy and legislative environment to guide the response;
2) comprehensive prevention initiatives to address the delays in promoting effective behavior change at individual family and community levels;
3) enhanced quality of treatment, care and support for those living with or affected by HIV and their families, and those infected with STIs; and
4) strategic information and communication, to ensure the response is built on a strong foundation of evidence, and informed by ongoing analysis of the situation.

[1] Based on MOH Case surveillance data, in Presentation to the NAC, Dr Zachariah, MOH, November 2011

(d) indicator data in an overview table

Targets	No.	Indicator	Applicable[2]	Status	Source	Comment
Target 1: Reduce sexual transmission of HIV by 50% by 2015						
General population	1.1	% of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	Yes	*8.4% of males were able to answer all 5 questions on knowledge of HIV prevention correctly* *3.8% of women were able to answer all 5 questions on knowledge of HIV prevention correctly*	Youth SGS 2006	Most recent data available
	1.2	% of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Yes	*15% of young women who have had sexual intercourse before the age of 15* *24.6% of young men who have had sexual intercourse before the age of 15*	Youth SGS 2006	Most recent data available
	1.3	% of adults aged 15-49 who had more than one sexual partner in the past 12 months	Yes	*Among those who have had sexual intercourse in the last 12 months:* *3.3% of women aged **15-49** who have had sexual intercourse with more than one partner in the last 12 months.* *9% of men aged **15-49** who have had sexual intercourse with more than one partner in the last 12 months.*	DHS 2007	Most recent data available
	1.4	% of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during last intercourse*	Yes	*10.6 % of women aged 15-49 who had more than one sexual partners in the past 12 months who report the use of a condom during their last intercourse** *19.5% of men aged 15-49 who had more than one sexual partners in the past 12 months who report the use of a condom during their last*	DHS 2007	Most recent data available

[2] That is, the topic of interest to RMI situation, although data may not be available or the estimates may be unreliable or not possible due to small actual numbers and absence of relevant and necessary population data.

Targets	No.	Indicator	Applicable[2]	Status	Source	Comment
				intercourse * based on 25-49 un-weighted cases.		
	1.5	% of women and men aged 15-49 who received an HIV test in the last 12 months and know their results	Yes	94.28% of women and men aged 15-49 who received an HIV test in the last 12 months and know their results	Routine MOH surveillance data	Best data available; although not all data entered.
	1.6	% of young people aged 15-24 who are living with HIV*	Yes	0.10% of young people aged 15-24 who are living with HIV*	Routine MOH surveillance data	Alternate data: 2006 Antenatal SGS: A total of 346 pregnant women were surveyed from May-September 2006: none of the women tested for HIV were positive.
Sex workers	1.7	% of sex workers reached with HIV prevention programs	Yes	No data available	na	No behavioral surveillance surveys available. MOH routine surveillance data not available
	1.8	% of sex workers reporting the use of a condom with their most recent client	Yes	No data available	na	No behavioral surveillance surveys available. MOH routine surveillance data not available
	1.9	% of sex workers who have received an HIV test in the past 12 months and know the results	Yes	No data available	na	No sero or behavioral surveillance surveys available. MOH routine surveillance data not available
	1.10	% of sex workers who are living with HIV	Yes	No data available	na	No sero or behavioral surveillance surveys available. MOH routine surveillance data not available
Men who have sex with men	1.11	% of men who have sex with men reached with HIV prevention programs	Yes	No data available	na	No behavioral surveillance surveys available. MOH routine surveillance data not available
	1.12	% of men reporting the use of a condom the last time they had anal sex with a male partner	Yes	No data available	na	No behavioral surveillance surveys available. MOH routine surveillance data not available
	1.13	% of men who have sex with men who have received an HIV test in the last 12 months and know their results	Yes	100% of men who have sex with men who have received an HIV test in the last 12 months and know their results	MOH routine surveillance	Sample refers to self revelation of orientation in routine screening data. No sero or behavioral surveillance surveys available.
	1.14	% of men who have sex with men who are living with HIV	Yes	No data available	na	MOH HIV Register
Target 2: Reduce transmission of HIV among people who inject drugs by 50% by 2015						
	2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programs	No	No data available	na	No programs operating in RMI
	2.2	% of people who inject drugs who report the use of a condom at last sexual intercourse	No	No data available	na	Local knowledge advises no IDU in RMI in contrast to Youth Risk Behavior

Targets	No.	Indicator	Applicable[2]	Status	Source	Comment
						survey 2009
	2.3	% of people who inject drugs who reported using sterile injecting equipment the last time they injected	No	No data available	na	na
	2.4	% of people who inject drugs that have received an HIV test in the last 12 months and know the results	Yes	No data available	na	na
	2.5	% of people who inject drugs who are living with HIV	Yes	No data available	na	na
Target 3: Eliminate mother to child transmission of HIV by 2015 and substantially reduce AIDS-related neonatal deaths						
	3.1	% of HIV-positive pregnant women who receive anti-retrovirals to reduce the risk of mother to child infection	Yes	100% of HIV-positive pregnant women who receive anti-retrovirals to reduce the risk of mother to child infection	MOH Routine Surveillance	Refers to one client
	3.2	% of infants born to HIV-positive women receiving a virological test for HIV within two months of birth	yes	0% of infants born to HIV-positive women receiving a virological test for HIV within two months of birth	MOH Routine Surveillance	Refers to one infant born in the reporting period and who is yet to be tested.
	3.3	Mother to child transmission of HIV (modeled)	No	na	na	Modelling estimates not reliable given population numbers
Target 4: Have 15million people living with HIV on antiretroviral treatment by 2015						
	4.1	% of eligible adults and children currently receiving antiretroviral therapy*	Yes	87.5% % of eligible adults and children currently receiving antiretroviral therapy*	MOH routine surveillance	
	4.2	% of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Yes	100% of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	MOH Routine Surveillance	Refers to one client only.
Target 5: Reduce tuberculosis deaths in people living with HIV by 50% by 2015						
	5.1	% of HIV-positive incident TB cases that received treatment for both TB and HIV	Yes	100% of HIV-positive incident TB cases that received treatment for both TB and HIV	MOH Routine Surveillance	
Target 6: Reach a significant level of annual global expenditure (US22-23billion) in low and middle income countries						
	6.1	Domestic and international AIDS spending by categories and financing sources	Yes	See online report	See online report	
Target 7: Critical enablers and synergies with development sectors						
	7.1	National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programs, stigma and discrimination, and monitoring & evaluation)	Yes	See online report	See online report	
	7.2	Proportion of ever-married	Yes	27% of ever-	DHS 2007	In the past 12

Targets	No.	Indicator	Applicable[2]	Status	Source	Comment
		or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months		married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months		months: 5.3% of women have been sexually abused by their previous husbands; and 21.4% have been physically abused by their previous husbands 50.2% of women have been sexually abused by their current husbands; and 71.5% have been physically abused by their current husbands
	7.3	Current school attendance among orphan and non-orphans aged 10-14*	No	No data available	DHS 2007	No child is without a family within the Marshallese culture.
	7.4	Proportion of the poorest households who received external economic support in the last 3 months	Yes	No data available	MDG Tracking Report 2011	
New indicator	7.5	Alcohol consumption & youth risk behaviors	Yes	Among students who had sexual intercourse during the past three months, 39.2% reported they drank alcohol or used drugs before last sexual intercourse 42.2% of students who had sexual intercourse with one or more people during the past three months	Youth Risk Behavior Survey 2009	

2. Overview of the AIDS epidemic

The national context[3]

The Marshall Islands consists of 29 coral atolls and 5 coral islands lying between 160-173 degrees east longitude and 4-14 degrees north latitude, in the North Pacific Ocean. These atolls and islands form two parallel groups – the Ratak (sunrise) chain, and the Ralik (sunset) chain. The Marshallese people are of Micronesian origin. The matrilineal Marshallese culture revolves around a complex system of clans and lineages tied to land ownership The Marshall Islands total land mass measures around 181 square kilometres and its exclusive economic zone measures about 2 million square kilometers. The highest elevation is around 10 meters above sea level, with the average elevation at 2 meters.

The Marshall Islands became an independent country in 1986 with the termination of trustee arrangements under 1945 UN Trusteeship Council Agreement. Although the country assumed responsibility as an independent entity, it retained a political economic and defense relationship with the United states under the Compact of Free Association. The agreement underlying the Compact has been renewed twice since 1945. The current Compact agreement between the RMI and the USA operates until 2018.[4]

The Republic of the Marshall Islands is a parliamentary democracy. Its government is modeled on the Westminster system, with a bi-cameral legislate composed of two houses: the Council of Iroij (Chiefs) and the Nitijela (Parliament). Legislative power sits with the Nitijela; the House of Iroij has the power to comment on bills in relation to customary and traditional practices. At the municipal level, each atoll has a local government composed of an elected mayor and council.

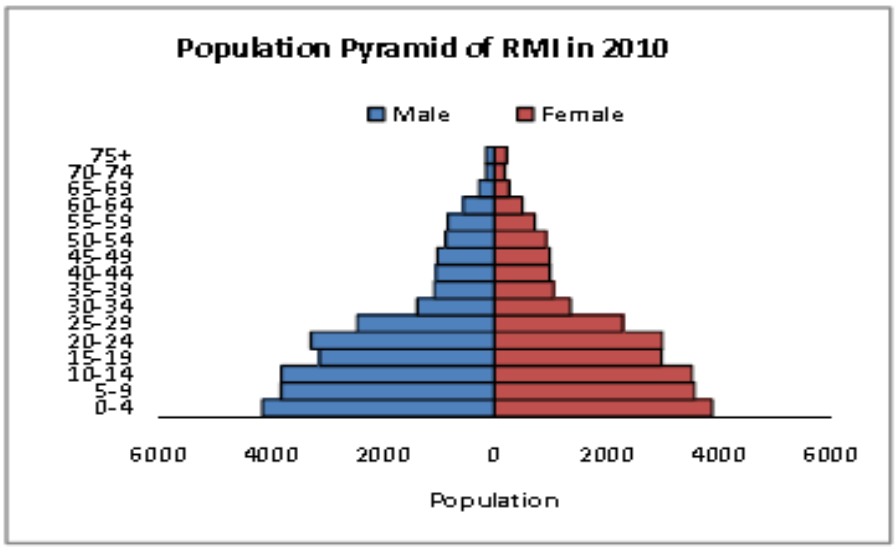
Although high fertility rates contributed to high population growth during the 1990s, population began to decrease in the early 2000s, with a fall in fertility rates and an increase in outward migration, largely to the United States. The estimated population in 2007 was 53,000[5]. RMI has an estimated median age of 19.2, making it one of the youngest populations in the Pacific, and indicating that future population growth could be high, subject to outward migration.

[3] We acknowledge the 2009 Progress Report on the Millennium Development Goals, EPPSO, 2009 and 2007 Demographic Health Survey, EPPSO, 2008; the 2010 Annual Report of the Ministry of Health, RMI, Ministry of Health, 2011

[4] The Millennium Development Goals 2009 Report on Progress, Republic of the Marshall Islands, Economic Policy, Planning and Statistics Office, RMI Government, 2009 Vision 2018: The Strategic Development Plan Framework 2002-2018, the Marshall Islands, 2001; the case for Justice for Micronesians in Hawai'i, 2011, Hawaii Appleseed Centre for Law and Economic Just Policy Brief; Millennium Development Goals

[5] Although a census was undertaken in 2011, this data was not yet available: a pre-release 'running total' identified that the population for the RMI Census stands at 52, 558, and a 3.42% change on the 1999 census. Although this was an increase overall of 1738, it represented a decrease in the population of 18 atolls. Kwajalein experiences an overall percent change increase of 4.3% (469 more persons). Majuro experienced an overall increase of 16.3% (3,862 persons). A major contribution fact is the migration rate. Source: Preliminary running totals for Census 2011 to date, EPPSO website accessed 15 March 2011

Population Pyramid of RMI in 2010



Source: RMI MOH Annual Report 2010 – revised population pyramid by EPPSO

RMI is highly urbanized, with the largest urban centre located at Majuro (on Majuro atoll) and Ebeye islands, across from the Kwajelein military base, is the second largest urban centre. Housing conditions in these islands are crowed, with the average urban household carrying up to 7.6 members (compared to 6.6 in rural areas). With large household sizes, and limited land, living conditions are dense and challenging. One quarter of all households uses only one room for sleeping.

Whilst services such as education, health and housing, and associated infrastructure, including transport and telecommunications, and utilities such as electricity, water and sewerage are available in Majuro and Ebeye, access to these services in the outer islands is less regular – although access to solar power is changing some aspects of this situation in the outer islands.

RMI's economy is described as similar to many Pacific island nations: it is remote from major markets, has a narrow production and export base and is vulnerable to external shocks, and relatively depended on official (aid) transfers. Funding from the Compact of Free association provides over half of the RMIs annual budgetary resources. Remittances are not a major contributor to the household incomes in RMI. The public sector plays a dominant role in contributing to Gross Domestic Productivity and employment. The primary commercial industries include wholesale and retail trade, general business services, commercial fisheries, construction, tourism and light manufacturing

Over the last decade, while infant mortality and life expectancy improved, the incidence of child malnutrition and adult obesity has increased. As a result, a large proportion of the budget is dedicated to curative health care programs due to life style disease such as diabetes, hypertension, heart disease and cancer. With on-island heath care services unable to address many of these issues, off-island referrals consume much of the health resources.

The organisation of health care services

In 1986 the RMI Government adopted the concept of Primary Health Care declared by the WHO in 1978.

The Ministry's executive function is headed by the Secretary who provides overall leadership in administering the affairs of the Ministry. The Secretary facilitates cooperative efforts with other Ministries and supplies the Minister of Health with policy advice and assistance with Cabinet level concerns. The secretary is assisted by five Assistant Secretaries directing the areas of Policy and Planning.

The health care system is comprised of two hospitals, one in Majuro and one in Ebeye and fifty eight (58) health care centers in the outer atolls and islands[6]. Both hospitals provide primary and secondary care, but limited tertiary care. Patients who need tertiary care are referred to Honolulu or the Philippines.

In addition, there are three private clinics in Majuro – a general practice, dental surgery and optical care. There are also clinics which directly provide primary health care services to those whose atolls experienced the nuclear testing; alongside the Kumiti 'wellness' centre operated by Canvasback Mission, and the Taiwan Health Centre, both of which offer programs addressing the prevention of NCDs.

MOH works in conjunction with the Community Health Councils (CHC) in the outer islands. The system requires community participation in health care and ensures that the community beyond the urban centers are involved and included in the provision of health care services.

Health centers in the outer islands are the focus for preventative, promotive and essential clinical care services. All health care centers are permanently staffed by full time Health Assistants who provide health services and work with the Community Health Councils to promote and foster the concept of shared responsibility for health.

The National Health Strategy 2012-2014

The Ministry of Health recently developed a revised National Health Strategy 2012-2014. This Strategy acknowledges the national Goals and Objectives as stated in the Vision 2018 Strategic Development Plan Framework, 2003-2018 with specific reference to Goal 4: A Healthy People.

The Strategy identifies the Bureau of Primary Health Care Services (BPHC) as responsible for strengthening preventive programs/services at the community level. The Bureau is responsible for the provision of services related to HIV & STIs, under its related programs in Infectious Diseases and Reproductive Health, which provides medical direction in prevention and treatment services related to reproductive health and family planning; hepatitis prevention; sexually transmitted infections (STIs); HIV and AIDS; TB; leprosy; and filariasis. The

[6] RMI MOH Annual Report 2010 notes: 1 101-bed hospital and 2 health centres on Majuro atoll,1 45-bed hospital /health centres on Ebeye and 1 health centre on Santo island; and 26 dispensaries/health centres on the Ratak chain and 24 in the Ralik chain.

Bureau coordinates these services across Majuro, Ebeye and to the outer islands.

National HIV Coordination Mechanism

The Ministry of Health re-established the National AIDS Committee as a coordination mechanism for the response to HIV, STIs and TB in November 2010 (RMI/HIV-STI-TB NAC)

The NAC is responsible for supporting engagement and coordination between the Ministry of Health, other state local agencies, non-government organizations, and community representatives for identifying needs, determining priorities, and developing comprehensive HIV, STI & TB plans.

Membership of the NAC is limited to fifteen members. Its current membership includes representation from: NGOs in the community and health sectors, private sector, higher education institutions, faith based organizations, and the Ministry of Health. Meetings are scheduled each quarter. A join secretariat operates between the Ministry and WUTMI[7] to provide administrative and other support.

The role and responsibilities of the NAC addresses the following functions:

- promoting collaboration between the government and non-government sector through the development of plans and activities aimed at preventing the spread of HIV, STIs and TB in the RMI;
- promoting legislative review and implementation on matters related to HIV, STI &TB;
- monitoring the effective implementation of HIV, STI &TB prevention programs across RMI;
- Policy and procedural review and oversight in relation to HIV, STI &TB prevention – and assisting local government and community organizations to effectively implement these policies and procedures;
- Review and oversight of grant proposals, in collaboration with the Ministry of Health;
- Reporting on progress of implementation of the response to the Secretary for Health.

The NAC by laws allow for the provision of three sub-committees to provide direction in relation to health education, legislation and policy, and grants.

Key initiatives underway under the NACs guidance since its establishment include:

- Development of the National Strategic Plan for HIV & STIs, with two workshops held over the last four months; a draft Plan is expected to be circulated to stakeholders by the end of April;
- Scheduling the M&E training and development of the MEF;

[7] Women United Together Marshall Islands, the local NGO which represents grassroots women from across the Marshall Islands; it advocates for gender equity, particularly the empowerment and advancement of women. It has played a key role in the advocacy for legislation protecting women and their families from domestic violence.

- Initiating a review of HIV related legislation in RMI to assess and clarify responsibilities for data collection and reporting; and for the protection of people who are positive.
- Advertising to establish a CDO mechanism, under the SPC Response Fund, to support capacity strengthening across the civil society organization/sector in relation to HIV & STIs (especially addressing vulnerability issues).
- Representation at regional high level meetings to discuss RMIs response to HIV and STIs, such as the PIJAAG face to face forum in Honolulu, and the MDG meetings in Bangkok.

The National HIV & STI Strategy 2012-2017

In light of the expiry of the 2005-2009 National HIV & STI Strategic Plan, the MOH has collaborated with the NAC and the MOH over the last six months to review and develop the next National Strategic Plan to address HIV & STIs. Two workshops were held in December 2011 and March 2012. As a result, the Draft National Strategic Plan 2012-2017 is almost completed.

The NAC identified that one of the key barriers to effectively addressing HIV in the Marshall Islands is the stigma and discrimination surrounding HIV. The NAC identified that it would draw on both the strengths and address the challenges represented by culture to effectively address HIV in RMI. The development of vigorous and transparent partnerships across government and civil society is intended to be the foundation for a strong response. The membership of the new NAC, drawn from government, community NGOs and the private sector and learning institutions, is the first step in developing strong and effective collaborative partnerships.

The Strategy aims to establish a coordination national response against HIV & STIs that promotes sexual and reproductive health; encourage respect among all individuals, families and the community; and acknowledge the strength of culture.

The main components of the Draft Strategic Plan include

1) strong governance and coordination at local and regional levels, with a particular focus on promoting a strong policy and legislative environment to guide the response;
2) comprehensive prevention initiatives to address the delays in promoting effective behavior change at individual family and community levels;
3) enhanced quality of treatment, care and support for those living with or affected by HIV and their families, and those infected with STIs; and
4) strategic information and communication, to ensure the response is built on a strong foundation of evidence, and informed by ongoing analysis of the situation.

Monitoring and evaluation of the national response

The national response is currently monitored through routine case surveillance collected by the Ministry of Health's BPPHS clinical teams at the various sites offering counseling and testing and/or referral services at the two major urban

centres of Ebeye and Majuro. In addition to the HIV & STI clinics, these include the ANC and Family Planning clinics, the Outpatient clinic and the Outer Islands mobile Outreach services. In addition, Youth to Youth Health Services in Majuro, which also offers counseling and testing (in collaboration with the MOH clinical teams) also records case surveillance data, which it submits to the Ministry of Health.

Quarterly program reports, including data analysis and narrative reporting, are submitted to Bureau heads by the clinical program manager in Majuro. Ebeye submits its data to Majuro for inclusion in the national database. A review of the national reports over 2010-2011 showed that often, data analysis was inconclusive and sometimes, information was repeated across quarters.

Currently, data is entered either by the clinical staff at the point of testing or is referred to the IT Department, who, in the absence of dedicated data entry staff, are relied on to respond to all requests for surveillance data. The IT Department's Director is supported by a UN volunteer and the office of Vital Statistics.

The other primary source of monitoring and evaluation information is the program reports. Quarterly reports are compiled to meet internal MOH reporting requirements. The internal reports are the basis of the six monthly and annual reports complied by MOH in response to compliance with donor funding conditions. These Program reports are routinely requested on a six monthly or annual basis by SPC's Pacific HIV & STI Response Fund and Global Fund; and, for the US Federal funds from CDC and HRSA, on a 6-month interim and annual basis for each of the HIV Prevention, Surveillance and Comprehensive STD Management grants. These reports include surveillance and financial data in addition to narrative comment. A total of 12 reports are required annually to meet all funders' guidelines.

These reports operate under each individual funder's grant cycle, so reports may be due at the same time or consecutively. The reports are comprehensive and sometimes complicated. The SPC reporting format is a new and evolving format released during 2011. CDC advises that they intend to merge their funding opportunities for HIV, STD and TB in the near future, although they intend to maintain separate reporting.

There was a gap in MOH Program reporting, both internal and in response to external funders compliance requirements, in 2011. MOH advised that this was due to the change in program management personnel. Their subsequent records demonstrated that the Ministry had undertaken extensive efforts to redress the delays in reporting, particularly in relation to the Ryan White Funds and these are now close to up to date.

Few in-depth surveillance surveys or program evaluations were identified during the GAPR process. The last Demographic Health Survey was undertaken by SPC and EPPSO in 2007. Whilst these are often conducted every five years, EPPSO, the office responsible for the last DHS, has no plans to conduct another DHS in the near future. In addition to routine case surveillance, Ebeye health

centre has also undertaken an epi-analysis of all routine surveillance for 2009-2010 with the assistance of CDC. The team at Ebeye also conducted a school-based youth risk behavior survey in 2008; and a community based sexual risk behavior survey in one of the outer islands during 2010. An evaluation of Youth to Youth was reported to be undertaken by SPC Program staff in 2010[8]. Two community NGOs, WUTMI and MIEPI whose work engages the broader issues around vulnerability related to HIV and STIs[9], demonstrated examples of epidemiological research and qualitative program evaluations in their specific fields, reflecting systemic and rigorous approaches to the collection and analysis of community-level data[10].

The NAC and MOH intend to develop a monitoring and evaluation framework once the developing National Strategic Plan is confirmed. The MOH has liaised with UNAIDS to arrange preliminary training in monitoring and evaluation in the second quarter of 2012. After this, UNAIDS will provide additional support to develop the monitoring and evaluation framework in collaboration with the MOH and NAC teams.

Funding the national response

Funding sources for the national response derive from three key areas.

1) There is a substantial contribution from the Compact funds, supporting ongoing MOH staff positions in public health and associated support areas (such as pharmacy, laboratory, and administration finance).

2) US Federal Grant Funds through the CDC and HRSA support HIV prevention and surveillance, comprehensive care for STDs and support to those infected with HIV (specifically under the Ryan White funds).

3) The Pacific HIV &STI Response Fund and the Global Fund, both managed by SPC, are also now major sources of funding for the national response in RMI, supporting additional programs and capacity strengthening in governance management and coordination, prevention and access to treatment and care.

As the tables below indicate, grant allocations across the 2009-2011 fiscal (and in some grants, calendar) years totaled US$1439719. Total expenditure across all grants for the same period was recorded as US$745,598 – just over half the possible funds available was expensed. Key areas where funds were available but underutilized included the Ryan White funds, the HIV Prevention, STD and surveillance grants. There were initial delays in expenditure under the Global Fund, but this increased during 2010 and 2011. Although total allocations for the NSP and Competitive grants were not available, it is thought that there was an

[8] The consultant was unable to locate a copy.

[9] MIEPI is one of a number of NGOs now working to address alcohol related risk behaviour with a particularly focus on research; WUMIT, as noted earlier, addresses gender equity and the empowerment of women – it has substantive programs addressing violence against women, substance abuse and the development of parenting skills.

[10] Substance Abuse Epidemiological Profile 2011, Republic of the Marshall Islands, RMI Epidemiological Work group, Marshall Islands Epidemiology and Prevention Initiatives Inc (MIEPI)

under-spend in these areas also. Another grant, the Capacity Development Organisation Grant which supports civil society capacity strengthening, has been available to RMI for three years and is yet to be negotiated with SPC.

Annual allocations by External Funder by Year – US$
Source: Aggregated data, MOH Finance 2011

	US Federal Funds (inc CDC & HRSA)				SPC			Total US$
	HIV Prevention	Surveillance	STD Management	Ryan White	NSP	Comp	Global	
2009	122518	13532	136934	52968	*na*	*na*	132500	**458452**
2010	122518	18042	136934	52820	69578[11]	15514[12]	94500	**509906**
2011	122518	18042	136660	25479	48375	39534[13]	80753	**471361**
	367554	49616	410528	131267	117953	55048	307753	***1439719***

Estimated expenditure by GARP categories by year[14] US$
Source: Aggregated data from MOH Finance 2011

	Prevention	**Care & Treatment**	**Program management**	**Total US$**
2009	80464	31845	13532	**125841**
2010	242882	90302	57749	**390933**
2011	132064	63360	33400	**228824**
Total	**455410**	**185507**	**104681**	***745598***

Youth to Youth In Health (YTYiH) advised that they also received support from UNFPA for their Adolescent Health Development program, but the level of funds was not available. Discussion with a representative from Youth to Youth indicates that recent communications from UNPFA suggest that funds will be reduce substantially in the next year in the expectation that the MOH will fund the current salaried officer supported by UNFPA. YTYiH expect to retain operational funds.

HIV epidemiology in 2011

The number of people reported to be living with HIV in the Marshall Islands remains low. The MOH HIV registry records the cumulative incidence of HIV is 25 cases since the first case was identified on-island in 1984, indicating low level prevalence. This is an increase of 3 cases on the most recent published SPC data in 2009, which recorded 22 cases. Current MOH HIV registry data indicates ten cases have died since diagnosed – indicating that 2 cases have died since the 2009 data was published. Another seven cases have left the island, leaving eight currently living and receiving medical care in RMI.

[11] Overall allocations were not available so actual disbursements have been used instead. Source: MOH Finance Department 2011

[12] Overall allocations were not available so actual disbursements have been used instead. Source: YTY Finance Report 2011.

[13] Overall allocations were not available so actual disbursements have been used instead. Source: YTY Finance Report: 2011.

[14] These are estimates ONLY, given time and data constraints: SPC funds are allocated to a range of activities to support implementation of National Strategic Plans, and encompassing prevention, including testing and counselling; laboratory infrastructure, drugs and supplies; capacity strengthening across all technical areas; governance, and management. So expenditure from these funds have been estimated to match the respective 'most likely' category. In comparison the US Federal funds are dedicated by categories such as HIV Prevention, STD Management or HIV+ support (Ryan White). These more readily lend themselves directly to the GARP categories. A more detailed analysis of funding is recommended

Status of HIV cases, RMI, 2011
Source: MOH via HIV register

Sex	Migrate out	Died	Active	Total
Male	2	5	3	10
Female	1	5	5	11
Unknown	4	0	0	4
Total	7	10	8	25

Only one new case was identified during the 2010-2011 who was a co-infection with TB. Of the 8 people living with HIV, seven are currently on ARV treatment; the eighth has decided to stop ART due to the side effects. All are living in Majuro. Three are male and five are female. The age range of those currently living with HIV on-island is between 21-40 years, with the biggest cluster of four in the 26-30 year age range.

Active Cases by Age Group RMI 2011
Source: MOH HIV Registry

Age group(yrs)	Male	Female	Total
0-20	0	0	0
21-25	1	0	1
26-30	2	2	4 (50%)
31-35	2	0	2
36-40	0	1	1
41+	0	0	0
Total	5	3	8

Of the 25 cases thus far, heterosexual transmission appears to be the dominant mode in the 23 cases. Mother to child transmission is the next most common mode of transmission. There was one pregnancy in an HIV+ client during the reporting period. This client was monitored and the child delivered. The child is yet to be tested, so its status is unknown.

HIV cases by Transmission RMI 2011
Source MOH HIV Registry

Sex	Heterosexual	MSM	Drug Users	MTCT	Total
Male	9	0	0	1	10
Female	10	0	0	1	11
Unknown	4	0	0	0	4
Total	23	0	0	2	25

Low levels of knowledge and unprotected sexual activity, particularly among young people, is thought to be the most significant risk factor, but there has been little new data since the 2007 Demographic Health Survey, so any shifts in risk factors are not well-documented. Alcohol use associated with unprotected sexual behaviors, particularly amongst young people, was identified as a significant risk in the 2009 Youth Risk Behaviors Survey, one of the few recent behavioral surveys recently documented[15].

The recent development of the National Strategic Plan identified mobile people (including local and expatriate travelers), young people, sex workers, seafarers and prisoners as key risk groups.

3. National response to the AIDS epidemic

3.1 Prevention

The NCPI Survey identified that a stronger focus on integration of HIV & STI and Sexual & Reproductive Health information and awareness into other programming is emerging over the last two years. In addition to the services provided by the Ministry of Health, Youth to Youth in Health continues to operate as the premier service providing clinical and prevention services to young people and specifically addressing risk behaviors such as safer sexual behaviors including access to condoms. However, there are also a number of agencies whose briefs have extended, or developed, to address areas related to vulnerability to HIV such as MIEPI and Kumiti's work with the Single State Agency on substance abuse; WUTMI's work on addressing the protection of women through reducing domestic violence; and WAM's ongoing work to improve life skills of young people through a renewed sense of cultural traditions. Each of these has already addressed, or intends to address, HIV issues in their awareness programming.

[15] Youth Risk Behaviours Survey, CDC Atlanta, 2009

Recently the NAC advertised for a civil society agency to support capacity strengthening related to HIV and STIs in the civil society sector. The role is yet to be assigned, but this would greatly promote integrated programming on HIV & STI issues amongst civil society organizations.

3.1.1 Young people

Teen pregnancies

The most recent MOH Annual Report, for the fiscal year 2010, identified a teenage pregnancy rate[16][17] of 31 teen pregnancies per 1,000 populations less than 20 years old, continuing the decreasing trend of the last four years.

Despite the decreasing trend, the teen pregnancy rate is still considered high. Apart from concerns over individual well-being – nearly 19% of births are low weight, and there is a high risk of premature labor, anemia and high blood pressure - the MOH are concerned that these births represent complications for the family, government and teenage mothers (and fathers) such as potential disruptions to schooling and consequences for income-earning potential as we as household over-crowding and associated issues. Family planning services are offered through the Maternal and child health program; and Youth to Youth health clinic offers counseling and contraceptives.

Teen pregnancy for 2007-2010 FYs
source MOH Annual Report 2010 FY

	FY 2007	FY 2008	FY2009	FY2010
Teen pregnancy	278	253	232	198
% of teen pregnancy from all births	17%	17%	14%	14%
Teen pregnancy rate per 1000 population	40	39	36	31

Alcohol and youth

Over the last two years, there has been a growing focus on the relationship between alcohol and its influence on young people in the Marshall Islands. The Single State Agency, has attracted substantial US Federal funds to support and expand programming to address substance abuse prevention, treatment and recovery services across the Marshall Islands. Partnerships have been established with over 12 different community groups to identify and deliver services. Each of these partnerships is required to integrate HIV & TB related prevention education into their programs.

In 2011, the Marshall Islands Epidemiology Prevention Initiative (MIEPI) undertook a review of all current data related to substance abuse in the Marshall

[16] That is, pregnancy occurring in women less than 20 years old
[17] Based on FY2010 Total fertility rate of 3.18 Marshallese women will have 3 children in her lifetime – reflecting the continuing trend to smaller families, even though the population is growing with a natural increase of 2.04 . Source: RMI MOH Annual Report Fiscal Year 2010, MOH, 2011

Islands[18]. In relation to youth alcohol use, they identified the Youth Risk behavior surveys 2007 and 2009 as the most valid source of data.

The Youth Risk behavior survey 2007 reported an overall 41.7% of students had had at least one drink of alcohol on 1 or more of the 30 days preceding the survey. The YRBS 2009 showed a negligible decrease to 41.4%. Both surveys reported on youth episodic drinking, with YRBS 2007 reporting that 26.6% of students consumed 5 more dinking of alcohol in a row on 1 or more of the 30 days preceding the survey. This increased in 2009 YRBS to 28.9%

The YRBS reported the overall, 10.9% of students had their first drink before the age of 13, but YRBS 2009 showed a return to 2003 levels (but only a small drop); with 10.5% of students trying their first drink of alcohol other than a few sips, before the age of 13 years.

In relation to the broader population, the study found that alcohol was the most frequently used substance, and the substance creating the most problems. Aside from alcohol and tobacco, betel nut was the most preferred substance. Informants identified a relation between substance abuse and domestic violence. The data indicated a relationship between alcohol and deaths, traffic accidents and violations and to other offences of disorder. Alcohol was also shown to be related to mental health and well-being; employee termination and absenteeism.

MIEPI is one of a number of community based groups currently working to address substance abuse and related issues. MIEPI works with the Single State Agency and community groups, such as the KUMIT coalitions, to address substance abuse. It aims to provide primary prevention and related services to address substance abuse and the general health and well being of young people and their families in the Marshall Islands. It has particular experience in epidemiological surveillance, planning and monitoring, including capacity strengthening on data collection and communication, on substance abuse issues and programming.

WUTMI has also entered an agreement with the SSA to deliver services to address substance abuse. WUTMI's role focuses on the identification and capacity strengthening of community coalitions to develop and implement prevention strategies to address substance abuse. This program began in 2011.

Education and employment and youth

The same study indicated that while the vast majority of Marshallese attend school, many do not complete primary school and few go on to complete secondary or higher education[19]. Starting at age 14, attendance rates decline noticeably for all children. As a result, RMI struggle to meet its human development goals and the provision of basic education is a major challenge.

[18] Substance Abuse Epidemiological Profile 2011, Republic of the Marshall Islands, RMI Epidemiological Work group, Marshall Islands Epidemiology and Prevention Initiatives Inc (MIEPI)

[19] Substance Abuse Epidemiological Profile 2011, Republic of the Marshall Islands, RMI Epidemiological Work group, Marshall Islands Epidemiology and Prevention Initiatives Inc (MIEPI)

Only 40% of adults have completed the full cycle of primary and second schooling. According the 1999 census, literacy rates in the Marshall Islands were 77%

Citing the ADB report on Hardship and Poverty in the Pacific (2005), the study also identified claims that RMI has the highest estimated rate of youth (15-24 years) unemployment in the Pacific, with 62.6% of the youth population over the years 1999-2000 considered unemployed. More recent data from the 2011 census was not yet available.

The Waan Aelon in Majel (WAM) is one of the key community based groups working with young Marshallese people to provide vocational and life skills training to counteract the impact of high unemployment. WAM's program centres on the traditions associated with the outrigger canoe as a mechanism through which to build self esteem and confidence and establish individual vocational skills. WAM also addresses counseling on substance abuse, in recognition of its impact on employment and individual confidence. WAM works with prison inmates as well as unemployed youth. It collaborates with a range of organizations, including Youth to Youth, PIMA Pacific Partnership and the MOH Mental Health Program.

WAM's annual reports for 2010-2011 showed that its vocational training program reaches approximately 25 trainees in each annual program with between 1-3 trainees dropping out over the two years; the rest completed the course. Its jail program reached 8 clients. Its vocational follow-up, including the Employee Assistance liaison, reached 26 over the 2010-2011 period. WAM noted that 7 clients subsequently found employment; 2 returned to school; and one migrated. One client died due to suicide. A number of clients from the jail program reported a reduction in alcohol consumption on 3-month follow-up.

WAM has plans to expand its advocacy work with the prison inmates as well as continue it's vocational and employee assistance programs.

Youth friendly health services

Youth friendly health services are offered primarily by Youth to Youth at its clinic in Majuro and in Ebeye. Youth to youth in health has been in operation in Majuro over 15 years and is well-recognized for its contribution to youth health. The service in Ebeye has only recently re-opened, with support from the Ebeye Health Centre. YTYiH work with young people in school and out of school settings.

The YTYiH service in Majuro offers STI & HIV counseling and testing, family planning contraceptive distribution, based on choice, and physical examinations for males and females.

In addition to clinic services, YTYiH also provides a range of health education and awareness programs, utilizing awareness activities, education sessions, drama, focus groups, peer education and other innovative means to reach audiences as diverse as taxi drivers, sex workers and school students. In

addition to providing access to condoms at its clinic location, it also distributes condoms to bars and nightclubs and hotels.

At the Majuro centre, young people can also access a range of IEC materials on health and wellbeing, as well as access to computers for their own research. The Majuro site runs a homework program and an arts program. It also links with the National Training Council to provide life skills and vocational-related training programs.

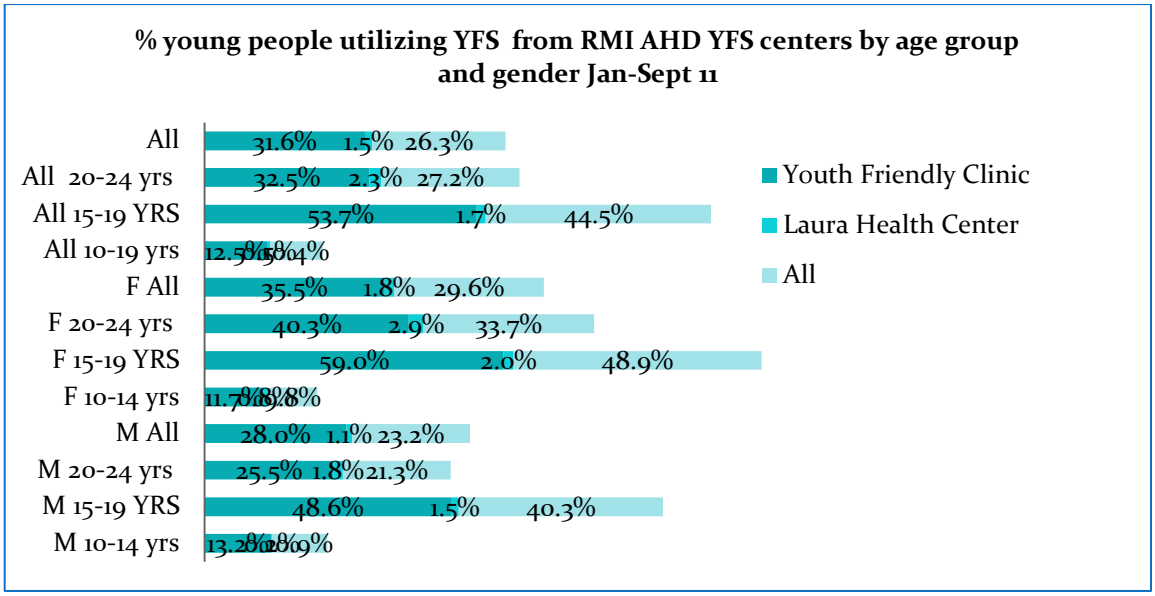
Formal and informal sexual and reproductive health services

Young people can also access the hospital clinic in Majuro and Ebeye, although these services are not specifically targeting young people. However, YTYiH is recognized as the key agency delivering formal and informal sexual and reproductive health services specifically for young people in RMI.

The NCPI Survey revealed that the Ministry of Education has funding to integrate sexual and reproductive health, including HIV & STI awareness and education, into its national curriculum. However, the Ministry is aware that it lacks capacity in this area and progress has been slow. The Ministry has sought YTYiH and MOH's advice to assist them develops an appropriate curriculum and teacher training program. One of the recommendations discussed during the recent National Strategic Planning workshop was the development of a curriculum advisory committee to ensure that SRH are integrated into the national curriculum as a priority.

Number of adolescents and youth utilizing youth friendly health services

Comparative data on the number of adolescents and youth using youth friendly health services was difficult to ascertain. However, YTYiH's Adolescent Health Development program, which operates from the Majuro clinic and the Laura health centre, has captured information related to its reach in the first three quarters of 2011. The following tables present the data on the proportion of young people using each centre by age group and gender between January – September 2011: it shows that the two services offered services to 26.2% of all youth in Majuro, encompassing 23.2% of all males youth and 29.6% of all females.



With a total youth population 10-24 years of 16760 across Laura and Majuro town, YTYIH, identified the following proportion of total youth who accessed all services: these encompassed HIV information; STI information; counseling; contraceptives; and condoms. The following table provides more detail:

% of total youth catchment accessing SRH services Under the AHD program at Youth to Youth in Health - Jan-Sept 2011

Source: Youth to youth Adolescent Health Program

% of	HIV info	STI info	Counseling	Contraceptives	condoms
Male	5.8	4.9	0.4		2.8
Female	6.8	5.8	0.1	1.5	1.4
All	6.3	5.4	0.3		2.1

It is difficult to comment when there is limited comparative data available, but the low proportions suggest that the program would benefit from extending its audience reach. More exploration of the data and stronger program analysis, such as that gained through a specific program evaluation, is required.

3.1.2 Specific sub-populations with higher risk of HIV exposure

Populations at higher risk

The NCPI survey and discussions during the National Strategic Planning workshops, identified Sex workers, seafarers, travelers and prisoners specific sub-populations which may have a higher risk of HIV exposure due to their behaviors.

For sex workers, the noted risks included: multiple and concurrent partners, often without protection; the likelihood of violent or forced sex. Prisoners were identified as a previously un-engaged group that may be at higher risk of HIV exposure due to needle use or male-to-male sex. Taxi drivers and seafarers were a group who were also noted as likely to engage in multiple sex with

concurrent partners and without protection. They were also identified as at risk of forced or violent sex and male to male sex. Travelers were similarly seen as a group who may be at risk because of multiple sexual activity with concurrent partners, and without protection.

However, there is very little documented research on the size or behaviors of any of these groups in RMI. There are few services specifically targeted at the needs of any of these groups. These groups are expected to access mainstream services. With the shortcomings in the data entry identified earlier, it is difficult to assess how well any of these groups access mainstream services for HIV & STI testing and counseling, or other education and prevention programs.

Youth to Youth in health in Majuro and Ebeye are the only group who specifically work with any of these vulnerable groups in a systematic way.

YTYiH did attempt to conduct a behavior surveillance study of the sex workers in 2008. However, sex work is an illegal activity in RMI and the steps to progress the study brought unwanted attention on the sex workers, with some subsequently being deported and others disappearing to avoid prosecution. As a result, YTYIH ran a number of focus groups with their network of sex workers to identify issues and develop a program.

YTYIH are currently funded through the SPC Response Fund to provide education and awareness programs, as well as access to testing and counseling, sex workers (as well as for taxi drivers). YTYIH reports showed interactions with approximately 50 sex workers over a three month period. No evaluation data was available.

The prison population, which is predominantly male, was recently offered STI testing and counseling by the MOH under a grant through the Global Fund. This was the first time this service was offered in the prison. The level of hepatitis identified was significant, generating interest among MOH health care workers that this service should be offered routinely in the prison.

Over the last two years, RMI has successfully attracted additional and significant funding to implement programs to address substance abuse. The Single State Agency the government agency with responsibility in this area is responsible for monitoring grants to a number of NGOs who work in prevention and treatment for substance abuse. Representatives from these groups – MIEPI and SSA – were confident that reports of IDU in the recent Youth Risk behaviour surveys showed misunderstanding of the questions rather than reflected the practice of IDU. There are no programs operating in this area, although it is acknowledge that prevention needs to be the focus.

Programs for Vulnerable populations:

The last two years has seen a growing momentum in addressing gender-related violence in RMI. This has culminated in the recent domestic violence legislation, which aims to protect all those in the family home from violence. WUTMI has played a key role in advocacy on this issue. WUTMI now has a grant to develop

training and other programming to promote implementation of the domestic violence legislation. It intends to incorporate education and awareness on HIV as part of its programming.

3.2 Care Treatment and Support

3.2.1 Sexually Transmitted Infections

Most STIs continue to be a concern across RMI, although the MOH data for 2008-2010 indicates a decrease in case positivity (and assumed prevalence rate) for Chlamydia, syphilis and hepatitis, with only gonorrhea showing an increase. It is not clear from the data whether this reflects a more rigorous picture of the situation due to increase testing reported by Ebeye and Majuro public health programs or a decrease in assumed prevalence. [20]

STIs recorded by MOH Majuro and Ebeye 2008-2010
Source: MOH HIV & STI Clinical Care Program 2012

STI s	**2008 Positive cases**	**Prevalence Rate** Per 100,000 pop.	**2009 Positive Cases**	**Prevalence Rate** Per 100,000 pop.	**2010 Positive Cases**	**Prevalence Rate** Per 100,000 pop.
Syphilis	302	**567**	486	**904**	342	**628**
Gonorrhea	27	**51**	107	**199**	116	**213**
Chlamydia	67	**126**	393	**731**	331	**608**
Hepatitis	104	**195**	77	**143**	44	**81**
HIV	4	**8**	10	**18**	8	**15**

RMI has introduced presumptive treatment for Chlamydia in response to advice from SPC on the efficacy of this approach in high prevalence Chlamydia environments. Ebeye has moved first, introducing presumptive treatment for pregnant women and their partners from August 2011. The first six months of the campaign conclude in February 2012. It is now intended to wait until June, when the first round of tests using the gram stain is undertaken, prior to moving into the second phase of the campaign. This will conclude in early 2013 when an assessment of the situation will be undertaken. Clinics in Majuro started presumptive treatment in late 2011 and the first phase of the campaign is ongoing.

[20] Based on MOH Case surveillance data, in Presentation to the NAC, Dr Zachariah, MOH, November 2011

3.2.2 HIV testing and counseling services

There are four sites that offer counseling testing and referral services. Two are in health care settings at the Major Atoll health centre (also known as the hospital) and Kwajalein Atoll health centre. The other two sites are at the Youth to Youth clinics in Majuro and Ebeye.

RMI's approach to HIV testing and counseling is guided by the HIV Guidelines and Protocols developed in 2007 by the Ministry of Health[21]. The Clinical Care Program Manager advises that these National Guidelines remain the current policy guidance to all HIV & STI health care workers in RMI.

These Guidelines address counseling testing and referral; confidentiality and informed consent; HIV clinical management and care for adults and adolescents; and guidelines for people with TB and HIV co-infection, women who are pregnant and children. The National Guidelines clearly state that a health care practitioner will refer to OSSHHM's recommendations in relation to screening, reactive and confirmatory screening, and the testing algorithm. It also refers to OSSHHM recommendations for the diagnosis of HIV in the infants of mothers living with HIV.[22] The HIV testing algorithm was recently modified in light of advice on rapid testing from SPC's HIV Advisor.

These protocols are in accord with the OSSHHM guidelines under the advice of SPC and WHO regional office in Suva. Periodically, OSSHHM circulates updated advice in response to WHO or other technical agencies.

The guidelines refer to both Counseling Testing and Referral, as well as Voluntary Counseling and testing. It nominates 14 different groups how should be routinely screened for HIV. These include

- Pregnant women
- People already diagnosed with an STD, including hepatitis B
- People with symptoms and signs indicating an STD, or concerned about an STD
- People who inject drugs
- Mean who have sex with other men
- Foreign workers who have recently moved to RMI
- Pre-employment clients
- Students attending high school (10th grade) and college entrants
- People diagnosed with TB
- Blood donors
- Seafarers
- Commercial sex workers
- Children experiencing severe malnutrition, with parents consent

During discussions in the National Strategic Planning workshops recently, clinical care managers advised that they do routinely offer HIV testing to these groups: and also noted that if need be, they can require people to be tested

[21] RMI National Guidelines for HIV Care and Prevention, Ministry of Health, October 2007STD clients
[22] RMI National Guidelines for HIV Care and Prevention, Ministry of Health, October 2007, p15

under the provisions of the Communicable Diseases Protection Act. Although this is rarely utilized, one practitioner explained that they used the threat of this legislation, with support from traditional leaders and the police, to persuade someone to test for HIV and then take treatment for another illness in the last year.

Discussion canvassed the difference between mandatory testing and routine testing, and the consequent implications for voluntary and confidential counseling and testing. Most clinical care managers refer to the screening groups as 'mandatory'. One participant highlighted that the RMI Public Sector employment regulations indicate that a test and 'clean' results are required before a person may be employed in RMI's Public Service.

This is an area that would benefit from clarification and agreement on the desired policy and procedures to clarify and agree on the importance of informed consent and confidentiality in providing these services.

A number of stakeholders raised concern during the GAPR and National Strategic Planning discussions about the confidentiality and integrity of the counseling and testing process in some locations, suggesting that this is an area which would benefit from more focused review. Reports indicate that one site has undergone accreditation with the Pacific Counseling and Social Services, which identified some shortcomings in the service that required addressing before it met the essential standards. It is not clear from the reports whether other sites were also assessed by PCSS during 2011. In light of the emphasis placed on testing and counseling as a key strategy in the future National Strategic Plan, the anecdotal concerns, together with the available assessments,

National data on the numbers counseled and tested for 201-2011 is inconsistent. Data identifying the routine screening groups with test results is not available. In this absence, the preliminary analysis of RMI's 2009-2010 data provides some guidance in relation to trends in testing and counseling, based on their smaller population[23]. Overall there were 1250 valid tests across 2009-2010 at the Ebeye Health centre. The majority of persons tested were female, followed by male and transgendered individuals. The largest age category was 20-29 years of age for both female and males in each year. Nearly 100% of clients tested were Marshallese. The highest risk category was high-risk heterosexual contact, defined as sex without a condom, with a person who is HIV+, in exchange for drugs, money or gifts, while using alcohol or drugs or while diagnosed with any STD. More females than males were recorded as having engaged in high risk heterosexual contact. Interestingly, in 2010, 25% of men reported no acknowledged risk. The prenatal clinic represented the majority testing site each year for females; and for males, most were tested at the HIV & STI clinic. For both males and females the majority of test type was confidential. Results were returned to over 93% and 98% of persons tested in 2010 and 2009 respectively. In 2009, over 46% had previously been tested. In 2010, over 26% had previously been tested.

[23] This is intended as a guide on trends only: specific data is not provided because it is only a preliminary analysis.

The concern expressed in relation to the integrity of routine data collection analysis and dissemination is shared by the Ministry. Despite the adoption of the CTR Epi-profile data base, its use has not been fully maximized because of gaps in staff and training. There is agreement that there is limited evidence on which to base trend analysis and a need for more sensitive data collection system to ensure rigorous data is available and utilized for analysis. One strategy proposed by the HIV & STI Program Manager is to report cases directly to CDC, thereby drawing on their expertise. Legislation governing reporting is necessary to enable RMI to do this.

3.2.3 PMTCT services

The two main hospitals in Majuro and Ebeye are the main source of antenatal care. These provide prenatal services for pregnancy management, STI & HIV screening, Pap smear screening oral health and immunization. Health centres in the outer islands provide pregnancy management only, because of the unavailability of laboratory services. ANC clients are referred to the HIV & STI Program should more extensive HIV-related services and care be required.

The Ministry of Health advises that the total number of births between 2007-2010 as per the table below:

Total number of births by main islands
Source: MOH 2011

Fiscal year	Majuro	Ebeye	Outer island	Total
2007	1000	375	216	1591
2008	1015	345	166	1526
2009	1030	383	190	1603
2010	944	311	141	1396
2011	982	337	81	1400

The 2007 DHS reports that 77.1% of mothers who gave birth in the last three years in RMI, had at least 4 antenatal care visits for their last birth. There was little variation in these figures across urban or rural mothers. Just over 94% of births were assisted by a doctor, nurse of other health personnel. Of these, 85.1% of births took place in a hospital or health facility. 63.6% of mothers received postnatal care within 2 days of delivery for their last birth.

RMI's National Guidelines for HIV care and prevention provide guidance on the policy and procedures for dealing with the diagnosis and care of an infant born of an HIV positive mother[24] as well as those women who are positive and wish to become pregnant.

Three of the total of 25 cases related to maternal to child transmission. During 2010-2011, one HIV positive female became pregnant. She was managed in accord with the RMI guidelines in relation to MTC (based on OSSHHM and WHO guidelines) and she was safely monitored[25].

[24] RMI National Guidelines for HIV Care and Prevention, Ministry of Health, October 2007
[25] RMI National Guidelines for HIV Care and Prevention, Ministry of Health, October 2007, p26

This was the female's 3rd child born while she has been HIV+. Her first two children were managed in accord with the National Guidelines, on the advice of OSSHHM and WHO. Each child has been tested through virological PCR tests, which require dry blood spots, and sent off-island for confirmation. Their status identified as negative. The status of her 3rd child born in the last year is yes to be determined, however, as the child has not yet been tested. The child is now older than two months.

The available data from Majuro does not provide a breakdown of the numbers of ANC clients screened and tested for HIV for most the 2010-2011 period. In the new reporting format, covering July-December 2011, Majuro advises that a total of 479 routine HIV tests of a total of 1171 were for prenatal clients. Of these, none were positive for HIV although 2% were confirmed for syphilis, 25% for Chlamydia and 3% for gonorrhea. This illustrates the usefulness of these forms.

In Ebeye, the preliminary analysis of the 2009-2010 data showed that 68% of 448 tests in females were for prenatal clients in 2010; and 71% of 497 tests were in females were for prenatal clients in 2009. In both years, females were the majority of tests conducted.

The Ebeye preliminary analysis provides the most comprehensive source of comparative data for considering the number of women who were tested and counseled amongst ANC clinic attendees. In the absence of comprehensive national surveillance data, this data is used below.

HIV testing at prenatal/ObGyn clinic Ebeye
Source: Preliminary Epi-Analysis 2009-2010 MOH Ebeye

Year	Total No of HIV tests	%	No of females tested	%	No. of males tested	%
2009	357	59.4	355	71.4	2	1.9
2010	307	47.3	303	67.6	2	1.0

A breakdown of those tested, and locations where tested, and receiving the results of their test was not available. In general terms though, among the HIV test results for 2009, all were negative therefore no confirmatory testing was needed. Results were provided to 98% of people tested, 2% (n=10) were of test results were not provide because the individual did not return or could not be located and 1% were missing. In 2010, results were provided to 93% of persons tested for HIV in 2010, with 6% (n=40) test results were not provide because the individuals did not return or could not be located, and 1% of results were missing.

3.2.4 ART treatment (prophylaxis), care and support

RMI's clinical care program is guided by reference to the technical advice generated by CDC and SPC, through its regional partners in Oceanic Society for Sexual Health and HIV Medicine and WHO. The senior clinical care program

manager is a member of the OSSHM. OSSHMs guidelines for ART, including eligibility, are available on their website: http://www.osshhm.org. A recent update released by WHO in relation to stages for assessment for ART was endorsed and circulated by OSSHHM to all members. The Clinical Program Manager advises that the treatment regimens/options (first line) used in RMI are in accord with those identified in the National Guidelines and updated in the 2009 recommended by SPC /OSSHM and WHO.[26]

Adherence, as well as prompt treatment, is a critical area for RMI's treatment and care program. Previously, cases have usually been diagnosed late. At least 10 of the 25 HIV cases recorded have prematurely died due to complications of AIDS. Although most of these deaths are from the 1980s and 1990s, the rate is high. It is important that the MOH understand the factors that led to such a high mortality rate and strengthen its clinical care services. Access to free ARV is one factor which has supported a stronger quality of care as has clinical training.

Currently, 7 of the 8 people who are living with HIV in RMI are on ART. These seven have been on ART between 1-5 years. Currently, only one HIV+ person discontinued ART during 2010-2011, due to a dislike of the side-effects. Efforts to recommence ART have as yet been unsuccessful. The HIV register indicates that 6 of the 8 have undertaken Cotrimoxazole preventive therapy, prior to, or in parallel to moving on to ART.

RMI's access to ART is financed through the Global Funds regional procurement mechanism, based in Fiji. Respondents to the NCPI Survey indicated overwhelming support for the efficacy and effectiveness of the regional procurement mechanisms. ART is supplied by the pharmacy in Majuro hospital; and, when needed through the pharmacy in Ebeye hospital.

The one patient who diagnosed with HIV in 2011 was also TB positive. This client makes a total of two cases who have been HIV-TB co-infected. The most recent case was first treated under the TB protocols and then moved on to ART in accord with the National Guidelines (as recommended by OSSHHM and WHO)[27]. Previously, other positive clients have discontinued their treatment due to side-effects, and opting to choose traditional medicines instead. These patients did not survive.

SPC, together with the HAETC, regularly provide updates and advise remotely as well as on-site to the RMI clinical care manager in relation to the care of patients. The North Pacific island countries hold regular case presentations through Skype. Also the clinicians in the US-affiliated Pacific island countries attend the annual scientific meetings on HIV in Hawaii (organized by HAETC) as well as the annual HIV meetings held in Atlanta, Georgia (organized by CDC). Whilst training is one contribution to patient care, exposure to more patients as well as direct in-country clinical mentoring and supervision also enhances patient outcomes.

[26] National Guidelines for HIV Care and Prevention, Ministry of Health, October 2007, p21; and supplemented by the Updated Recommendation for Use of Antiretroviral Drugs based on the WHO Rapid Advice documents, November, 2009

[27] National Guidelines for HIV Care and Prevention, Ministry of Health, October 2007, p25

RMI would benefit from a review of its guidelines and protocols and their implementation.

3.3 Human Rights

Recent discussions held by the NAC and during the National Strategic Planning workshops agreed that the meaningful involvement of people who are living with HIV, or other key or vulnerable populations, in the development and implementation of the response to HIV, will not occur in RMI without addressing the issue of stigma and discrimination. This point was repeatedly emphasized in the responses to the NCPI surveys.

In 2009, the MOH had submitted a draft policy on the prevention of stigma and discrimination for those who are positive, and criminalization for intentional transmission, to the legal counsel. However, at the time, there seemed little appreciation or capacity within the National Program to address the requirements to establish relevant and appropriate legislation. A review of HIV, Human Rights and the Legislative environment by SPC's RRRT in 2009 scoped a range of areas where the existing legislation required attention to ensure due respect for human rights.

The RRRT Review 2009 identified that although the anti-discrimination protections of the Communicable Diseases Prevention and Control Act are helpful, other aspects were likely to impede prevention of HIV and sexual health. In particular, some provisions were inconsistent with a human rights based approach to prevention, treatment care and support. IT was suggested that a review might consider:

- Excluding HIV from the definition of communicable disease to greater protect confidentiality and privacy provisions;
- Excluding HIV from mandatory testing provisions for employment and other purposes, except in accord with international guidelines, in relation to blood donors;
- Limit notifications of HIV diagnosis to medical practitioners (and not to schools and day centers etc);
- Strengthen the privacy and confidentiality provisions.

In relation to existing Criminal laws, it was suggest that a review might:

- Repeal certain provisions in Ant-Prostitution Act and Immigration Act that criminalize sex workers;
- Repeal Section 1511 in CDPC Act for intentional transmission, suggesting it is draconian and likely to be ineffective for public health purposes, and may add to stigma. Instead, general criminal provisions such as assault, should apply.

In prison settings, the review recommended access to free condoms and HIV information in prisons; confidential health records; and the prohibition of discrimination on basis of HIV or sexual status.

Existing anti-discrimination protection should be widened to include people

assumed to have HIV and families, careers and other associates of HIV+ people. It recommended that RMI enact legislation to make discrimination on the basis of sex, sexuality or sexual orientation and transgender status unlawful.

This would also require reconsideration of some aspects of the Constitution to ensure no inconsistencies in relation to the status of vulnerable populations. There many need to be amendments to legislation to ensure protection on the basis of sex where there is potential for conflict between customary law and the Constitution which may impinges on women's economic or social status. This also includes amendments of legislation on marital or male rape, to ensure protection against sexual violence.

In relation to workplaces & employment: the review recommended that government and private sector should develop codes of practice on HIV in the workplace which protects from stigma and encourages information and education and confidentiality.

Finally, the review noted, there is no legal framework for ethical human research – which means that there are no laws to protect and ensure that ethical research occurs.

Under the leadership of the re-invigorated NAC and MOH, the way the legislative environment can be utilized to prevent, or discourage, stigma and discrimination, is being reviewed and reconsidered. There is now much greater experience in the NAC in relation to legislative advocacy and implementation. There is a much stronger experience in advocating for change through and with the Nitijela. The legal counsel, who is responsible for drafting new legislation, is part of the NAC. WUTMI, who carried a leadership role in promotion and advocating for the recently passed Domestic violence legislation, is an integral part of the re-vitalised NAC – with the previous CEO the Chair of the NAC and one staff member operating with the MOH to undertake secretariat functions.

3.4 Knowledge and behavior change

There was limited data available advising on changes in knowledge and behavior since the 2007 DHS survey on knowledge and behavior in relation to HIV and STIs undertaken by EPPSO. The 2007 DHS concluded that there was substantial disconnect between knowledge of HIV transmission and prevention and the level of unprotected sexual activity. This is more pronounced for women, with nearly twice as many women not using condom during last sex, high risk sex or first sex. With the majority of Marshallese young men and women reporting sexual activity before they turned 18 years, and very few reporting use of a condom during first sexual activity. While knowledge of HIV is high, safer behaviors are reported to be low. The DHS recommended that different strategies, including a greater focus on behavior change, are needed.

This is a concern also expressed by a number of stakeholders during the recent National Strategic Planning workshops and in the responses to the NCPI Surveys. There is a real concern that despite all the work in prevention over the

last 5 years since the DHS survey, behaviors have not shifted towards safer sexual practices. However, there continues to be limited data available to measure the change in behaviors. Very few programs have conducted specific evaluations of the effectiveness of their programs in contribution to behavior change.

3.5 Impact alleviation

The NCPI survey enabled respondents to rate the effectiveness of the response across strategic planning, political leadership, civil society involvement, human rights, prevention, treatment care and support, monitoring and evaluation. Overwhelmingly however, the picture which continues to emerge is that the Marshall Islands either does not collect, or does not analyse the data it already collects, to assess the impact of the response in reducing the spread and impact of HIV & STIs.

A review of the responses to the 32 indicators described earlier in the report reveals that there was very little current evaluative material available through which to assess progress in these indicators. On one hand, some of these measures are not as relevant given the size of the population under consideration. However, in some instances, more information about the nature of some key risk groups such as sex workers or men who have sex with men would greatly enhance the effectiveness of the response.

The response to HIV & STIs in the Marshall Islands would greatly benefit from a follow up survey to the 2007 DHS survey as well as specific research and program evaluations. This could be part of the ongoing development of stronger and rigorous surveillance and other monitoring and evaluation systems, as outlined in other parts of this report.

IV. Best practices

A number of key steps have been taken over the last two years to contribute to a stronger and more effective response to HIV & STIs in the Marshall Islands.

Governance and program management:

This is an area where RMI has made substantial progress since the last country progress report. RMI now has a functioning and representative NAC with a supportive secretariat in place.

Since its inauguration in November 2011, the NAC have

- Initiated a review of the previous national strategic plan
- Initiated the development of the next national strategic plan
- Initiated discussions to review the current legislation relating to key areas of the response – particularly the protection of positive people form stigma and discrimination and the development of legislation governing data sharing and reporting.

Its engagement has stimulated far stronger and broader representation from within the Ministry of health as well as across civil society. As an example, whereas meetings to discuss the national strategic plan in 2010 attracted 5-

6people, the recent national strategic planning workshop attracted 20-30 people, with representation from most relevant programs within the Ministry of health and from many civil society organizations. The representation of the legal counsel and his staff during the National Strategic Planning workshop was an excellent example of stronger engagement with different sectors who can contribute to a strong and vigorous response.

In addition to this, the leadership within the Ministry has demonstrated strong and vigorous approach to address outstanding program management issues in relation to under-expenditure and program reporting to re-establish the financial strength of the program.

The challenges for the NAC and ministry will be to maintain this level of engagement. Open and transparent communication, continuing strong leadership and the demonstration of equitable access to resources will assist.

A supportive policy environment:

As noted above, steps are now in train to establish a supportive policy and legislative environment through the review of the current legislative environment in relation to HIV and the protection of human rights in the Marshall Islands.

This will need to be complemented by a review of the national guidelines for HIV Care and Protection. These were first drafted in 2007 and are intended for review every two years.

Scale up of prevention programmes:

The allocation of resources and establishment of partnerships under the Substance Abuse Prevention and Treatment grants awarded through the US Federal Department of Health and Human Services/Substance Abuse & Mental Health Services will have an influence on the vulnerability of key groups in the population. This will influence capacity to prevent HIV and STI transmission.

Although not directly arising from the leadership of the HIV & STI response, the establishment of partnerships, alongside the allocation of resources, between the Single State Agency for Substance Abuse and a number of community NGOs and coalitions is having, and is forecast to have, a substantial impact on the level of NGO engagement in areas related to reducing vulnerability to HIV and STIs arising from alcohol-related risk settings, or gender-related risk factors.

Similarly, the leadership demonstrated by WUTMI in its advocacy around gender violence and the establishment of legislation to protect families from domestic violence represents a powerful role model for others across the community and in Government to take inspiration.

In Ebeye, the Health Centre has provided consistent examples which demonstrate the link between the clinical care provided through the heatlh centre and the community through the ongoing role of ‘zone’ volunteers and community leaders to support activities, such as contact tracing and community engagement on the presumptive treatment campaign. The Health Centre’s capacity to engage with traditional and church leaders to ensure community support for the

presumptive treatment campaign is an impressive example of partnership and collaboration to improve the health of the community. It demonstrates the importance of strong relationships built on open communication and trust.

These are important and substantial examples of the strength and capacity generated by 'kumiti' - the capacity generated when individuals, working together, catalyse and advocate for change. An effective response will need to work from this foundation.

Scale-up of care, treatment and/or support programmes;

With continuing low numbers of people reported to be living with HIV, the important issue for treatment care and support in RMI is that the quality of care for those currently diagnosed and their families, is established and maintained. In the past, ongoing adherence to ART medication has clearly been an issue for the clinical care of positive clients. The current situation, where 7 of 8 positive clients maintain compliance with the medication, is a positive sign of improvement.

An important consideration raised during the NCPI validation meeting was that the small size of the known population of positive people has meant that the care for these people can also be personal and specific. So, for example, when the fear of being known – because it is such a small community – prevents a positive person from going to the laboratory for ongoing CD4 monitoring, then this also means that the HIV & STI health practitioners can take a personal approach. One HIV nurse reported that she ensures that one patient's CD4 monitoring occurs outside the laboratory by the same laboratory technician each time to reduce the risks to the client's status being known in social circles and thereby maintain the client's right to confidentiality.

Monitoring and evaluation:

Given the low reported numbers of positive people in the Marshall Islands, and the high rates of other STIs, the link between education, screening, testing and diagnosis across all STIs cannot be underestimated. With clinic resources stretched, it is important to know whether the right people are being reached with screening and treatment. It is important the surveillance data is adequately and accurately captured and then able to be analysed to enhance program improvement.

The epi-analysis of 2009 and 2010 surveillance undertaken by the Ebeye Health Centre, drawing on the resources of CDC, is an excellent example of how analysis of routine case surveillance can assist with program improvement. It provides insight into the kinds and levels of risk behaviors amongst those screened, which can inform choices around which groups to target in the future.

The advent of a new reporting template which encourages data to be capture in a way which monitors whether those who are routinely screened are diagnosed and treated, is a great advance. The collaboration of SPC and CDC in creating a template that is easy to understand and use is commended.

It is recommended that Youth to Youth also consider carefully how they capture data generated through their grant to promote CTR in the Outer islands and perhaps liaise with Ebeye and CDC or SPC to identify support.

V. Major challenges and gaps

The 2010 Country Progress report identified a number of key challenges in three key areas: treatment care and support; national coordination and planning; and civil society engagement.

In relation to the 2010 Country Progress report's recommendations on Treatment Care and Support:

- With 7 of the 8 patients living with HIV currently maintaining their compliance with ART treatment regimen, indicates an improvement in aspects of treatment care and support. However, the case review of current cases to build a stronger appreciation of the link between education, screening and diagnosis has not been undertaken.
- The NCPI responses indicated ongoing concern that prevention strategies have not effectively established the momentum for behavior change – with many indicating that a stronger emphasis on testing may assist. Support to develop and strengthen the quality of testing and counseling, particularly confidentiality aspects, remains a strongly expressed need.
- The national guidelines have not been reviewed; this remains a need as they have now been in place for five years.
- There is still a need to improve access to services in the Outer islands: Youth to Youth in Health are looking forward to taking the opportunity to build a baseline of the current situation in relation to HIV and STI status through their grant to offer testing and counseling services to a number of outer islands in 2012.
- There is recognition of the need to engage positive people in all aspects of the response; the strong focus on addressing stigma and discrimination in the forthcoming National Strategic Plan is seen as a critical platform to address this and break through some of the barriers to positive people's meaningful involvement.

In relation to National Coordination and Planning:

- The NAC and the MOH have reviewed the implementation of the previous National Strategic plan and a new National Strategy is in progress.
- The development of the next Monitoring and Evaluation framework, to support the new National Strategy, is scheduled for mid-2012.
- Steps are in place to improve data surveillance with the establishment of the HIV reporting law, which will facilitate the sharing of information with CDC and enable their resources in analysis to be brought to bear on RMI's routine surveillance system.

- The opportunity to also use the engagement with CDC to review and implement the MES recommendations remains.
- A functional and effective NAC is in place, demonstrating initiative and leadership.
- The opportunity for more specific evaluations of program effectiveness and resource allocation across all aspects of the response remains.

In relation to strengthening Civil Society engagement in the national response:

- The NAC includes representation from civil society and private sector – strengthening the stakeholder reference groups. This is reflected in the strength of engagement around the GAPR process and the National strategic Planning workshops.
- The MOH has identified an opportunity to engage WUTMI to facilitate civil society engagement on behalf of the Ministry and the NAC. The effectiveness of this is reflected in the strength of engagement around the GAPR process and the National Strategic Planning workshops.
- WUTMI, alongside MIEPI and others bring to the NAC and national response discussions, an array of experience and network sin lobbying for legislative change as well as a commitment to human rights. This is already in evidence with engagement on legislative review issues.
- The engagement of the Ebeye Clinical Care Manager as the interim National Program manager as well as the representation of 3 members of the NAC from Ebeye, has resulted in much stronger participation and representation from Ebeye's Health Care team.
- Apart from the MIEPI profile on the relationship between alcohol and broader vulnerabilities, there has been limited research into at-risk groups, such as sex workers, seafarers and young men in urban and rural areas to better understand their vulnerability and develop appropriate interventions. This remains an opportunity to explore.

These areas continue to present ongoing challenges for the response. With the growth in leadership and capacity to analyse and address these issues, under the guidance of the MOH and NAC, there are strong prospects that these will be addressed under the future National Strategy.

VI. Recommendations

Program management:

The adjustments in leadership, including the establishment of the NAC, over the last year have clearly had an impact on the level of support for the HIV & STI program within the Ministry and in the broader community. The Ministry is to be congratulated on this positive step.

The establishment of links to the civil society sector through the engagement of WUTMI as a liaison and secretariat on behalf of the MOH and the NAC is a positive step.

The inauguration of the NAC, with representation from community groups and NGOs, the church and private sector, as well as the Ministry of Health, is

positive. The recent extensive representation from Ministry and other stakeholders during the GARP process and the in the development of the National Strategy are evidence of renewed vigor and interest.

The Ministry is to be encouraged to continue to provide this level of engagement and support to the response. It is important that the Ministry continue to provide supportive and far-sighted leadership. Financial and human resources need to continue to be dedicated to support the program.

The engagement of civil society, as well as the government health workforce, in the response needs to be encouraged. The Ministry, as well as the NAC, need to prioritise open and transparent communication on the response and its effectiveness to all stakeholders to maintain their interest and stimulate their ongoing enthusiasm.

Policy/ coordination:

The NAC has initiated important steps towards creating a supportive policy and legislative environment to protect the rights of those who are positive. It needs to be supported by agreement on what rights are to be protected, and how these rights are critical to an effective response to HIV.

It is suggested that the recommendations of the RRRT Review of HIV, Human Rights and the Law be reviewed and implemented as pertinent. The NAC should continue to take an active role in supporting this review. It should set a timeframe for the review and agree on an implementation plan for establishing effective legislation to protect those who are infected or affected by HIV from stigma and discrimination on the basis of status, sex, sexual orientation or gender.

A rights-based approach to HIV also needs to be monitored. This can be resource-intensive. It also needs to be clearly impartial. The recent submissions to the Human Rights Council working group for the universal periodic review of Human Rights proposed that a regional mechanism for monitoring human rights be instituted[28]. This would maximize expertise and resources and promote impartiality. It is suggested that the NAC consider its support for this proposal and, if so, identify ways to encourage its establishment.

Prevention, knowledge and behavior change:

The most recent survey of knowledge and behavior in relation to HIV and STIs is the 2007 DHS survey undertaken by EPPSO. The DHS concluded that there was substantial disconnect between knowledge of HIV transmission and prevention and the level of unprotected sexual activity. This is more pronounced for women, with nearly twice as many women not using condom during last sex, high risk sex or first sex. With the majority of Marshallese young men and women reporting sexual activity before they turned 18 years, and very few

[28] Summary prepared by the office of the high commission for human rights in accordance with paragraph 15 9c) of the annex to Human rights council resolution 5/1 Marshall Islands. a/HRC/WG.6/9MHL/3/ PRNGO Submission to the United National Universal Periodic Review; the 9th session of the UNPR working Group, November 2010. Submission of the Coalition for NGOs Marshall islands.

reporting use of a condom during first sexual activity. While knowledge of HIV is high, safer behaviors are reported to be low. The DHS recommended that different strategies, including a greater focus on behavior change, are needed.

The DHS report of 2007 also raised a challenge in relation to teenage pregnancy. Although admitting to considerable improvements have occurred in lowering RMI fertility from 7.2 to 4.5 live births, it noted that teenage fertility has remained almost unchanged – and high compared to regional standards. The DHS 2007 data suggested that one in four girls and you women aged 15-19 was either pregnant or had already given birth to her first child. The high proportion, plus the marked difference between rural (43%) and urban (20%) Marshallese suggests that there may be a strong cultural acceptance. The report raised the challenge that promoting education on Sexual and Reproductive Health, including HIV education, is insufficient in itself to establish change.

This is a concern also expressed by a number of stakeholders during the recent National Strategic Planning workshops and in the responses to the NCPI Surveys. There is a real concern that despite all the work in prevention over the last 5 years since the DHS survey, behaviors have not shifted towards safer sexual practices. However, there continues to be limited data available to measure the change in behaviors. Very few programs have conducted specific evaluations of the effectiveness of their programs in contribution to behavior change. It is recommended that the NAC seriously consider identifying and undertaking specific program evaluations of the key prevention programs that have been in operation over the last five years since the 2007 DHS survey to assess their effectiveness and identify opportunities for improvement.

HIV testing and counseling:

This is a key focal area for the forthcoming national strategy. It is important that these services are effective. We do not know

- how accessible counseling and testing services are;
- how well services are accessed;
- how well services maintain privacy and confidentiality – or are able to facilitate follow-up, particularly in relation to partner or contact tracing.

We do know that data in relation to counseling and testing is poorly maintained and difficult to access.

A review of testing and counseling services and policies is recommended.

Care, treatment and support:

With continuing low numbers of people reported to be living with HIV, the important issue for treatment care and support in RMI is that the quality of care for those currently diagnosed and their families

As with prevention, a review of the quality and access to care and treatment services is recommended to identify opportunity for improvement.

Financing:

Clearly, the disparity between the level of funds available to RMI to support the response and its capacity to spend these funds is disappointing, especially in light of the level of demand for additional resources from parts of civil society to enhance capacity in areas such as testing and counseling services for youth or research into more effective prevention strategies.

It is acknowledged that the Ministry of Health has recognized this as a serious issue and is taking steps to address this disparity. The recruitment of additional support through WUTMI to maximize engagement with the civil society organisations is supported.

In addition to a stronger leadership of the program, it is also suggested that the response would benefit from a review of financial expenditure patterns in light of program reach and effectiveness to identify specific areas for improvement. Given that some areas of shortfalls are already apparent – such as those under the Ryan White program, it is also recommended that such a review be immediately undertaken of the support currently provided for people living with HIV and their families, so that additional programming can be identified and implemented.

Human resources:

Whilst most programs might seek support for additional staff resources, the absence of data on which the NAC can draw its own conclusions about the effectiveness of the responses suggests that identifying and supporting resources for ongoing monitoring and evaluation, including surveillance is a priority.

Monitoring & Evaluation and Surveillance:

The GAPR process clearly identified ongoing shortcomings in the way data is collected, analysed and reported. This was an issue in 2010. It remains an issue now. This issue must be addressed as a priority.

Many of the recommendations arising in the Monitoring & evaluation assessment undertaken in 2008 and identified again in the Country Progress Report of 2010 have not been addressed.

The Ministry of Health needs to decide on the level of priority it wants to give to systems to support the systematic collection and analysis of data and allocate the resources to ensure it is effectively and routinely undertaken. This applies to routine case surveillance and to program evaluations.

The NAC has recognized the importance of understanding what data to collect and how: it has initiated steps to develop and implement reporting legislation in relation to data sharing on HIV. This is supported.

The jointly-developed CDC and SPC routine surveillance template is an excellent example of collaboration which provides stronger guidance on what data is useful to collect and how to collect it in ways which promotes analysis for program improvement. This should be expanded and continued.

The recommendations of the 2010 Country Progress Report in relation to surveillance, monitoring and evaluation should be reviewed by the NAC and a plan instituted for their implementation.

Support for the establishment of the HIV reporting legislation is encouraged. In addition, there needs to be support for additional and dedicated staff and systems, to support stronger and more rigorous systems for data collection analysis and program evaluation. The strengths represented by MIEPI, as a local stakeholder with capacity is this area, could be explored. Perhaps a sub-contracting arrangement to the NAC to assist with either capacity building and/or implementation of the monitoring and evaluation framework, including the maintenance of routine surveillance, could be canvassed.

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

The Marshall Islands received technical assistance, including capacity strengthening, from multiple agencies across the Pacific and the USA, from international donor agencies, technical agencies as well as international NGOs. The following table identifies the range and frequency of technical assistance field trips during 2010-2011.

Component of the Response	2010	2011
Prevention	VCCT M&E Site Visit Majuro and Ebeye - PCASS	HIV & Sports training workshop – Olympic AIDS committee OSEP & RMI National Olympics Committee
	World AIDS Day support and PLWHA awareness-raising - PIAF	Transformational Leadership & Development training Workshop – UNAIDS & Pacific Youth Council
		World AIDS Day support and advocacy for PLHIV - PIAF
Treatment care and support	Lab TA/BD Probetec Training - SPC	Chlamydia presumptive treatment rollout – SPC & WHO Joint mission
	CDC STD Branch Site Visit - CDC	Laboratory strengthening t improve lab based surveillance In Majuro – SPC DCU
	HIV Rapid Testing Roll-out and HIV Core Team Training and (a) strengthening the international referral of blood samples for CD4 testing; (b) the use of dried blood spots (DBS) for early infant diagnosis (EID) of HIV infection; (c) possible full clinical training or update on	

	the new WHO guidelines and PMTCT – SPC & Consultant	
	Regional Pharmacists to provide TA on regional ARVs and related consumables procurement mechanisms (Majuro/Ebeye) – FPBS & SPC	
Governance/management & Coordination/M&E	UNGASS Report TA (Burnet & UNAIDS)	UNICEF – child baseline study -
	Seafarer DIC Follow-up - Kelly and Emi + RF follow-up with MOH and YTYIH + PRHP follow-up with YTYIH and CARE / Sem - GF R& HIV Phase II application TA	RF Monitoring with RMI MOH and YTYIH; progress NAC establishment; progress NSP planning with Burnet, completion of RF MOH logframe and Jan-Jun 2011 reports + WUTMI proposal – joint Burnet & SPC GMU
	Support to parliamentarians to address key development issues, including HIV/AIDS, gender, climate change, youth and governance – SPC PLPG	Work with MOH and local stakeholders to review current HIV/STI situation and response, develop 1st draft of NSP and identify next steps for f/up and regional collaboration and TA – Burnet & UNIADS
	RF and GF TA, DIC follow-up and attendance at PIJAAG Summit– SPC GMU & Others -	
	PIJAAG _ Dr Alan Garvez, Tim Bryar, Kamma Blair and Linda Peterson (SPC); Suzanne O'Neill (Burnet); Walter Chow and Dr Wan Choi (CDC); Ed Tepporn (APIAHF), Sapna (APIWC); Dr Cyril Goshima (HAETC); Kunane Drier (Life Foundation); Peter Silva (Hawaii Department of Health); Melissa Boyette (Alaska Department of Health); Henry Ocampo (OMH)	
	Conduct PH database assessment and EpInfo support - SPC	
	CDC Site Visit (after PIJAAG) and CTRS Training - CDC	
	Excel 101 Training Workshops for MOH staff in Ebeye and Majuro to support surveillance and M&E work – local consultant	
	YTYIH End of Project Evaluation and MSC Training + RF PDM follow-up with YTYIH and MOH – SPC Staff	

	Development of RMI's National Strategic Plan for HIV/STIs - Burnet	
	JCS Mission review and update and preparation for 2011-14 JCS Mission in 2011 - SPC	
	Site Visit of country GF program office and funded activities as discussed during PIRMCCM meeting – GF Geneva	

In addition, a range of activities were deferred until 2012:

- UNAIDS - National M&E training based on M&E ToT regional workshops using Regional M&E
- UNAIDS - RMI National AIDS Spending Assessment (NASA)

VIII. Monitoring and evaluation environment

The NCPI surveys were sparse in their response to monitoring and evaluation. Few respondents were able to identify the current structures or processes for monitoring and evaluation. The recent efforts to standardize reporting was noted as a strength, as was training in monitoring and evaluation and the forthcoming opportunity to develop the monitoring and evaluation framework for the next National Strategic Plan. Staff capacity was recognized as a key issue: there is no dedicated resource to support HIV & STI surveillance entry analysis and reporting. This means the workload often falls on clinical staff and data entry can be ad hoc as a result. There was concern that some reports required for submission to funders were not completed, which has jeopardizes funding relationships and access to funds.

The national response is currently monitored through routine case surveillance collected by the Ministry of Health's BPPHS clinical teams at the various sites offering counseling and testing and/or referral services at the two major urban centres of Ebeye and Majuro. In addition to the HIV & STI clinics, these include the ANC and Family Planning clinics, the Outpatient clinic and the Outer Islands mobile Outreach services. In addition, Youth to Youth Health Services in Majuro, which also offers counseling and testing (in collaboration with the MOH clinical teams) also records case surveillance data, which it submits to the Ministry of Health.

Data in relation to HIV case surveillance is collected through four different forms:

- The STI Case Record form, capturing a patient's personal details and reason for examination as well as behavioral information in relation to sexual risk behaviors, contact partners and treatment plan.
- The RMI HIV informed consent form, confirming that the patient has voluntarily given their consent to the test for HIV antibodies and reassuring of confidentiality procedures; this form also asks for the reason for the test and modes of transmission.

- The Pacific Islands HIV Test Form, noting patient personal details and testing history, test results and risk factors. This form is also referred to as the Counseling Testing and Referral (CTR) form.

Quarterly program reports, including data analysis and narrative reporting, are submitted to Bureau heads by the clinical program manager in Majuro. Ebeye submits its data to Majuro for inclusion in the national database. A review of the national reports over 2010-2011 showed that often, data analysis was inconclusive and sometimes, information was repeated across quarters.

The national report appears to have adopted the new joint CDC-SPC reporting format in the latter half of 2011. This report is a significant improvement on the previous format used for national reporting. It provides information on the four main STIs (gonorrhea, Chlamydia, syphilis and HIV) and the assessed detection rate by sex, age and patient category (or clinic). Unlike other countries however, the one 6-month report reviewed did not also include treatment rates for assessed cases. This data would be useful.

The Ebeye team is not using the new report template yet. When a copy of the new reporting format was shared with Ebeye HIV & STI staff during the GARP process, they agreed that it was useful and said they would consider using this report template. Despite this, data provided by Ebeye was comprehensive, up to date and accessible.

During the review of case surveillance data for inclusion in the Global AIDS Response Progress Report (GARP), the MOH advised that although data from the HIV consent forms were up to date on the MOH central database, the (more comprehensive) data from the Counseling Testing and Referral (CTR) forms had not been entered since 2008 due to clinic workloads and the shortage of data entry staff. A submission is in progress with the Ministry of Finance, requesting additional staff positions to meet this shortcoming.

Currently, data is entered either by the clinical staff at the point of testing or is referred to the IT Department, who, in the absence of dedicated data entry staff, are relied on to respond to all requests for surveillance data. The IT Department's Director is supported by a UN volunteer.

The other primary source of monitoring and evaluation information is the program reports. Quarterly reports are compiled to meet internal MOH reporting requirements. The internal reports are the basis of the six monthly and annual reports complied by MOH in response to compliance with donor funding conditions. These Program reports are routinely requested on a six monthly or annual basis by SPC's Pacific HIV & STI Response Fund and Global Fund; and, for the US Federal funds from CDC and HRSA, on a 6-month interim and annual basis for each of the HIV Prevention, Surveillance and Comprehensive STD Management grants. These reports include surveillance and financial data in addition to narrative comment. A total of 12 reports are required annually to meet all funders' guidelines.

These reports operate under each individual funder's grant cycle, so reports may be due at the same time or consecutively. The reports are comprehensive and sometimes complicated. The SPC reporting format is a new and evolving format released during 2011. CDC advises that they intend to merge their funding opportunities for HIV, STD and TB in the near future, although they intend to maintain separate reporting.

There was a gap in MOH Program reporting, both internal and in response to external funders compliance requirements, in 2011. MOH advised that this was due to the change in program management personnel. Their subsequent records demonstrated that the Ministry had undertaken extensive efforts to redress the delays in reporting, particularly in relation to the Ryan White Funds and these are now close to up to date.

Few in-depth surveillance surveys or program evaluations were identified during the GAPR process. The last Demographic Health Survey was undertaken by SPC and EPPSO in 2007. Whilst these are often conducted every five years, EPPSO, the office responsible for the last DHS, has no plans to conduct another DHS in the near future. In addition to routine case surveillance, Ebeye health centre has also undertaken an epi-analysis of all routine surveillance for 2009-2010 with the assistance of CDC. The team at Ebeye also conducted a school-based youth risk behavior survey in 2008; and a community based sexual risk behavior survey in one of the outer islands during 2010. An evaluation of Youth to Youth was reported to be undertaken by SPC Program staff in 2010[29]. Two community NGOs, WUTMI and MIEPI whose work engages the broader issues around vulnerability related to HIV and STIs[30], demonstrated examples of epidemiological research and qualitative program evaluations in their specific fields, reflecting systemic and rigorous approaches to the collection and analysis of community-level data[31].

The NAC and MOH intend to develop a monitoring and evaluation framework once the developing National Strategic Plan is confirmed. The MOH has liaised with UNAIDS to arrange preliminary training in monitoring and evaluation in the second quarter of 2012. After this, UNAIDS will provide additional support to develop the monitoring and evaluation framework in collaboration with the MOH and NAC teams.

[29] The consultant was unable to locate a copy.

[30] MIEPI is one of a number of NGOs now working to address alcohol related risk behaviour with a particularly focus on research; WUMIT, as noted earlier, addresses gender equity and the empowerment of women – it has substantive programs addressing violence against women, substance abuse and the development of parenting skills.

[31] Substance Abuse Epidemiological Profile 2011, Republic of the Marshall Islands, RMI Epidemiological Work group, Marshall Islands Epidemiology and Prevention Initiatives Inc (MIEPI)

ANNEXES

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

The Focal Point for RMI attended a UNAIDS/SPC training workshop in Nadi in late January to discuss the purpose of the GAPR. Subsequently the consultant agreed on a workplan for data collection, analysis and submission of the report with the Focal Points from Government and the NGO sector. A small working group was nominated, and key contact points identified.

Four key processes for data collection were agreed:

- A review of program reports, including any evaluations or other assessments on the response.
- Completion of the survey by government and NGO stakeholders representative of the response
- Review of all surveillance data for inclusion in the indicators table
- Collation and analysis of financial data for inclusion in the Funding matrix

The focal point for government and the NGO sector liaise with a range of stakeholders to collect and forward program reports to the consultant for review.

Meetings were held with three key groups of stakeholders from the NGO Sector, Government, and those from the NGO and Government and private sectors who might be able to contribute to completion of the survey or the indicators. The Focal points chaired these meetings.

The survey instrument was trialed with each group; and minor amendments made to improve its accessibility in the Marshallese context. The Survey instruments were then distributed widely across each stakeholder group. The focal point from Government and NGO sector then monitored completion and submission of the surveys over a three-week period, encouraging stakeholders to respond to the Survey. Surveys were submitted either electronically or in hard copy. The Consultant reviewed the surveys and aggregated the data for presentation at the Validation meeting as discussed below.

All Ministries, civil society organizations and private sector individuals who were involved in the meetings or other communications to discuss the purpose of the Global AIDS Progress Report, assist with the data collection process, or to whom a survey was distributed, or who responded to the surveys, was invited to the Validation meeting. Prior notice of the meeting had been advised during the preparation meetings.

A soft copy of the aggregated final draft survey Part A and Part B was distributed by email prior to the meeting. A hard copy of the aggregated final draft survey, together with the draft indicators matrix, was available at the meeting.

The consultant presented the key ratings and responses in relation to each category in the surveys, i.e. categories I-VI in Part A and categories I-V in Part B,

identifying the achievements and challenges noted for each effectiveness rating; and briefly discussing key issues raised throughout the response to the Category. The group discussed each rating and the associated achievements and challenges to confirm, explain and verify the information. The ratings were then endorsed by group agreement. When necessary, representatives from the Ministry of Health translated questions and comments to encourage discussion in Marshallese. The final aggregated survey was completed following the meeting and forwarded to the focal points for endorsement by the Ministry of health and upload.

In parallel with this process, the Focal points collated the financial data for discussion and aggregation into the funding matrix. The draft funding matrix was circulated and endorsed by the Ministry and uploaded.

Finally, the report was drafted and circulated to the Focal Points and the Secretary of Health for review prior to endorsement and upload.

At each point in the process, communication was maintained through face to face meeting, or, where location did not permit, skype and email.

ANNEX 2: National Commitments and Policy Instrument (NCPI) - Part A (Government) and Part B (Civil Society)

See uploaded documents on the online reporting tool.

ANNEX 3: National Funding Matrix

See uploaded documents in the online reporting tool.