Global AIDS Progress Report 2014

Republic of the Marshall Islands

Submission date: 31st March 2014

NATIONAL ADVISORY COMMITTEE
HIV • STIs • TB
REPUBLIC OF THE MARSHALL ISLANDS

FOREWORD

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MESSAGE FROM THE MINISTER AND SECRETARY OF HEALTH

The Ministry of Health adheres to its commitment in fighting the epidemic of HIV/AIDS here in the Marshall Islands. In the past 2 years, we have progress steadily in implementing our activities with partnership with RMI National Advisory Committee, National and Local Government, Non-Government Agencies, and the community.

We have encountered challenges but stood up on the waves of tide. Our commitment to a healthy and happy Marshallese population is our main purpose.

We would like to thank all the people that gave their best in this program. To the People Living with HIV/AIDS, the Ministry is capable of helping you without hesitation and discrimination.

On behalf of the Ministry of Health, we are endorsing this Global AIDS Program Reporting 2012-2013.

Komol Tata

Casten Nemra
Interim Secretary of Health

Hon. Phillip Muller
Minister of Health

ACKNOWLEDGEMENT

The Republic of the Marshall Islands' National Advisory Committee for HIV, STIs and TB extends its gratitude to all partners and stakeholders who contribute to the national response and to this national Global AIDS Response Progress Report.

All of this would not have been possible without the commendable commitment of the Government of the Marshall Islands, most specifically the Ministry of Health, and Women United Together Marshall Islands who provided the leadership and guidance toward the achievement of Millennium Development Goals #6.

I would like to acknowledge the partnerships between the RMI NAC, Civil Society and the Ministry of Health who have stimulated the discussion about HIV and STIs in the Marshall Islands.

Finally, the NAC extends its appreciation to the UNAIDS and national stakeholders for their technical and financial support to this national report.

Daisy Alik-Momotaro
Chair
National Advisory Committee for HIV, STIs and TB

Table of Contents

Acronyms

AIDS	*Acquired Immune Deficiency Syndrome*
ARV/ART	*Anti-Retro-Viral Therapy/Treatment*
CDC	*Center for Disease Control*
CEO	*Chief Executive Officer*
CTR	*Counseling Testing and Referral*
DHS	*Demographic Health Survey*
EPPSO	*Economic Planning and Policy Statistics Office*
GARP/GAPR	*Global AIDS Response Progress/Global AIDS Progress Report*
GF	*Global Funds for HIV Malaria and TB*
HAETC	*Hawai'i AIDS Education and Training Center*
HIV	*Human Immunodeficiency Virus*
HRSA	*Health Resources & Services Administration*
MDG	*Millennium Development Goals*
M&E	*Monitoring and Evaluation*
MIEPI	*Marshall Islands Epidemiology for Prevention Initiative*
MOH	*Ministry of Health*
NAC	*National AIDS Committee*
NASA	*National AIDS Spending Assessment*
NCPI	*National Commitments and Policy Instrument*
NGOs	*Non GovernmentOrganizations*
PIJAAG	*Pacific Islands AIDS Advisory Group*
PMTCT	*Prevention of Mother to Child Transmission*
PTCT	*Prevention of Parent to Child Transmission*
RMI	*Republic of the Marshall Islands*
RRRT	*Regional Rights Resource Team*
SPC	*Secretariat of the Pacific Community*
SRH	*Sexual & Reproductive Health*
STD	*Sexually Transmitted Disease*
STI	*Sexually Transmitted Infections*
TB	*Tuberculosis*
ToT	*Training of Trainers*
UNAIDS	*United Nations AIDS Coordination Group*
US	*United States of America*
WAM	*WaanAelon in Majel*
WHO	*World Health Organisations*
WUTMI	*Women United Together in the Marshall Islands*
YTYiH	*Youth to Youth in Health*

1. STATUS AT A GLANCE

1.1 The Report Writing Process and the Inclusiveness of the Stakeholders in this Process

UNAIDS provided an in-country workshop in Majuro, Marshall Islands in February to discuss the purpose of the Global AIDS Progress Report (GARP). Subsequently the focal points from Government and NGO sector agreed on a workplan for data collection, analysis and submission of the report. 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.

Various meetings through face-face and e-meeting 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 results from previous reporting period were used 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 encouraging stakeholders to respond and provide updates to the Survey. Response to surveys submitted either electronically or in hard copy. A validation meeting for government sectors took place and results were presented ad discussed below.

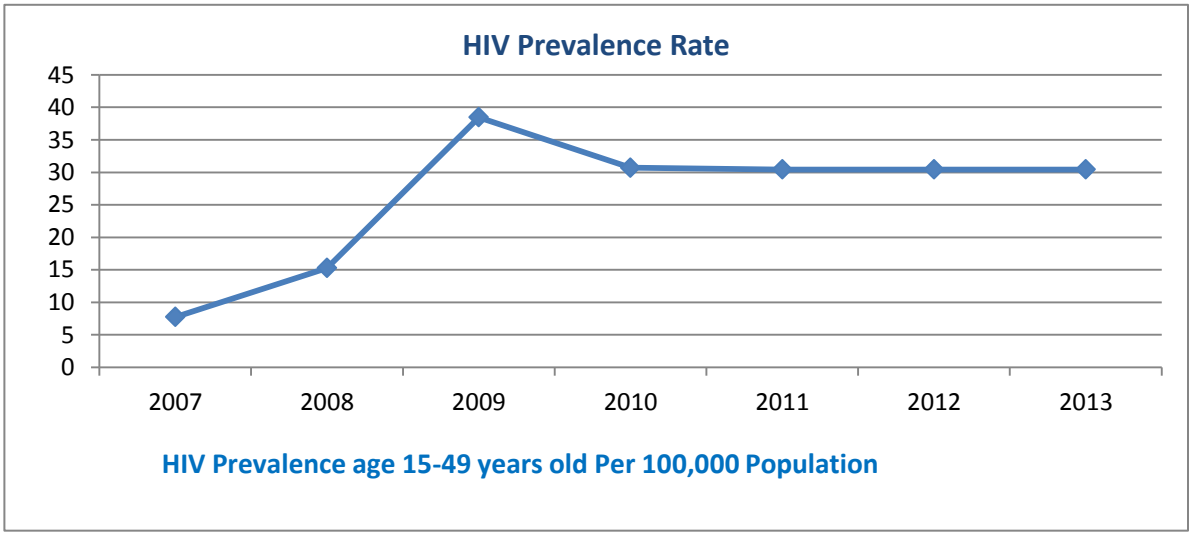
Government sectors were invited to a validation meeting to discuss and update NCPI results, discuss purpose of Global AIDS Progress Report, and data collection process. Prior notice of the meeting had been advised during the preparation meetings. NGO representatives held an e-meeting which was coordinated by NAC secretariat.

The government and NGO focal points presented the key ratings and responses in relation to each category in the surveys identifying the achievements and challenges noted for each effectiveness rating; and briefly discussing key issues raised throughout the response to the Category.

1.2 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 2013, the cumulative incidence of HIV in the Republic of the Marshall Islands was 26 cases, since the first case was identified in 1984.

HIV Prevalence Rate for 15-49 years old



Two new cases were identified during the 2011-2013; both clients presented as co-infection with TB. However, one of the newly identified cases have known to have left the country which puts RMI with 8 people living with HIV. 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 26 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.

There is only minimal increase in positive syphilis cases. In Ebeye, difficulty in accessing BD Probtec machine in Majuro laboratory. There is also difficulty in performing swabs with the limited capacity for swab culture and sensitivity in local laboratory. Most GC diagnosis were syndromic in nature. For Chlamydia testing, it is often found challenging in accessing BD Probtec machine in Majuro laboratory. Rapid testing relatively unreliable. However, presumptive Chlamydia treatment is provided to all prenatal women and their partner;, and just recently, STD high risk groups have been included.

Sexually transmitted infection poses as one of the greater risks among all ages, but more so for the youths. Syphilis and Chlamydia remain to be the two most common form of STI which threaten the livelihood out of the population. The Marshall Islands, although, it has been considered a low prevalence for HIV, RMI cannot live with a feeling of complacency. All the known and recommended measures have been postulated as our protection and control procedure.

Summary of STI/HIV Cases

STI	***FY 2009***		***FY 2010***		***FY 2011***		***FY2013***	
	Positive Case	***Prevalence Rate***	***Positive Case***	***Prevalence Rate***	***Positive Case***	***Prevalence Rate***	***Positive Case***	***Prevalence Rate***
Syphilis	*342*	*63*	*165*	*31*	*87*	*34*	*185*	*35*
Gonorrhea	*116*	*21*	*96*	*18*	*25*	*5*	*6*	*1*
Chlamydia	*331*	*61*	*152*	*29*	*120*	*23*	*102*	*19*
HIV	*8*	*2*	*8*	*2*	*8*	*2*	*8*	*2*

Source: STI/HIV Program, Majuro & Ebeye Prevalence rate is per 10,000

1.3 The Policy and Programmatic Response

The Republic of the Marshall Islands was a signatory to the UN Political Declaration on HIV and AIDS in 2011. This declaration aims to eliminate HIV throughout the world, and has commitments to prevention, treatment, elimination of stigma and discrimination and supporting the human rights of people living with HIV or perceived to be at high risk.

The Marshall Islands response is coordinated by the National Advisory Committee on HIV, STIs and Tuberculosis (National Advisory Committee), which was appointed in 2011. The Terms of Reference permit up to 15 members, with seven from NGOs. Of the new members elected, they are from the following sectors: Ministry of Health 4; private sector 2; Non-Government Organizations 3; Church 1; traditional leaders 1; Other Ministries 1; Higher Education 1.

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.

With a new National Strategy updated in 2012, the National Advisory Committee on STDs, HIV & TB (NAC) and MOH are currently implementing the newly developed and endorsed National Strategic Plan 2013-2017.

There have been advances in political leadership of the response to HIV and STIs in the Marshall Islands. The Parliament's induction session in 2012 invited consultants from UNFPA and UNAIDS to meet with members to discuss issues including women, poverty and HIV. The Majuro HIV Clinician was invited to provide an update on the HIV situation in the Marshall Islands, including the numbers of people living with HIV and receiving antiretroviral medications. In late 2011, the Secretary for Health spoke at the National Advisory Committee Inauguration. The Attorney General's Office has been involved in drafting proposed new legislation.

In Ebeye, the Mayor and traditional leaders endorsed the HIV and STI prevention efforts during World AIDS Day, and the initiation of the chlamydia presumptive treatment campaign.

A review of HIV, Human Rights and the Law was conducted by the regional organization RRRT in 2009. This reviewed existing legislation to identify its scope for protecting the human rights of those who are living with HIV or at risk of HIV. This review identified a number of inconsistencies between existing policies, legislation and practice related to the protection of human rights. Although the anti-discrimination protections of the Communicable Diseases Act are helpful, other aspects are likely to impede prevention of HIV and sexual health. Some provisions of the Communicable Diseases Act are inconsistent with a human rights based approach to prevention, treatment care and support. The review recommends strengthening the privacy and confidentiality provisions, removing HIV from the definition of communicable disease, exclusion of HIV from mandatory testing provisions, changes in criminal law (e.g. criminalizing sex work), provision of information and condoms for prisoners, and protection against sexual violence.

The RRRT review also suggests that Government and the private sector should develop a code of practice on HIV in the workplace which protects people from stigma and encourages information, education, access to services and confidentiality.

There is policy within the Ministry of Health to respect the confidentiality of clients. However, there is not yet any law to protect people who are positive. There is no legal framework for ethical

human research – which means that there are no laws to protect and ensure that ethical research occurs.

Mandatory testing is required for some population groups, contrary to global recommendations on HIV and human rights. The HIV screening policy states that screening (or evidence of a test) is required for people seeking visas, public servants, and foreign workers (although testing is not universally enforced for entrance).

In addition to legislation specifically about HIV, protection is provided through other laws and treaties. The Republic of the Marshall Islands is party to several UN treaties on human rights (including the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child (CRC). The Marshall Islands has oversight, although monitoring and compliance are still in planning stages. There is also a discussion about identifying an Ombudsman's office. The Domestic Violence Prevention & Protection Act which was enacted in 2011 includes protection of anybody living under the same roof. Violence is defined as physical harm inflicted, psychological verbal or economic or social abuse.

1.4 Global Reporting Republic of the Marshall Islands Indicator Summary Data

Targets	Indicator #	Indicator	Status	Source
Target 1: Reduce sexual transmission of HIV by 50% by 2015 General Population	1.1	Percent 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*	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	2006 Youth SGS
	1.2	Percent of young women and men aged 15-24 who have had sexual intercourse before the age of 15	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	2006 Youth SGS
	1.3	Percent of adults aged 15-49 who had more than one sexual partner in the past 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.	Population-based survey, DHS 2007
	1.4	Percent 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*	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	Population-based survey, DHS 2007

			more than one sexual partners in the past 12 months who report the use of a condom during their last intercourse * based on 25-49 un-weighted cases.	
	1.5	Percent of women and men aged 15-49 who received an HIV test in the last 12 months and know their results	Overall= 95% Female: 57% Male: 43%	Routine MOH surveillance data
	1.6	Percent of young people aged 15-24 who are living with HIV*	Female: 13% Male: 0% Overall: 13%	Routine MOH surveillance data
Sex Workers	1.7	Percent of sex workers reached with HIV prevention programs	No data available	
	1.8	Percent of sex workers reporting the use of a condom with their most recent client	No data available	
	1.9	Percent of sex workers who have received an HIV test in the past 12 months and know the results	No data available	
	1.10	Percent of sex workers who are living with HIV	No data available	
Men who have sex	1.11	Percent of men who have sex with men reached with HIV	No data available	

with men		prevention programs		
	1.12	Percent of men reporting the use of a condom the last time they had anal sex with a male partner	No data available	
	1.13	Percent of men who have sex with men who have received an HIV test in the last 12 months and know their results	No data available	
	1.14	Percent of men who have sex with men who are living with HIV	No data available	
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 needle and syringe programs operate in RMI.	
	2.2	Percent of people who inject drugs who report the use of a condom at last sexual intercourse	No data available	
	2.3	Percent of people who inject drugs who reported using sterile injecting equipment the last time they injected	No data available	
	2.4	Percent of people who inject	No data available	

		drugs that have received an HIV test in the last 12 months and know the results		
	2.5	Percent of people who inject drugs who are living with HIV	No data available	
Target 3: Eliminate mother to child transmission of HIV by 2015 and substantially reduce AIDS-related neonatal deaths	3.1	Percent of HIV-positive pregnant women who receive anti-retrovirals to reduce the risk of mother to child infection	0%	MOH Surveillance data
	3.2	Percent of infants born to HIV-positive women receiving a virological test for HIV within two months of birth	0%	MOH Surveillance data
	3.3	Mother to child transmission of HIV (modeled)	None	MOH Routine Surveillance
Target 4: Have 15million people living with HIV on antiretroviral treatment by 2015	4.1	Percent of eligible adults and children currently receiving antiretroviral therapy*	8 eligible for ART and 7 are on ART – one chooses not to take ART. There are no children who are HIV+; 5 females- all on ARV tx; 3 males, but only two on ARV tx.	MOH routine surveillance
	4.2	Percent of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral	all 8 are on ART although most recent diagnosis started ART within last 12 months.	MOH routine surveillance

		therapy		
Target 5: Reduce tuberculosis deaths in people living with HIV by 50% by 2015	5.1	Percent HIV-positive incident TB cases that received treatment for both TB and HIV	2012: Male= 1 Female= 0 Overall= 100 % on treatment	MOH Surveillance data
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	2012: Domestic= 69000 International=441542 2013: Domestic= 68000 International=410000	MOH Financial Data
Target 7: Critical enablers and synergies with development sectors	7.1 Government	Overall, how would you rate strategic planning efforts in the country's HIV programmes	2012=5 2013=8	RMI NCPI
		Overall, how would you rate political support for the country's HIV programmes	2012=2 2013=4	
		Overall, how you rate policy efforts in implementation of the HIV prevention programmes	2012=5 2013=7	
		Overall, how you rate the efforts of the implementation of the	2012=2 2013=5	

		treatment, care, and support programmes		
		Overall, how you rate the efforts to meet the HIV related needs of orphans and other vulnerable children	No data available	
		Overall, how you rate the monitoring and evaluation	2012=2 2013=5	
	Civil Society	Overall, how you rate the efforts to increase civil society participation in 2012 & 2013	2012=5 2013=7	
		Overall, how you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2012 & 2013	2012=0 2013= 1	
		Overall, how would you rate the effort to implement human rights related policies, laws and regulations in 2012 & 2013	2012=0 2013=2	
		Overall, how you rate the efforts in the implementation of treatment, care and support	2012=5 2013=7	

		programmes in 2012 & 2013		
	7.2	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	In the past 12 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	DHS 2007
	7.3	Current school attendance among orphan and non-orphans aged 10-14*	No data available	
	7.4	Proportion of the poorest households who received external economic support in the last 3 months	No data available	
	7.5	Percent of alcohol consumption & youth risk	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 EPIDEMIC

2.1 The National Context[1]

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 kilometers 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 2023[2].

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. Atthe municipal level, each atoll has a local government composed of an elected mayor and council.

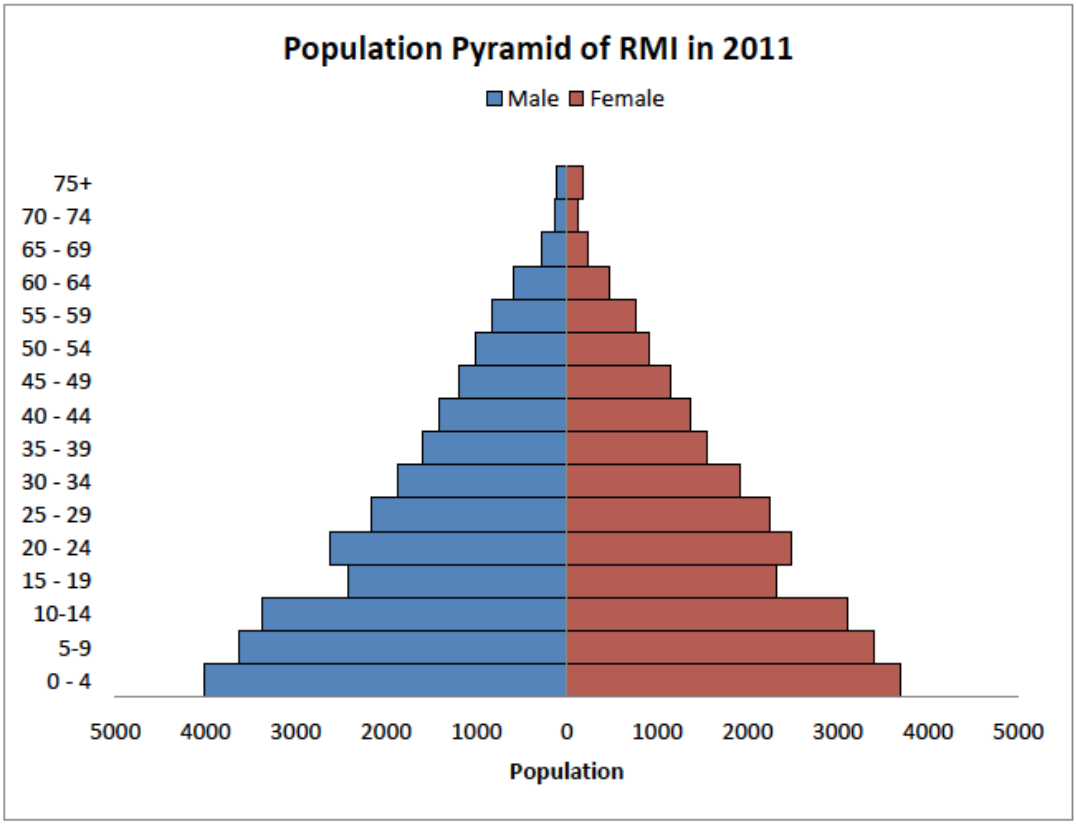
Although high fertility rates contributed to high population growth during the 1990s, population began to decrease in the early 2000s, with a fall in fertility rates and an increase in outward migration, largely to the United States. The estimated population in 2007 was 53,000 [3]. RMI has an estimated 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.

[1] We acknowledge the 2009 Progress Report on the Millennium Development Goals, EPPSO, 2009 and 2007 Demographic Health Survey, EPPSO, 2008; the 2012 Annual Report of the Ministry of Health, RMI, Ministry of Health

[2] 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 Center for Law and Economic Just Policy Brief; Millennium Development Goals

[3] 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 2011



Source: RMI MOH Annual Report 2012 – revised population pyramid by EPPSO

RMI is highly urbanized, with the largest urban center located at Majuro (on Majuro atoll)and Ebeye islands, across from the Kwajalein military base, is the second largest urban center. 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.

While 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.

HIV data is incomplete because testing is still in its infancy, voluntary testing is rare, and virtually no testing has been done on outer islands. The majority of testing has been testing of women visiting the antenatal clinic, taxi drivers, and food handlers. These groups might not be the people at highest risk, but they enable testing of the same identifiable groups of people year by year. Hence, if the HIV epidemic was to rapidly expand, this testing would quickly identify that change was occurring.

In 2013, a cumulative total of 26 people in the Marshall Islands were reported as living with HIV. Of these, 11 were male, 11 female and 4 unknown (because gender was not reported). In 2009, the cumulative incidence was 40.7 per 100,000 (this is included to enable comparison with other countries, even though the population is not 100,000). Only 8 of the people living with HIV currently reside in the Marshall Islands.

2.2 The Organization 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-one (51) active health care centers in the outer atolls and islands . 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 twp private clinics in Majuro – a general practice and an 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' Center operated by Canvasback Mission, and the Taiwan Health Center, 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.

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

2.4 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 2011 (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 [4]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;
- 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.
- 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.

2.5 The National HIV & STI Strategy2013-2017

In light of the expiry of the 2005-2009 National HIV & STI Strategic Plan, the MOH has collaborated with the NAC and the MOH to review and develop the next National Strategic Plan to address HIV & STIs. As a result, the endorsed National Strategic Plan 2013-2017 is in its implementation phase.

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

[4] 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.

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 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 is a multi-sectoral coordinated 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 National Strategic Plan include

- 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;
- comprehensive prevention initiatives to address the delays in promoting effective behavior change at individual family and community levels;
- enhanced quality of treatment, care and support for those living with or affected by HIV and their families, and those infected with STIs; and
- strategic information and communication, to ensure the response is built on a strong foundation of evidence, and informed by ongoing analysis of the situation.

2.6 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 centers 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 2012-2013showed 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 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, but this has changed during CY2013 when CDC has integrated all communicable disease into one funding application that has reduced the number of programmatic reports.

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.

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. While these are often conducted every five years, EPPSO, the office responsible for the last DHS, has no funding to conduct another DHS in the near future. An evaluation of Youth to Youth was reported to be undertaken by SPC Program staff in 2010 but no report has been disseminated to date. Two community NGOs, WUTMI and MIEPI whose work engages the broader issues around vulnerability related to HIV and STIs , 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 .The NAC and MOH have developed a monitoring and evaluation framework and is currently being used and monitored by NAC and MOH.

2.7 Funding the National Response

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

- 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).
- 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).
- The Pacific HIV &STI Response Fund and the Global Fund, both managed by SPC, are also 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 2011-2013 fiscal (and in some grants, calendar) years totaled US$1454342.8. Total expenditure across all grants for the same period was recorded as US$1080366– 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. Due to recent change in funding mechanism under Global Fund in 2012, there were initial delays in expenditure under the Global Fund, but this increased during 2013.

Annual allocations by Year – US$

Source: Aggregated data, MOH Finance 2011-2013

	US Federal Funds (inc CDC & HRSA)				SPC			*Local Fund*		Total US$
	HIV Prevention	Surveillance	STD Management	Ryan White	NSP	Comp	Global	*RMI Health Care Rev*	*Indirect Local Fund*	
2011	122518	18042	136660	25479	48375	39534	80753	*10000*	*35000*	**481361**
2012	158999	18008	95662	17006	91541.2			*10000*	*65000*	**456216.2**
2013	176595	17141.2	117028	1001	40000		80000	*20000*	*65000*	**516765.56**
Total	458112	53191.2	349350	43486	179916.2	39534	160753	*40000*	*165000*	**1454342.8**

Estimated expenditure by GARP categories by year[5] US$

Source: Aggregated data from MOH Finance 2011-2013

	Prevention	**Care & Treatment**	**Program management**	**Total US$**
2011	*132064*	*63360*	*33400*	***228824***
2012	*253257*	*64829*	*123456*	***441542***
2013	*285000*	*40000*	*85000*	***410000***
Total	***670321***	***168189***	***241856***	***1080366***

[5]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 has 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 GAPR categories. A more detailed analysis of funding is recommended

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 increased as compared to previous years.

2.8 HIV Epidemiology

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 26 cases since the first case was identified on-island in 1984, indicating low level prevalence.

Status of HIV cases, RMI, 2012-2013

Source: MOH via HIV register

Sex	Migrate out	Died	Active	Total
Male	3	5	3	11
Female	1	5	5	11
Unknown	4	0	0	4
Total	8	10	8	26

Only one new case was identified during the 2012-2013 who was diagnosed 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 three 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 2013

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+	*1*	*0*	*0*
Total	***6***[6]	***3***	***8***

Of the 26 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.

HIV cases by Transmission RMI 2013

Source MOH HIV Registry

Sex	***Heterosexual***	***MSM***	***Drug Users***	***MTCT***	***Total***
Male	*10*	*0*	*0*	*1*	*11*
Female	*10*	*0*	*0*	*1*	*11*
Unknown	*4*	*0*	*0*	*0*	*4*
Total	***24***	***0***	***0***	***2***	***26***

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[7].

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

Target 1: Reduce sexual transmission of HIV by 50% by 2015

Many successful initiatives have been occurring in prevention of HIV and STIs. This has included community education and awareness campaigns on a large scale, such as World AIDS Day campaigns, Youth to Youth and Women United Together Marshall Islands (WUTMI) education of young people in and out of schools, and the national campaign to promote chlamydia treatment.

[6] Patient diagnosed in December 2013 migrated out in late December
[7] Youth Risk Behaviours Survey, CDC Atlanta, 2009

Funding for prevention has been available through the regional SPC Response Fund, the Global Fund and USA Federal funds provided through the Centers for Disease Control.

As a result, there has been an increase in knowledge of risk behaviors, and this has been demonstrated through survey results. However, planning participants noted the need to now focus on support for behavior change, not just knowledge.

There has been safe blood transfusion as a means of preventing transmission of HIV. The increase in knowledge has also resulted in more people being tested voluntarily, with counseling being provided for all people tested in Majuro and Ebeye.

Access to condoms has improved, though there have been some problems with ongoing reliable supply of condoms. This has been a problem especially for outer islands, but stock outs of condoms have also sometimes occurred in Majuro. Condoms are provided within different services of the Majuro Hospital and the Ebeye Health Centre, and condoms are also available in local stores.

There has been some success in addressing the cultural taboos about talking about HIV and STIs. This has included raising awareness in public, talking on the radio, and distributing condoms. People are taught how to use condoms and understand why this is important.

1.1 Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*

Data from 2006 Youth SGS indicates that 8.4% of males were able to answer all 5 questions on knowledge of HIV prevention correctly while 3.8% of women answered all 5 questions on knowledge of HIV prevention correctly.

2007 DHS Survey: 39.4% of men aged 15-24 years demonstrated comprehensive knowledge about AIDS; 26.6% of women aged 15-24 years demonstrated comprehensive knowledge about AIDS. 2007 data suggests a shift – improvement – in the reach and/or quality of prevention education and awareness through 2007.However, SGS survey shows young people's knowledge of where to get a test or condom is low; but 2007 DHS data suggests higher, but who have got a test and know the results is low

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

From the 2006 SGS 15% of young women and 24.6% of young men have had sex before the age of 15. There remains a high rate of teenage pregnancy, therefore, there are still a high number of young men and women having sexual intercourse without using contraception like a condom.

The most recent MOH Annual Report, for the fiscal year 2012, identified a teenage pregnancy rate[8][9] of 31 teen pregnancies per 1,000 populations less than 20 years old, continuing the decreasing trend of the last four years.

[8] That is, pregnancy occurring in women less than 20 years old

[9] Based on FY2012 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 2011, MOH, 2012

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.

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 Center. YTYiH work with young people in schools, and out of formal 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 center, 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.

1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months

2007 DHS survey showed that 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.
2007 DHS survey also provided another (different) measure of high risk sex for 15-24 age group:38.7% of young women aged 15-24 who have had higher risk sexual intercourse (ie with someone who was neither spouse nor living with the respondent) in the last 12 months. 71.8% of young men aged 15-24 who have had sexual intercourse who have had higher risk sexual intercourse (ie with someone who was neither spouse nor living with the

respondent.

1.4 Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse*

The Demographic Health Study of 2007 reported that 10.6% of women and 19.5% of men use condom during their last intercourse who had more than one sexual partner in the past 12 months. .

No new survey or data has been collected to measure the amount of information young women and men have gained since the 2006 SGS. However, there has been an increase in awareness outreach discussing transmission modes, stigma and discrimination and the misconceptions about HIV.

1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results

From the Routine MOH Surveillance Data 94.28% of men and women aged 15-49 who received an HIV test in the last 12 months and know their results.

1.6 Percentage of young people aged 15-24 who are living with HIV*

MOH Routine Surveillance Data: .10% of young people aged 15-24 who are living with HIV.

Populations at higher risk

The NCPI survey and discussions, 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 therefore decided to run a number of focus groups with their network of sex workers to identify issues and develop an alternative program.

YTYIH are currently funded through the SPC Response Fund to provide education and awareness programs, as well as access to testing and counseling, for 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 behavior 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.

Sex Workers

1.7 Percentage of sex workers reached with HIV prevention programmes
1.8 Percentage of sex workers reporting the use of a condom with their most recent client
1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results
1.10 Percentage of sex workers who are living with HIV

There is no data available related to sex workers both within the MOH surveillance data as well as national surveys.

Men who have Sex with Men

1.11 Percentage of men who have sex with men reached with HIV prevention programmes
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a

male partner

1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results

1.14 Percentage of men who have sex with men who are living with HIV

There is no data available related to sex workers both within the MOH surveillance data as well as national surveys.

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

2.2 Percent of people who inject drugs who report the use of a condom at last sexual intercourse

2.3 Percent of people who inject drugs who reported using sterile injecting equipment the last time they injected

2.4 Percent of people who inject drugs that have received an HIV test in the last 12 months and know the results

2.5 Percent of people who inject drugs who are living with HIV

There is no data available related to inject drug users within the MOH surveillance. Local knowledge advises no IDU in RMI in contrast to Youth Risk Behavior survey (YRBS) 2009.

YRBS 2009 reported 6.4% of students reported use heroin one or more times during their life

9.6% of students reported they took steroid pills or shots without a doctor's prescription one or more times during their life; 11.2% of students report using a needle to inject any illegal drug into their body one or more times during their life. MIEPI & SSA advise that evidence indicates IDU is not present in RMI so this indicator is not applicable. Prevention is an issue though.

Target 3: Eliminate mother to child transmission of HIV by 2015 and substantially reduce AIDS-related neonatal deaths

3.1 Percent of HIV-positive pregnant women who receive anti-retrovirals to reduce the risk of mother to child infection

3.2 Percent of infants born to HIV-positive women receiving a virological test for HIV within two months of birth

3.3 Mother to child transmission of HIV (modeled)

Modelling estimates not reliable given population numbers

None of current active cases were pregnant during this reporting period. However, when children were born to women diagnosed with HIV in 2010-2011, the guidelines on Prevention of Maternal to Child Transmission were implemented. Rapid tests were taken and confirmatory tests followed. Prophylaxis medicines were available at the Majuro hospital. A pediatrician is a member of the HIV Core Care team at the Majuro hospital. Of those three children born to an HIV+ mother in the last three years, two children were tested with a PCR test (results show a normal or negative PCR), and the third remains to be tested. This demonstrates that the

processes work to prevent children being born with HIV.
There is not information available about the current situation for the children of those who have been diagnosed as HIV+. Normal cultural practice is that all children who are left without parents will be taken in by other family members. This has led to an assumption that there is little or no negative impact on the children who have already been born to parents living with HIV. However, there is no follow up evidence of what has happened for specific families.

Target 4: Have 15million people living with HIV on antiretroviral treatment by 2015

All people living with HIV in the Marshall Islands are entitled to treatment with antiretroviral drugs. 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[10].

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 26 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 2010-2012, 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.

[10] 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

The one patient who diagnosed with HIV in late 2013 was also TB positive. This client makes a total of three cases who have been HIV-TB co-infected. The most recent case was first treated under the TB protocols and then was believed to have migrated out of country after completing TB medications. 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). While 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.

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

4.1 Percent of eligible adults and children currently receiving antiretroviral therapy

87.5% of eligible adults and children currently receiving antiretroviral therapy

4.2 Percent of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

100% of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

Target 5: Reduce tuberculosis deaths in people living with HIV by 50% by 2015

5.1 Percent of HIV-positive incident TB cases that received treatment for both TB and HIV

100% of HIV-positive incident TB cases that received treatment for both TB and HIV.
In the last five years – 3 co-infections in total –previous two cases were diagnosed with HIV first.

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

See Annex 3

Target 7: Critical Enablers and Synergies with Development Sectors

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.

7.1 National Commitments and Policy Instrument (NCPI)

7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months

The Marshall Islands has made vital progress towards achieving the Millennium Development Goals for women and girls. With regards to MDG 5, our strengthened prenatal and postnatal program, and an increased emphasis on preventative care, have made giving birth safer than ever. However, keeping skilled practitioners and specialists in our hospital is a challenge, but we must overcome to ensure that women can continue to have safe pregnancies and births.

Teenage pregnancy continues to be at an alarming high rate. Teenage girls are most likely discriminated against and will often drop out of school or be terminated from school by the school or by the parents. Teenagers are already engaged in sexual activity. This compounded with little knowledge on the transmission of these diseases and the little importance put on testing will put teenagers at a higher risk of contracting HIV and other STIs.

Physical and sexual violence rates in the Marshall Islands is high. The RMI Demographic Healthy Study of 2007 reported that 27% of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past. Violence in the past twelve months (per the DHS 2007) 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.

A new survey was conducted in 2012 by a national women's organization, Women United Together Marshall Islands (WUTMI), called the Family Health and Safety Survey. However, the report has yet to be released for usage for this report.

To achieve the Millennium Development goals in both letter and spirit, we must devote adequate attention and resources to overcoming the barriers that stand in the way of progress. In the last two years, we have enacted the Domestic Violence Prevention and Protection Act, and will soon complete a new Gender Policy. A grant from the UN Trust Fund to End Violence Against Women to WUTMI is helping support implementation of this new law as WUTMI works in partnership with the Ministry of Internal Affairs. Furthermore, we expect to have the RMI initial CEDAW report completed shortly, with support from UN Women.

The challenges we face in implementing the MDGs are not limited to a lack of resources and capacity, but also in the course prescribed for us. Violence against women hinders regional progress towards achieving gender equality and the empowerment of women. Special attention must be paid to eliminating violence against women, to women and girls with disabilities, and to protecting the legal and human rights of women.

Target 8: Eliminating Stigma & Discrimination

8.1 Discriminatory attitudes towards people living with HIV

The Marshall Islands currently has eight people living with HIV. All patients reside on Majuro, capital of the Marshall Islands. There remains a lot of stigma and discrimination towards people living with HIV, hence, no patients have been able to disclose their status and share their experiences and be represented on the National Advisory Committee for HIV, STIs and TB.

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.

An initial legislation and policy review was conducted in September 2013 by the Ministry of Health, the Attorney General's Office and WUTMI to include provisions to support and protect the rights of people living with or affected by HIV.

In 2013 the International Labor Organization conducted a HIV in the Workplace workshop, which resulted in three draft workplace policies regarding HIV. The Ministry of Health, WUTMI and the College of the Marshall Islands drafted HIV workplace policies, which will now be used as templates for other government ministries and agencies, non-government organizations and academia institutions.

4. 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.

4.1 Governance and Program Management

This is an area where RMI has made continuous 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
- Revised and completed RMI 2013-2017 national strategic plan on HIV/STI's
- Developed and have already implemented M&E activities for RMI NSP 2013-2017
- 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.

4.2 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.

4.3 Scale-up of Prevention Programs

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 Center has provided consistent examples which demonstrate the link between the clinical care provided through the health center 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 Center'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.

4.4 Scale-up of Care, Treatment and/or Support Programs

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.

4.5 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 analyzed to enhance program improvement.

The epi-analysis of 2009 and 2010 surveillance undertaken by the Ebeye Health Center, 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.

5. Major Challenges and Gaps

The 2012 Country Progress report identified a number of key challenges in three key areas: treatment care and support; data collection and resources.

5.1 Treatment Care and Support

The situation in relation to the 2012 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, this 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 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 2014.

- 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.

5.2 Data Collection

There has been some standardization of HIV and STI data collection and reporting, but this is not universal. There is a need to strengthen data collection, analysis and sharing of information. There is not consistent use of the same indicators across all programs. There is a need to strengthen leadership, communication and coordination of Monitoring and Evaluation.

Most of the national HIV database is with the national Program Manager for the HIV and STI program. The identification of data for the Global AIDS Progress Report indicators revealed that this data base is inconsistent and incomplete. There is currently no dedicated staff to support HIV and STI surveillance data entry, analysis and reporting in Majuro, so the task rests with the staff currently delivering clinical programs. Workload sometimes precludes accurate and timely entry of data. In addition, with substantial changes in staff roles and capacity during 2012-2013, some reports required for submission to funding sources were not completed.

5.3 Resources

Funding and resources are inconsistent. Access to Ryan White funds for the support of people living with HIV has varied over last two years. There is a need for more resources to support outreach, client follow up and contact tracing, including access to a vehicle and staff. There are not enough health care providers in Ebeye. There are still some shortages of some supplies. For example, test kits and vaccines are slower to reach Ebeye due to shipping from Majuro.

Marshall Islands Social Security (MISSA) support is one mechanism which is available to provide benefits to assist those who are sick and disabled. The physician who examines all applicants for MISSA purposes has not identified anyone who has cited HIV as the reason for their disability application.

The Marshall Islands is a Sub-Recipient for Global Fund grants, which means that supplies of antiretroviral medicines are ordered through the regional Fiji Pharmaceuticals (FPCC), linked to SPC. SPC's HIV Program works alongside the FPCC to purchase medications for the Marshall Islands. On a six monthly basis a supply inventory is submitted to FPCC; supplies usually take 1-2 weeks to reach the Marshall Islands. However, medicines were sometimes not available because either the accounts were not paid or the paperwork was not completed.

Resources to fully staff community service organization facilities are an ongoing concern. The Youth to Youth clinic is still awaiting a full time nurse from the Ministry of Health so that the

clinic can be open every day instead of the current 8 hours per week. Providing services to the outer islands remains a major challenge.

6. Recommendations

6.1 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 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 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 prioritize open and transparent communication on the response and its effectiveness to all stakeholders to maintain their interest and stimulate their ongoing enthusiasm.

6.2 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. 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.

6.3 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 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.

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.

6.4 HIV Testing and Counseling

This is a key focal area for the forthcoming national strategy. It is important that these services are effective. Based on the available data, 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.

6.5 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.

6.6 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 organizations 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.

6.7 Human Resources

While 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.

6.8 Monitoring & Evaluation and Surveillance

The GAPR process clearly identified ongoing shortcomings in the way data is collected, analyzed and reported. This was an issue in 202 and 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 2010 and identified again in the Country Progress Report of 2012 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 2012 Country Progress Report in relation to surveillance, monitoring and evaluation should be reviewed by the NAC and a plan instituted [11]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.

7. 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 2012-2013

Component of the Response	***2012***	***2013***
Prevention	*World AIDS Day support and PLWHA awareness-raising - PIAF*	*VCCT M&E Site Visit Majuro and Ebeye - PCASS*
	HIV Quality Assurance/Quality Improvement Training	*World AIDS Day support and advocacy for PLHIV - PIAF*
Treatment care and support	*HIV Clinical Training*	*Laboratory strengthening t improve lab based surveillance In Majuro – SPC CDC*
	CDC STD Branch Site Visit - CDC	*AETC site visit and Chart review*
Governance/management & Coordination/M&E	*GAPR TA*	*HIV M & E training and workshop*

[11] 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.

	RF Programmatic Meeting	*RF Monitoring with RMI MOH and YTYIH; progress NAC establishment; progress NSP planning with Burnet, completion of RF MOH logframe*
	RF and GF TA, DIC follow-up and attendance at PIJAAG Summit– SPC GMU & Others	*ILO Training*
	International AIDS Conference 2012	*CDC Site Visit*
	Conduct PH database assessment and EpiAnywhere support - CDC	*CDC HIV Surveillance Grantee MEeting*
	PIJAAG 2012	*Program Collaboration Service Integration (PCSI- HIV/STD, Viral Hepatitis, TB) - CDC*
	Making Waves, HIV/STI Workshop, CDC/SPC	*End of Project Evaluation and MSC Training + RF PDM follow-up with YTYIH, WUTMI and MOH –SPC*
		HIV/STI Technical Working Group Meeting in Fiji
		VCCT Site Assessment

8. Monitoring and evaluation environment

The NCPI surveys were sparse in their response to 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 properly implement the monitoring and evaluation framework for the 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 centers 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 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 2012-2013 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 a data encoder has been provided for the program, there are still data from 2013 that have not been entered due to lack of management.

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. However, for FY2013, CDC has integrated all

communicable disease programs which has significantly reduced the number of programmatic reports.

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.

An evaluation of Youth to Youth was reported to be undertaken by SPC Program staff in 2010 but report has not been shared to MOH. Two community NGOs, WUTMI and MIEPI whose work engages the broader issues around vulnerability related to HIV and STIs , 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 .

The NAC and MOH are currently implementing monitoring and evaluation framework, but have realized that there needs to be more frequent meetings to monitor progress and update understanding on data collection. The MOH has liaised with UNAIDS to arrange preliminary training in monitoring and evaluation in the third quarter of 2014. After this, UNAIDS will provide additional support to develop the monitoring and evaluation framework in collaboration with the MOH and NAC teams.

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

UNAIDS provided an in-country workshop in Majuro, Marshall Islands in February to discuss the purpose of the Global AIDS Progress Report (GARP). Subsequently the focal points from Government and NGO sector agreed on a workplan for data collection, analysis and submission of the report. 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.

Various meetings through face-face and e-meeting 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 results from previous reporting period were used 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 encouraging stakeholders to respond and provide updates to the Survey. Response to surveys submitted either electronically or in hard copy. A validation meeting for government sectors took place and results were presented.

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.