

# UNGASS COUNTRY PROGRESS REPORT

## Republic of the Marshall Islands

*Reporting period: January 2008–December 2009*

***Submission date: 31<sup>st</sup> March 2010***

## **Abbreviations:**

ADB	Asian Development Bank
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
CCM	Country Coordination Mechanism
CDC	Centers For Disease Control And Prevention
CPG	Community Planning Group
CRT	Counseling Referral And Testing
CSO	Civil Society Organisation(S)
DHS	Demographic Health Survey
EPPSO	Economics, Policy, Planning And Statistics Office
FGD	Focus Group Discussion
GF	Global Fund
M&E	Monitoring And Evaluation
MDRTB	Multi-Drug Resistant Tuberculosis
MESS	Monitoring And Evaluation System Strengthening
MICNGOS	Marshal Islands Non Government Organisations
MOF	Ministry Of Finance
MOH	Ministry Of Health
NCPI	National Composite Policy Index Questionnaire
NSP	National Strategic Plan
PCASS	Pacific Counseling And Social Services Organisation
PIJAAG	Pacific Islands Jurisdictions Aids Advisory Group
PRHP	Pacific Regional Hiv & Aids Project
RMI	Republic Of The Marshall Islands
SGS	Second Generation Surveillance
SPC	Secretariat Of The Pacific Community
SPS	
SSA	
STA	Short Term Advisor
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
TSF	Technical Support Facility
UNAIDS	United Nations Aids Coordination Group
UNGASS	United Nations General Assembly
VCCT	Voluntary Confidential Counseling And Testing

WAD	World AIDS Day
WAM	The Canoe Program
WUTMI	Women United
YTYIH	Youth to Youth in Health

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## II. Status at a glance

*A brief summary of:*

*(a) the inclusiveness of the stakeholders in the report writing process;*

The process of stakeholder consultation to participate in the compilation of the Country Progress Report on HIV in the Republic of the Marshall Islands (RMI) began in August 2009 when the UNAIDS Pacific Office, in collaboration with the RMI Ministry of Health's Clinical Care Manager for the STD and HIV & AIDS Program, convened a Pre-Planning Meeting to explain the purpose and process for compiling the UNGASS Country Progress Report on HIV. Up to 30 different government and civil society stakeholders were invited to the meeting to identify their contribution to the Report. A number of different processes and tools for participation, engagement and contribution were identified:

- Focal points were identified for each of the government and civil society organisations sectors, to act as a central point for information dissemination, collection and analysis.
- The focal points were responsible for distributing the National Composite Policy Index Questionnaire to government representatives (Part A) and civil society representatives (Part B); these questionnaires were subsequently distributed during February when the Short Term Advisor commissioned by the UNAIDS Pacific Office was in the RMI to assist in the compilation of the report.
- During the Pre-Planning meeting, participants reviewed the UNGASS Indicators, a collection of 25 core measure of progress, and agreed on which indicators were applicable in the RMI and where data could be sourced to assess the indicators and who was responsible for the collection of the data.
- In February 2010, UNAIDS Pacific, through the TSF for South East Asia and the Pacific, in agreement with the Ministry of Health in RMI, commissioned a Short Term Advisor to assist the MOH to collect and analyse the data and compile the draft Report for the endorsement of RMI.
- During 15-28th February, the STA worked in collaboration with the Clinical Care Manager for the STD and HIV & AIDS Program to collect and analyse the agreed data.
- During this period, in addition to collecting the completed Questionnaires (as noted above) the STA and Clinical Care Manager, with the assistance of the Acting Director of MICNGOs, the umbrella organisation representing civil society organisations across the Marshall Islands, convened three consultation meetings with government and civil society stakeholders; the first two meetings consulted government and civil society on the specific programs operated by each; the third and final meeting presented the preliminary findings of the consultation for the validation of the broader group of stakeholders.

- In addition, the STA convened follow-up and additional meetings and interviews with a range of stakeholders to complement the participation in the broader workshops.

Over 40 people from 8 government departments and 7 civil society organisations participated in the workshops, meetings and interviews held in February 2010. This included discussions with the Secretary for Health and representatives from the key program areas within the Ministry, including the finance managers; and representatives of the Attorney General's Department; EPPSO; the Ministry of Internal Affairs; the Ministry of Education; the College of Marshall Islands; and the Courts; and, in relation to civil society, discussions with representatives from WUTMI women's advocacy group, Youth to Youth in Health, WAM Canoe Program; Marshall Islands Epidemiology and Prevention Initiative; the University of the South Pacific (technical vocational program); the Parents Association for Children with Disabilities; Care/Mission Pacific; and representatives from the Secretariat of the Pacific Community and the Global Fund.

The draft report was then compiled by the STA and submitted to the Secretary for Health and Clinical Care Manager for their comment and endorsement. This final Report was submitted online by the Ministry of Health.

None of those who are living with HIV in the Marshall Islands have disclosed their status publicly. Although an invitation to people living with HIV to participate in the consultations to compile the Report was canvassed with the Clinical Care Manager, it was not possible to identify a local source who was willing to openly discuss the situation for the purpose of this Report.

*(b) the status of the epidemic;*

At end of December 2008<sup>1</sup>, RMI had reported a cumulative incidence of 35.5 per 100,000 with a cumulative total HIV cases (including AIDS) of 19; with 5 new cases reported in 2008 and 11 deaths (7 of which were deemed AIDS related deaths).

Country / Region	Mid year Population 2008	New cases for 2008	New deaths for 2008	Cumulative Cases			HIV Cumulative Incidence per 100,000	HIV		
				HIV (including AIDS)	AIDS (incl. deaths)	AIDS related deaths		M	F	UK
Marshall Islands	53,889	5	1	19	11	7	35.3	7	8	4

<sup>1</sup> SPC Cumulative reported HIV, AIDS and AIDS deaths: cases, incidence rates and gender, plus cases with missing details. All Pacific Island Countries and Territories and December 2008. SPC website. SPC data for December 2009 is not yet available.

By March 2010, another 6 people had been diagnosed with HIV, bringing the total number of people diagnosed with HIV in RMI to 24 since 1984. Of those, 10 were diagnosed during 2008-09. In March 2010, there were 8 people living with HIV in RMI; of these, there were 4 cases on ARV, and 2 more needing to be ARV, with treatment regimes under discussion. One case is yet to proceed to stage 1; another was placed on ART during her pregnancy and delivery and is now being monitored. Two cases of HIV-TB co-infections have been diagnosed. The STD & HIV Quarterly Report for Quarter One 2010 identified that three patients had chosen to stop taking ARV, two of whom believed that local medication was of greater benefit; and a third claiming the side effects were too difficult. One patient who chose to stop ARV treatment has since died.

The HIV epidemic in RMI is assumed to be of low prevalence due to the small size of the reported numbers of cases. As with much of the Pacific, it is difficult to accurately assess incidence, as individuals testing positive for the first time could have been infected many years previously. It is possible that the rise in the number of reported cases may be at least partly due to increased testing rather than an increase in HIV incidence. Furthermore, it is challenging to estimate prevalence, or report on the designated UNGASS indicators, because the known actual numbers are simply too small in most instances to provide accurate and reliable basis for modeling.

*(c) the policy and programmatic response;*

In 2006, the MOH approved the RMI National Strategic Plan 2006-2009 for implementation. The Plan supported 5 priorities which encompassed the national response to HIV and STIs. These priorities were:

1. Coordination of the responses to HIV/AIDS;
2. Preventing and controlling Sexually Transmitted Diseases (STDs);
3. Reducing vulnerability;
4. Care and support for people living with and affected by HIV/AIDS;
5. Providing a safe blood supply.

In 2007 and 2009, two key documents were drafted to provide guidance to health care workers in the prevention, treatment, care and support for those living with HIV. These are the Draft Guidelines on HIV Prevention and Care (2007), which have been circulated to MOH health workers and appear to be in wide use; and the draft National Health Sector Policy for Strengthening HIV/AIDS and STI Prevention, Care and Treatment (2009). In addition to expanding on the objectives and protocols underlying the five priority areas of the National Strategic Plan, the National Health Sector Policy advises on the responsibilities and obligations of health care workers to refrain from actions that discriminate or stigmatise persons living with HIV and affirms the ethical rights of all to health care, confidentiality and to exercise choice in testing, treatment and care. The draft Policy is intended as the basis for prospective legislation in the Nitijela, the law-making body for RMI.

*(d) UNGASS indicator data in an overview table.*

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Indicator	Assessment	Indicator definition	Data Source (inc UNGASS Data tools0	Comment based on available data
<b>National Commitment and Action</b>				
<p><b>1. AIDS Spending</b></p> <p><i>Domestic &amp; international AIDS spending by categories and financing sources</i></p>	<p><i>International expenditure:</i></p> <p><b>Expenditure in 2008 by category:</b></p> <p><i>Prevention: \$302,453.96</i></p> <p><i>Care &amp; Treatment: \$265.37</i></p> <p><i>*Program Management &amp; Administration: \$275,016.87</i></p> <p><b>Expenditure in 2009 by category:</b></p> <p><i>Prevention: \$157,844.02</i></p> <p><i>Care &amp; Treatment: \$83,558.90</i></p> <p><i>*Program Management &amp; Administration: \$289,438.84</i></p> <p><i>Human Resources \$8,049.76</i></p> <p><i>*includes Domestic expenditure: MOH advises 'in-kind' contribution from the national health budget to support the HIV &amp; STI Program of approx. \$250,000 per annum</i></p>		<p>National Health Accounts/ MOF Financial Statements (encompassing CDC Funds) &amp; SPC financial reports (encompassing Global Fund, ADB &amp; AusAID and NZAID)</p> <p>National Funding Matrix (Guidelines Appendix 3)</p>	<p>The information available from RMI and SPC indicates that total approved donor allocations of <b>US\$1,355,018</b> were available to RMI for the national HIV response in 2008-2009; these funds were sourced from 10 different funding programs and channeled through two technical agencies, SPC &amp; CDC<sup>2</sup>.</p> <p>Details of disbursements were not available across all funding programs. Available data indicates that total of <b>US\$504,635</b> had been acquitted to March 2010.</p> <p>The total funds allocated by SPC through the Pacific HIV&amp;STI Response Fund is <b>US\$583,000</b>. Draw down of these funds is yet to be agreed with RMI.</p> <p>If we consider the total amount of funds approved less funds acquitted and less funds yet to be negotiated, the amount approved but not drawn down by RMI is <b>US\$267,383</b> outstanding which could have been utilised to implement the national response in RMI. With the addition of the funds available and yet to be negotiated, this amount increases to US\$850,383.</p> <p>Funds under the CDC Ryan White were not available in 2008-2009 but are expected to be negotiated in 2010.</p>

<sup>2</sup> This is estimated on the basis of advised allocations: however, some allocations have been made over three years, and others over one; in the absence of clear budget and programming information, an approximation has been made for the purpose of comparison:

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<b>National Commitment and Action</b>				
	<p><i>An estimate of domestic private expenditure was not able to be identified.</i></p>			
<p><b>2. Government HIV and AIDS Policies</b></p> <p><i>National Composite policy index, covering prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programs, stigma and discrimination, and monitoring &amp; evaluation.</i></p>	<p><b>Prevention:</b> <i>rated between '0' and ' 6-7' by different stakeholder groups; with government stakeholders noting YTYiH's achievements as substantial, in recognition of the continuing awareness and education activities underway – and CSOs agreeing that while YTYiH's achievements are significant, more needs to be done by, including a stronger focus on sex workers, and seafarers.</i></p> <p><b>Treatment, Care And Support of People living with HIV:</b> <i>rated between '1' and '8' by different stakeholder groups, with government stakeholders citing the improvements in access to treatment, confidentiality and counseling in the last two years as a strength, although noting that the absence of legislative protection remains an issue; CSO stakeholders, however, were not aware of much of the work being undertaken by government, and consequently, marked this area down.</i></p>		<p>Completed National Composite Policy Index Questionnaires Part A &amp; B (Guidelines Appendix 4)</p> <p>Interviews with Government &amp; CSO stakeholders.</p> <p>Consultation workshops with government and CSO stakeholders, including final workshop to discuss &amp; validate NCPI findings</p> <p>Desk review of relevant documents including: <i>( i.e. policy, law, guidelines, reports, review - cannot use draft documents)</i></p>	<p>Overall, the focus of the national response is on prevention, counseling, screening and testing, and treatment and care. There have been significant efforts to improve access to treatment, with additional funds sourced through the Global Fund; and to improve the quality and access to counseling, with support for training and accreditation extended to government &amp; NGO staff; and in improved care, with the integration of the HIV &amp; TB programs in relation to screening &amp; treatment protocols and a review/circulation and professional development in relation to revised HIV Treatment and Care Guidelines.</p> <p>However, it was agreed that Coordination of the response remains a serious shortcoming, exacerbated by the continuing absence of a national coordination authority which overlooks the quality, strategic directions and achievements of the national response. Limited attention has been given to the protection of human rights, including legislative support for people living with HIV, despite the development of a draft policy focusing on rights to care, confidentiality and choice and the obligations of health professionals to prevent stigma and discrimination. Given the significant concerns expressed around stigma and discrimination, the absence of legislation encompassing all citizens is a shortcoming. The weaknesses demonstrated in the areas of national coordination, advocacy on human rights and the extent of stigma and discrimination, lead to concerns about the strength of national leadership and commitment to respond to HIV.</p>

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<b>National Commitment and Action</b>				
	<p><b>Civil Society Involvement:</b> rated between '0' and '5', with calls particularly from CSOs for stronger coordination between government and CSOs to cooperate and collaborate to implement the response. CSOs claimed that there were few examples of areas where government and CSOs worked together, although the work of YTYIH &amp; MOH was cited by a number as an example of good engagement.</p> <p><b>Human Rights:</b> rated between '0' &amp; '3' ie poor: with many explaining that there was an absence of information on HIV or the response to HIV, with a strong demand that HIV be more strongly prioritised by national leaders; amongst CSO reps, there was a lack of confidence that any legislation, should it exist, would 'address the real needs and concerns' of people living with HIV well. The MOH draft policy to protect rights of PLWH was not widely known; and remains to be legislated. MOH reports Communicable diseases legislation prohibits discrimination on the basis of health status.</p> <p>The following areas were not specifically rated by</p>			<p>Apart from the significant contribution of Youth to Youth in Health, there has been limited conscious engagement of civil society in the response to HIV. YTYIH are identified as the primary NOG engaged in the prevention activities, primarily with youth but also other marginalised groups in the population. However, few other NGOs are familiar with the national response; whilst their activities may complement and assist the national response, most commentators acknowledged the need to strengthen collaboration between government and civil society. Many respondents were unaware of the treatment services available at the hospital in Majuro, for instance, whilst others reported instances of care that raised concern about quality. The challenges of educating the broader community, and specifically the Nitijela and government departments, in relation to HIV &amp; the protection of individuals from stigma and discrimination would assist to promote national leadership and engagement. A formal public review of the 2006-2009 National Strategic Plan, which engaged broad mix of government and CSO stakeholders, and an evaluation of specific programs, would be useful next steps.</p>

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<b>National Commitment and Action</b>				
	<i>stakeholders during the consultations: Gender; Monitoring &amp; Evaluation; Workplace Programs; Stigma And Discrimination.</i>			
<b>3. Blood safety</b>  <i>Percentage of donated blood units screened for HIV in a quality assured manner</i>	<i>Unable to assess due to absence of data</i>		<i>RMI MOH –Laboratory 'FRAME' tool (not accessed).</i>	<p>The laboratory at MOH advises that they screen all blood for transfusion; and that they regularly participate in External Quality Assessment of Laboratory tests.</p> <p>The absence of readily available data to respond to the indicator suggests need to inquire into the rigor of the surveillance system and responsibilities for recording, storing and analyzing and disseminating data.</p> <p>With the planning officer position vacant it is unclear whether there is a central surveillance unit within MOH to assist coordination of data recording, storage and analysis and dissemination across various program areas.</p>
<b>4. HIV Treatment: Antiretroviral Therapy</b>  <i>Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy</i>	<i>Unable to assess given the nature of the data available - with such low actual numbers, modeling estimates tools not prove likely to provide useful analysis.</i> <ul style="list-style-type: none"> <li>• – report raw numbers</li> </ul>	<b>N</b> -Number of adults/children with advanced HIV infection receiving ART within nationally approved treatment protocol  <b>D</b> -Estimated number of adults/children with	<b>N:</b> facility-based ART registers/drug supply management system  <b>D:</b> HIV prevalence estimation models	MOH advise that:  There were <b>3380</b> tests for HIV conducted between Oct 2008-Dec 2009 <sup>3</sup>  10 new cases of HIV were diagnosed 2008-09 with 1 adult death in Feb 2010 and 1 child of 17 months = total of 9 current cases being monitored

<sup>3</sup> The reviewer was not able to locate the data in relation to numbers screened between Jan 2008-Sept 2008; it is presumed this data is available in the HIV & STD Annual Program report for Oct 2007-Sept 2008.

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Indicator	Assessment	Indicator definition	Data Source (inc UNGASS Data tools0	Comment based on available data
<b>National Commitment and Action</b>				
	on those screened vs diagnosed, vs ARVs	advanced HIV infection (using Spectrum/some sort of modeling)		<p>MOH advise at March 2010 that 4 persons are currently on ART – with 2 others diagnosed at stage 1 and needing ART but not taking.</p> <p>One pregnant female and infant were treated with ART in accord with RMI protocols during delivery – both are now being monitored (the child's status is yet to be confirmed).</p> <p>One death related to a newly diagnosed case of HIV who subsequently refused treatment; a second case which refused treatment is now on ART.</p>
<p><b>5. Prevention of Mother-to-Child Transmission</b></p> <p><i>Percentage of HIV – positive pregnant women who receive antiretroviral medicines to reduce the risk of mother to child transmission</i></p>	<p><i>Unable to assess given the nature of the data available - with such low actual numbers, modeling estimates tools not unlikely to provide useful analysis.</i></p>	<p><b>N:</b> No. of HIV-infected pregnant women who receive ART</p> <p><b>D:</b> Estimated number of HIV-infected pregnant women in the last 12 months</p>	<p><b>N:</b> Program monitoring tools i.e. patient registers</p> <p><b>D:</b> Antenatal clinic surveillance surveys, demographic data, Spectrum</p>	<p>MOH advise that three pregnancies placing infants at risk of HIV transmission due to maternal HIV infection were under consideration in 2008-2009:</p> <p>One pregnant female was diagnosed with HIV – both mother and infant treated during pregnancy/delivery in accord with protocols; subsequently, confirmation tests for both showed they were negative for HIV.</p> <p>One pregnant female (not on ART at onset of pregnancy) and infant were treated with ART in accord with protocols; now monitoring both (and awaiting 3 month outcome for infant).</p> <p>One baby died and diagnosed with HIV post-mortem; transmission route unconfirmed.</p> <p><i>Given that the small numbers means estimates for this indicator are unreliable, MOH may like to consider an alternative means of monitoring from routine surveillance data to produce more useful data for analysis. A review of the surveillance system to ascertain the total number of attendees at ANC clinics, the numbers of Rapid Test Positives &amp; confirmed positives vs the overall number of deliveries in a health facility nationally may assist to provide an indication of the proportion of screening</i></p>

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<b>National Commitment and Action</b>				
				<p><i>and confirmed diagnoses in relation to the overall numbers of deliveries in the female population.</i></p> <p><i>From a broader perspective, it may be useful to also consider a review of the cases and supporting programs in light of current WHO/UNICEF guidelines on PMTC transmission, to ascertain whether there are areas for enhancement in the areas of primary prevention, for males as well as females, as well as clinical care.</i></p>
<p><b>6. Co-management of Tuberculosis and HIV Treatment</b></p> <p><i>Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV</i></p>	<p><i>Unable to assess given the nature of the data available - with such low actual numbers, modeling estimates tools not likely to provide useful analysis.</i></p>	<p><b>N:</b> No. adults with advanced HIV infection receiving ART and started on TB treatment</p> <p><b>D:</b> Est. no. of incident TB cases in PLHA</p>	<p>Facility ART registers and reports</p> <p>Programme monitoring tools</p>	<p>MOH advises two cases of HIV –TB co-infection diagnosed and currently under care. Case A was diagnosed with HIV then screened and confirmed for TB; case B was diagnosed for both HIV &amp; TB on arrival at clinic with demonstrated symptoms. MOH advises that the Guidance advises that the protocol is that all TB diagnoses are screened for HIV and vice versa. Anecdotal reports from clinic program staff confirmed this occurs; it would be useful for MOH to review the data to confirm the actual numbers of HIV cases screened for TB and vice versa.</p>
<p><b>7. HIV Testing in the General Population</b></p> <p><i>Percentage of women &amp; men aged 15-49 who received an HIV test in the last 12 months and who know the results</i></p>	<p><i>21.9% of women respondents aged 15-49 yrs were tested in the last 12 months;</i></p> <p><i>66.9% of women respondents aged 15-49 yrs received counseling with AIDS test in last 12 months</i></p> <p><i>21.8% of men aged 15-49 yrs were tested in the last 12 months</i></p> <p><i>55.1% of men aged 15-49 yrs</i></p>	<p><b>N:</b> No. of respondents 15-49 who have been tested and know their results</p> <p><b>D:</b> Number of respondents</p>	<p>Population-based survey DHS 2007, pp197-199</p>	<p>2007 DHS analysis suggests that although most Marshallese men and women know where to go for an HIV test, only a little over 1 in 3 had ever been tested. Almost equal proportions of men and women had been tested in the last 12 months pre-DHS – with over two thirds of women and half the men receiving counseling with the test. The MOH advises that the new HIV Guidelines on Treatment and Care had been introduced in 2007.</p> <p><i>With the numbers small or difficult to access, it may be that alternate ways of gathering this data could be useful to consider. This indicators is a measure of the quality of the HIV testing and counseling and</i></p>

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<b>National Commitment and Action</b>				
	<i>received counseling with AIDS test in last 12 months</i>			<i>referral. It may be possible to consider an alternate measure into the referral or consent form, for example, so that the quality of program counseling level is monitored.</i>
<p><b>8. HIV Testing in the Most-at-risk Populations</b> (in any given country)</p> <p><i>Percentage of most at risk populations that received an HIV test in the last 12 months and who know the results</i></p>	<p><i>2.6% Men 15-19 yrs who were tested in the last 12 months and know their results</i></p> <p><i>2.2% of men 20-24 yrs who were tested in the last 12 months and know their results</i></p> <p><i>1.2% of women 15-19 yrs who were tested in the last 12 months and know their results</i></p> <p><i>8% of women 20-24 yrs who were tested in the last 12 months and know their results</i></p>	<p><b>N:</b> No. of MARP respondents who have been tested and know results</p> <p><b>D:</b> Number of MARP respondents tested</p>	<p>2006 Youth SGS Behavioural Surveillance survey – RMI Secretary for Health has confirmed data able to be released in this report.</p>	<p>DHS 2007 Survey advised:</p> <p>22.7% of women aged 15-24 yrs were tested for HIV in the last 12 months; and 70.5% of women received counseling with their HIV test in the last 12 months</p> <p>19.6% of men aged 15-24yrs were tested for HIV in the last 12 months; with 44.9% of men receiving counseling with their HIV test in the last 12 months.</p>
<p><b>9. Most-At-Risk Populations: Prevention Programmes</b></p> <p><i>Percentage of most at risk populations reached with HIV prevention programs</i></p>	<p><i>84.1% of men aged 15-24 yrs know where to go for an HIV test</i></p> <p><i>84.3% of women aged 15-24 yrs know where to go for an HIV test</i></p> <p><i>90.8% of men aged 15-24 yrs know where to get a condom</i></p> <p><i>82.3% of women aged 15-24 yrs know where to get a condom</i></p>	<p><b>N:</b> No. of MARP respondents saying yes to both/all</p> <p><b>D:</b> Total number surveyed</p>	<p>2007 DHS Survey, Table 12.12..1 &amp; 2; Table 12.15 &amp; 12.16</p>	<p><i>This indicator is a measure of the quality of the prevention programs. With the numbers small or difficult to access, it may be that alternate ways of gathering this data could be useful to consider in addition to periodic DHS surveys.</i></p>
<p><b>10. Support for Children affected by HIV and AIDS</b></p>	<p><i>Not assessed because not considered applicable in RMI setting – indicator relevant to settings with high HIV</i></p>	<p><b>N:</b> No. of OVC who have received at least one type of support</p>		

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Indicator	Assessment	Indicator definition	Data Source (inc UNGASS Data tools0	Comment based on available data
<b>National Commitment and Action</b>				
<i>Percentage of orphans &amp; vulnerable children whose households received free basic external support in caring for their child</i>	<i>prevalence (5% of greater)</i>	<b>D:</b> Total no. of OVC		
<p><b>11. Life-Skills based HIV Education in Schools</b></p> <p><i>Percentage of schools that provided life skills based HIV education within the last academic year.</i></p>	<i>Data not available to assess the indicator</i>	<p><b>N:</b> No. of school that provided life-skills based HIV education.</p> <p><b>D:</b> No of schools surveyed</p>	<p>Youth Risk behaviors Survey 2007 conducted by CDC</p> <p>2009 YRBS will be released in May 2010.</p>	<p><i>2007 YRBS notes that 46% Percent of students respondents had ever been taught in school about AIDS or HIV infection – a decrease from 61.5% in 2003</i></p> <p>MOE advises 'all high school students' are taught HIV and STI education through the curriculum. In addition, YtYIH &amp; MOH (Public Health) provide education and awareness sessions at schools regularly and in response to requests.</p> <p><i>2007 YRBS also noted:</i></p> <p><i>Increases were noted in the proportion of students who:</i></p> <ul style="list-style-type: none"> <li>- <i>ever had sexual intercourse;</i></li> <li>- <i>reported that either they or their partner had used a condom during last sexual intercourse (among students who were currently sexually active); and,</i></li> <li>- <i>reported that either they or their partner had used birth control pills to prevent pregnancy before last sexual intercourse, (among students who were currently sexually active).</i></li> </ul> <p><i>But there were reported decreases in the proportion of students who</i></p> <ul style="list-style-type: none"> <li>- <i>had sexual intercourse for the first time before age 13 years;</i></li> </ul>

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<b>National Commitment and Action</b>				
				<ul style="list-style-type: none"> <li>- had sexual intercourse with four or more persons during their life;</li> <li>- had sexual intercourse with at least one person during the 3 months before the survey;</li> <li>- and, among students who were currently sexually active, the percentage who drank alcohol or used drugs before last sexual intercourse (YRBS, Marshall Islands Results: 2003 Compared with 2007)</li> </ul>
<b>Knowledge and Behaviors Indicators</b>				
<p><b>12. Orphans: School Attendance</b></p> <p><i>Current school attendance among orphans aged 10-14 yrs</i></p>	<p><i>Considered not applicable (no data available)</i></p>	<p><b>Part A:</b></p> <p><b>N:</b> No. of children who have lost both parents and attend school.</p> <p><b>D:</b> No. of children who have lost both parents.</p> <p><b>Part B:</b></p> <p><b>N:</b> No. of children both of whose parents are alive, who are living with at least one parent and attend school.</p> <p><b>D:</b> No. children both of whose parents are alive who are living with at least one parent</p>	<p>DHS 2007.</p> <p>For every child 10-14 living in a household, household member is asked: is the child's mother and father alive and do they live in the house? Did the child attend school at any time during the school year.</p>	<p>2007 DHS:</p> <p><i>A person up to the age of 18 yrs is a child in Marshallese society. Four in 10 Marshallese households include one or more children who stayed with neither their natural father nor mother. One in 10 Marshallese households contains orphans.</i></p> <p><i>Marshallese children not living with either parent constitute about a quarter (23.32%); are likely to be aged 2-17 yrs, living in rural areas and in the lowest to middle wealth quintile households, with little variation between sexes. Attendance at school was not queried.</i></p> <p><i>47.6% of children aged 10-14 live with both parents; 32.5% of children aged 10-14 do not live with a biological parent; and 5.9% have one or both parents dead; while 29.8% have both parents alive but do not live with either parent.</i></p>

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Indicator	Assessment	Indicator definition	Data Source (inc UNGASS Data tools0	Comment based on available data
<b>National Commitment and Action</b>				
<p><b>13. Young People: Knowledge about HIV Prevention</b></p> <p><i>Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission</i></p>	<p><i>8.4% of males were able to answer all 5 questions on knowledge of HIV prevention correctly</i></p> <p><i>3.8% of women were able to answer all 5 questions on knowledge of HIV prevention correctly</i></p>	<p><b>N:</b> No. respondents aged 15-24 who gave the correct answer to all 5 Qs</p> <p><b>D:</b> No. of all respondents aged 15-24.</p>	<p>2006 SGS on Youth</p>	<p><i>2007 DHS:</i></p> <p><i>39.4% of men aged 15-24 yrs demonstrated comprehensive knowledge about AIDS</i></p> <p><i>26.6% of women aged 15-24 yrs demonstrated comprehensive knowledge about AIDS</i></p>
<p><b>14. Most-at-risk Populations: Knowledge about HIV Transmission Prevention</b></p> <p><i>Percentage of most at risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission</i></p>	<p><i>No reliable data was available to assess the indicator in relation to potential at risk populations: sex workers; men who have sex with men; seafarers.</i></p>	<p><b>N:</b> No. MARP respondents who gave the correct answer to all 5 Qs</p> <p><b>D:</b> No. of all MARP respondents aged 15-24.</p>	<p>Special behavioural surveys for MARP</p>	<p>Attempts to conduct an SGS amongst sex workers in 2006-07 were abandoned due to a fear of prosecution (either for illegal activities or being in the country illegally). Instead an intervention was identified to identify the sexual behaviours and issues facing sex workers through focus group discussions.</p>
<p><b>15. Sex Before the Age of 15</b></p> <p><i>Percentage of young women and men who have had sexual intercourse before the age of 15</i></p>	<p><i>15% of young women who have had sexual intercourse before the age of 15</i></p> <p><i>24.6% of young men who have had sexual intercourse before the age of 15</i></p>	<p><b>N:</b> No. respondents (15-24) who report age of first sex &gt; 15 years</p> <p><b>D:</b> No. all respondents (15-24)</p>	<p>Population-based survey, DHS 2007</p> <p><i>DHS 2007: 60% of young women and 73% of young men in 15-24 yrs who have had sexual intercourse before the age of 18</i></p>	<p><i>2006 Youth SGS Survey (unpub)</i></p> <ul style="list-style-type: none"> <li>• <i>17.3% of males aged 15-19 have had first sex under the age of 15;</i></li> <li>• <i>17.4% of males aged 20-24 have had first sex under the age of 15</i></li> <li>• <i>11.2% of females aged 15-19 have had first sex under the age of 15</i></li> <li>• <i>0% of females aged 20-24 have had first</i></li> </ul>

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Indicator	Assessment	Indicator definition	Data Source (inc UNGASS Data tools0	Comment based on available data
<b>National Commitment and Action</b>				
				<p><i>sex under the age of 15</i></p> <ul style="list-style-type: none"> <li>• 78% of males aged 15-24, and 61% of females aged 15-24, had ever had sex</li> <li>• The average age at first intercourse is around 15 for males and 16 for females</li> <li>• 17% of males and 11 % of females had first sex when younger than 15</li> </ul> <p>YRBS 2007: 8.3% of students who had sexual intercourse for the first time before age 13 years, a drop from 10.2% in 2003</p>
<p><b>16. Higher-risk Sex</b> <i>Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months.</i></p>	<p><i>Among those who have had sexual intercourse in the last 12 months:</i></p> <p><i>3.3% of women aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months.</i></p> <p><i>9% of men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months.</i></p>	<p><b>N:</b> No. respondents (15-49) who had sex with more than one partner in the last 12 months</p> <p><b>D:</b> No. all respondents (15-49)</p>	<p>Population-based survey, DHS 2007</p>	<p>2007 DHS survey (uses different definition of high risk sex):</p> <p>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.</p> <p>71.8% of young men aged 15-249 who have had sexual intercourse who have had higher risk sexual intercourse (ie with someone who was neither spouse nor living with the respondent) in the last 12 months.</p> <p>2006 Youth SGS:</p> <ul style="list-style-type: none"> <li>- 20.5% of males aged 15-19 have had sex with more than one partner in the last 12 months</li> <li>- 16.8% of females aged 15-19 have had sex with more than one partner in the last 12 months</li> <li>- 32.6% of males aged 20-24 have had sex</li> </ul>

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Indicator	Assessment	Indicator definition	Data Source (inc UNGASS Data tools0	Comment based on available data
<b>National Commitment and Action</b>				
				<p><i>with more than one partner in the last 12 months</i></p> <ul style="list-style-type: none"> <li>- <i>24% of females aged 20-24 have had sex with more than one partner in the last 12 months</i></li> </ul>
<p><b>17. Condom Use During Higher-risk Sex</b></p> <p><i>Percentage of adults 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</i></p>	<p><i>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*</i></p> <p><i>19.5% of men aged 15-49 who had more than one sexual partners in the past 12 months who report the use of a condom during their last intercourse</i></p>	<p><b>N:</b> No. respondents (15-49) who had sex with more than one partner in the last 12 months and reported using a condom the last time they had sex</p> <p><b>D:</b> No. all respondents reporting having had more than one sexual partner in the last 12 months (15-49)</p>	<p>2007 DHS</p>	<p>* based on 25-49 unweighted cases.</p> <p><i>2006 Youth SGS:</i></p> <ul style="list-style-type: none"> <li>- <i>15.6% of males aged 15-19 have had sex with more than one partner in the last 12 months and used a condom during last sex</i></li> <li>- <i>18.5% of females aged 15-19 have had sex with more than one partner in the last 12 months and used a condom during last sex</i></li> <li>- <i>26.7% of males aged 20-24 have had sex with more than one partner in the last 12 months and used a condom during last sex</i></li> <li>- <i>0% of females aged 20-24 have had sex with more than one partner in the last 12 months and used a condom during last sex</i></li> </ul>
<p><b>18. Sex Workers: Condom Use</b></p> <p><i>Percentage of female and male sex workers report the use of a condom with their most recent client</i></p>	<p><i>Unable to assess due to absence of data</i></p>	<p><b>N:</b> No. respondents who reported using a condom with their last client</p> <p><b>D:</b> No. of respondents who reported having commercial sex in the last 12 months</p>		<p><i>2007 DHS: 0.5% of men aged 15-49 yrs reporting payment for sexual intercourse in the past 12 months.</i></p> <p>SWIP Workshops asked 20 interviewees in Focus Group Discussions: Do you use a condom when you have sex?</p> <p>Responses:</p> <ul style="list-style-type: none"> <li>• Sometimes - 8</li> <li>• No – 7</li> </ul>

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Indicator	Assessment	Indicator definition	Data Source (inc UNGASS Data tools0	Comment based on available data
<b>National Commitment and Action</b>				
				<ul style="list-style-type: none"> <li>• Yes – 4</li> <li>• Unavailable on Ebeye – 1</li> <li>• No time to use it - 1</li> </ul>
<p><b>19. Men Who Have Sex with Men : Condom Use</b></p> <p><i>Percentage of men who report the use of a condom the last time they had anal sex with a male partner</i></p>	<p><i>Unable to assess due to absence of data</i></p>	<p><b>N:</b> No. respondents who reported using a condom last time they had anal sex</p> <p><b>Da:</b> No. of respondents who reported having anal sex with a male partner in the last 6 months</p> <p><b>Db:</b> No. of respondents who reported having anal sex with a female partner in the last 6 months</p>		<p><i>The 2006 SGS on Youth asked all male participants whether they had ever had sex with a man; 4.3% answered yes; of these six, only two had had male partners in the last 12 months. Due to the small numbers, no further analysis was performed.</i></p>
<p><b>20. Injecting Drug Users: Safe Injection Practices</b></p> <p><i>Percentage of injecting drug users who report using sterile injecting equipment the last time they injected</i></p>	<p><i>Considered not applicable – Unable to assess due to absence of data</i></p>	<p><b>N:</b> No. respondents who report using sterile injecting equipment last time they injected drugs</p> <p><b>D:</b> No. respondents who report injecting drugs in the last month</p>		
<p><b>21. Injecting Drug Users: Condom Use</b></p> <p><i>Percentage of injecting</i></p>	<p><i>Considered not applicable – Unable to assess due to absence of data</i></p>	<p><b>N:</b> No. respondents who reported using a condom the last time</p>		

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Indicator	Assessment	Indicator definition	Data Source (inc UNGASS Data tools0	Comment based on available data
<b>National Commitment and Action</b>				
<i>drug users who report using a condom at last sexual intercourse</i>		they had sex <b>D:</b> No. of respondents who reported injecting drugs and having sex in the last month		
<b>Impact Indicators</b>				
<b>22. Reduction in HIV Prevalence</b>  <i>Percentage of young women and men aged 15-24 who are HIV infected</i>	<i>Considered not applicable – Unable to assess due to absence of data – applicable in countries with generalised epidemics</i>	<b>N:</b> No. of antenatal clinic attendees (15-24) tested whose HIV results are positive  <b>D:</b> No. of antenatal clinic attendees tested	<i>2006 ANC SGS</i>	<i>2006 Antenatal SGS:</i>  <i>A total of 346 pregnant women were surveyed from May-September 2006: none of the women tested for HIV were positive. However, routine screening of patient in ANC clinic led to a confirmed diagnosis in January 2009; mother and child were treated with ARV in accord with guidelines.</i>  MOH advise that the compulsory screening: blood donor and ANC screening in 2008 identified 2 cases of HIV in ages group 15-24yrs  <i>Again, the absence of data and potential small population numbers means estimates for this indicator may be unreliable. MOH may like to consider an alternative means of monitoring based on routine surveillance data (or perhaps undertake periodic surveys) so that some useful analysis can be considered. For example, draw on routine surveillance birthing data and compare with ANC attendees and testing data to assess how many women may not be presenting at ANC and therefore not tested at all.</i>
<b>23. Most-at-risk Populations: Reduction in HIV Prevalence</b>  <i>Percentage of most at risk</i>	<i>Unable to assess given the data available</i>	<b>N:</b> No. of members of MARP who test positive for HIV  <b>D:</b> No. of members of		Of the 10 new cases diagnosed in 2008-09 – 4 are between ages of 15-24 consisting of 2 adult male and two adult female (pregnant). Seven were under 30 yrs and two were children of the two females – the status of a third infant child is yet to be

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Indicator	Assessment	Indicator definition	Data Source (inc UNGASS Data tools0	Comment based on available data
<b>National Commitment and Action</b>				
<p><i>populations aged 15-24 who are HIV infected</i></p>		<p>MARP tested for HIV</p>		<p>confirmed.</p> <p><i>Again, given the absence of data and potential 'hidden' populations are likely to represent for small actual numbers, estimates for this indicator may be unreliable. MOH may like to consider an alternative means of monitoring drawn from routine surveillance data (or perhaps undertake periodic surveys ie for set periods of time, routinely monitor datasets) so that some useful analysis can be considered. For example, consider using the existing STI clinic surveillance data to compare numbers attending the clinic with numbers of those tested for STIs, and of these, those numbers confirmed positive or assumed to have an STI &amp; treated (if symptomatic treatment and management is adopted). This is premised on the reasonable assumption that if the person has an STI then we can assume unprotected sex and thus high risk behaviours. Ideally, for some population groups, eg sex workers, it would be useful to undertake specific surveys to link behavioral and serological data.</i></p>
<p><b>24. HIV Treatment: Survival After 12 months on Antiretroviral Therapy</b></p> <p><i>Percentage of adults and children with HIV know to be on treatment 12 months after initiation of antiretroviral therapy</i></p>	<p><i>Unable to assess given the nature of the data available -</i></p>	<p><b>N:</b> No. adults and children who are still alive and on ART at 12 months after initiating treatment</p> <p><b>D:</b> Total no. adults and children who initiated ART who were expected to achieve 12-month outcomes within the reporting period, including those who died since starting therapy, stopped or</p>	<p>Programme monitoring tools, cohort/group analysis forms.</p> <p>ART registers and ART cohort analysis report form</p> <p>Aggregate data for monthly cohorts of patients who have completed 12 months of treatment</p>	<p>HIV &amp; STD Program Annual Report Quarter 1, Jan 2010, advised that 5 clients are taking ART and another 3 clients have stopped taking ARV because they prefer local medication or wish to avoid side effects. In February 2010, MOH advised that one of the cases who had refused to continue their ARV medications has died. As a result, MOH advises that at March 2010, there were 4 cases currently on ARV, and another two positive diagnoses who need ART but were yet to be placed on it. Of these four currently on ART: one case has been on ART since 2007; two cases have been on ART since 2008; and a fourth case has been on ART since arrival in RMMI in 2009.</p> <p><i>The interest in this indicator is in measuring the</i></p>

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Indicator	Assessment	Indicator definition	Data Source (inc UNGASS Data tools0	Comment based on available data
<b>National Commitment and Action</b>				
		were lost to follow up		<i>quality of treatment - with small numbers its is difficult to undertake meaningful analysis; an investigation of the quality of care in specific cases would be more meaningful.</i>
<b>25. Reduction in Mother-to-child Transmission</b>  <i>Percentage of infants born to HIV-infected mothers who are infected</i>	<i>Considered not applicable – Unable to assess due to absence of data – applicable in countries with generalised epidemics</i>		Spectrum or statistical modeling using programme coverage and efficacy studies	1-baby – late-stage diagnosis and died prior to treatment initiated. As result, 1 F (mother) then diagnosed but late-stage and died prior to effective treatment.  I F (pregnant) diagnosed as result of 1 M (husband) diagnosed – mother and child treated during pregnancy and post-birth, now awaiting 3 month point to re-test child.

### III. Overview of the AIDS epidemic

#### Screening & Testing:

The following table describes the screening and testing data collated by the MOH STD & HIV Annual Program Reports for 2008 and 2009<sup>4</sup>. The reporting follows the fiscal-year cycle of October-September, so data does not reflect a full calendar year.

Year	STI Tests (Syphilis)			HIV tests			Confirmed for HIV	Referred for care for HIV
	M	F	Total	M	F	Total		
Oct 2007- Sept 08 <sup>5</sup>								
Oct 2008- Sept 09	1480	3171	4651	930	1812	2746	4	4
Oct 2009- Dec 09 (Qtr1/2010)	330	705	1035	244	390	634	4	4

It appears from the data provided in the Quarterly and Annual Program Reports for 2008 and 2009 that those screened for HIV are additional to the numbers screened for STIs. It is not clear, however, in the available reported data, what proportion of the estimated populations that make up the 'mandatory screening' sub-populations<sup>6</sup> have been screened. There is no estimate of these size of these sub-populations available. With four different clinic sites available in Majuro where counseling, referral and/or testing may occur (STI & HIV/Public Health, Youth to Youth Clinic, ANC Clinic, and the Family Planning Clinic), and another two in Ebeye (at the hospital and Youth to Youth Service), as well as the services of the Mobile clinics to the outer islands, it would also be useful to clarify where the broader population, as well as each sub-population seeks and receives counseling, referral and testing services.

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<sup>4</sup> HIV & STD Annual Program Reports, 2008, 2009, 2010, Ministry of Health, RMI

<sup>5</sup> The HIV & STD Annual Program Report and data to end 2007 was not available; another report, the Annual Program Report to CDC for Jan-Dec 2008 records 2535 tested for HIV, with 5 cases confirmed and 4 referred for care.

<sup>6</sup> These categories include Others, School/College Students, Prenatal Mothers, Pre-employment/Foreign workers and private sector employees, STD clients, and TB clients.

**Current Cases**

In relation to current cases, including those diagnosed between 2008-2009, the MOH routine surveillance provides the following information:

*Cases 2002-2009<sup>7</sup> (including deaths): Gender & Age Group*

	0-14	15-19	20-24	25-34	35-44 <sup>8</sup>	Total
Male	2		1	3	2	8
Female		1	3	3		7
Total	2	1	4	6	3	15

*New cases diagnosed 2008-2009<sup>9</sup>: Gender & Age Group*

	0-14	15-19	20-24	25-34	35-44 <sup>10</sup>	Total
Male	2		1	2	1	
Female			3	1		
Total	2		4	3	1	10

*Current cases by outcome 2002-2010*

	Not on ARVs <sup>11</sup>	ARVs	Deaths <sup>12</sup>	Total
Male	2	1	5	8
Female	3 <sup>13</sup>	2	2	7
Total	5	3	7	15

<sup>7</sup> STD & HIV Annual and Quarterly Program Reports, MOH, 2008-2010;

<sup>8</sup> Includes one cases diagnosed elsewhere and relocated to RMI in 2009 and seeking care

<sup>9</sup> STD & HIV Annual and Quarterly Program Reports, MOH, 2008-2010;

<sup>10</sup> Includes one cases diagnosed elsewhere and relocated to RMI in 2009 and seeking care

<sup>11</sup> Includes two cases – 1 male 1 female, where ARV is currently under discussion

<sup>12</sup> Includes one case on ARV then discontinued and subsequently has died.

<sup>13</sup> Includes pregnant mother & child on ARV for delivery in accord with guidelines, now being monitored

*Newly diagnosed Cases by screening 'trigger' 2008-2010*

	Routine screening	Walk in	Contact <sup>14</sup>	Not known <sup>15</sup>	
Male		1	3	2	6
Female	1 (ANC)	2	1		4
<b>Total</b>	<b>1</b>	<b>3</b>	<b>4</b>	<b>2</b>	<b>10</b>

*Newly diagnosed cases by outcome 2008-2010*

	Not on ARVs <sup>16</sup>	ARVs	Deaths <sup>17</sup>	Total
Male	1	1	3	6
Female	3	2		4
<b>Total</b>	<b>4</b>	<b>3</b>	<b>3</b>	<b>10</b>

The data available in relation to those diagnosed with HIV is sensitively considered in small island states such as RMI. Given the close ties of family and friends across the community, the MOH has made only general demographic data available in relation to those cases diagnosed between 2008-2010:

- Age range – all under 30yrs, most in 15-27 yr age range
- Most are unemployed and not at school
- Most attained mid-level high school
- Most are from urban settings
- The primary mode of transmission is thought to be heterosexual

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<sup>14</sup> Includes one case where a relative was approached for blood transfusion, and on screening, HIV diagnosed: and subsequently diagnosed in other family members.

<sup>15</sup> Includes one case diagnosed elsewhere

<sup>16</sup> Includes two cases – 1 male 1 female, where ARV is currently under discussion

<sup>17</sup> Includes one case on ARV then discontinued and subsequently has died.

The majority of cases were diagnosed as a result of presentations at the clinic due to apparent symptoms, or through tracing from such presentations. Only two cases emerged through the screening of those groups subject to mandatory screening in accord with the RMI National Guidelines for HIV Care and Prevention – one of which was as a result of a routine blood screen when a blood transfusion was sought for a family member, subsequently also diagnosed with HIV. The other diagnosis arose as a result of ANC screening.

## **Surveys**

Four sources of surveillance data into HIV & AIDS related knowledge, behaviours and practices were produced in the period between 2008– 2010. These were Second Generational HIV Surveillance Survey of Women at the Majuro Hospital Prenatal Clinic; the Second Generational Surveillance Surveys of Sexual and Risk Behaviours among Youth in the Republic Of the Marshall Islands<sup>18</sup>; and the 2007 Demographic & Health Survey<sup>19</sup>; and the 2007 Youth Risk Behaviours Survey, undertaken by CDC through the Ministry of Education. The 2007 DHS, as indicated, relates to data collected during 2007, analysed and released in 2009. While data for the two SGS Surveys of youth and antenatal women was collected in 2006, each of these studies is yet to be officially released by the MOH.

### ***Knowledge & Behaviors***

The 2007 DHS survey found that while general knowledge of HIV is high amongst men & women, only 33% of women and 46% of men demonstrated comprehensive knowledge of how to prevent HIV transmission – with the number of men and women reporting one or more of a range of high risk sexual behaviours high<sup>20</sup>. The number of adult men who use of condoms was low, with less than 20% indicating they used a condom either at last sexual activity and/or during high risk sexual activity. For women, particularly during high risk sexual activity, the numbers reporting condom use were very low. Reports of the full range of ‘high risk’ sexual behaviors were of concern – with reports of multiple concurrent partners; early initiation of sexual activity; and sexual activity with a partner other than a spouse all frequent.

Although the 2007 DHS report noted that knowledge of where to get an HIV test was relatively high – approximately 89% of adult men and women - only 21% of respondents (for men and women) had had an HIV test in last twelve months.

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<sup>18</sup> Second Generational HIV Surveillance Survey of Women at the Majuro Hospital Prenatal Clinic, Republic of Marshall Islands, 2006, Marshall Islands SGS Management team; Second Generational Surveillance Surveys of Sexual and Risk Behaviours among Youth in the Republic Of the Marshall Islands, Marshall Islands SGS Management Team,

<sup>19</sup> 2007 Demographic Health Survey, EPPSO, RMI 2009

<sup>20</sup> The 2007 DHS defines high risk behaviors as sexual activity outside usual sexual partnership, with one or more partners, and without a condom; SGS survey defines high risk activity as sexual activity with one or more partners, without a condom.

The 2007 DHS reports of frequent high risk sexual activity were also confirmed by the 2006 ANC SGS, which showed that 25% of pregnant women tested positive for Chlamydia, indicating sexual activity without a condom. This trend in STI rates is supported by routine screening data<sup>21</sup>. Of interest, the 2007 DHS indicates that only 10% of women and 3% of men reported that they had an STI or symptoms on an STI in the previous 12 months, with 46% of those women and 85% of those men seeking treatment from a clinic, hospital, private doctor or health professional.

For youth respondents, the demonstrated comprehensive knowledge of prevention strategies reported in the 2007 DHS was low (29% (F) & 39% (M)). In relation to one key prevention measure however, a high percentage (82.3% of women and 90.8% of men) knew where to source a condom – but only approximately 9% of women and 22% of men reported using a condom during last sexual activity or whilst engaging in high risk sexual activities; and similar numbers using a condom during first sexual activity. And whilst 84% of young men and women knew where to get an HIV test 84%, only 22% of women and 19% of men had been tested in last 12 months.

The 2007 DHS concluded that there was a substantial disconnect between knowledge and practice: despite reports of high awareness of HIV, knowledge of how to prevent HIV transmission was at best variable, at worst, low; and unprotected, high risk sexual activity appears common, particularly for women. The high numbers of men and women reporting early initiation of sexual activity, together with the low rates of condom use confirm the need for concern about the potential risk of HIV transmission, particularly amongst young people. The 2007 DHS concluded that this disconnect indicated the need for revised strategies and a greater focus on behaviour change.

## **IV. National response to the AIDS epidemic**

### **National Commitment and Action in Prevention: Knowledge and Behaviours:**

The consultations conducted during the compilation of this Report indicated anecdotal evidence for an increase in the level and frequency of education and awareness programs in the last two years. Prevention programs, encompassing the spectrum of education and awareness, condom distribution and counseling and referral, are operated by Government and civil society organisations.

The Ministry of Health's Public Health program, represented by the clinical care managers as well as the public health nursing staff, offer ongoing education and awareness sessions on sexual and reproductive health, with a focus on 'HIV 101', in collaboration with the Ministry of Education to school students. The College of Marshall Islands' school nurse offers education programs, including condom distribution. The

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<sup>21</sup> This seems to be an accurate trend, although there is some inconsistency between data captured in the tables and corresponding narratives in each of the Quarterly and Annual Reports for 2008 and 2009. It would be helpful to review the data at source to confirm.

Ministry's Health Education and Promotion team coordinates annual education and awareness activities during the World AIDS Day (WAD) celebrations, including the conduct of HIV awareness activities at schools – high schools, elementary schools and community sites. The WAD activities in 2009 included offers of testing at the local NGO, Youth to Youth in Health, with 50 youths counseled and tested on the day as result. The Ministry of Education, through its Health team, also conducts ongoing education on sexual and reproductive health as part of the curriculum, with a focus on HIV awareness and education. This is complemented by an annual Student Health Conference, which addresses a range of health issues including HIV education.

Youth to Youth in Health (YTYIH) is acknowledged by both the Ministry of Health and its CSO counterparts as the key NGO working in the HIV-related programs. Whilst primarily focused on youth in the 0-25 years age groups, it does also welcome extended age groups to use its services, offering education, information, condom distribution, and counseling referral and testing for a range of sexual and reproductive health issues, with a focus on HIV & AIDS; in addition to programs and support around school drop-outs, unemployment, suicide prevention, substance abuse and teenage pregnancy.

During 2008-2010, YTYIH continued to offer education and awareness programs in schools, counseling services, as well as training in life skills and reproductive health and peer education programs targeting out of school youth as part of the range of services offered through its resource centre in Majuro. In the last two years, YTYIH has expanded its sexual and reproductive health services to establish an STI clinic, in collaboration with the MOH's Public Health Program, in Majuro; and to develop a youth resource centre in Ebeye. In 2009, YTYIH, in collaboration with the Marie Stopes Pacific Program, established a new Condom Social Marketing program, featuring a locally designed Defender condom, in addition to its free condom distribution program. The condom is now on sale through retail outlets including local hotels, supermarkets and bars. The regular free condoms are also available at a range of outlets: bars, hotels, taxi drivers, schools and prison; as well as through the hospital's Family Planning and STI clinics.

A number of other CSOs offer programs, often in collaboration with YTYIH, or which are complementary to the response to HIV. WUTMI, an advocacy and support organisation for women and children to prevent vulnerability to family violence, often collaborate with YTYIH on presentations in schools; and with young mothers. YTYIH provides support with information and education on substance abuse and sexual and reproductive health. Similarly, WAM, the Canoes program, offers two programs of support to youth audiences which complement the work undertaken by WUTMI and YTYIH. WAM operates a social development program which targets a bi-annual intake of up to 25 youth in each six-month rotation, assisting them to develop personal, social and employment skills and confidence with programs in literacy, numeracy, sexual health education and substance abuse. WAM also work with prisoners in the local prison to promote strategies to support reintegration in to society.

The relationship between substance misuse and unprotected sexual activity was acknowledged by the 2007 DHS survey<sup>22</sup>. A number of the community organisations consulted during the compilation of this Report expressed concern about the level of substance abuse and the relationship to sexual activity while under the influence of alcohol, particularly for young men in rural and urban areas<sup>23</sup>. Two new initiatives have emerged in response to this concern in the last two years. A new community based organisation, the Marshall Islands Epidemiology & Prevention Initiative, targets substance abuse prevention. Its prime focus has been improved data collection, resulting in the compilation of an epidemiological profile on substance abuse in 2009. MIEPI has initiated an awareness and education campaign, targeting vendors and the general public, in relation to sales of alcohol and tobacco to minors. They report some success in increased awareness of the benefits of reduced alcohol and tobacco use, with evidence of public and vendor support for their efforts. In the government arena, a substantial amount of funds has been identified under the State Substance Abuse (SSA) program funds to develop a specific Government-supported substance abuse program.

The CARE/Mission Pacific program continues to develop a DVD on 'HIV101' in the Marshallese language. The DVD features local leaders and youth and has been developed through a continuous process of consultation and education on a range of HIV issues, including stigma and discrimination. It is hoped that the DVD will be able to be launched at the forthcoming PIJAAG meeting of all the northern Pacific countries in April 2010.

#### **National Commitment and Action: Counseling, Treatment & Care:**

The Ministry of Health reports that its capacity to provide counseling, referral and testing services, and enhanced access to treatment, has increased since the last UNGASS report was submitted<sup>24</sup>. Additional funding over the last two years, sourced primarily through the Global Fund and the Pacific HIV & STI Response Fund since 2008 has contributed to a range of events which have enhanced the capacity to deliver the national response. These included: increased supplies of test kits, additional ARV medication, including paediatric ARVs and STI medication; capacity training and onsite training in HIV, UNGASS requirements, SGS, STI management and VCCT; supply of a probtech machine for GC and Chlamydia testing in the Majuro laboratory; and additional program staff at Ebeye and Majuro Hospitals, supporting clinical, data entry and coordination functions across the HIV & STI Program; and support for the organisation and management of the forthcoming PIJAAG Summit.

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<sup>23</sup> Substance Abuse Epidemiological Profile 2009, Republic of the Marshall Islands, RMI Epidemiological Working Group, Marshall Islands Epidemiology & Prevention Initiatives, Inc, p13

<sup>24</sup> Majuro HIV Cases Update: Presentation to the HIV Clinical Care Team, MOH, STI & HIV Program Manager, November 2009

### ***STI Clinics***

Currently, there are four clinics offering counseling, referral and testing (CRT) services in relation to STIs in Majuro and another two in Ebeye. These are complemented by the mobile clinic team which provides services on an occasional basis to the outer islands. Specific services in relation to HIV testing are offered through the Hospital's STI and prenatal clinics in Majuro and the hospital clinic in Ebeye.

In 2009, the MOH, in collaboration with Youth to Youth, established a new STI clinic outpatient service through the YTYIH Resource Centre in Majuro. Although yet to be evaluated, anecdotal reports indicate it is considered successful in attracting clients and delivering services in a youth friendly manner.

There were concerns expressed that CRT services in the outer islands can be less regular, relying on the mobile services which are subject to the uncertainties of transport and staff availability.

### ***Counseling Guidelines and training***

In the last two years, the MOH has initiated a stronger focus on counseling, with counseling services in relation to STIs and HIV now offered, in Majuro, through the FP clinic at the hospital and YTYIH clinic. Currently 8-10 staff from MOH and YTYIH are enrolled in the PCASS training on counseling. It is planned that counseling services will be expanded to include the TB, family planning and inpatient clinic pending certification of the staff currently enrolled in the PCASS training this year.

Following the initial training of 13 government and CSO (YTYIH) health professionals, a Fiji based organisation, PCASS (funded through SPC's Response Fund) continues to offer support to 2 health professionals who intend to upgrade their training through an online course at the Diploma level.

The Ministry has drafted Guidelines on HIV Care and Treatment for all health professionals, outlining protocols for Counseling Referral & Testing and Clinical Care and Management services offered through the Ministry of Health's HIV STI & Family Planning Clinics. The Guidelines also define the health care professional's obligation to protect and promote the confidentiality of the patient, the importance of informed consent and their right to choose health care and medication treatment. Under the Guidelines, HIV screening is now mandatory for those with confirmed STIs; pregnant females; those seeking pre-employment and work visas as part of their immigration applications; college entrants; and TB cases. The opportunity for HIV screening is also routinely offered to 'walk-ins' at the STI and FP clinics.

Since 2008, all HIV & STD staff have undertaken a refresher training course on HIV treatment and care.

### ***Laboratory Services***

The main laboratory in the Marshall Islands is in Majuro. Global Funds approved the procurement of critical testing equipment to improve testing capacity for STIs in Majuro. However, the Majuro laboratory's capacity to conduct CD4 and viral load testing has

been constrained by limitations on the procurement of regular laboratory supplies. In the interim, samples have been sent to Hawai'i for testing, but this has not always been satisfactory. While there is a laboratory service in Ebeye, the MOH reports that Ebeye's laboratory has suffered from staff shortages and management constraints over the last two years. Access to laboratory services is more challenging for outer islands health care facilities.

### **Treatment**

In 2008, the Global Fund approved additional funds to support the supply/procurement of ARV medication and professional training. A review of Annual Program Reports from the STD & HIV program indicates the adequate supply of ARVs had been an ongoing issue since the 2<sup>nd</sup> Quarter of 2008. With the increase in funds, the Ministry now reports that it has sufficient capacity to supply ARVs to all who need them – on-island.

In addition, Global Fund monies facilitated access to training, in response to ongoing request for support from the STI & HIV clinical team. Clinical care managers participated in training in caring for PLWH and the identification of co-infections. Following the recognition of the outbreak of MDRTB in 2009, the MOH reports that the TB & HIV programs are collaborating better, with expectations that this will increase the health care system's capacity to prevent MDRTB.

MOH has also drafted a National Health Policy for Strengthening HIV & AIDS and STI Prevention, Care and Treatment. IN the context of the five priorities of the national response, the policy covers the principles which guide Counseling Referral and testing. Importantly, the policy identifies the principles which underlie the provision of HIV & STI services in prevention care and treatment: the right to health, the right to confidentiality, and the right to choose to partake of services. It also identifies the obligations of health care professionals to ensure that services are offered without stigma or discrimination to those with suspected perceived or known HIV status; and to discourage others from actions which may stigmatise or discriminate against those with HIV. It also defines the limits to any legislation which may address the criminalisation of HIV transmission, seeking to define criminalisation to cases where 'the index HIV infected person knows of his or her HIV status, Fully understands how HIV is transmitted, acts with intention to transmit HIV and does, in fact, transmit HIV to another person'<sup>25</sup>. This policy is intended to provide the basis for proposed legislation outlining health care workers' duty of care to people living with HIV drafted & prohibiting intentional transmission of HIV.

With the number of cases increasing, the MOH reports challenges arising in ensuring all avenues of partner/contact tracing are pursued as well as the quality management and care of patients. CD4 and viral load tests have been difficult to ensure, with reports of

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<sup>25</sup> National Health Sector Policy for Strengthening HIV & AIDS and STI Prevention, Care and Treatment. (Draft), August 2009, MOH, RMI

constraints in the laboratory testing procedures and capacity. Contact tracing in some instances has been challenging with patients sometimes unaware of how to trace previous partners, with some living in the outer islands and others off-island. Adherence and compliance with treatment regimes has been difficult, with reports in three cases of patients discontinuing ARV because of side effects, or a preference for local (traditional) medicines. Because of concerns about confidentiality, strategies have been put in place to ensure that client access to their clinical Care manager is handled as discreetly and sensitively as possible, whilst ensuring ongoing adherence and compliance with treatment regimes. This could be improved. With the increase in clinical care requirements, the HIV Program Manager reports that the combination of increased clinical care responsibilities together with the administrative burden of overall program management has created a heavy workload, sometimes at the cost of clinical care for clients.

### **National Commitment and Action: National Impact**

During the consultations for this report, government and civil society organisations presented anecdotal evidence of an increase in education and awareness programs targeting key groups – taxi drivers, sex workers, and youth – over the last two years. There is evidence of efforts to ensure a broad audience reach. For example, in 2008, the MOH offered HIV 101 and Awareness training program to 30 RMI National Police as part of policy of annual training on STIs and HIV.

Some stakeholders, particularly at the local College, reported an increase in the number and frequency of students taking condoms from the local distribution points. Similarly, although only a few months launched, anecdotal reports suggest that sales of the locally designed 'Defender' condom are solid, with one hotel reporting that they sell out as soon as they restock.

With the establishment of the HIV Core Care team in 2007, the MOH reports that allocation of additional funds through the Global Fund and the Pacific HIV & STI Response Fund in 2008 have enhanced the capacity of medical service providers to provide quality care for people living with HIV as a result of training, additional staff positions and the procurement of key equipment to support the laboratory's testing services.

Despite the anecdotal reports of an enhanced response, with indications of increased prevention activities, more specific targeting of screening and enhanced access to treatment and care, there is limited evidence available to assess impact of the implementation of the national response.

Whilst the 2007 DHS survey provides the opportunity for a 'baseline' of knowledge attitudes and behaviors related to HIV and STIs, there is no comparative readily accessible evaluation data available which indicates progress since then. Consistent & reliable, routine monitoring data is not easy to access. Whilst one profile on substance abuse was made available to the Report team, no program evaluations appear to have been conducted in the last two years (or earlier). The NSP M&E framework expired in

2009 and although revised internally, is in clear need of assessment, revision & updating through a broad consultation process.

## **V. Best practices**

### **Best Practice in Prevention:**

#### *Education and Awareness in Schools*

Over the last two years, YTYIH have established a routine presence at key high schools during lunchtimes, providing students with the opportunity to sit down with staff (who are also peers) from the YTYIH services to discuss HIV and seek advice on aspects of sexual and reproductive health. Staff at YTYIH believe that this has improved access to counseling and testing services. The critical condition which has contributed to the success of this program has been the support of the principals and teachers at the high schools. The view cited by the YTYIH staff is that 'students want more!'.

#### *Sex workers Intervention Project on Majuro and Ebeye*

In 2006, YTYIH, in collaboration with MOH and SPC, attempted to initiate an SGS survey of the 'hidden' population of sex workers across Majuro and Ebeye. Despite relative success in establishing relationships of trust, issues of legality, confidentiality and human rights stimulated discussions and concerns that proved insurmountable. Whilst the Marshallese sex workers were willing to participate, many of the non- Marshallese sex workers feared the possible consequences of deportation if they drew attention to themselves. As a result, YTYIH focused instead on the provision of education and training for Marshallese sex workers in Majuro and Ebeye over a number of evenings. Twenty women who worked as sex workers participated in the Focus Group Discussions on knowledge & protective behaviours. The response indicated that many sex workers report high risk sexual activity, with limited condom use and multiple partners. Although local Marshallese were reported to engage in transactional sexual activity, clients from other countries – particularly Americans, but also Filipino, Chinese, Kiribati and Japanese – constituted a major part of the client base for sex workers. Key recommendations emerging from the Focus Group discussions included the promotion of safer sexual practices through improving sex workers' knowledge of HIV transmission, enhancing their negotiation skills and making condoms more accessible.

#### *Communicating sensitively on sexual matters in mixed audiences:*

Radio is a key means of communication about community issues in the Marshall Islands. One NGO told the story of how community feedback of an HIV transmission and prevention message which was communicated through radio helped them to think more creatively about communications in the public domain, while still sending important messages about HIV prevention. Initially, the way a message on HIV prevention was communicated caused concern amongst parents, who believed that the message displayed a lack of respect for cultural values and ignored cultural sensitivities about what information is appropriate to share with children and mixed (male and female, especially related) audiences. Much of the feedback commented that 'its ok for me to

hear it, but not my children'. In response, the NGO revised the script to ensure the message was sensitive to cultural values: a message from the Secretary for Health preceded the core message, with the advice on the content of the following message and that suggestion that parents 'may not want your child to hear the following information'. This advice was positively received.

### **Best Practice in Counseling Treatment & Care**

Example 1: In 2007, the MOH, in collaboration with CDC, introduced a new CRT data entry form in a pilot study in response to the HIV Program manager's concerns about the quality of data entry at the STI & HIV Clinics. As a result of analysis of the results of the pilot study, the MOH subsequently revised its testing protocols in 2008 to remove compulsory testing for perceived low-risk groups (food handlers and middle school students), thus 'freeing up' limited staff resources to target the identified high risk groups – pregnant females, STD 'walk-in' clients and youth aged 15-24 yrs. The MOH believes that this has resulted in improved service delivery through their enhanced capacity to test key target groups, with information and results accompanied by counseling. It is hoped that this change, together with the ongoing counseling training for MOH and NGO staff employed in clinics in Majuro, will encourage and promote improved testing, diagnosis and care outcomes for all clients.

Example 2: Although only in its first few months of operation, the establishment of an STI Clinic at YTYIH, operating in collaboration with the MOH STI and HIV (Public Health) Program was also cited as an example of best practice. YTYIH staff are enthusiastic about the prospects of the service, and expect the clinic's operation to promote a more holistic service to be offered to YTYIH's clientele in the one location, thereby minimising the risk of clients 'dropping out' because they have been referred to a different service (location) for testing.

### **Best Practice in Monitoring & Evaluation:**

There were very few examples of how data had been collected and analysed to monitor and assess the effectiveness and efficiency of programs as part of the national response.

Example 1: During consultations with civil society organisations in compiling this report, however, the WAM 'Canoe program' was cited as a program which had demonstrated improved responses to substance abuse through the way it had measured outcomes against national indicators to show increased numbers of its trainees had achieved employment, returned to school or returned to the outer islands: all of which were considered successful outcomes by the Program.

Example 2: Similarly, the Marshall Islands Epidemiology and Prevention Initiative, which has produced the Substance Abuse Epidemiological Profile, 2009, was cited as an excellent example of data collection and analysis in order to provide the foundation for advocacy around substance abuse. This group is now actively lobbying for changes to the Alcohol and Tobacco legislation to protect and promote healthier choices, particularly for young people.

The conduct of the DHS2007 is a significant body of analysis; in the absence of the publication of the SGS survey on youth and prenatal mothers, this provides the only reliable sources of data on HIV and related knowledge behaviours and practices.

## **VI. Major challenges and remedial actions**

*(a) progress made on key challenges reported in the 2007 UNGASS Country Progress Report if any;*

The 2008 UNGASS Report identified four key challenges:

- Routine surveillance data collation, analysis and dissemination;
- Surveillance data or research on at-risk behaviours of specific population groups, such as visiting seafarers; and Marshallese who join the military – in order to develop appropriate prevention programs, such as; IEC materials and condom distribution to promote knowledge and behaviour change;
- Advocacy to acknowledge and address the existence and impact of commercial sex activities;
- An integrated and coordinate approach to implementation of the National HIV & STI Strategy under a cohesive framework.

### *Routine surveillance data:*

The concerns raised in the 2008 Report about the integrity of the routine surveillance data collection, collation, analysis and dissemination continues to be an ongoing issue. Whilst the creation of a new position for data entry (through Global Funds) together with the review of the CRT forms is reported by MOH to have alleviated some challenges, a review of the Annual Program Reports reveals continuing challenges in accessing reliable data for analysis. Data presented in the various MOH Annual Program reports often cited inconsistent dates or figures between the table and the narrative text. There was often insufficient information from which to draw relevant and meaningful analysis on, for example, screening trends.

There seems to be no central point for data collection, analysis and dissemination nor agreement on key data definitions. During consultations, it was unclear how data analysis may have informed the development of subsequent program strategy across complementary Program areas, such as the TB and HIV programs. During the process of data collection for this report, it was difficult to access data from the various MOH programs: each referred program area referred enquiries to other program areas. Representatives from the MOH continued to report that it was difficult to access data from Ebeye Hospital, even when this data related to programs for which they carried responsibility.

### *Strategies to respond to the needs of 'at risk' groups, including commercial sex workers:*

Many of those consulted during the compilation of this report cited the fear of stigma and discrimination, as well as an absence of specific information, as continuing and

significant barriers to open communication and consultation into the needs of groups perceived to be 'at risk', such as seafarers and sex workers – and also for people living with HIV.

This seems to have been a factor in the lack of progress in the development of appropriate strategies targeting vulnerable groups. For example, despite the allocation of additional funds by ADB to establish a seafarers drop-in centre, recent discussions between SPC and the Port Authority have revealed that there was not clear agreement across stakeholders as to whether the key target group for the program was local or foreign seafarers – a critical point, given the very different audiences composing each group. The delays of the last two years can be attributed to the misunderstanding on the agreement on the purpose, and consequently, the potential operations of such a centre.

Similarly, efforts by a collaboration of MOH, SPC and the YTYIH to survey the knowledge, attitudes and behaviours of foreign (and possibly illegal) sex workers, as well as local sex workers, in Majuro and Ebeye stalled due to fear of negative consequences if information about the individuals became known. With sex work an illegal activity in the Marshall Islands and a number of those involved thought to be involved in sex work also thought to be in the Marshalls illegally, the 'hidden' foreign sex worker population was reluctant to be involved in a survey, expressing concerns about legal and confidentiality issues. Although the local sex worker population was willing to participate, it was decided not to proceed with the proposed survey when its timing coincided with a Ministry of Immigration 'crack down' on the 'illegal' immigrant populations in the Marshall Islands. Subsequently, YTYIH undertook a series of Focus Group Discussions with local sex workers instead. The FGD discussions with over 20 local sex workers in Majuro and Ebeye identified some critical issues facing sex workers. While many sex workers engaged in commercial sex activities to generate an income to support their children, a number engaged in sex work because it was fun, or they need smokes or other things. Some engaged in sex work because they had no other work. Most received money or food for sexual transactions. On Ebeye, a significant number of sex workers reported that their clients were foreigners, with the majority coming from Kwajalein Island. Whilst nearly half of the sex workers reported using a condom 'sometimes' when they had sex, a clear majority did not use condoms – and most often, because their partner did not want to use one. Often, they were not prepared with a condom, or none was available. There was a critical need for more HIV & STI education and information, targeting sex workers and their clients; training in negotiation skills; and improved access to condoms and screening services for all sex workers.

*An integrated and coordinated approach to implementation of the National HIV & STI Strategy under a cohesive framework.*

In 2008, the UNGASS Report commented on the need for an integrated and coordination approach to implementation of the National HIV & STI Strategy under a cohesive framework. Two years on, this remains an issue of concern. Each of the Quarterly STD and HIV Program Reports for 2009 and continuing into 2010, reported on

the absence of a central coordinating authority, be it a National AIDS Council or Community Planning Group, to lead the national response as the most 'important challenge' that needed to be addressed 'as soon as possible'. In its absence, the National Strategic Plan had not been formally revised, and a new plan for 2009-2013 has not been developed. The delays in establishing a national strategic coordination and leadership group is considered to continue to impede program development and implementation to improve the effectiveness of the national response. For example, in recognition of the nascent development of the civil society sector, SPC has offered a substantial sum of money to MICNGOs for the purpose of strengthening its organisational capacity so it may, in turn, undertake a role as a central capacity development organisation, supporting and strengthening the civil society sector to build program management and technical skills to respond to HIV. SPC and the Ministry of Health have not been able to reach agreement on the transfer of funds; the absence of a CPG or NAC has been one of the barriers to approving the transfer of funds.

*(b) challenges faced throughout the reporting period (2008 - 2009) that hindered the national response*

### **National Impact – Treatment & Care**

Despite the relatively small numbers of actual cases, the increase in the number of recent cases could be considered a concern given the trends over time. However, there is limited evidence of which to base trend analysis. There is a need for more sensitive data collection systems to ensure rigorous data is available and utilised for analysis. The increase in cases diagnosed in 2008-09, particularly in light of the emphasis on diagnoses arising as a result of 'walk-ins' and consequent contact tracing, needs investigation. For example, the death of the 17-month old child in Ebeye, in the absence of further information around the mode of transmission, requires investigation to help us understand whether the health care system could have assisted this child better.

Further, the indications are that very few cases in the last two years were identified through the existing routine or mandatory screening programs. One of the ten new cases was identified through the mandatory ANC screening. Three cases, however, emerged as a result of 'walk-ins', relatively 'late stage' symptomatic presentations at the hospital outpatients or STI & HIV clinic. A further five cases arose as a result of contact tracing partners of these 'walk-in' late presentations. These require investigation to ascertain the relationship between the apparent 'late' presentations and the existing education and screening programs. Similarly, the diagnosis of a child of 3 months, outside the antenatal care screening program, which led to his mother's diagnosis, also raises questions about the situation for those females (and their children) who do not access antenatal care. There is a concern that those in the outer islands may not always have access to the health care they require. Given the scattered populations and available resources, considered strategies are required to ensure appropriate access to health care, with a focus on helping the populations in the outer islands to develop sustainable strategies to improve their health. A focus on education and prevention is critical.

There needs to be a review of linkages across the awareness, education, referral and screening programs to reassure whether programs are both targeted and supporting each other appropriately. It would also assist to review the way screening/testing data collection and analysis, to confirm that data is rigorously and strategically recorded, interpreted, disseminated and analysed to inform (or re-align) program strategies. Given the small number of actual HIV cases so far recorded, even with the recent increase in reporting, perhaps a useful way of collating information could be to undertake a 'case series' investigation as a precursor to establishing a more rigorous surveillance system and/or revised program strategies.

### **National Impact – Prevention**

Consultations during this Report identified anecdotal data of vulnerability & risk amongst some groups, such as sex workers and seafarers; but apart from the findings of the Focus Group Discussions led by YTYIH with sex workers, there is limited information and even less rigorous research evidence of the particular knowledge, attitudes and behaviors of perceived 'at risk' groups. In the absence of rigorous evidence, sometimes, as the Seafarers Drop-In Centre example shows, strategies can go awry, despite the availability of funding. The MOH needs to consider how to build a stronger research /evidence base so that already approved funds can be committed to more usefully build targeted programs for such groups.

Similarly, while the consultations revealed that education programs at the schools and counseling services in most of the clinics have increased, with training in progress to consolidate the counseling skills of a number of government and NGO staff, the limited information available about programs and services in some areas suggested gaps for some populations, such as the rural areas (outer islands), especially for women but also for men; young women; and young men, especially those who have left school & are not employed. The 2007 DHS data<sup>26</sup> indicates that these groups are less likely to have the knowledge of HIV transmission and risk behaviors or prevention approaches or the access to services to ensure adequate screening and testing (as well as care, should it be necessary). The final validation workshop held during the compilation of this report also identified that the disabled members of the community were often forgotten, and proposed that there need to be more consideration given to education programs and services which specifically respond to the needs of the disabled in the community.

### **National Impact – Coordination and leadership of the Response**

During the consultation for this Report, the initial response of many stakeholders was that there was little, if any, collaboration to effect the national response. However, as the consultation probed, particularly in the two consultation workshops with representatives of government and civil society organisation, stories emerged of collaborations between the MOH and some NGOs (particularly YTYIH), and between NGOs, to implement programs which form part of the national response. It became

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<sup>26</sup> Cite the tables....

evident that there are a number of dedicated individuals across both government and CSOs working to prevent the spread of HIV and reduce its harm. Others, particularly in the CSO sector, are working in areas that complement and respond to underlying issues that impact/influence the capacity to respond to, and reduce, the spread of HIV.

Despite this, there was a strong demand from each sector for more leadership and better collaboration between government and civil society. As the responses to the NCPI Questionnaires (Part B) demonstrate, many commentators in the civil society sector were not familiar with the National Strategic Plan for HIV nor the extent of programs and funding available to respond to HIV. The current National Strategic Plan on HIV expired in 2009. Despite an internal review within the Ministry of Health's HIV & STD program, it was apparent that not many in Government or CSO were confident of what had been achieved under the response for the last 4 years. In fact, many stakeholders, particularly in the CSO sector, were pessimistic, and unaware of much that had been achieved, such as revitalised access to treatment and care on the Marshall Islands. Others cited the need for stronger leadership to strengthen support nationally to prioritise the commitment to respond to HIV. The 2006 NSP proposed a 're-invigoration' of the Community Planning Group, with the support of the Ministry of Health and the Centre for Disease Control and Prevention. However, the CPG is yet to be re-convened. The reasons for the delays are not clear: the impetus to reinvigorate the CPG seem to have lapsed, with some suggestion that the crisis of an increase in the number of TB cases, including the threat of Multi-Drug Resistant TB has overshadowed the capacity to address HIV related issues. With the allocation of ongoing funds for TB & HIV under the Global Fund in 2008, a discussion to reinstitute the CPG or a CCM (as required under the Global Fund), complemented by a single national coordination body with responsibility for oversight of strategies (funding and programming) for both diseases, is underway between the donors and the Ministry. The dilemma of balancing transparency in selection and administration practice with substance and timeliness remains a challenge. The Ministry agrees that development of a coordination group – be it a CPG or a NAC – is critical to enhance coordination and implementation of the national response across government and civil society. In the course of the compilation of this Report, the Ministry has proposed that it will convene an interim body to ascertain the purpose, membership, function and operations of such a group, with clear Terms of Reference, roles and responsibilities defined and agreed.

A review of the financial allocations to RMI to support implementation of the national response shows that despite the commitment of substantial sums by international donors and others, there remains significant under-spending in key program areas. Despite the additional allocations of funds by SPC, CDC and the Global Fund over the last two years, less than half of those funds have been drawn down to support program implementation, raising concerns about the capacity of the MOH to maximise the opportunities available. A review of the national response, in light of current funding commitments, would assist also to develop a better appreciation of the reasons for the discrepancies between the approved funds and program delivery – and assist to refocus

the strategy and resources accordingly. In light of the increase in cases diagnosed in the last two years, this report suggests that this is urgently required.

### **National Impact – Reducing Stigma and Discrimination, Protecting the rights of People Living with HIV**

There remains a strong need to strengthen the protection available to people living with HIV to provide support for protection from stigma & discrimination. The 2006 ANC SGS shows that beliefs that create stigma are widespread. The 2007 DHS shows only 4.3% of women and 7.7% of men expressed accepting attitudes towards positive people on all 4 nominated indicators<sup>27</sup>. While the National Health Sector Policy reflects a commitment to develop a legislative framework to protect and support people living with HIV, it is still at draft stage. Much work is required to move it to legislation. Advocacy is likely to be required, across various Ministries of Government as well as across civil society and within the Nitijiela, to ensure support for the protection of people living with HIV. Legislation will support current education programs to improve knowledge and reduce unnecessary fear of HIV – need to balance education with advocacy for legislation to protect the rights of people living with HIV and their families.

### **National Impact – Monitoring and Evaluation**

There is very little evaluative data on which to assess the achievement of the national response. While the conduct of the 2007 DHS Survey provides a substantial body of analysis from which to draw; and the development of the Marshall Islands Epidemiology and Prevention Initiatives signifies a hopeful move towards encouraging more reflective practice based on rigorous analysis of the evidence, the delays in publication of some of the available epidemiological analysis data, such as the 2006 SGS surveys on Prenatal Women and on Youth is concerning. The absence of reliable data within the MOH in relation to specific program areas, such as the services to Outer islands or in Ebeye, is a concern. It is not clear how the experience of programs is shared, or on what basis decisions about the quality of services are made or how resources for program delivery are allocated.

*(c) Concrete remedial actions that are planned to ensure achievement of agreed UNGASS targets*

Key areas which require consideration for program review and improvement and which may benefit from dedicated funding commitments would include:

#### **Treatment care and support:**

- The HIV Clinical Care Team should undertake a case series review of the current cases should be undertaken to build a more informed understanding of the links

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<sup>27</sup> In summary, these indicators encompass attitudes to: willingness to look after a family member with HIV virus in own home; willing to buy fresh vegetables from a shopkeeper with HIV virus who is not sick; agree a female teacher with virus can continue to teach; would not want to keep secret that a family member was infected with HIV.

between education, screening and diagnosis. It may be that support from SPC's treatment and care advisor would be of benefit. This review would assist to identify:

- The effectiveness of linkages (or absence of) between current strategies in education, screening and testing
- Strategies to enhance the linkage between education and behavior changes activities, particularly for women and young men out of school.
- Enhanced counseling and screening programs – particularly targeting groups not currently screened.
- Explore the opportunity to review the adherence to the National Guidelines for Treatment Care and Prevention; and to improve/extend services for screening, treatment and care in the outer islands.
- There is a need to strengthen the involvement of people living with HIV in all aspects of the national response. The investigation of the need for the establishment of programs to support home and community care for people living with HIV could be a starting point. Exploration of the reasons for the reluctance to disclose publicly may also be useful. These may be areas for linkage with civil society.

#### **National Coordination and Planning:**

- Review the implementation and achievements of the National Strategic Plan on HIV 2006-2009 – taking the opportunity to develop a new NSP and national monitoring and evaluation plan.
  - This would include the development of a strategy to improve the data surveillance, monitoring and evaluation processes and training skills – perhaps extending to revitalize or establish a Health Information and Management System, with training and capacity building to ensure the data is accurately entered, analysed and disseminated. A review of the MESS recommendations to ascertain the status of the implementation of the recommendations (and their continuing relevance) is suggested.
  - Explore the establishment of a national coordination authority with responsibility for strategic oversight of the implementation and evaluation of the National response to HIV; this committee may also include responsibility for strategic oversight and leadership of other priority focus diseases, such as TB.
  - This would include a review of program effectiveness and resource allocations.

#### **Civil Society engagement in the national response:**

- Investigate strategies to strengthen the capacity of civil society to respond to HIV – particularly in the prevention and advocacy areas.

- Advocate for programs to reduce stigma and discrimination - including advocacy for legislative protection for people living with HIV.
- Explore ways to support and strengthen the services and programs operating in Ebeye.
- Undertake research into at-risk groups, such as sex workers, seafarers and young men in urban and rural areas to better understand their vulnerability and develop appropriate interventions.

## **VII. Support from the country's development partners**

Between 2008 and 2010, two key technical agencies – the Centre for Communicable Disease Control in Atlanta, and the HIV & STI Program at the Secretariat for the Pacific Community – supported RMI's implementation of the National Strategic Plan 2006-2009. In addition to technical advice, these agencies have supported program implementation with financial commitments from 10 different funding programs:

- CDC providing funding support in relation to HIV prevention and surveillance; STIs prevention, diagnosis and care; the HIV Care II (Ryan White) Funds, supporting access to ARV medications and treatment;
- SPC, through the AusAID/NZAID-funded PRHP Grant Scheme, providing ongoing funds to prevention activities implemented by NGOs Youth to Youth in Health & CARE Project; and then,
- Through the Global Funds, support for enhanced access to ARVs for increased treatment and care; improved coordination, through support to three new positions in MOH to support HIV and TB; and improved counseling testing and referral, with funds supporting ongoing counseling training for MOH & NGOs staff.

In addition, SPC, through the new joint donor Pacific HIV & STI Response Fund, has allocated funds to RMI support the implementation of the national response in accord with activities outlined in the National Strategic Plan; civil society capacity strengthening with funds to support an 'umbrella' CSO to facilitate the HIV response in civil society organisations; and additional funds to develop and deliver HIV activities in civil society. Negotiations are ongoing between SPC and the MOH to secure these funds and their commitment to programming.

The information available from RMI and SPC indicates that total approved donor allocations of US\$1,355,018 were available to RMI for the national HIV response in 2008-2009; these funds were sourced from 10 different funding programs and

channeled through two technical agencies, SPC & CDC<sup>28</sup>. Details of disbursements were not available across all funding programs. Available data indicates that total of US\$504,635 had been acquitted to March 2010. The total funds allocated by SPC through the Pacific HIV&STI Response Fund are US\$583,000. Draw down of these funds is yet to be agreed with RMI. If we consider the total amount of funds approved less funds acquitted and less funds yet to be negotiated, the amount approved but not drawn down by RMI is US\$267,383 outstanding which could have been utilised to implement the national response in RMI. With the addition of the funds available and yet to be negotiated, this amount increases to US\$850,383. Funds under the CDC Ryan White were not available in 2008-2009 but are expected to be negotiated in 2010.

The gap between the level of funding approvals and actual expenditure in nearly all program areas over the last years should raise concern. The Global Fund and CDC Grants are significantly under-spent. The approved allocations under SPC's Response Fund are yet to be drawn down – despite being available for the 12 months. Although there is evidence of many improvements in prevention, counseling and testing and treatment and care under the national response, there remains much that could be done to continue to improve the quality and implementation of the response. Donors need to consider support for a joint review of the effectiveness of current program implementation and funding allocations to confirm and clarify that funds are appropriately targeted and effectively utilised to implement agreed and effective programs. The forthcoming PIJAAG meeting in Majuro presents an opportunity for donor and technical development partners to establish a mutual commitment to collaboration and cooperation in relation to support for ensuring effective development outcomes in RMI's HIV sector.

## **VIII. Monitoring and evaluation environment**

Although the National Strategic Plan 2006-2009 proposed a draft Monitoring and Evaluation framework, this does not appear to have been utilised over the last four years. In July 2008, SPC supported the RMI MOH to assess its monitoring and evaluation system (MESS) as part of preparations for the transfer of approved Global Funds to RMI. The information identified in that assessment, known as the MESS Report, provides the basis for the following summary of the current approach to M&E in RMI.

*(a) an overview of the current monitoring and evaluation (M&E) system;*

The collection and recording of STD and HIV data is guided by the National Guidelines for HIV Care and Prevention (s14). Three systems are used to collect STD and HIV related

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<sup>28</sup> This is estimated on the basis of advised allocations: however, some allocations have been made over three years, and others over one; in the absence of clear budget and programming information, an approximation has been made for the purpose of comparison:

data in RMI's MOH – two in Majuro, and a third in Ebeye. A possible fourth system was also identified, the CDC Pacific Islands HIV test data.

In 2008, the Ministry planned to develop a Health Information System to improved overall data collection and analysis. There were plans to develop a standardised reporting system, the National Data Reporting system for HIV & AIDS program with support from CDC (or SPC). Neither system appears to have been implemented in the 18 months since.

*(b) challenges faced in the implementation of a comprehensive M&E system*

The MESS Report identifies a number of challenges in the current system of data collection, analysis and reporting within the Ministry:

- Whilst the STD & HIV program used a patient identification number to reduce the potential for duplication, this practice was not consistently followed in the broader health care system.
- The sharing of patient identification numbers across the three key centres of service delivery (Majuro, Ebeye and the Outer Islands) appeared limited; and the sharing of information between these centres in relation to mutual patients did not appear to be common.
- Whilst the STD Protocol and the CTR protocols provide advice on most relevant definitions for data recording, some definitions (such as what constitutes a person counseled and the definition of post-test counseling) required clarification; and the adherence to these definitions across the various program areas – such as the laboratory and the STD clinic – needed review to confirm adherence. For the laboratory and the clinic it is not clear whether data is aggregated or whether individuals are being tested more than once are counted more than once. The TB Quarterly form was suggested as a good example of a form for the aggregation of data in all program areas.
- Information had only recently been computerised: the detailed database for patient information was yet to be implemented (as of mid-2008). As a result, there was no evidence of monitoring and reporting on patient follow-up although the small numbers and personal contact with HIV clients suggest that this was being pursued in relation to HIV cases, although possibly less so with STI cases.
- In the absence of a dedicated health planner or statistician within the Department, data was being forwarded to the EPPSO via the Office of Health Planning and Statistics for analysis.
- More training was needed to build capacity across all program areas to aggregate, analyse, review and verify data. There was evidence of some on-the-job training in the laboratory. There is no centralised aggregation of training undertaken and completed.

- Security of hard copies of data is an issue, with reports of lost or missing data records in some program areas.
- There is no record of condom distribution to clients by MOH; rather, condom supply from UNFPA is monitored.

In relation to data collection, analysis and reporting within civil society, the MESS report found the following:

- Despite efforts to clarify operational definitions of the target audience and services in light of national and international standards, this was only partly met; there was no consistency in definitions or measurement across the civil society sector – attributed in part to the absence of an agreed M&E framework.
- However because of the size of the sector, most NGOs were familiar with the services each offered, minimising area sofa overlap; although double counting of individuals could occur due to the lack of quality record keeping.
- Whilst data collection is expected within each NGO, it is rarely included in job descriptions; there is no evidence of standardised data collection forms; or of national forms to guide evaluations. NGOs tend to rely on donor forms and reporting templates to capture most data – and these are not necessarily consistent across donors. Varying levels of review of data and quality assurance prior to submission to donors or others occurs.
- A record of condom distribution is kept , with details of locations, age and gender, as well as inventory stock list
- Some NGOs keep a record of training they have conducted, and ‘double-counting’ is monitored largely through personal connexions rather than any formal process.

In summary the MESS suggested the following strengths and weaknesses:

STRENGTHS	WEAKNESSES
Raw data is mostly being collected in relation to age, gender, location and risk factors.	There appears to be no data collection concerning follow-up (for STD and non-positive HIV tests)
On-the-job training for staff appears to be outstanding, considering staff often lack experience and formal qualifications	There does appear to be potential for double-counting, with patients being issued with more than one hospital ID number
Initiative has been taken in the area of human resources, to identify the needs of staff	Training provided to staff appears to be ad hoc, with little information-sharing between department and HR concerning training initiatives, and little measurement of the effectiveness of the training provided

There are plans for an overall health information system which should address some of the issues relating to data collection, analysis and double counting.	There is no monitoring of the quality of services such as VCCT to ensure that they are meeting minimum standards
Most raw data collected appears to be retained	There seems to be a general lack of capacity in relation to both basic computer skills, and in data collection and analysis
Centralised supply management system currently under development has potential to improve issues relating to stock-outs and improve cooperation and efficiency in purchase of goods for all three bureaus	Systems for aggregation, cross-checking and ongoing analysis of data (at all levels) need to be strengthened
	More space and security around storage of data appears to be necessary
	Improved data sharing between Government and non-Government partners and the three bureaus (Majuro, Ebeye & outer islands) is needed

*(c) remedial actions planned to overcome the challenges*

The MESS Report agreed on the following actions to strengthen the data collection and reporting systems:

Equipment and infrastructure:

- Procure two filing cabinets for storage of hard copy service delivery data.
- Purchase of desktop computer and desk for Ebeye HIV Coordinator to facilitate improved storage and monitoring of data.
- Expand and secure appropriate storage space and furniture (e.g.: coolers) for all commodities and laboratory stock to facilitate management of inventory.

Staff:

- Identify a dedicated person to cover the M&E aspects of the national programme (including reviewing and aggregating data).

Protocols and Guidelines:

- Complete and endorse STD protocol and provide further training on minimum data set and case definitions (for both Government and NGO staff) ensuring national and international standards are met.

- Creating national reporting procedures for both clinical and non-clinical service delivery (for both Government and NGOs) - including standardised templates for data collection, channels for national aggregation of data, filing and storage guidelines and computerised back up of data (in the M&E framework for HIV, STI and RH) Support creation of a centralised, streamlined, national stock inventory system.

National Planning:

- Review and update RMI's NSP and operations guidelines.

Training:

- Further training for VCCT/CTR staff (Government and NGO) to meet minimum requirements (including collection of data concerning risk factors for HIV and STD infection, improved follow-up and contact tracing).
- Basic computer training and typing for community and clinical and laboratory staff.
- Training for supply staff on materials management and MSDS (Material Safety Data Sheets).

*(d) highlight, where relevant, the need for M&E technical assistance and capacity-building.*

The Report recommended:

- the sourcing of technical assistance to undertake a needs assessment of the professional development needs of HIV and STD staff, and development of costed action plan (incorporating capacity development for HR staff in this area).
- recruitment of a health statistician to support and mentor staff in data collection, analysis and reporting.

## Annexes

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

Consultations and preparations for the country report to monitor the progress towards implementation of the Declaration of the Commitment on HIV & AIDS in the Republic of Marshall Islands began when UNAIDS Pacific convened a Pre-Planning meeting in August 2009. The meeting was attended by over 30 representatives of Government and Civil Society Organisations based in the Republic of the Marshall Islands. During the Pre-Planning Meeting, stakeholders reviewed the UNGASS data tools and identified relevant sources of data across the different programs in response to HIV. Two focal points from RMI were appointed, representing civil society and government respectively. The focal points were responsible for distributing and collecting the National Composite Policy Index Questionnaires (Parts A and B). The MOH agreed to identify a third focal point from its finance team to ensure completion of the National AIDS Spending Assessment Funding Matrix.

The participants also reviewed the Indicator table. Overall the participants agreed to report on 17 of the 25 indicators. Some indicators, such as those concerning injecting drug use were not deemed to be applicable to this setting, while others, such as for MSM and sex workers, it was identified that these are difficult populations to access and so far, no data has been able to be collected in these populations. In relation to a number of Indicators which relied on population estimates, it was agreed that because RMI's population size and prevalence is too small to use the recommended estimation models, the data available regarding the actual patient records would be entered with an explanation, as per the Iran "Best Practice" UNGASS Report from 2006.

As a final point of the meeting, the Outputs Checklist was reviewed and timelines for data collection, narrative reporting, and validation processes were agreed.

In February 2010, UNAIDS, in collaboration with RMI's HIV Program Manager, commissioned a Short Term Advisor (STA) to assist RMI to finalise the collection and analysis of the identified data and compile the narrative report, including the assessment of progress in relation to the core indicators and examples of 'best practice' stories, of achievements and challenges.

The STA and RMI's HIV Program Manager led this process between 15-28<sup>th</sup> February, 2010. During this time, three consultation workshops were held with Government and Civil Society stakeholders, with the first two workshops focused on each respective stakeholder group, and the final workshop bringing together all stakeholders to present preliminary findings for validation by the stakeholders.

The consultations engaged representation from many key stakeholder agencies in Government and Civil Society, and included: the College of the Marshall Islands, CARE program/Mission Pacific, Wutmi (the national women's group advocating to reduce violence to women), WAM (a local organisation advocating to improve the social development of young women and men, through training and support), Marshalls

Islands Epidemiology and Prevention Initiatives, (a local organisation advocating to reduce substance abuse), Youth To Youth In Health (the key HIV prevention organisation, working primarily but not exclusively with youth); the Attorney General's Dept; the Ministry of Internal Affairs; the Ministry of Education; and representatives from a range of clinical and public health programs in the Ministry of Health, including: TB Clinical Care, Infection Control, HIV Treatment and Clinical Care

In addition, because a number of key stakeholders were unable to attend the consultation workshops due to other commitments, semi-formal interviews and meetings were held with representatives of the following agencies: the Directors of the TB Program and the Laboratory and Outer Islands Health Services; senior health practitioners from the Family Planning, Public Health and Health Education and Promotion Programs; the Health team in the Ministry of Education; the Adolescent Health Worker and Peer educator at Youth to Youth In Health; the Director of the Port Authority; the Health advisor at EPPSO; and the Acting Executive Director at MICNGOs, the local NGO umbrella organisation.

The NCPI Questionnaires (Part A) were circulated amongst all Government representatives who were invited to the consultation workshops, prior to the arrival of the STA in February. Due to the transfer of the focal point for the Civil Society to another role shortly after the pre-planning meeting in August, the NCPI Questionnaires had not been circulated with the identified CSOs prior to the arrival of the STA. Following discussions, MICNGOs undertook to circulate and collect the completed NCPI Part B Questionnaires amongst Civil Society Organisations. A total of 10 completed questionnaires were received, 1 from Government and 9 from CSOs.

Although the NASA had not been completed by the time the STA arrived in-country, a meeting with the MOH financial managers provided financial information for the various donor and national programs for the years 2008-2009. The availability of financial data was hampered by the difficulty in accessing Financial Status Reports from the Ministry of Finance (MOF). With the support of SPC's Northern region Financial Manager, this information was later forwarded for analysis following the in-country visit.

The data was analysed by the STA on her return to base, with a draft report forwarded to the MOH for their endorsement in the week of 22<sup>nd</sup> March. The draft report was also circulated to SPC's Northern Regional Program and the UNAIDS Pacific office for comment. Following feedback and the endorsement of the Secretary for MOH in RMI, the HIV Program Manager for MOH in RMI finalised the report and uploaded the document to the UNGASS website on the 31<sup>st</sup> March 2010.

**ANNEX 2: National Composite Policy Index questionnaire**

*Please submit your complete UNGASS Country Progress Report **before 31 March 2010** using the UNGASS reporting website ([www.unaids.org/UNGASS2010](http://www.unaids.org/UNGASS2010)).*

*See NCPI Questionnaires Part A and B in attached documents.*