

Marshall Islands Report NCPI

NCPI Header

COUNTRY

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:

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Describe the process used for NCPI data gathering and validation:

The Focal Point for RMI attended a UNAIDS/SPC training workshop in Nadi in late January to discuss the purpose of the GAPR. Subsequently the consultant and focal points from Government and the NGO sector agreed on the process for collecting data through the Surveys. Meetings with each of the three key groups of stakeholders were arranged: the NGO Sector, Government, and those from the NGO and Government and private sectors who might be able to contribute to sourcing data for the indicators. The survey instrument was trialed with each group; and minor amendments made to improve its accessibility in the Marshallese context. The Survey instruments were then distributed widely across each stakeholder group. The focal point from Government and NGO sector then monitored completion and submission of the surveys over a three-week period, encouraging stakeholders to respond to the Survey. Surveys were submitted either electronically or in hard copy. The Consultant reviewed the surveys and aggregated the data for presentation at the Validation meeting as discussed below. All Ministries, civil society organizations and private sector individuals who were involved in the meetings or other communications to discuss the purpose of the Global AIDS Progress Report, assist with the data collection process, or to whom a survey was distributed, or who responded to the surveys, was invited to the Validation meeting. Prior notice of the meeting had been advised during the preparation meetings. A soft copy of the aggregated final draft survey Part A and Part B was distributed by email prior to the meeting. A hard copy of the aggregated final draft survey, together with the draft indicators matrix, was available at the meeting. The consultant presented the key ratings and responses in relation to each category in the surveys, ie categories I-VI in Part A and categories I-V in Part B, identifying the achievements and challenges noted for each effectiveness rating; and briefly discussing key issues raised throughout the response to the Category. The group discussed each rating and the associated achievements and challenges to confirm, explain and verify the information. The ratings were then endorsed by group agreement. When necessary, representatives from the Ministry of Health translated questions and comments to encourage discussion in Marshallese. The final aggregated survey was completed following the meeting and forwarded to the Focal Points for upload.

Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:

The process for data collection and analysis took four clear steps to ensure that disagreements were either prevented or appropriately resolved. These were: • Agreement on the method and approach to all aspects of the data collection, analysis and reporting process for the Global AIDS Progress Report with the Focal Points to confirm the appropriate people to contact, and the appropriate process for communication. The Focal points communicated through email and face-to-face with all stakeholders as necessary. • Agreement on the timelines for data collection, analysis and reporting • Agreement on the survey tools and other data collection processes and relevant stakeholders; • Conduct of a validation meeting to confirm key ratings on the effectiveness of all elements of the response with key stakeholders. • Confirmation on inconsistencies or gaps in information on the response, such as funding allocations or treatment approaches, were cross-referenced with donors and other relevant technical stakeholders as possible, time and availability permitting. • Confirmation by the Focal Points prior to upload of all key documents The validation meeting presented an opportunity for many stakeholders to build a more comprehensive picture of the response. Not all stakeholders were aware of the breadth and depth of services and programs delivered under the response. This was demonstrated by the broad range in the responses to most of the questions relating to effectiveness ratings. One participant proposed changing the rating to reflect one 'true' rating – other members of the group argued that the range of responses should be recorded because this more accurately reflected how the issue was rated, and it reminded all of the breadth of areas that needed to be addressed. With the online reporting tool permitting only one rating entry, the consultant and focal points identified the median rating as the relevant rating for the purpose of upload. However, for the country's purpose in taking the 'lessons learnt' from the Global AIDS Progress Report forward, the range of responses will be used to inform the development of strategic approaches under the National Strategic Plan, which is currently in development.

Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):

Three key issues about the survey format and the ease with which the questions might be understood – and which therefore might affect the quality of the overall responses were: • the complexity of the survey questions, particularly for those not familiar with English as a first language or the ‘organisational culture’ of data collection and analysis through surveys; • the short period of time available to distribute and respond to the surveys; and • the wide-spread knowledge and availability of current data on the response. To address these concerns, there was substantial discussion with all stakeholders about the survey questions and the ease of comprehension during the preparations. This issue was also discussed during the Validation meeting. Some of the key points for UNAIDS to note for reviewing the quality and appropriateness and relevance of the survey instrument include: • A substantial number who responded to the survey spoke English as a second language – with the short timeframe for completion of the GAPR process and the limited resources available, and stakeholders other existing commitments on the ground, it was not possible to translate the survey document or to conduct participatory processes as an alternative. Some of the questions are double-barreled or sequenced and require an overview of the whole series of questions to fully respond. This needs to be addressed so that the survey is easier to understand; alternatively, the time available for technical support needs to be extended, so that a different process for answering survey questions can be utilised. • Many of the questions did not permit for an alternate answer of ‘Do not know’ or ‘Not applicable’ which risked leaving many marginalized by the survey questions because they could not answer at all, or honestly. We therefore introduced these options into the survey template for some questions. However, this still risked many feeling marginalized because it seemed that they did not know enough about the response – which meant the survey was not an effective capacity development instrument, which is important when you are trying to build an effective response across civil society and government with varying capacity across stakeholders. • Whilst many HIV & STI programs in Pacific countries are small overall, these programs still needs to provide for the possibility of delivering the full range of possible services and programs required for a comprehensive response: i.e., the full span of prevention through to treatment and care. In addition, many program stakeholders wear many hats across multiple program responsibilities in addition to HIV & STIs. Stakeholders are often stretched, and even if they are comfortable responding to a survey in English, they do not always have time. • In a small community, respondents are sometimes careful about their responses because it is easy to identify a person who may be associated with a concern raised. This can alter the accuracy or comprehensiveness of responses, even if the responses are ‘anonymous’. • With capacity varying greatly across Government and NGO stakeholders, some ratings reflected the absence of communication between those who were intimately involved in program delivery and those who were on the periphery fo the HIV & STI response, rather than a true or accurate picture of what was happening in the response. Although a valuable perspective which demonstrates that communication is an issue, responses may not always reflect on the full range of services and programs in place. • In low prevalence and low resource settings, which is common in the Pacific, the role of STIs and broader sexual and reproductive health capacity as well as overall health systems infrastructure and capacity, are critical in addressing the HIV response. Often, limitations in the response to HIV reflect on limitations in overall systems and capacity in the broader health and other sectors. This connection was a gap in the survey instrument; again, we modified the survey to accommodate this to some degree, but we may not have satisfactorily done so and we suggest it needs review for next time. • Related to this, with capacity varying across Government and NGOs, often the data required to respond fully to the GAPP process is often not readily available; and with competing demands on the limited group of stakeholders common to low resource settings, it is difficult to pull so much information together in a short space of time: re-consideration of the timing, the process, or support, is necessary.

NCPI - PART A [to be administered to government officials]

Organization	Names/Positions	A.I	A.II	A.III	A.IV	A.V	A.VI
Ministry of Health	Public Health-TB Program	Yes	No	No	Yes	Yes	No
Majuro Hospital Laboratory	Manager	Yes	Yes	Yes	Yes	Yes	Yes
Majuro Private Clinic	-	No	Yes	No	Yes	Yes	No
Health Promotion-MOH	NCD Program	Yes	No	No	Yes	Yes	No
Taiwan Health Centre	Project Manager	Yes	No	Yes	Yes	Yes	No
Ministry of Health	HIV Program, Ebeye & Majuro	Yes	Yes	Yes	Yes	Yes	Yes
Single State Agency for Substance Abuse Prevention and Treatment services	Director	Yes	Yes	Yes	Yes	Yes	Yes
Ministry of Health	JOCV	Yes	No	No	Yes	Yes	No

NCPI - PART B [to be administered to civil society organizations, bilateral agencies, and UN organizations]

Organization	Names/Positions	B.I	B.II	B.III	B.IV	B.V
Waan Aelon in Majel Program	Female Coordinator	Yes	Yes	Yes	Yes	No
Majuro Cooperative High School	Principal	Yes	Yes	Yes	Yes	No
Youth to youth in health	Administrator	Yes	Yes	Yes	Yes	Yes
Marshall Islands Epidemiology & Prevention Initiatives Inc. (MIEPI)	Projects Manager, Senior Data Analyst	Yes	Yes	Yes	Yes	Yes

A - I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?

(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2):

Yes

IF YES, what was the period covered:

Draft National Strategic Plan 2012-2017

IF YES, briefly describe key developments/modifications between the current national strategy and the prior one.

IF NO or NOT APPLICABLE, briefly explain why.:

Two respondents were familiar with implementation of the National Strategic Plan 2005-2009, with one noting subsequent activities from a revision in 2009. A small group of respondents – largely those associated with the NAC - were familiar with the current ongoing work to develop the 2012-2017 National Strategic Plan. This group reported that the current NSP would focus on more culturally-appropriate strategies with five main objectives: a) stronger governance and coordination; b) effective strategic information and communication (M&E); c) comprehensive prevention services ; and d) more effective treatment, care and support. A large number of respondents from MOH and other government agencies were not aware of the work to develop the 2012-2017 National Strategic Plan.

1.1 Which government ministries or agencies

Name of government ministries or agencies [write in]:

MOH, MOE, Attorney Generals and Ministry of Foreign Affairs, Port Authority, Immigration with support from the Local Government, CMI, NGOs (Youth to Youth in Health, WUTMI and MIEPI), Traditional Leaders (Council of Iroj), Church Leaders, Private Sector (Businesses),inc Hotel and Travel Agencies, Airlines, Bars, Nightclubs, Fishing Companies

1.2. Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

SECTORS

Included in Strategy Earmarked Budget

Yes	Yes
Yes	Yes
Yes	Yes
-	-
-	-
-	-
-	-

Other [write in]:

Single State Agency has a current strategy with budget and earmarked budget. Resources and Development (Fisheries and MIMRA), Attorney Generals, Ministry of Internal Affairs, Public Services Commission; the extent of these sectors' engagement in the current response was not clear from the diversity of responses. The funding matrix suggest that the above 'yes' areas are officially funded to deliver programs, which impact on the HIV & STIs response, either directly or indirectly. However, it seemed that most respondents thought that most of these sectors should be engaged in the NSP and where necessary, should have a budget earmarked to support and facilitate their contribution -- with particular reference made to education and the attorney general's office (and the office of Legal Counsel which support legislative development and review in the Nitijela (Parliament)).

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?:

Respondents indicated the available funding from the MOH national Budget, US Federal agencies and SPC's Pacific HIV & STI Response Fund and Global Fund. It is noted that the MOH is in a position to 'open' up funding opportunities for NGOs, such as Youth to Youth or WUTMI, to access other grant funding for HIV & STIs,. The NAC and MOH, as joint convenors, are also able to allocate funds for NGO or community based activities, such as the SPC Pacific HIV & STI Response Fund CDO Grants or NAC Grants. Others suggested that UNFPA, WHO, JICA, UNICEf also provide support including funds for integrated HIV & STI into existing or complementary programs, such as the cancer program, substance abuse programs, just and court grants, TB program, Adolescent Health Development Program and Domestic Violence Programs, as well as other grants to support data collection and analysis and human services (in capacity building?).

1.3. Does the multisectoral strategy address the following key populations, settings and cross-cutting issues?

Men who have sex with men:

Yes

Migrants/mobile populations:

Yes

Orphans and other vulnerable children:

No

People with disabilities:

No

People who inject drugs:

No

Sex workers:

Yes

Transgendered people:

Yes

Women and girls:

Yes

Young women/young men:

Yes

Other specific vulnerable subpopulations:

Yes

Prisons:

Yes

Schools:

Yes

Workplace:

Yes

Addressing stigma and discrimination:

Yes

Gender empowerment and/or gender equality:

Yes

HIV and poverty:

Yes

Human rights protection:

Yes

Involvement of people living with HIV:

Yes

IF NO, explain how key populations were identified?:

There were different views on which key populations and other vulnerable groups should be targeted under the Strategy. Respondents argued for the selection of key populations on the basis that available data or current programming supported the concern that these groups were more at risk (vulnerable to) HIV & STDs or for the role they could play in advocacy to reach those at risk or reduce discrimination: • MSM – epi analysis shows recorded STDs and high risk sexual behaviors (reference the EPI-Info STD Program Data base in Ebeye) • Seafarers: national data supports this as a risk group – especially in relation to foreign seafarers who visit Marshalls periodically • Young men and women: data evidence supports high rates of STDs – especially those out of school or no longer going to school (drop outs) • Prenatal mothers: data evidence supports high rates of STDs • Commercial sex workers: data evidence supports high rates of STDs in these groups • Infants born to HIV & STI positive mothers: strong data supports MTCT of HIV and STDs which needs to be addressed. • Those already diagnosed with an STD. Key points of difference : • Whether mobile populations, such as those returning from US states or other jurisdictions represented a risk group: the Ebeye group proposed that although there may be potential preventive benefits in testing people who worked and live abroad on their return to RMI (such as using the current testing law for expatriate workers) they argued that there is no conclusive data that supports the benefit of testing in mobile populations, although Majuro might hold a different view. (Note: identifying vulnerable groups relates to the whole focus of the strategy, not only testing). • Whether children who were neglected, abused or in poverty represented a risk group: Ebeye also indicated there was no conclusive evidence that supports neglected children as vulnerable to risk of HIV or STDs. • People who use substances or have addictions – some thought IDU was not evident in RMI. Clarification sought on these issues: • Workplaces should specifically focus on workplaces where sex work occurred rather than general workplace locations • There was no conclusive data that injecting drug use occurred in the RMI • Clarify why disability would constitute or add to risk and vulnerability • Whether gender empowerment and equality was a cross-cutting issue to be address • Whether HIV & poverty was an issue to address • There were different views on the significance of the population of men who have sex with men

1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country [write in]?:

Current populations addressed in the current response were agreed: • Teens and young people aged 10-15/16-25 including students in and out of school • Seafarers • Women of child bearing age-group including pregnant mothers • Migrants, including foreign workers • STI patients and their contacts • Men who have sex with men • Prisoners • Sex workers • Health workers • Blood donors • HIV+ clients • HIV negative infants born to HIV+ mothers • Children who are neglected or vulnerable • People who use other substances or have addictions

1.5. Does the multisectoral strategy include an operational plan?: Yes

1.6. Does the multisectoral strategy or operational plan include

a) Formal programme goals?:

Yes

b) Clear targets or milestones?:

Yes

c) Detailed costs for each programmatic area?:

Yes

d) An indication of funding sources to support programme implementation?:

Yes

e) A monitoring and evaluation framework?:

Yes

1.7

1.7. Has the country ensured “full involvement and participation” of civil society in the development of the multisectoral strategy?:

Active involvement

IF ACTIVE INVOLVEMENT, briefly explain how this was organised:

The majority of respondents were not aware of who or how involved civil society was in the last Strategy nor the extent of engagement of CSO in the current Strategy. Of those who were involved in developing the last Strategy, they advised that CSO was actively involved. Of those involved in developing the current Strategy, they identified the role of the MOH in convening a general meeting to discuss the need to re-organise and re-establish the National advisory committee for HIV, STD and TB. MOH convened the NAC in a clear, step by step approach including: defining talking point for discussion, invitation and nomination for new NAC members, the election of officers, the establishment of bylaws and meeting protocols, implementation of member engagement strategies, and direct accountability to the establishment of the next (current) national Strategic Plan. Currently the new NAC is composed of highly active members and MOH continues to implement strategies to ensure engagement and sustainability. The NAC Terms of Reference permit up to 15 members, with 7 from NGOs. Of the new members elected, they are from the following sectors: MOH: 4; private sector: 2; NGOs: 3; Church: 1; traditional leaders: 1; Other Ministries: 1; Higher Education: 1.

1.8. Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?:

No

1.9

1.9. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?:

No

IF SOME PARTNERS or NO, briefly explain for which areas there is no alignment/harmonization and why:

Whilst not everyone was familiar with the process of external development partner endorsement, it was noted that the previous NSP (2005-2009) was endorsed by SPC; with the new NSP (2012-2017) still in development, it is proposed that it be endorsed by other development partners, such as SPC, CDC and the UN agencies. The NSP is being developed with recognition of the priorities and approaches and advice of the key funding agencies: SPC, US Federal agencies, and others. It is expected that, once the NAC confirm the Draft in April, the Plan will be shared with Funders for their information, and if possible, their endorsement.

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?:

Yes

2.1. IF YES, is support for HIV integrated in the following specific development plans?

Common Country Assessment/UN Development Assistance Framework:

N/A

National Development Plan:

Yes

Poverty Reduction Strategy:

N/A

Sector-wide approach:

N/A

Other [write in]:

Most respondents were uncertain about the influence of these frameworks on the HIV & STIs response in RMI. In some instances, they noted that although the framework may not formally exist, there is support from the relevant UN agency for HIV & STIs in its other programming. In relation to the specific RMI national development plan-Vision 2018, it specifically notes the need to address HIV & STIs as part of establishing and maintaining a healthy nation.

2.2. IF YES, are the following specific HIV-related areas included in one or more of the development plans?

HIV impact alleviation:

No

Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support:

No

Reduction of income inequalities as they relate to HIV prevention/treatment, care and/or support:

No

Reduction of stigma and discrimination:

No

Treatment, care, and support (including social security or other schemes):

Yes

Women's economic empowerment (e.g. access to credit, access to land, training):

No

Other[write in below]:

See above 2.1 response. MISSA and the Ryan White/Global Fund support treatment, care and support for those who are positive. Vision 2018 supports an enhanced acceptable reproductive health program (objective 5, goal 4: healthy people) but there is no mention of gender equality, and while HIV is noted, little mention of stigma or income support.

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?:

No

4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?:

-

5. Has the country followed up on commitments made in the 2011 Political Declaration on HIV/AIDS?:

Yes

5.1. Have the national strategy and national HIV budget been revised accordingly?:

No

5.2. Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?:

Estimates of Current Needs Only

5.3. Is HIV programme coverage being monitored?:

Yes

5.3

(a) IF YES, is coverage monitored by sex (male, female)?:

Yes

(b) IF YES, is coverage monitored by population groups?:

Yes

IF YES, for which population groups?:

The following groups are monitored through the MOH (and associated NGOs, such as Youth to Youth) routine surveillance programs: Young People including those entering high school and college Men who have sex with men Sex workers Migrant workers Women of Child-bearing age – through the ANC and Family Planning clinics Blood donors

Briefly explain how this information is used:

This information is used for surveillance monitoring and to inform strategic planning. *Note 1: there have been significant delays in entering CTR data into the MOH database, which has limited the usefulness (reliability and credibility) of surveillance data

(c) Is coverage monitored by geographical area:

Yes

IF YES, at which geographical levels (provincial, district, other)?:

Geographical areas are monitored at national level and by (district) village, island and atolls. Limited largely to Majuro and Ebeye areas due to resource constraints. *Note 2: in outer islands, Health Assistants are unable to conduct screening tests for HIV & STDS due to resource constraints.

Briefly explain how this information is used:

Surveillance data is used for epidemiology (mapping the disease patterns on the population) planning, contact tracing, referral and reporting.

5.4. Has the country developed a plan to strengthen health systems?:

Yes

Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications:

Few respondents were aware of the country's NHP or could identify how the country's plan to strengthen health systems had impacted on HIV-related infrastructure human resources and capacity and logistical systems. The MOH has recently developed the National Health Plan 2012-2014 addressing key areas: Prevention and Public health; Majuro Hospital Operations; Public health and Hospital Operations in Ebeye; Administration and Other Support; Planning and Statistics; and Referrals. Ebeye has developed a complementary Health Plan. In addition, various funding grants through CDC (HIV Surveillance, HIV Prevention and Comprehensive STD Prevention Services) the Global Fund and the Response Fund, each support different elements of strengthening the health system. Respondents identified the impact of these grants in increasing human resources enhanced laboratory capacity as well as training, drug inventory systems and supplies and data management systems.

6. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy

planning efforts in the HIV programmes in 2011?:

7

Since 2009, what have been key achievements in this area:

Some were unable to identify achievements. Of those who were able to identify achievements, they listed the following: • MOHs' efforts to establish the national advisory committee • MOH's commitment to establish a new National Strategic Plan –with the first workshop held in December 2011 and the next and final workshop scheduled for March 2012 • National HIV & STI Program members participated in the Monitoring and evaluation skills seminar • At the local level, in Ebeye, the team was proud it had implemented its annual strategic work plan: overall the plan's objectives were achieved particular in relation to improving clinical evaluation and classification of STD cases. In 2011, Ebeye developed its 2012-2017 KAHCB PHC Strategic plan, with new objectives and indicators.

What challenges remain in this area:

• Strengthening the engagement of key agencies to take ownership and feel valued, in helping RMI Government to address the issues associated with strategic Planning for HIV & STIs. • NGOs contribution needs to be recognised. • Private sector need to provide better health care to their employees • Strengthening MOH resources and commitment – including the establishment (or clearly identifying) the working group responsible for HIV & STI programming; engaging with NGOs to deliver programs; ensuring follow-up meetings and updates on the program; ensuring sufficient staff are engaged to deliver the program. • Completion of the National Strategic Plan - and ensuing the inclusion of budget and funding sources in the Plan • Implementation of bureau-level work plans • Alignment of the different plans across the various funding agencies • Implementation of M&E

A - II. POLITICAL SUPPORT AND LEADERSHIP

1. Do the following high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year

A. Government ministers:

No

B. Other high officials at sub-national level:

No

1.1

(For example, promised more resources to rectify identified weaknesses in the HIV response, spoke of HIV as a human rights issue in a major domestic/international forum, and such activities as visiting an HIV clinic, etc.):

Yes

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:

Most respondents could not identify regular occasions when high officials spoke publicly and favorably about the HIV & STI efforts in a key domestic or national forum, with some citing the sensitivity associated with HIV as reason why it is rarely discussed publicly – although in Ebeye and Majuro, two respondents were able to identify demonstrated leadership in the HIV & STI area by a head of government and other high officials in the last 12 months. In Majuro, one respondent reported, the Parliament's induction session invited consultants from UNGPA and UNAIDS to meet with members to discuss issues including Climate Change and the MDGS – and particularly issues around women and poverty, and HIV. The Majuro HIV Clinician was invited to provide an update on the HIV situation in RMI, including the numbers of cases living with and receiving ART. Supporting this, in late 2011, the Secretary for Health spoke at the NAC Inauguration on the importance of the National Advisory Committee for HIV, STIs and TB. In Ebeye, the Mayor and traditional leaders endorsed the HIV & STI prevention efforts during the World AIDS Day and the initiation of the Chlamydia presumptive treatment campaign.

2. Does the country have an officially recognized national multisectoral HIV coordination body (i.e., a National HIV Council or equivalent)?:

Yes

2.1. IF YES, does the national multisectoral HIV coordination body

Have terms of reference?:

Yes

Have active government leadership and participation?:

Yes

Have an official chair person?:

Yes

IF YES, what is his/her name and position title?:

Daisy Alik-Momotaro, Secretary of Ministry of Internal Affairs, co-chaired by Jessica Ducey, Administrator for Youth to Youth in Health

Have a defined membership?:

Yes

IF YES, how many members?:

15 members

Include civil society representatives?:

Yes

IF YES, how many?:

7 members

Include people living with HIV?:

No

Include the private sector?:

Yes

Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?:

Yes

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?:

Yes

IF YES, briefly describe the main achievements:

The NAC undertakes the role of promoting interaction between Government, CSO and Private Sector. Through MOH, the NAC delegates specific responsibility for implementation to the relevant implementing agencies, such as MOH Programs or Youth to Youth. The NAC is guided by its bylaws in this role, and supported (facilitated) through the National Strategic Plan. One respondent identified that the first phase of NSP Planning showed significant discussion and interaction amongst the NAC on the burden of HIV in the Marshalls and agreement on common objectives. Another respondent noted that NGOs have included HIV and STI prevention strategies into their action plans, demonstrating their commitment and contribution.

What challenges remain in this area:

Respondents identified the following challenges over the last two years: • Formation of the NAC took some time, with commitment and motivation a key factor • Finalizing the National Strategic Plan also took time • The lack of human resources – with gaps in the Coordination and Clinical Care roles impacting on the program's implementation through 2011 Looking forward, respondents identified these challenges: • Strengthening engagement with other sectors, including representation from PLWH

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?:

50%

5.

Capacity-building:

Yes

Coordination with other implementing partners:

Yes

Information on priority needs:

Yes

Procurement and distribution of medications or other supplies:

No

Technical guidance:

Yes

Other [write in below]:

Most respondents were able to define expectations of a NAC role in these areas. With the ANC newly established, the specific nature of their role is evolving. Currently, the MOH on behalf of the NAC is negotiating with SPC to confirm access to Capacity Development Organisation (CDO) funds which will strengthen the capacity building and coordination functions on behalf of the NAC – as well as access to technical guidance and priority needs. Currently, these functions are pursued by MOH and WUTMI's representative (who is supported by MOH funds). Procurement is handled through the MOH and regional procurement mechanism. It is not suggested that NAC play a role in this.

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National HIV Control policies?:

Yes

6.1. IF YES, were policies and laws amended to be consistent with the National HIV Control policies?:

No

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the political support for the HIV programme in 2011?:

4

Since 2009, what have been key achievements in this area:

Few respondents were able to identify any achievements – with one group noting that nationally, there is no visible strong support for HIV & STI response. In Ebeye, the Mayor's support (although passive) for HIV & STIs prevention efforts in the community is a key achievement.

What challenges remain in this area:

The major challenge identified by respondents was to address stigma and discrimination against HIV & STIs. Another asserted that the nation's leaders, and the community, needed to admit that HIV & STIs are a serious problem and stop using cultural taboo as a reason for not talking about the seriousness of the problem. Another respondent noted that the absence of an identified champion for HIV in the Nitijela – even though champions for women's empowerment, climate change and young people were identified – indicates how little support there is at national levels, and particularly in the (last) parliament.

A - III. HUMAN RIGHTS

1.1

People living with HIV:

No

Men who have sex with men:

No

Migrants/mobile populations:

No

Orphans and other vulnerable children:

No

People with disabilities:

No

People who inject drugs:

No

Prison inmates:

No

Sex workers:

No

Transgendered people:

No

Women and girls:

Yes

Young women/young men:

Yes

Other specific vulnerable subpopulations [write in]:

People who use substances/have addictions- NO

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?:

Yes

IF YES to Question 1.1. or 1.2., briefly describe the content of the/laws:

The RMI Constitution was identified as the key source of general law on non-discrimination by some; another noted the confidentiality, discrimination and other human rights protections available under the Communicable Diseases legislation (s15). Others noted the need to 'find these laws and ensure everyone has a copy' arguing that everyone has a right to health care services no matter who they are.

Briefly explain what mechanisms are in place to ensure these laws are implemented:

Other than one respondent who noted that the Marshall Islands citizens have access to a universal health insurance scheme which should ensure access to health services, no respondents were able to identify a mechanism to support implementation of the Constitution and any laws.

Briefly comment on the degree to which they are currently implemented:

No respondents were able to identify the degree to which any legislation is currently implemented.

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?:

Yes

IF YES, for which subpopulations?

People living with HIV:

Yes

Men who have sex with men:

Yes

Migrants/mobile populations:

Yes

Orphans and other vulnerable children:

-

People with disabilities:

-

People who inject drugs :

-

Prison inmates:

Yes

Sex workers:

Yes

Transgendered people:

Yes

Women and girls:

-

Young women/young men:

-

Other specific vulnerable subpopulations [write in below]:

-

Briefly describe the content of these laws, regulations or policies:

There were inconsistencies in the responses here which suggest that the question was not easily understood – many reported don't know as their answer to Question 2, or but yes to its sub-questions. One respondent identified that the illegality of sex work can impede sex workers access to health services; another identified that mandatory testing of immigrants, young girls and women and STI clients (who area all required to have a physical examination including HIV tests) may be at odds with other laws.

Briefly comment on how they pose barriers:

The RRRT Review 2009 identified: • Although the anti-discrimination protections of the CDPC Act are helpful, other aspects are likely to impede prevention of HIV and sexual health. • Some provisions are inconsistent with the a human rights based approach to prevention, treatment care and support o Exclude HIV from the definition of communicable disease o Exclude HIV from mandatory testing provisions - e.g. for employment & other purposes, - except in accord with international guidelines, e.g. on blood donors o Limit notifications of HIV diagnosis to medical practitioners (and not to schools and day centers etc) o Strengthen the privacy and confidentiality provisions • Criminal law o Provisions in Ant-Prostitution Act and Immigration Act that criminalize sex works should be repealed o Section 1511 in CDPC Act for intentional transmission is draconian and should be repealed as it is likely to be ineffective for public health purposes, and may add to stigma. General criminal provisions e.g. assault, should apply. • Prisons o Provide for free condoms and HIV information in prisons; confidential health records; prohibit discrimination on basis of status. • Anti-discrimination legislation o Existing anti-discrimination protection should be widened to include people assumed to have HIV and families, careers and other associates of HIV+ people o Enact legislation to make discrimination on the basis of sex, sexuality or sexual orientation and transgender status unlawful. • Status of vulnerable populations o Amend legislation to ensure protection on the basis of sex where there is potential for conflict between customary law and the Constitution which may impinges on women's economic or social status o Amend legislation on marital or male rape, to ensure protection against sexual violence • Workplaces & Employment: o Government and private sector should develop a code of practice on HIV in the workplace which protects from stigma and encourages information and education and confidentiality. • There is no legal framework for ethical human research – which means that there are no laws to protect and ensure that ethical research occurs.

A - IV. PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?:

Yes

IF YES, what key messages are explicitly promoted?

Abstain from injecting drugs:

-

Avoid commercial sex:

-

Avoid inter-generational sex:

-

Be faithful:

Yes

Be sexually abstinent:

Yes

Delay sexual debut:

Yes

Engage in safe(r) sex:

Yes

Fight against violence against women:

Yes

Greater acceptance and involvement of people living with HIV:

Yes

Greater involvement of men in reproductive health programmes:

-

Know your HIV status:

Yes

Males to get circumcised under medical supervision:

-

Prevent mother-to-child transmission of HIV:

Yes

Promote greater equality between men and women:

-

Reduce the number of sexual partners:

Yes

Use clean needles and syringes:

Yes

Use condoms consistently:

Yes

Other [write in below]:

Whilst most respondents indicated that they did not know of policies or strategies addressing prevention, others noted that no written or approved policies, were in operation, but strategically, in practice, program implementation still addresses these messages. However, there were key discrepancies in all respondents' advice on which key messages were or were not promoted. This requires clarification. It is possible that the survey question was misunderstood.

1.2. In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?:

No

2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?:

No

2.1. Is HIV education part of the curriculum in

Primary schools?:

No

Secondary schools?:

No

Teacher training?:

No

2.2. Does the strategy include age-appropriate, gender-sensitive sexual and reproductive health elements?:

No

2.3. Does the country have an HIV education strategy for out-of-school young people?:

No

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for key or other vulnerable sub-populations?:

No

Briefly describe the content of this policy or strategy:

Although most respondents answered 'Don't know' to this question, a number of respondents still identified various groups in the table below who are addresses in practice by the programs. One respondent also added that various information is provided through the local newspaper, local channels and community outreach programs by the zoning and mobile team. NGO, such as Youth to Youth, and WUTMI, also play a role in prevention through conferences and workshop, drama and skits, and role plan – to out of school and in-school youth as well as those in outer islands. The last Strategy did address some key vulnerable groups for prevention interventions, including IEC and other BCC strategies – and these are also identified in the current strategy, in development.

3.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate policy efforts in support of HIV prevention in 2011?:

6

Since 2009, what have been key achievements in this area:

There were mixed response: few respondents identified achievements in this area; those who did nominated: • An increase in HIV & STI testing • The conduct of risk behavior survey, alongside CTR and HIV & STI testing (in Ebeye) • Safe blood transfusion • Public awareness campaigns, such as World AIDS Day • Implementation of Policies to ensure confidentiality • Distribution of condoms: to the outer islands; and local outlets in Majuro; and within the Majuro hospital (ER, Lab, Inpatients wards, OPD, PH, and x-ray) • Global Fund, Response Fund and CD Federal funding for prevention • Access to condoms locally through the Ebeye Health Centre (HIV & STI clinic, OPD and ER) , and local stores

What challenges remain in this area:

Those few who responded identified these challenges: • The need to establish appropriate policies at a national level to support HIV & STI reporting legislation, the protection of HIV+ people and information dissemination. • Allocation of funds to support civil society programming. • Additional resources (vehicle) to support contact tracing and conduct outreach activities. • The timely development of new IEC materials • The timely payment of accounts. • Stronger team work to support program implementation

4. Has the country identified specific needs for HIV prevention programmes?:

Yes

IF YES, how were these specific needs determined?:

Assessment of various reports: surveillance case reports, program management reports and other surveys or assessments, such as the UNGASS report 2010. Meetings with funders – such as UNFPA and SPC – which have contributed to the establishment of the stakeholder advisor council boards to discuss needs. The following areas were identified as potential programs for scale up: • Education and counseling – especially for young people • Stronger campaigns to increase education and awareness (in the general population) • Enforcement of policies and legislation • Implementation of agreed workplans under current funders

4.1. To what extent has HIV prevention been implemented?

Blood safety:

Agree

Condom promotion:

Agree

Harm reduction for people who inject drugs:

N/A

HIV prevention for out-of-school young people:

Agree

HIV prevention in the workplace:

Disagree

HIV testing and counseling:

Agree

IEC on risk reduction:

Agree

IEC on stigma and discrimination reduction:

Agree

Prevention of mother-to-child transmission of HIV:

Agree

Prevention for people living with HIV:

Agree

Reproductive health services including sexually transmitted infections prevention and treatment:

Agree

Risk reduction for intimate partners of key populations:

Agree

Risk reduction for men who have sex with men:

Strongly Disagree

Risk reduction for sex workers:

Strongly Disagree

School-based HIV education for young people:

Strongly Disagree

Universal precautions in health care settings:

Strongly Disagree

Other[write in]:

A number of respondents responded 'Don't know' or 'Not applicable' to this question.

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in implementation of HIV prevention programmes in 2011?:

7

A - V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?:

Yes

If YES, Briefly identify the elements and what has been prioritized:

Respondents identified the following elements are priorities: Standard treatment guidelines are in place and implemented, supported by well-trained clinical staff and encompassing • Access to free Anti-retroviral therapy for HIV and STI treatment • Treatment for opportunistic infections and co-infections • Rapid testing and confirmatory tests • HIV care and support groups One respondent noted that although adequate testing and treatment services were in place, the comprehensiveness of support services was an area for discussion.

Briefly identify how HIV treatment, care and support services are being scaled-up?:

Treatment Care and Support services were scaled up through: • Support for trained physicians, with refresher and short course training every year • Consultation with SPC and AETC HIV experts on specific cases • HIV training for new recruits and refresher training to clinical and public health nurses.

1.1. To what extent have the following HIV treatment, care and support services been implemented?

Antiretroviral therapy:

Strongly Agree

ART for TB patients:

Agree

Cotrimoxazole prophylaxis in people living with HIV:

Agree

Early infant diagnosis:

Agree

HIV care and support in the workplace (including alternative working arrangements):

Neutral

HIV testing and counselling for people with TB:

Agree

HIV treatment services in the workplace or treatment referral systems through the workplace:

Disagree

Nutritional care:

Strongly Agree

Paediatric AIDS treatment:

Disagree

Post-delivery ART provision to women:

Agree

Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault):

Disagree

Post-exposure prophylaxis for occupational exposures to HIV:

Agree

Psychosocial support for people living with HIV and their families:

Disagree

Sexually transmitted infection management:

Agree

TB infection control in HIV treatment and care facilities:

Disagree

TB preventive therapy for people living with HIV:

Disagree

TB screening for people living with HIV:

Disagree

Treatment of common HIV-related infections:

Agree

Other [write in]:

A number of respondents answered 'don't know' or 'not applicable to much of the question – of interest, was the variation in the agreement around the perceived access to services between Majuro and Ebeye. This is an area which may benefit from further discussion and evaluation.

2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?:

No

Please clarify which social and economic support is provided:

Respondents were not clear whether any social or economic support specific to HIV infection was in place. One respondent identified the MISSA (Marshall Islands Social Security) support as one mechanism which is available to provide benefits to assist those who are sick and disabled. The examining physician who examines all applicants for MISSA purposes has not identified anyone who has cited HIV as the reason for their disability application.

3. Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV?:

No

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy medications, condoms, and substitution medications?:

Yes

IF YES, for which commodities?:

Most respondents were not aware whether the country has a policy for developing or using general medications or parallel imports of medications for HIV and STIs. One respondent was aware that the country has access to regional procurement and supplies for critical commodities, such as ART medications, condoms, and substitution medications. RMI is one of the Sub-Recipient for the Global Funds, which means the supplies of ART are ordered through the regional Fiji Pharmaceuticals (FPCC), linked to SPC. SPC's HIV Program works alongside the FPCC to purchase ART for RMI and other SR countries. On a six month basis a supply inventory is submitted to FPCC; supplies usually take 1-2 weeks to reach RMI. Other respondents also confirmed that laboratory supplies, including test kits and condoms are supplied under a regional mechanism. However, a number of respondents reported that access was not the problem – rather, the delay in processing papers and paying accounts promptly. For example, medicines were often not available because the accounts were either not paid or paperwork not done.

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2011?:

6

Since 2009, what have been key achievements in this area:

Key achievements in HIV & STI treatment care and support programs included: In Ebeye: • Improved availability of STD and Art medications system with very few instances of run outs of most drug supplies – this improvement was attributed in part to the quarterly drug procurement systems for ART and STIs established through the Fiji Regional Procurement under SPC • The establishment of new STD treatment guidelines, including both etiologic and syndromic treatment protocols for STDs. These new guidelines show applicability of the disease treatment guidelines based on the clinical setting. • Access to clinical training for STD and HIV health providers to improve overall treatment and care services. • Improved laboratory diagnosis for implementation of the etiologic treatment guidelines. • A better understanding of the disease burden and implementation of new strategic treatment approaches, such as presumptive treatment of Chlamydia infection amongst prenatal care users and their partners. • Almost 100% of diagnosed STD cases received appropriate treatment. Similarly, Majuro respondents

reported: • The full support and well-planned inventory and order system implemented with Fiji Pharmaceuticals • Technical support and capacity building from SPC technical advisors – especially in relation to managing cases and co-infections • The development of a HIV testing algorithm for diagnosis of HIV on-island – rather than sending blood specimens to a reference laboratory for confirmation (also with SPC support) • US Federal funds supported on-site activities at Majuro hospital and outreach services to outer islands (where most vulnerable groups reside) One respondent noted surprise that, despite the risk factors present in RMI – such as high levels of unprotected sexual activity in some key groups, high rates of STIs – there has not been a corresponding increase in reported HIV cases. A number of respondents were unable to identify key achievements in this area.

What challenges remain in this area:

In Ebeye: Some shortages of medicines and test kits (such as Bicillin) due to shipping difficulties with those drugs or supplies procured through international vendors (and outside the Fiji Regional Procurement process) • Access to Ryan White funds for the support HIV+ people and those affected, such as the families of positive clients, has been difficult. (Note: although Ebeye has no current HIV cases, it has experienced difficulty with its most recent case in 2009 in accessing funds for broader welfare support to positive clients and also access 2nd line drugs for resistance cases and opportunistic infections – ART was available though.) • The provision of partner services (testing and treatment of partners) • Stigma and discrimination delays treatment for both STDs and HIV • The provision of regular treatment services to outer island communities – and identifying (locating) and bringing in clients for timely treatment (as well as in Ebeye) • The shortage of health care providers. In Majuro, some of the challenges identified include; • Patient compliance in relation to follow up for care and support – stigma and discrimination are noted as one reason, but the quality, timeliness and confidentiality of testing and client care services was also raised as a concern by one respondent • Compliance with reporting obligations to the funders, particularly the Ryan White funds for care of those with HIV. • Resources to support outreach, client follow up and contact tracing – including access to a vehicle and staff • Quality care to ensure the prevention of mother to child transmission One respondent noted the need to build active support across the community for HIV and STDs, such as the Cancer support group. And to ensure the MOH works with the Attorney General's office to establish strong legislative and policy support to assist health care providers to address HIV & STIs.

6. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?:

No

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?:

5

Since 2009, what have been key achievements in this area:

Most respondents disagreed with the idea that there were children who are orphans, noting that in Marshallese culture, children who lose their parents are taken into the broader family. Consequently, there were different views on whether there were children who may be neglected or vulnerable as a result of HIV & STIs in the community. One group of respondents said that there was no plan to address the needs of children who may be at risk or vulnerable because of HIV & STIs. Another respondent identified that, for those children of HIV+ pregnant women born through the 2010-2011, the PMTCT guidelines were implemented: rapid tests were taken and confirmatory tests were instituted; the prophylaxis is available at the Majuro hospital; and a paediatrician is a member of the HIV Core Care team at eh Majuro hospital. Of those three children born to an HIV+ mother in the last two years, two children were tested with PCR test (results show a normal or negative PCR), and the third remains to be tested.

What challenges remain in this area:

We do not have information available which informs us of the actual (or past) situation for the children of those who have been diagnosed as HIV+. There is an assumption that because cultural practices means that all children who are potentially left without parents will be taken in by other family members, that there is little or no negative impact on the child. We do not have any evidence of what happens (or has happened) for specific families. This should be explored.

A - VI. MONITORING AND EVALUATION

1. Does the country have one national Monitoring and Evaluation (M&E) plan for HIV?:

No

Briefly describe any challenges in development or implementation:

Most respondents were not aware whether RMI has a national Monitoring and Evaluation Plan for HIV & STIs. Consequently, the majority of respondents either answered "Don't Know" or did not respond to this section. One group of respondents thought that nationally, both Majuro and Ebeye have uniform M&E obligations for specific funding agencies. However, there is no national M&E plan that clearly measures the overall country response to HIV & STIs. This group noted the need to establish an M&E plan that corresponds to the National Strategic Plan. The NAC, working with MOH, has identified technical assistance from the UNAIDS office in Suva to support the development of a Monitoring and Evaluation Framework. This is scheduled for the 2nd Quarter of 2012. The Monitoring and Evaluation Framework will complement and link with the National Strategic Plan. The MEF will reflect the same time span as the National Strategic Plan

Briefly describe what the issues are:

There was agreement that an aligned and harmonized M&E plan would assist to accurately measure the overall effectiveness of the national response to HIV & STIs. Such a plan should address most of the aspects noted below in (2) A number of respondents noted they had never seen any reports on the M&E of the HIV & STI program. They noted that if each partner understood the M&E needs of the Program, they would have a better understanding of each others' roles.

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy:

-
A data analysis strategy:

-
A data dissemination and use strategy:

-
A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate):

-
Guidelines on tools for data collection:

3. Is there a budget for implementation of the M&E plan?:

No

4. Is there a functional national M&E Unit?:

In Progress

Briefly describe any obstacles:

One group of respondents noted that the main objective of the NSP in development is to have a centralised M& E unit for the national response. The main challenge is the process of developing the centralized surveillance/M& Unit for HIV & STI data and information. Shortage of skilled personnel is a challenge.

4.1. Where is the national M&E Unit based?

In the Ministry of Health?:

-

In the National HIV Commission (or equivalent)?:

-

Elsewhere [write in]?:

-

Permanent Staff [Add as many as needed]

POSITION [write in position titles in spaces below] Fulltime Part time Since when?

-

-

-

-

Temporary Staff [Add as many as needed]

POSITION [write in position titles in spaces below] Fulltime Part time Since when?

-

-

-

-

4.3. Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?:

No

Briefly describe the data-sharing mechanisms:

There is currently no established mechanism. MOH receives information from partners only by request. MOH reported that they are also currently developing a broader Monitoring and Evaluation framework for the Public Health program.

What are the major challenges in this area:

The need to establish and train the M&E unit.

5. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?:

No

6. Is there a central national database with HIV- related data?:

Yes

IF YES, briefly describe the national database and who manages it.:

Most of the national database is with the national Program Manager for the RMI MOH HIV & STID program. The identification of data for the GAPR indicators has revealed that this data base is inconsistent and incomplete. MOH has advised that they are currently reviewing their Department-wide Health Information System with UNFPA assistance. This assessment is not yet available.

6.1. IF YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?:

Yes, but only some of the above

IF YES, but only some of the above, which aspects does it include?:

The database has fields to include prevalence/incidence, age-group distribution , geographical coverage.

6.2. Is there a functional Health Information System?

At national level:

Yes

At subnational level:

Yes

IF YES, at what level(s)?:

-

7. Does the country publish an M&E report on HIV , including HIV surveillance data at least once a year?:

Yes

8. How are M&E data used?

For programme improvement?:

Yes

In developing / revising the national HIV response?:

Yes

For resource allocation?:

Yes

Other [write in]:

-

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:

At program level, staff in most programs are required to compile monthly data on numbers of clients seen and their respective follow-up. Ebeye health Centre undertook a risk survey of all clients participating in their screening programs in 2011 – and used this information to review the program's effectiveness and develop program proposals for funders. The MOH submits quarterly and annual program reports to all funders as well as compiles and Annual Report for the Government of RMI. Key challenges, particularly in Majuro, has been the timely and accurate entry of program data: including completion of CTR data; as well as the timely and accurate completion of program reports to funders. Staff workload and capacity (number of staff as well as expertise and experience) as well as the absence of systems to support data entry, analysis and reporting were identified as the reasons for delays or gaps in data entry, analysis and reporting.

9. In the last year, was training in M&E conducted

At national level?:

Yes

IF YES, what was the number trained:

3

At subnational level?:

-

At service delivery level including civil society?:

-

9.1. Were other M&E capacity-building activities conducted` other than training?:

Yes

IF YES, describe what types of activities:

Initial planning has been undertaken to establish a national M & E Plan and unit.

10. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluation (M&E) in 2011?:

5

Since 2009, what have been key achievements in this area:

Some standardization - between the Majuro and Ebeye Health Centres – in relation to HIV & STI Data collection and reporting.

What challenges remain in this area:

• Need more standardization of indicators (including the data required by various funding agencies). • Data dissemination and utilization should also be improved. • Staff capacity: there is currently no dedicated staff to support HIV & STI surveillance data entry and analysis and reporting in Majuro, so the task rests on the capacity of staff currently delivering clinical programs. Workload sometime precludes accurate and timely entry. In addition, with substantial changes in staff roles and capacity during 2011, some reports required for submission to funders were not completed, jeopardizing funding relationships and funds. • To strengthen leadership, communication and coordination of M&E in the HIV & STI program.

B - I. CIVIL SOCIETY INVOLVEMENT

1. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?:

2

Comments and examples:

Most respondents thought that civil society had contribution strongly to strengthening the political commitment of top leaders and national strategy and policy development. Some nominated civil society engagement to actively strengthen political commitment in relation to the work of WUTMI (noting the Domestic violence legislation, awareness raising on the MDGs) and Youth to Youth, as well as the development of the Family life education curriculum. Others nominated the representation of civil society in the National Aids Council (NAC) as an example of strength of the CSO sector. The NAC is comprised of multi-sectoral representation including that of Civil society members such as WUTMI and YTYIH. Women are active through WUTMI. Dr. Hilda Heine (WUTMI Advisor and member of the WUTMI Executive Board) is a member of the Nitijela. While a number reported that they thought government and civil society members work hand in hand to promote and instill political commitment and to develop national strategies, some thought that policy on the Government's part could be stronger – they nominated, for

example the perception that some held that the MDGs were a civil society campaign – rather than understanding that the MDGs are a commitment expressed by the RMI government. Others noted the need for government counterparts who are willing to challenge stigma and cultural mores to address the controversial issues surrounding HIV policy. The absence of an HIV Champion in the Nitijela – when Champions could be found for Women’s empowerment and Climate Change - was noted.

2. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?:

4

Comments and examples:

A number of respondents were not able to comment on this question. Others however, noted that civil society was highly involved, to the extent of taking a leadership role, in the formation of the National Advisory Committee on HIV/STIs/TB and through the process of drafting the national strategic plan. The executive committee of the NAC includes two directors of national NGOs, indicating that civil society is well-represented in a planning process that is still in its infancy. Another respondent explained that some NGOs are becoming more engaged in part due to request from the MOH to assist with the HIV & STI response. They also observed that the formulation of the NAC has also brought in others amongst civil society e.g. CMI, Church, Youth to Youth - and considering the strong partners that each of these have with civil society, they could bring in others or who will participate or speak out about HIV and include HIV in their programs.

3.

a. The national HIV strategy?:

3

b. The national HIV budget?:

2

c. The national HIV reports?:

2

Comments and examples:

While the degree of detail varied across the respondents, most were aware that both Youth to Youth and Wutmi both provide supporting programs as part of the HIV & STI response, primarily in prevention, and access to testing and treatment. Others nominated the work of the Salvation Army in counseling and care, although they were unable to comment on the level of services provided. Few were familiar with the extent of the budget dedicated to supporting civil society programming in the HIV & STI area; there was a perception that there were resources and funds available, but how effectively funds were utilized to support the response was a question. One agency initiated a proposal to seek funds for new work in the HIV area – which would complement their existing program of work - because they had heard there were funds not spent at the MOH. Few were familiar with current reporting in relation to the work of civil society. One respondent emphasized the need to ensure that work in the civil society sector was seen as a critical and important aspect of reporting. Another commented that including CSOs in budgets and reporting has been less successful, mainly due to a lack of standardized reporting formats and a lack of communication amongst all relevant actors. CSO inclusion feels last minute and haphazard, with the government offices collecting any available reports just before reporting deadlines, rather than providing CSOs with standardized reporting formats to be tracked and updated year-round. Standardizing data collection and analysis in one format and in one location would go a long way towards making the response more effective and improving reporting.

4.

a. Developing the national M&E plan?:

3

b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?

:

3

c. Participate in using data for decision-making?:

1

Comments and examples:

Whilst respondents identified that they are involved in the monitoring and evaluation of their own individual programs, few were familiar with the monitoring and evaluation of the national response to HIV & STIs. Some respondents forecast that due to the strong engagement of civil society plays in the NAC, their involvement in the development of the forthcoming national M&E plan would be substantial. One respondent noted that discussions are underway with UNAIDS to confirm development of the Monitoring and Evaluation framework for the response once the NSP is developed. This would include training in Monitoring and evaluation. One respondent said given what we know about the high prevalence of STIs, the presence of HIV and RMIs obligations under the MDGs, ‘we need to do something’ to M&E RMI’s work in this area. Another respondent noted that data collection is still haphazard and un-standardized in the RMI. HIV data in particular is incomplete as testing is still in its infancy, and virtually no testing has been done on outer islands. They suggested that streamlining data collection so that CSO data was in the same format and submitted to the same location as government data would be an important early step in formulating an effective response as well as national M&E plan.

5. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. organisations and networks of people living with HIV, of sex workers, and faith-based organizations)?:

3

Comments and examples:

Most respondents considered CSO representation in the response to representative of the diversity of organisations engaged in STIs and HIV work in RMI. In addition to CSO representation on the NAC, they noted the engagement of WUTMI and YTYIH in the response, noting that they each have contributed well to gather representation from diverse organizations. It was also noted that there are a lot of women, youth, faith-based, men, private sector, teaching institutions/schools and government engaged in the response. It was noted by a number of respondents that two key risk groups - sex workers and people living with HIV - are seen to actively participate in the response, either in treatment/prevention or data collection efforts. This was attributed to stigma and the reluctance within Marshallese culture to engage these groups. There is still a gap in bridging representation from the faith based community. Faith based organizations' involvement varies but was considered an untapped resource, particularly for reducing stigma, encouraging testing, and assisting with care and support.

6. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society able to access

a. Adequate financial support to implement its HIV activities?:

3

b. Adequate technical support to implement its HIV activities?:

3

Comments and examples:

Whilst most of the respondents thought that civil society access to funds was reasonable – and could give examples where civil society was accessing funding – they also nominated areas for improvement. One respondent noted that they were aware the MOH had not used all funds allocated by funders to implement the HIV & STI program: this was an area where MOH could collaborate with NGOs to implement programs (and make better use of existing funds). Although discussions to re-allocate funds were underway, this took time – and in the meantime, CSOs were forced to use their other funds to support programs until MOH could distribute (or re-allocate) funds. Youth to Youth said it had encountered challenges and delays in receiving aid and therefore implementing programs in a timely fashion. Although external funding sources were more flexible for civil society, they also had lower levels of funding. They also reported the inadequate capacity of laboratory and testing services (due to equipment breakdowns) as an area which handicapped their organisation's capacity to provide better services. One agency reported that SPC was an excellent source of support: IEC materials, stories of what other people have done, share different techniques for different audiences; how to gather information to develop programs. The MOH was a source of support in relation to the role of the NAC.

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

People living with HIV:

<25%

Men who have sex with men:

<25%

People who inject drugs:

<25%

Sex workers:

51-75%

Transgendered people:

-

Testing and Counselling:

25-50%

Reduction of Stigma and Discrimination:

51-75%

Clinical services (ART/OI)*:

<25%

Home-based care:

<25%

Programmes for OVC:**

<25%

8. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to increase civil society participation in 2011?:

7

Since 2009, what have been key achievements in this area:

The recent engagement of WUTMI in the HIV & STI response was noted as a key achievement. One respondent noted that civil society cooperation among CSOs and/or government has been increasing, giving the example of collaboration on the Chlamydia presumptive treatment campaign. Testing and other services at the Youth to Youth clinic are also increasing as more people become aware of the clinic. Youth to Youth recently received a grant to support MOH outreach trips by recruiting patients on outer islands for HIV and STI testing. This will be the first major effort to establish baseline prevalence rates on outer islands. The engagement of the NAC was identified as an achievement – this provides guidance to MOH and CSOs; it helps focus on the issues.

What challenges remain in this area:

Laboratory facilities are the weakest link in the counseling-testing-treatment chain, as broken equipment has led to clients being turned away or lost to follow-up. While awareness raising has been effective at educating the population, there is still limited evidence of behavior change (especially regarding condom use). Resources to fully staff CSO facilities is an ongoing

issue: the Youth to Youth clinic is still awaiting a full time nurse from MOH so that the clinic can be open every day instead of the current 8 hours per week- and providing services to the outer islands remains a major challenge. Funding is a critical challenge: the prospect of losing Global & Response Funds by the end of 2013 (or 2012) is a critical issue. Cultural challenges to discussing sexual issues: people accepting the issue, talking about it, taking action, getting treated, the whole stigma and discrimination against people talking about HIV, having HIV

B - II. POLITICAL SUPPORT AND LEADERSHIP

1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?:

Yes

IF YES, describe some examples of when and how this has happened:

Respondents were mixed in their response to this question. Most thought government had not through political and financial support, involved people living with HIV, key populations or other vulnerable people in the response. Some attributed the lack of involvement by HIV+ people to stigma and fear, as well as their relatively small numbers, rather than any lack of effort on the government's part. Other thought that the representation of WUTMI and YTYIH meant that the views of women and young people were well-represented through the National Advisory Committee as well as working relationships with MOH.

B - III. HUMAN RIGHTS

1.1.

People living with HIV:

No

Men who have sex with men:

No

Migrants/mobile populations:

No

Orphans and other vulnerable children:

No

People with disabilities:

No

People who inject drugs:

No

Prison inmates:

No

Sex workers:

No

Transgendered people:

No

Women and girls:

Yes

Young women/young men:

Yes

Other specific vulnerable subpopulations [write in]:

Seafarers- NO

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?:

Yes

If YES to Question 1.1 or 1.2, briefly describe the contents of these laws:

Few of the respondents provide a clear response to this question. A number identified that the Constitution as which protects people from discrimination on the basis of gender, origin and religion or race political interests – article of the Bill of Rights, s12. Some referred to the Bill 93, also known as Domestic Violence Prevention & Protection Act which has been enacted and currently known as Public Law 2011-60. This law protects anybody living under the same roof – whoever is considered a family – violence is defined as physical harm inflicted, psychological verbal or economic or social abuse.

Briefly explain what mechanisms are in place to ensure that these laws are implemented:

Respondents identified the court system in general as a monitoring mechanism. In relation to the Domestic Violence legislation, the Ministry of Internal Affairs was expected to monitor implementation, working with support from WUTMI. WUTMI noted that they are looking for funds to implement the legislation: training, awareness about the legislation with government, first responders and court officials (A-G's office, counselors, police and ambulance). WUTMI is already funded to support training with police and health care providers on the DV legislation. The Constitution is monitored by Attorney General's office, with support from the Parliament.

Briefly comment on the degree to which they are currently implemented:

However, a number of respondents commented on the recent experience of the Women's Mock Parliament where the incumbent Parliamentarians (last parliament) protested women's use of their chairs in the Nitijela as embarrassing and disrespectful, raising questions about how the Parliamentarians had chosen to ensure the rights of women under the Constitution would be enforced. Similarly, during the reading of the DV bill, one of the parliamentarians challenged whether

women can come in and sit in the parliament. “ who are these women to go into the chamber to sit on chairs when culturally they must sit on the floor – you will bring in the bad spirit and do black magic to the chairs(men)’. In this instance, both women and men got angry, and a lot of men in the parliament backed supported the women. Others thought the DV legislation was against culture – the bill had to go thru the house of chiefs – through the House of Iroj to assess cultural appropriateness. This was the only Bill that they ‘highly requested’ – the Chiefs passed it.

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?:

Yes

2.1. IF YES, for which sub-populations?

People living with HIV:
Yes

Men who have sex with men:
Yes

Migrants/mobile populations:
Yes

Orphans and other vulnerable children:
-

People with disabilities:
-

People who inject drugs:
-

Prison inmates:
Yes

Sex workers:
Yes

Transgendered people:
Yes

Women and girls:
-

Young women/young men:
-

Other specific vulnerable subpopulations [write in]:
Seafarers- YES

Briefly describe the content of these laws, regulations or policies:

The responses to the question of whether the country has non-discrimination laws or regulations which specify obstacles for specific key populations and other vulnerable subpopulations was similarly mixed. For each group that one respondent thought there were laws and regulations which presented obstacles, another respondent answered in the opposite. No clear conclusions on what respondents knew or thought was the situation could be drawn. They may have thought there were such laws or regulations. Or they may not have known. One respondent did clearly identify that those engaged in sex work, injecting drug use, men having sex with men, are considered to be engaged in illegal activities – so this would prevent people accessing services or others knowing what services to provide.

Briefly comment on how they pose barriers:

Most answered not known.

3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?:

Yes

Briefly describe the content of the policy, law or regulation and the populations included:

Again, most respondents noted the existence of the recently enacted Domestic violence law although none were aware whether it had a specific mention of HIV+ owmen. The criminal code was also noted as addressing rights of victims for sexual assault.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?:

Yes

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

No respondents were able to identify whether there was an HIV & STI policy in existence which protected human rights. A number of respondents thought that the National HIV Strategic Plan (in development) as implemented/monitored by NAC and/or the Ministry of Health would provide this opportunity, with its focus on creating an inclusive society and reducing stigma and discrimination.

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and/or other vulnerable sub-populations?:

No

6. Does the country have a policy or strategy of free services for the following?

Provided free-of-charge to all people in the country	Provided free-of-charge to some people in the country	Provided, but only at a cost
Yes	-	-

Yes

-

-

Yes

-

-

If applicable, which populations have been identified as priority, and for which services?:

Although the responses were mixed, most identified that in RMI< people have access to free antiretroviral drugs (although one was unsure whether all HIV care and treatment services were free), testing and condoms. Others noted that Youth to Youth offers its prevention/support services for free.

7. Does the country have a policy or strategy to ensure equal access for women and men to HIV prevention, treatment, care and support?:

Yes

7.1. In particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?:

No

8. Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?:

Yes

IF YES, Briefly describe the content of this policy/strategy and the populations included:

Respondents were unclear. One noted that, as before, there is no current strategy in place, but draft strategy stresses equal access without specifically mentioning particular groups.

8.1

8.1. IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?:

No

9. Does the country have a policy or law prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?:

No

10. Does the country have the following human rights monitoring and enforcement mechanisms?:

a. Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work:

No

b. Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts:

No

IF YES on any of the above questions, describe some examples:

-

11. In the last 2 years, have there been the following training and/or capacity-building activities:

a. Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)?:

Yes

b. Programmes for members of the judiciary and law enforcement on HIV and human rights issues that may come up in the context of their work?:

No

12. Are the following legal support services available in the country?:

a. Legal aid systems for HIV casework:

Yes

b. Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV:

No

13. Are there programmes in place to reduce HIV-related stigma and discrimination?:

Yes

IF YES, what types of programmes?:

Programmes for health care workers:

Yes

Programmes for the media:

No

Programmes in the work place:

No

Other [write in]:

Programmes in faith-based organizations, particularly the Salvation Army.

14. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2011?:

3

Since 2009, what have been key achievements in this area:

Respondents were mixed in their rating of the policies laws and regulations in place to promote human rights in relation to HIV & STIs in 2011. The Domestic Violence Legislation (Bill 93) was clearly seen as an achievement affecting the status of women – and thereby reducing their vulnerability, particularly in the home. Others noted the enforcements by SSA and Kunit of the regulation around sales of alcohol and tobacco assisting the police on enforcing legislation and contribution to a reduction in public and associated violence.

What challenges remain in this area:

Generating awareness of policy and rights. Making the laws.

15. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the effort to implement human rights related policies, laws and regulations in 2011?:

4

Since 2009, what have been key achievements in this area:

Respondents identified the following achievements in the efforts to implement human rights related policies, laws and regulations: • There is now legislation to address domestic violence. • Establishment of the NAC, beginning the draft process for national strategic plan.

What challenges remain in this area:

Challenges are • Educating the public and access to people on outer islands. • Finishing, ratifying and implementing strategic plan. • Despite the achievement in getting the domestic violence legislation through, there is still much work to do to build the commitment of others civil society orgs to support WUTMI, including across the faith-based organizations and the irjs, some of whom are against the legislation because they fear that WUTMI is trying to bring up women to take over from men – to take over parliament, to take over decision-making in the household and in the parliament.

B - IV. PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?:

Yes

IF YES, how were these specific needs determined?:

Responses were mixed. Although some respondents identified agencies, such as Youth to Youth, who were clearly working with groups in response to specific needs (such as youth, schools, or counseling by the salvation army – with the youth, and in the neighborhoods), others were unsure of what the needs were. Others identified that the development of the new National Strategic Plan would identify specific needs for prevention programs, identifying the following target audiences: seafarers, young men, young women, pregnant women. These respondents also argued that prevention programs need to focus on behavior changes – knowledge is out there to some degree but need to strengthen our approach to behaviours; and the presumptive treatment awareness/screening campaign for Chlamydia.

1.1 To what extent has HIV prevention been implemented?

Blood safety:

Agree

Condom promotion:

Agree

Harm reduction for people who inject drugs:

N/A

HIV prevention for out-of-school young people:

Agree

HIV prevention in the workplace:

Disagree

HIV testing and counseling:

Disagree

IEC on risk reduction:

Agree

IEC on stigma and discrimination reduction:

Agree

Prevention of mother-to-child transmission of HIV:

Agree

Prevention for people living with HIV:

Agree

Reproductive health services including sexually transmitted infections prevention and treatment:

Agree

Risk reduction for intimate partners of key populations:

Agree

Risk reduction for men who have sex with men:

Strongly Disagree

Risk reduction for sex workers:

Strongly Agree

School-based HIV education for young people:

Agree

Universal precautions in health care settings:

Agree

Other [write in]:

Harm reduction programs for people who use substances/addictions- N/A Prevention programs in the outer islands-

DISAGREE

2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV prevention programmes in 2011?:

6

Since 2009, what have been key achievements in this area:

The key achievements in implementation of the HIV & STI prevention programs were: • Youth to youth does an excellent job educating young people; including the billboards on HIV and STIs • Establishment of NAC, outreach testing partnership between YTY and MOH, Chlamydia presumptive treatment campaign, widespread educational outreach in schools

What challenges remain in this area:

Challenges include: • Establishment of family life education/sex education curriculum in schools • Improve testing capacity • More attention to outer islands • Bridget the gap between condom knowledge and behavior change - Understanding how to change behaviors – if young people are not using condoms, then what do we need to do – “Planning ahead – do young people really do that?” • Addressing the cultural taboos – raising awareness in public, talking on the radio, having distribution of condoms – knowing how to use it, understanding why.

B - V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV and AIDS treatment, care and support services?:

Yes

IF YES, Briefly identify the elements and what has been prioritized:

The NAC is drafting a strategic plan focused four strategic areas: governance/coordination, strategic communication, prevention, and care/treatment.

Briefly identify how HIV treatment, care and support services are being scaled-up?:

They're still being established--not ready for scale up yet.

1.1. To what extent have the following HIV treatment, care and support services been implemented?

Antiretroviral therapy:

Agree

ART for TB patients:

Agree

Cotrimoxazole prophylaxis in people living with HIV:

Agree

Early infant diagnosis:

Agree

HIV care and support in the workplace (including alternative working arrangements):

Strongly Disagree

HIV testing and counselling for people with TB:

Agree

HIV treatment services in the workplace or treatment referral systems through the workplace:

Disagree

Nutritional care:

Agree

Paediatric AIDS treatment:

Agree

Post-delivery ART provision to women:

Agree

Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault):

Disagree

Post-exposure prophylaxis for occupational exposures to HIV:

Disagree

Psychosocial support for people living with HIV and their families:

Disagree

Sexually transmitted infection management:

Strongly Agree

TB infection control in HIV treatment and care facilities:

Agree

TB preventive therapy for people living with HIV:

Disagree

TB screening for people living with HIV:

Agree

Treatment of common HIV-related infections:

Agree

Other [write in]:

-

1.2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011?:

6

Since 2009, what have been key achievements in this area:

Few respondents were able to identify key achievements in this area.

What challenges remain in this area:

Challenges noted included: • stigma and fear of disclosure remain bigger obstacles than access to treatment, drugs, for example, patients are unwilling to visit the hospital for treatment, but are also reluctant to have MOH-affiliated vehicles visit them for fear of the community learning their status. • the need to ensure an island wide curriculum to educate children and adults of all ages on HIV & STIs, and broader sexual and reproductive health, to be presented in schools, churches, outer islands in English, Chinese, Marshallese, Tagalog.

2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?:

No

3. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?:

-

Since 2009, what have been key achievements in this area:

-

What challenges remain in this area:

-

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