# Survey Response Details

## Response Information

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## Response Details

### Page 1

**1) Country**

Marshall Islands (0)

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

Zachraias Zachraias

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**7) Date of submission:**

Please enter in DD/MM/YYYY format

31/03/2010

### Page 3

**8) Describe the process used for NCPI data gathering and validation:**

For the data gathering, we used different monitoring tools. We used the data from the HIV/AIDS database, Laboratory reports, TB database, and DHS Report 2007.

**9) Describe the process used for resolving disagreements, if any, with respect to the**

**responses to specific questions:**

Stakeholders were invited to participate and contribute to the Country Progress Report in a range of ways including consultation workshops, interviews and questionnaires. The multiple processes aimed to ensure the opportunity for the range of perspectives to be included in the Report. As a result of the multiple opportunities for engagement, this also meant there were multiple opportunities for differences in perspective to emerge. This was addressed by a range of strategies: • To ensure the broadest possible engagement in the identification and sourcing of data, government and community stakeholders were invited to a pre-planning workshop in August 2009 which identified the kind of data sought, sought input into the processes for identifying and sourcing data and outlined an agreed process for seeking data; • Differences in perspective on the progress of implementation and the quality of performance of the national response were ascertained and discussed in the consultation workshops held with government and community stakeholders during the data collection and analysis phase; in these workshops, the facilitator focused on seeking the range of perspectives in knowledge, identifying opportunities to test the evidence for claims and to assess different perspectives; where differences in perspective emerged, the facilitator aimed for understanding and learning across stakeholders. Where there was a significant difference in perspective that could not be resolved, the difference in understanding or assessment was noted. • The preliminary findings of the consultation workshops were presented to the mix of government and community stakeholders in the validation workshop for validation: again, there was an opportunity for discussion of views and substantial differences in perspective were noted. Gaps were noted for further exploration by the STA and MOH. Some differences in views were addressed through the presentation of evidence; other matters were agreed to form part of ongoing debate on the effectiveness of the national response and require ongoing consideration by the Ministry, civil society and donors. These were noted. • Preliminary findings were also presented to the Secretary for Health, and strategies to discuss some of the key issues were explored for the Ministry's ongoing consideration. • All stakeholders who were unable to participate in the consultation workshops were invited to also interview to ensure an opportunity for their perspectives to be considered in the data analysis. • MICNGOs agreed to coordinate the distribution and collection of questionnaires from civil society representatives. The opportunity and process for the submission of a Shadow Report was discussed with MICNGOs as an option should there be a view from CSOs that their perspective and voice was not 'heard'. This option was not pursued by CSO following the validation meeting.

**10)**

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

None

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**11)**

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

| | Organization Names/Positions | | Respondents to Part A [Indicate which parts each respondent was queried on] |
|---|---|---|---|
| Respondent 1 | MOH | Zachraias Zachraias / HIV Clinical Manager | A.I, A.II, A.III, A.IV, A.V |

**12)**

| | | | Respondents to Part A |
|---|---|---|---|

| | Organization | Names/Positions | [Indicate which parts each respondent was queried on] |
|---|---|---|---|
| Respondent 2 | MOH | Dr. Kenner Braind, Director of Primary Health Care | |
| Respondent 3 | MOH | Dr. Godfrey Waidubu/ Physician BOIHCS | |
| Respondent 4 | MOH | Theresia Kedi/ Global Fund HIV Coordinator | |
| Respondent 5 | MOH | Florina Nathan/ Chief Nurse Public Health | |
| Respondent 6 | MOH | Dr. Kevin Bisili/ OB GYN | |
| Respondent 7 | MOH | Hellen Jetnil-David/ RH Director | |
| Respondent 8 | MOH | Ione Debrum/ Health Promotion Director | |
| Respondent 9 | MOH | Zoya Tayag/ Global Fund Coordinator | |
| Respondent 10 | MOH | Mailynn Konelios-Lang/ Grant Manager | |
| Respondent 11 | MOH | Risa Bukbuk/ TB Program | |
| Respondent 12 | AG/MOJ | Rosania A Bennett/ Asst. AG | |
| Respondent 13 | MOIA | Lilly Samson | |
| Respondent 14 | MOE | Glorina Harris/Health | |
| Respondent 15 | MOE | Gideon Gideon / HIV | |
| Respondent 16 | MT&C | Joe Tiobech/ Port Authority | |
| Respondent 17 | CMI | Florence Peter/ Nursing | |
| Respondent 18 | MOH | Brenda Lee Baliguas/ Infection Control Nurse | |
| Respondent 19 | MOH | Altina Anien /STI Cooridinator | |
| Respondent 20 | MOH | Dwight P. Heine, MPH/ Asst. Secretary of Health | |
| Respondent 21 | MOH | Titus Bien/ Finance Manager | |
| Respondent 22 | UN/EPPSO | J.P. Yadav/UNV Statistician RMI MDG Project Manager | |
| Respondent 23 | | | |
| Respondent 24 | | | |
| Respondent 25 | | | |

**13)**

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

| | Organization | Names/Positions | Respondents to Part B [Indicate which parts each respondent was queried on] |
|---|---|---|---|
| Respondent 1 | YTYIH | Alicetha Katters/Adolescent Health Couselor | B.I, B.II, B.III, B.IV |

**14)**

| | Organization | Names/Positions | Respondents to Part B [Indicate which parts each respondent was queried on] |
|---|---|---|---|
| Respondent 2 | YTYIH | Molynne Joseph | |
| Respondent 3 | Waan Aelon in Majel, the Canoe Program | Jessica Brandt | |
| Respondent 4 | WUTMI | Mirim & Noni & Kathryn | |
| Respondent 5 | Mission Pacific/CARE | Amy Sasser | |
| Respondent 6 | Marshall Islands Council of NGOs | Bonny Taggart | |
| Respondent 7 | USP | Tamara Greenstone | |
| Respondent 8 | Association for the Handicapped | Parent representative | |
| Respondent 9 | Marshall Islands Epidemiology Information & Prevention Initiative | Maybelline Ipil | |
| Respondent 10 | USP Vocational Unit | USP Vocational Unit | |
| Respondent 11 | Majuro Church of Christ | Majuro Church of Christ | |
| Respondent 12 | KIO (Daughters of WUTMI) | KIO (Daughters of WUTMI) | |
| Respondent 13 | Marshalls Business Association | Marshalls Business Association | |
| Respondent 14 | Private citizen | Private citizen | |
| Respondent 15 | SPC Northern Regional Office | Emi Chutaro, Coordinator Northern Regional Office | |
| Respondent 16 | SPC | Kelly Robertson, ADB/Global Fund Representative | |
| Respondent 17 | SPC Northern Regional Office | Semenson/Finance Development Officers | |
| Respondent 18 | not known | | |
| Respondent 19 | not known | | |
| Respondent 20 | | | |
| Respondent 21 | | | |
| Respondent 22 | | | |

Respondent 23
Respondent 24
Respondent 25

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**15)**

**Part A, Section 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 (0)**

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**16)** **Part A, Section I: STRATEGIC PLAN**

**Question 1 (continued)**
**Period covered:**

2006 - 2009

**17)**

**1.1 How long has the country had a multisectoral strategy?**

**Number of Years**

4

**18)**

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

| | Included in strategy | Earmarked budget |
|---|---|---|
| Health | Yes | Yes |
| Education | Yes | Yes |
| Labour | Yes | |
| Transportation | Yes | |
| Military/Police | Yes | |
| Women | Yes | |
| Young people | Yes | |
| Other* | Yes | Yes |

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19) **Part A, Section I: STRATEGIC PLAN**

**Question 1.2 (continued)**
**If "Other" sectors are included, please specify:**

Civil Society Organisation (YTYIH, Mission Pacific, WUTMI, WAM, Church Faith organisation and etc)

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20)

**Part A, Section I: STRATEGIC PLAN**

**1.3 Does the multisectoral strategy address the following target populations, settings and crosscutting issues?**

| | |
|---|---|
| **Target populations** | |
| a. Women and girls | Yes |
| b. Young women/young men | Yes |
| c. Injecting drug users | Yes |
| d. Men who have sex with men | Yes |
| e. Sex workers | Yes |
| f. Orphans and other vulnerable children | Yes |
| g. Other specific vulnerable subpopulations* | Yes |
| **Settings** | |
| h. Workplace | Yes |
| i. Schools | Yes |
| j. Prisons | No |
| **Cross-cutting issues** | |
| k.HIV and poverty | Yes |
| l. Human rights protection | Yes |
| m. Involvement of people living with HIV | Yes |
| n. Addressing stigma and discrimination | Yes |
| o. Gender empowerment and/or gender equality | Yes |

21)

**1.4 Were target populations identified through a needs assessment?**

Yes (0)

**Page 10**

22)

**Part A, Section I: STRATEGIC PLAN**

**Question 1.4 (continued)**
**IF YES, when was this needs assessment conducted?**

Please enter the year in yyyy format

2006

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**23)**

## Part A, Section I: STRATEGIC PLAN

### 1.5 What are the identified target populations for HIV programmes in the country?

Prevention1. Youth: The youth population is 2. Out of school3. Taxi DriverScreening1. Pregnant Mother3. TB patients4. School Students College5. Immigrants6. Fishing Factory6. Chronic ill patients7. STD clients and sexual partners8. Pre-employment (applying for any job except food handlers)

**24)**

### 1.6 Does the multisectoral strategy include an operational plan?

Yes (0)

**25)**

### 1.7 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? | Yes |
| e. A monitoring and evaluation framework? | Yes |

**26)**

### 1.8 Has the country ensured "full involvement and participation" of civil society* in the development of the multisectoral strategy?

Moderate involvement (0)

**Page 12**

**27)**

### IF NO or MODERATE involvement, briefly explain why this was the case:

In April 2005, SPC consultant visit the Republic of the Marshall Islands to conduct a one week workshop with the staff of the MOH and representatives from the Civil Society. The purpose of the workshop was to create one National HIV Strategic Plan for Marshall Islands. First two days of the workshop was discussing on how to create a plan using many literature review and SPC guiding principles documents. There were more than twenty participants from the MOH and other government agencies including non-government organisations present to the workshop. After a lengthy discussion on how a plan is formed and what working priority RMI like to work on, the groups agree to work on the five working priorities and they priorities are: 1) Response to the HIV in the Republic of the Marshall Islands. 2) Prevention and treatment of the Sexually Transmitted Disease in the RMI. 3) Addressing the Vulnerable Groups in the RMI. 4) Caring and Treatment for

the PLWHA (People living with HIV and AIDS. 5) Provide safety blood to our blood donor clients (Blood Safety).Once the foundation or priorities have been identify, participants were divided into five groups and each group, there are 5-6 people and a priority is given to individual group to identify some goals and objectives. Next two days were designated for group work and each group select it chairperson and a reporter. On the fourth day or after the two days group work, each group presents their work on the priority, goal and objectives. Every group were able to list down at least 3-4 goals and objectives and identify key persons that need to follow and complete the group work and lastly propose timeframe to meet the milestones or activities. Because there were lot to discuss and added to the National Strategic Plan and it was a short time to cover many important issues, the consultant has to take all the work an compile them into one working plan and also assign relevance people to follow up on some of the unfinish issue such as the financial section. This was a learning experience and at the same time beneficial for RMI because at the time of the NSP implementation, RMI has not been a global fund member. The NSP was completed at the end of 2005 and approved for implementation from 2006 to 2009. Today, the plan is expire but there was an internal reviewed by the head of the ministry and few of the non-government organisation representatives that the plan is still valid and can continue on implementing the remain five priorities for the next five years (2010-2013)

**28)**

**1.9 Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?**

Yes (0)

**29)**

**1.10 Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?**

Yes, all partners (0)

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**30)**

**Part A, Section I: STRATEGIC PLAN**

**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?**

N/A (0)

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**31)**

**Part A, Section I: STRATEGIC PLAN**

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

No (0)

**Page 17**

**32)**

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

Yes (0)

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**33)**

**Part A, Section I: STRATEGIC PLAN**

**4.1 *IF YES*, which of the following programmes have been implemented beyond the pilot stage to reach a signifi cant proportion of the uniformed services?**

| | |
|---|---|
| Behavioural change communication | Yes |
| Condom provision | Yes |
| HIV testing and counselling | Yes |
| Sexually transmitted infection services | Yes |
| Antiretroviral treatment | Yes |
| Care and support | Yes |
| Other: Please specify | |

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**34)**

**Part A, Section I: STRATEGIC PLAN**

**Question 4.1 (continued)**
**If HIV testing and counselling *is provided* to uniformed services, briefly describe the approach taken to HIV testing and counselling (e.g, indicate if HIV testing is voluntary or mandatory etc):**

Since the police are government employees and consider not at risk group, it a voluntary basis for them to do HIV screening or testing.

**35)**

**5. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?**

Yes (0)

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**36)**

**Part A, Section I: STRATEGIC PLAN**

**5.1 *IF YES*, for which subpopulations?**

| | |
|---|---|
| a. Women | Yes |
| b. Young people | Yes |
| c. Injecting drug users | No |
| d. Men who have sex with men | Yes |
| e. Sex Workers | Yes |
| f. Prison inmates | No |
| g. Migrants/mobile populations | Yes |
| Other: STI Clients | Yes |

**37)**

**IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:**

1) Existing public law (Communicable Disease law) in place for addressing discrimination and stigma; 2) new PSC policy for all government employees to undergo physical examination including HIV screening; 3) Revised HIV policy on draft to address discrimination, stigma, confidentiallity , treatment and cares and social and spiritual support .

**38)**

**Briefly comment on the degree to which these laws are currently implemented:**

Although the MOH has drafted a national policy to provide guidance to health professionals on the protection of people living with HIV – particularly their right to access services free of stigma and discrimination and their right to confidentiality - the policy is yet to be translated into legislation under the guidance of the Attorney General and Nitijela.

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**39)**

**Part A, Section I: STRATEGIC PLAN**

**6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?**

Yes (0)

**Page 22**

**40)**

**Part A, Section I: STRATEGIC PLAN**

**6.1 *IF YES,* for which subpopulations?**

| | |
|---|---|
| a. Women | Yes |
| b. Young people | Yes |
| c. Injecting drug users | Yes |

| | |
|---|---|
| d. Men who have sex with men | Yes |
| e. Sex Workers | Yes |
| f. Prison inmates | |
| g. Migrants/mobile populations | Yes |
| Other: out of school youth and seafarers | Yes |

**41)**

### IF YES, briefly describe the content of these laws, regulations or policies:

HIV voluntary counseling and testing services should be especially encouraged and be made available in the states for the following individuals: a) women who receive antenatal care in health facilities; b) individuals volunteering to donate or blood for transfusion; c) individuals requesting HIV testing as a condition of employment or as may be required for travel to other countries; d) individuals who is contracting one of the sexually transmitted infectious such as syphilis, gonorrhea and Chlamydia. e) sexual partners of HIV and STI infected individuals; and, f) persons requesting or receiving inpatient, outpatient or emergency medical care who have indication of high risk of exposure to HIV. This includes but is not limited to persons: i. with high scores on the “Risk Assessment Forms;” and/or, ii. infected with other STIs, TB or “opportunistic infections;”and/or, iii. engaging in high-risk behaviors such as promiscuous sexual relations, sex work, men who have sex with men (MSM) or injecting drug use (IDU) and sea farers. Pre- and post-test HIV counseling in the RMI should be conducted by professional staff who are specially trained to assure that clients: understand why HIV testing is being performed; fully consent to being tested; are informed of the test results in a manner that is emotionally supportive and encourages risk reducing behavior; and, are appropriately referred for further care and treatment where indicated.

**42)**

### Briefly comment on how they pose barriers:

 Taboo nature of sex and sexuality  High unemployment  Limited number of youth programs throughout the country  Changes in levels of parental guidance  Low motivation of contraceptive use  Limited safer sex negotiation skills  Sex for money, alcohol or gifts  Changes in attitudes from restrictive to casual sex  High unemployment and limited economic growth  Alcohol and drug abuse  Fear and shame associated with positive HIV status  Fear of lack of confidentiality.  Limited IEC resources in Marshallese  Slower pace of sex and health education  Geographic isolation  Early age of sexual initiation  Lack of law enforcement, such as with commercial sex work  Limited understanding by Marshallese citizens of the law and its relation to HIV/AIDS  High mobility of people in the Marshall Islands  Limited participation by men in family planning and sexual health programs  Limited number of community organizations involved in reducing vulnerability  Gender inequality

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**43)**

### Part A, Section I: STRATEGIC PLAN

### 7. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?

No (0)

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**44)**

**Part A, Section I: STRATEGIC PLAN**

**7.3 Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?**

No (0)

**45)**

**7.4 Is HIV programme coverage being monitored?**

Yes (0)

**Page 26**

**46)**

**Part A, Section I: STRATEGIC PLAN**

**Question 7.4 (continued)**
**(a) IF YES, is coverage monitored by sex (male, female)?**

Yes (0)

**47)**

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

Yes (0)

**Page 27**

**48)**

**Part A, Section I: STRATEGIC PLAN**

**Question 7.4 (b) (continued)**
**IF YES, for which population groups?**

Data is collected from the STI program and HIV program in relation to those groups for whom screening in mandatory; and by age group.

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**49)** **Part A, Section I: STRATEGIC PLAN**

**Question 7.4 (continued)**
**(c) Is coverage monitored by geographical area?**

Yes (0)

**Page 29**

**50)**

**Part A, Section I: STRATEGIC PLAN**

**Question 7.4 (c) (continued)**
**IF YES, at which geographical levels (provincial, district, other)?**

**Yes, from the two key urban settings.**

**51)**

**7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?**

Yes (0)

**Page 30**

**52)**

**Part A, Section I: STRATEGIC PLAN**

**Question 7.5 (continued)**
**Overall, how would you rate strategy planning efforts in the HIV programmes in 2009?**

**6 (6)**

**53)**

**Since 2007, what have been key achievements in this area:**

A. Availability Of The Treatment And Cares: B. Capacity Buiding (Training On Ctr, Bcc And Hiv Clinical Care) C. Community Planning Group( Cpg): D. Health Education And Health Promotion. E. Blood Safety F. Prevention And Control Of Sexually Transmitted Disease G. Addressing Vulnerable Groups Like Women & Youth H. Monitoring And Evaluation System

**54)**

**What are remaining challenges in this area:**

1. Lack of human resource and capacity building. 2. Lack of resources such as vehicle and meeting space 3. Lack of testing kits or laboratory supplies 4. Lack of local technical assistance (grant writers) 5. Lack of manpowers to do hiv counseling and testing to the outer islands.

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**55)**

**Part A, Section II: POLITICAL SUPPORT**

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

| | |
|---|---|
| President/Head of government | No |
| Other high officials | No |

| | |
|---|---|
| Other officials in regions and/or districts | No |

**56)**

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

Yes (0)

**Page 32**

**57)**

**2.1 IF YES, when was it created?**

Please enter the year in yyyy format

1986

**58)**

**2.2 IF YES, who is the Chair?**

| | |
|---|---|
| Name | Dr. Kennar Briand |
| Position/title | Director pf Primary Health Care |

**59)**

**2.3 IF YES, does the national multisectoral AIDS coordination body:**

| | |
|---|---|
| have terms of reference? | No |
| have active government leadership and participation? | No |
| have a defined membership? | No |
| include civil society representatives? | No |
| include people living with HIV? | No |
| include the private sector? | No |
| have an action plan? | No |
| have a functional Secretariat? | No |
| meet at least quarterly? | No |
| review actions on policy decisions regularly? | No |
| actively promote policy decisions? | No |
| provide opportunity for civil society to influence decision-making? | No |
| strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting? | No |

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**60)**

**Part A, Section II: POLITICAL SUPPORT**

**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 (0)**

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**61)**

## Part A, Section II: POLITICAL SUPPORT

### Question 3 (continued)
### IF YES, briefly describe the main achievements:

There are few NGOs such YTYIH, Mission Pacific, Salvation and WUTMI that are actively involved in promoting and interact with the Ministry of Health in expanding the awareness and activity for HIV programs. • YTYIH: BCC training, condom distribution, training for peer educators, life skill training, producing media and video and etc. • Mission Pacific: Produce Video on HIV and IEC materials and etc. • WUTMI: Produce Video & Training on gender and women violent. 2. Conduct workshop on Health Issues include HIV topic. • Salvation Army: Site visit to outer islands to do HIV awareness and activity.

**62)**

### Briefly describe the main challenges:

Funding and manpower.

**63)**

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

Please enter the rounded percentage (0-100)

2

**64)**

### 5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

| | |
|---|---|
| Information on priority needs | No |
| Technical guidance | No |
| Procurement and distribution of drugs or other supplies | No |
| Coordination with other implementing partners | No |
| Capacity-building | No |
| Other: Please specify | No |

**65)**

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

No (0)

**Page 38**

**66)**

**Part A, Section II: POLITICAL SUPPORT**

**Question 6.1 (continued)**
**Overall, how would you rate the political support for the HIV programmes in 2009?**

7 (7)

**Page 39**

**67)**

**Part A, Section III: PREVENTION**

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

Yes (0)

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**68)**

**Part A, Section III: PREVENTION**

**1.1 IF YES, what key messages are explicitly promoted?**

Check for key message explicitly promoted (multiple options allowed)

a. Be sexually abstinent (0)
b. Delay sexual debut (0)
c. Be faithful (0)
d. Reduce the number of sexual partners (0)
e. Use condoms consistently (0)
f. Engage in safe(r) sex (0)
j. Fight against violence against women (0)
l. Greater involvement of men in reproductive health programmes (0)
o. Prevent mother-to-child transmission of HIV (0)

**69)**

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

No (0)

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**70)**

**Part A, Section III: PREVENTION**

**2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?**

Yes (0)

**71)**

**2.1 Is HIV education part of the curriculum in:**

| | |
|---|---|
| primary schools? | |
| secondary schools? | Yes |
| teacher training? | Yes |

**72)**

**2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?**

Yes (0)

**73)**

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

Yes (0)

**74)**

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

Yes (0)

**Page 42**

**75)**

**3.1 IF YES, which populations and what elements of HIV prevention do the policy/strategy address?**

Check which specific populations and elements are included in the policy/strategy

| | |
|---|---|
| Targeted information on risk reduction and HIV education | Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Prison inmates |
| Stigma and discrimination reduction | Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Prison inmates |

| | |
|---|---|
| Condom promotion | Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Prison inmates |
| HIV testing and counselling | Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Prison inmates |
| Reproductive health, including sexually transmitted infections prevention and treatment | Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Prison inmates |
| Vulnerability reduction (e.g. income generation) | Sex workers |
| Drug substitution therapy | Injecting drug user |
| Needle & syringe exchange | Injecting drug user |

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**76)**

**Part A, III. PREVENTION**

**Question 3.1 (continued)**
**Overall, how would you rate the policy efforts in support of HIV prevention in 2009?**

**7 (7)**

**77)**

**What are remaining challenges in this area:**

1. HIV PROGRAM 2. MOE 3. MOH 4. PORT AUTHORITY 5. POLICE

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**78)**

**Part A, III. PREVENTION**

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

Yes (0)

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**79)**

**Part A, III. PREVENTION**

**Question 4 (continued)**
**IF YES, how were these specific needs determined?**

Conduct survey

**80)**

**4.1 To what extent has HIV prevention been implemented?**

**The majority of people in need have access**

| HIV prevention component | |
|---|---|
| Blood safety | Agree |
| Universal precautions in health care settings | Agree |
| Prevention of mother-to-child transmission of HIV | Agree |
| IEC* on risk reduction | Agree |
| IEC* on stigma and discrimination reduction | Don't agree |
| Condom promotion | Agree |
| HIV testing and counselling | Agree |
| Harm reduction for injecting drug users | N/A |
| Risk reduction for men who have sex with men | Don't agree |
| Risk reduction for sex workers | Agree |
| Reproductive health services including sexually transmitted infections prevention and treatment | Agree |
| School-based HIV education for young people | Agree |
| HIV prevention for out-of-school young people | Agree |
| HIV prevention in the workplace | Don't agree |
| Other: please specify | |

**Page 47**

**81)**

**Part A, III. PREVENTION**

**Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?**

**7 (7)**

**Page 48**

**82)**

**Part A, Section IV: TREATMENT, CARE AND SUPPORT**

**1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).**

Yes (0)

**Page 49**

**83)**

**Part A, Section IV: TREATMENT, CARE AND SUPPORT**

**1.1 IF YES, does it address barriers for women?**

Yes (0)

84)

**1.2 IF YES, does it address barriers for most-at-risk populations?**

Yes (0)

85)

**2. Has the country identified the specific needs for HIV treatment, care and support services?**

Yes (0)

**Page 50**

86)

**Part A, Section IV: TREATMENT, CARE AND SUPPORT**

**Question 2 (continued)**
**IF YES, how were these determined?**

Yes, current setting now is the Ministry of Health under the HIV program is the only entity in the RMI responsible for the care and treatment of people living with HIV and AIDS. HIV counseling and testing are also conducted at the hospital and once a positive case is detected and confirmed, then a trained doctor and nurses are given the responsible to carry out treatment and care plan. On the other hand, PLWHA is given the option to disclose his or her HIV status to other working partners like internist, counselor, nurses, social workers, pastor, relative and etc for referral purposes and other treatment option like spiritual and family support. Unfortunately, the current clients have not decided to expose or disclose their status to other working partners. Therefore, it is difficult for the other working partners to know who are the HIV patients living on the island. At certain occasions, the clinical manager think the client need to be referred to a counselor or to see an pastor for spiritual support but it is so difficult without the client's approval to disclose his or her status to others. That place more burden on the program staffs because addition work has been given to the staffs. In addition, when clinical manager is off island attending conference or meeting and HIV staffs are given the responsibility to look after the clients and follow up any needs and something happen during this time or emergency event occur, most clients prefer to see and care by the clinical manager of the program. This type of incident can also give a burden to the staffs because sometime they don't know what to do. Overall solution to tackle this kind of problem is to do more clinical training and expand the number of trainee to make sure it accommodates the need of the program or hospital. The more number of training conducted here in RMI, the better chance to for the other to learn and assist in prevention and care and treatment.

87)

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

| HIV treatment, care and support service | The majority of people in need have access |
|---|---|
| Antiretroviral therapy | Agree |
| Nutritional care | N/A |
| Paediatric AIDS treatment | Agree |
| Sexually transmitted infection management | Agree |

| | |
|---|---|
| Psychosocial support for people living with HIV and their families | Agree |
| Home-based care | Agree |
| Palliative care and treatment of common HIV-related infections | Agree |
| HIV testing and counselling for TB patients | Agree |
| TB screening for HIV-infected people | Agree |
| TB preventive therapy for HIV-infected people | Agree |
| TB infection control in HIV treatment and care facilities | Agree |
| Cotrimoxazole prophylaxis in HIV-infected people | Agree |
| Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape) | |
| HIV treatment services in the workplace or treatment referral systems through the workplace | |
| HIV care and support in the workplace (including alternative working arrangements) | |
| Other: please specify | |

**Page 51**

**88)**

## Part A, Section IV: TREATMENT, CARE AND SUPPORT

**3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?**

**No (0)**

**89)**

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

Yes (0)

**Page 52**

**90)**

**Part A, Section IV: TREATMENT, CARE AND SUPPORT**

**Question 4 (continued)**
**IF YES, for which commodities?:**

Condoms, ARV

**Page 53**

**91)**

**Part A, Section IV: TREATMENT, CARE AND SUPPORT**

**Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?**

8 (8)

**Page 54**

**92)**

**Part A, Section IV: TREATMENT, CARE AND SUPPORT**

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

N/A (0)

**Page 57**

**93)**

**Part A, Section V: MONITORING AND EVALUATION**

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

In progress (0)

**Page 64**

**94)**

**4. Are M&E priorities determined through a national M&E system assessment?**

No (0)

**Page 65**

**95)**

**IF NO, briefly describe how priorities for M&E are determined:**

There does not appear to have been a national monitoring and evaluation assessment of the 2006-2009 NSP undertaken to date.

**96)**

**5. Is there a functional national M&E Unit?**

No (0)

**Page 66**

**97)**

**Part A, Section V: MONITORING AND EVALUATION**

**Question 5 (continued)**
**IF NO, what are the main obstacles to establishing a functional M&E Unit?**

Agreement and prioritisation on the skills and resources to support an M&E Unit.

**Page 70**

98)

**Part A, Section V: MONITORING AND EVALUATION**

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

**No (0)**

99)

**6.1 Does it include representation from civil society?**

No (0)

**Page 71**

100)

**7. Is there a central national database with HIV- related data?**

Yes (0)

**Page 72**

101)

**Part A, Section V: MONITORING AND EVALUATION**

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

HIV related data is held centrally by the STD & HIV Clinical Care manager. It covers information on the age, sex, location and means of transmission.

102)

**7.2 IF YES, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?**

Yes, all of the above (0)

**Page 73**

103)

**7.3 Is there a functional* Health Information System?**

| | |
|---|---|
| At national level | Yes |
| At subnational level | Yes |

**Page 74**

104) **Part A, Section V: MONITORING AND EVALUATION**

**For Question 7.2, you have checked "Yes, but only some of the above", please specify what the central database has included.**

**For Question 7.3, you have indicated "Yes" to "subnational level", please specify at what level(s)?**

Per Bureau and departments

105)

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

Yes (0)

106)

**9. To what extent are M&E data used**

**9.1 in developing / revising the national AIDS strategy?:**

5 (5)

107)

**Provide a specific example:**

There is the opportunity to draw on existing data in the future review of the NSP

**Page 75**

108) **Part A, Section V: MONITORING AND EVALUATION**

**9.2 To what extent are M&E data used for resource allocation?**

4 (4)

**Page 76**

109)

**Part A, Section V: MONITORING AND EVALUATION**

**9.3 To what extent are M&E data used for programme improvement?:**

**4 (4)**

**Page 77**

110) **Part A, Section V: MONITORING AND EVALUATION**

**10. Is there a plan for increasing human capacity in M&E at national, subnational and**

**service-delivery levels?:**

No (0)

**Page 78**

**111)**

**10.1 In the last year, was training in M&E conducted**

| | |
|---|---|
| At national level? | No |
| At subnational level? | |
| At service delivery level including civil society? | |

**Page 80**

**112)**

**Part A, Section V: MONITORING AND EVALUATION**

**10.2 Were other M&E capacity-building activities conducted other than training?**

No (0)

**Page 82**

**113)** **Part A, Section V: MONITORING AND EVALUATION**

**Question 10.2 (continued)**
**Overall, how would you rate the M&E efforts of the HIV programme in 2009?**

5 (5)

**114)**

**What are remaining challenges in this area:**

Need to review the programs and develop a strong M&E approach, built on reliable and rigorous surveillance, monitoring and evaluation data, systems and processes.

**Page 83**

**115)**

**Part B, Section I: HUMAN RIGHTS**

**1. Does the country have laws and regulations that protect people living with HIV against discrimination? (including both general non-discrimination provisions and provisions that specifi cally mention HIV, focus on schooling, housing, employment, health care etc.)**

Yes (0)

**Page 84**

**116)**

**Part B, Section I. HUMAN RIGHTS**

**1.1 IF YES, specify if HIV is specifically mentioned and how or if this is a general nondiscrimination provision:**

The National Guidelines are intended, in the words of the Guidelines, to 'include comprehensive information on ... legal and human right issues...'. They .identify provisions for the maintenance of privacy and confidentiality; the meaning of informed consent (to testing) and exceptions to the rule of informed consent; and the right to health care and medical treatment. The national Policy is intended to provide a framework for coherent activities to strengthen services for HIV, AIDS and STIS prevention care and treatment in ways which are: evidence based, ethically sounds, culturally appropriately ad fully affirm the rights of individuals family and communities. It identifies specific provisions to combat stigma and discrimination (section 7.2) and to promote ethical and human rights

**117)**

**2. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable subpopulations?**

Yes (0)

**Page 85**

**118)**

**Part B, Section I. HUMAN RIGHTS**

**2.1 *IF YES,* for which subpopulations?**

| | |
|---|---|
| a. Women | No |
| b. Young people | Yes |
| c. Injecting drug users | Yes |
| d. Men who have sex with men | Yes |
| e. Sex Workers | Yes |
| f. prison inmates | No |
| g. Migrants/mobile populations | Yes |
| Other: ] seafarers, antenatal women & their children, blood donors, those infected with STIs or TB or other infections. | Yes |

**119)**

**IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:**

MOH identifies the National Guidelines provide advice on ensuring that all people diagnosed/living with HIV are able to access appropriate proper and affordable health care services and medical

treatment. The Guidelines provide that if a health care workers refuses to treat a person living with HIV, the worker is to be reported to the Department; if the Department refuses to provide care, the person has redress by taking the matter to the HIV courts, which 'can review and overhaul the hospital's decision to refuse treatment' .

**120)**

## Briefly describe the content of these laws:

The Guidelines advise that the following principles guide access to HIV diagnosis/testing and care: • Clients' use of HIV CTR services should remains private and confidential personal information should not be divulged in to others in ways inconsistent with the client's original consent. • HIV testing should be voluntary and free of coercion; informed consent before testing is essential; and evidenced by the client's signature to informed consent. Exceptions to the rule (right/ obligation) for informed consent arise in the following situations: where a patient needs emergency care and is too unwell to give informed consent; in blood donations; where the patient is subject to a mental condition which prevents their ability to understand the nature and implications of the testing or treatment. Health care workers have an ethical and legal duty to keep patient information confidential – with exceptions arising in instances where the patient agrees to divulge information to others, the information relates to a child and the child's parents or guardians agree to share information; or the patient is dead, and again, the next of kin agrees to release information. The Guidelines also explicitly state that all persons under the RMI Constitution have a right to access affordable and proper health care services and medical treatment, including a right to proper care from a health care worker. It is against the law for a health care worker to refuse to treat a person because they have HIV; or to treat people with HIV any differently to other patients. The National Policy, at Section 7.2 specifically refers to the MOH's responsibility to combat stigma and discrimination through the development of programs to educate and inform the public about HIV, AIDS & STIS to reduce 'unfounded fear and shame' and generate community empathy and support for people affected by HIV AIDS & STIs. Clause 7.2.2 prohibits health personnel from 'any actions that stigmatise of discrimination against persons on account their suspected, perceived or known HIV status', especially in relation to participation or engagement in employment, studies, or access to health care. This extends to also prohibit health care workers from any 'speech, print display or other action that may be threatening or disrespectful to human autonomy or dignity of individuals perceived or know to be HIV infected'. These prohibitions also place a duty on health care workers to discourage or oppose such actions by others, be they individuals or groups. At section 7.3, the Policy affirms three 'ethical and rights affirming principles to be pursued in strengthening HIV, AIDS & STI prevention treatment and care in FSM (sic): the right to health; the right to confidentiality in relation to a person's medical status including information about their social or medical risk factors; and the right to decline HIV testing or follow-up at any stage in their care or treatment. The exceptions to these rights arise where it is necessary to share information for the care and support of individuals and families, or in compliance with specific legal reporting requirements defined the state or national government. Section 9.1 provides for a limit to criminalisation of HIV transmission to those cases where 'the index HIV infected person knows of his or her HIV status, fully understands how HIV is transmitted, acts with intention to transmit HIV and does, in fact, transmit HIV to another person.'.

**121)**

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

The effective implementation of the policy and guidelines requires a more extensive evaluation than that permitted in the course of the compilation of this Report. However, responses from a number of representatives from the MOH interviewed during the reporting period indicates MOH staff were familiar with the National Guidelines. There was anecdotal evidence gathered during interviews and in group consultations which suggested that not all stakeholders were either familiar or accepted and endorsed the existing obligations and duties placed on health care workers by the Guidelines. There were concerns expressed that either staff who 'needed to know' more about those cases diagnosed with HIV did not have access to that information; or that more staff 'needed to know'

who had been diagnosed with HIV so that they could 'take care of themselves' One senior staff member proposed protocols in direct contradiction to the provision for confidentiality and privacy explicitly noted under the Guidelines. Whilst the MOH advises that the policy 'is law', a number of typographical errors in the document also indicate that it is not yet finalised. It became evident through discussions with a number of stakeholders that the policy remains a draft document that has not been widely discussed across the MOH, and that it is yet to be presented to the Attorney Generals for legislative drafting and debate in the Nitijela. One member of the judiciary advised that, given other pressing health issues in the country – namely TB, Diabetes – and the limited numbers of actual diagnoses of HIV, there would be little community support for legislation to protect the rights of people living with HIV.

**Page 86**

**122)**

**Part B, Section I. HUMAN RIGHTS**

**3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations?**

Yes (0)

**Page 87**

**123)**

**Part B, Section I. HUMAN RIGHTS**

**3.1 *IF YES*, for which subpopulations?**

| | |
|---|---|
| a. Women | No |
| b. Young people | Yes |
| c. Injecting drug users | |
| d. Men who have sex with men | Yes |
| e. Sex Workers | Yes |
| f. prison inmates | |
| g. Migrants/mobile populations | |
| Other: Seafarers | Yes |

**124)**

**IF YES, briefly describe the content of these laws, regulations or policies:**

One respondent identified that commercial sex work, or prostitution, was illegal in the Marshall Islands; in addition, there is anecdotal information that a number of the commercial sex workers known to be in the country have entered RMI illegally;

**125)**

**Briefly comment on how they pose barriers:**

Policy constraints and barriers: All college entrants are compulsorily required to undertake an STI test as part of their entrance requirements for College. If an STI is identified, an HIV test is

considered routine. Commercial sex activities: the combination of the illegality of commercial sexual activity, together to the likelihood that many commercial sex workers are in RMI illegally, presents the likelihood of a high risk of either deportation or criminal prosecution for protestation which may prevent/discourage commercial sex workers from seeking prevention, screening/testing or treatment services. In addition, they may also be unable to access clinics during opening hours. (WHY Sea Farers: Whilst legal sea farers are able to access hospital services, there was a view expressed that if sea farers are in RMI without a valid visa, they might not be able to access treatment/prevention services; in addition, various shipping company policy was considered a factor which may prevent seafarers from seeking these services. The reason for this view was not clear. Outer-islanders: HIV clinic only available on Ebaye and Majuro.

**Page 88**

**126)** **Part B, Section I. HUMAN RIGHTS**

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

Yes (0)

**Page 89**

**127)**

**Part B, Section I. HUMAN RIGHTS**

**Question 4 (continued)**
**IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:**

The RMI's National Strategic Plan 2006-2009 identifies four principles which endorse the following rights: • All those who are tested for HIV have the right to know their result, and the result is confidential • Adolescents youth (12-19) have the right to access testing without parental consent • All persons living with HIV have the right to refuse treatment, and to choose whether or not to disclose their HIV status publicly • These rights are protected by government, legislation and through community support The principles also advise that everyone (should) have access to information and education to prevent HIV & AIDS, and to affordable, confidential testing, treatment and counseling.

**128)**

**5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most-at-risk populations and/or other vulnerable subpopulations?**

No (0)

**Page 90**

**129)**

**6. Has the Government, through political and fi nancial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and programme implementation?**

No (0)

**Page 91**

**130)**

**7. Does the country have a policy of free services for the following:**

| | |
|---|---|
| a. HIV prevention services | Yes |
| b. Antiretroviral treatment | Yes |
| c. HIV-related care and support interventions | Yes |

**Page 92**

**131)**

**Part B, Section I. HUMAN RIGHTS**

**Question 7 (continued)**
**IF YES, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:**

The respondent who identified that RMI does provide free HIV prevention services explained that although family planning awareness campaigns during the 19990s had been successful in addressing the prevention of STDs including HIV, the increase in birth rates since then suggested that prevention efforts has been less effective. Despite the large extent of foreign aid funds available for HIV, local priorities have focused on environmental and primary health, including water sanitation, non-communicable diseases such as diabetes.

**132)**

**8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?**

No (0)

**Page 93**

**133)**

**9. Does the country have a policy to ensure equal access for most-at-risk populations and/or other vulnerable subpopulations to HIV prevention, treatment, care and support?**

Yes (0)

**Page 94**

**134)**

**Part B, Section I. HUMAN RIGHTS**

**Question 9 (continued)**
**IF YES, briefly describe the content of this policy:**

None of the 9 CSO respondents was aware of whether RMI has a policy to ensure access for most-at-risk populations and/or other vulnerable subpopulations to HIV prevention, treatment, care and support The National Plan specifically identifies the need to reduce the vulnerability of most at risk and other vulnerable populations including women, youth, seafarers, sex workers. The national Policy on CRT identifies a range of groups for screening on the basis of their vulnerability – including pregnant women, people diagnosed with an STD, including Hepatitis B; people with other STDs or concern about an STD; people who inject drugs; men who have sex with men; people who have recently moved to RMI (Foreign workers); pre-employment clients (annual); people diagnosed with TB ; blood donors; seafarers; commercial sex workers; sever malnutrition children.

**135)**

**9.1 IF YES, does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable sub-populations?**

No (0)

**Page 95**

**136)**

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

No (0)

**137)**

**11.Does the country have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?**

No (0)

**Page 97**

**138)**

**– 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**

Yes (0)

**139)**

**– Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment**

No (0)

140)

**– Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts**

No (0)

**Page 98**

141)

**Part B, Section I. HUMAN RIGHTS**

**Question 12 (continued)**
**IF YES on any of the above questions, describe some examples:**

The constitution provides for oversight of the promotion and protection of human rights through the judiciary. A recent visit by the UN Protection Review identified concern that programs and policies to promote human rights required strengthening. More information is required.

**Page 99**

142)

**Part B, Section I. HUMAN RIGHTS**

**13. In the last 2 years, have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and human rights issues that may come up in the context of their work?**

Yes (0)

143)

**– Legal aid systems for HIV casework**

Yes (0)

144)

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

Yes (0)

145)

**– Programmes to educate, raise awareness among people living with HIV concerning their rights**

Yes (0)

146)

**15. Are there programmes in place to reduce HIV-related stigma and discrimination?**

Yes (0)

**Page 100**

**147)**

**Part B, Section I. HUMAN RIGHTS**

**Question 15 (continued)**
**IF YES, what types of programmes?**

| | |
|---|---|
| **Media** | **Yes** |
| **School education** | **Yes** |
| **Personalities regularly speaking out** | **Yes** |
| **Other: Outreach activities to communities, outside of schools** | **Yes** |

**Page 101**

**148)**

**Part B, Section I. HUMAN RIGHTS**

**Question 15 (continued)**
**Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009?**

**1 (1)**

**149)**

**Since 2007, what have been key achievements in this area:**

The nine respondents were equally divided in their rating of the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009, with 3 respondents each rating implementation at 0, 1 and 2 respectively. Since 2007, what have been key achievements in this area? What are remaining challenges in this area: The explanations for these choices ranged from: The ratings of 0 and 1 were explained by the absence of information on the existence of policies, laws and regulations, with one respondent noting that the MOH does occasionally run a story on HIV & AIDS in the weekly full page advertisement in the Marshall Islands Journal, they were not aware of much else; and another suggesting that even if there were policies and laws in place, they would expect their implementation to be weak and does not address the 'real needs and concerns of people living with HIV', given their knowledge of the enforcement of other health-related policy and legislation in RMI. The respondents thought that the remaining challenges were numerous, with one indicating that health outreach and education programs should be a starting point and lack of knowledge of existing legislation and resources as two key issues. For those who rated the policies, laws and regulations at 2: whilst two respondents could not identify any achievements, one respondent noted that the Ministry of Health had worked well to keep the identity of HIV-positive patients confidential. The remaining challenges identified were: to achieve progress in this area, HIV needed to be made a priority (of government) and people needed to talk about it; another wondered/was undecided as to whether it was a measure the personal awareness or the ineffectiveness of awareness campaigns on HIV-related policies, laws and regulations – or the fact that they did not exist, that had contributed to his/her ignorance of the existence of HIV-related policies, laws and regulations

**Page 102**

**150)**

**Part B, Section I. HUMAN RIGHTS**

**Question 15 (continued)**
**Overall, how would you rate the efforts to enforce the existing policies, laws and regulations in 2009?**

**1 (1)**

**151)**

**Since 2007, what have been key achievements in this area:**

Apart from two absences, all the respondents rated the effort to enforce the existing policies, laws and regulations as they had rated whether they were in place (above) and confirmed that similar strategies were required to take these challenges of implementation/enforcement forward also.

**Page 103**

**152)**

**Comments and examples:**

Although there was a view amongst the CSO respondents that civil society had an important role to play in the strengthening of political commitment of top leaders and national strategy/policy formulations, few of the CSO respondents were able to identify how civil society has contributed to strengthening the political commitment of top leaders and national strategy or policy. One described their contribution as minimal; another thought there was no contribution; another described the contribution of civil society as 'hands-off'., another notes that, when civil society is invited to participate, its contribution is strong; one commentator provided an explanation for the 'limited' response of civil society, noting that civil society and government (services) rarely work together with projects or services usually done by one or the other and rarely ever in collaboration. This perception was contrasted by the ways civil society organisations described collaboration between themselves during the workshops. Only YTYIH was able to describe a strong relationship of collaboration between the Ministry of health, particularly the HIV and STI program, in relation to the provision of awareness and education sessions as well as the STI Outpatients Clinic at the YTYIH Centre. Comments and examples: WUTMI – through seminars and awareness campaigns in: domestic violence, gender equality and leadership, parenting skills, women's rights. YTYIH – serves as part of the national strategy for STI/HIV education/prevention; partners with MOH/hospital ot delvier the STI clinic and prevention and education activities. MI-EPI – recognised for its work in substance abuse prevention and data collection on SA issues; advocating to change tobacco and alcohol laws, especially in relation to sales to minors.

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**153)**

**Comments and examples:**

Very few of the 9 CSO respondents seem to have been involved in the planning and budgeting process for the National Strategic Plan on HIV. One respondents identified the UNGASS pre-planning workshop in 2009 as an example of 'the most collaboration' between CS and government in the three years they had worked with their community organisation. Two respondents indicated they were not aware that there was a national strategy on HIV; others described civil society

involvement as ‘to no extent’. A number did not respond to the question.

**Page 105**

**154)**

**Comments and examples:**

One respondent who was not familiar with RMI’s national Strategic Plan was able to identified YTYIH as the ‘primary’ organisation ‘involving HIV’. Another: ‘really don’t know’.

**Page 106**

**155)**

**Comments and examples:**

None of the CSO respondents were able to offer examples.

**Page 107**

**156)**

**Comments and examples:**

Two respondents identified Youth to Youth in Health as the primary HIV prevention organisation, noting that it works with sex workers, prisoners and youth. The remaining respondents were unable to identify any other civil sector representation in HIV efforts, particularly none in relation to ‘diverse’ organisations. One respondent attributed this to the interest of such groups in keeping a low profile because it is a small community where people are readily recognised.

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**157)**

**a. adequate financial support to implement its HIV activities?**

3 (3)

**158)**

**b. adequate technical support to implement its HIV activities?**

3 (3)

**159)**

**Comments and examples:**

Overall, respondents to the questionnaire were not familiar with the extent of financial support available in RMI to implement HIV activities; most did not know what funding was available, or who contributed funds. One respondent indicated that they thought most financial support was directed towards the government, and another indicated was aware that Youth to Youth In Health also received financial support. One suggested that there was the need for more programs and evidence based practices, should more resources (funding, training, capacity building) become available.

**Page 109**

**160)** **Part B, Section II. CIVIL SOCIETY PARTICIPATION**

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

| | |
|---|---|
| Prevention for youth | <25% |
| **Prevention for most-at-risk-populations** | |
| - Injecting drug users | <25% |
| - Men who have sex with men | <25% |
| - Sex workers | <25% |
| Testing and Counselling | <25% |
| Reduction of Stigma and Discrimination | <25% |
| Clinical services (ART/OI)* | <25% |
| Home-based care | <25% |
| Programmes for OVC** | <25% |

**Page 110**

**161)**

**Since 2007, what have been key achievements in this area:**

One respondent identified the launch of the new condom program 'the Defender' by Youth to Youth in Health as a key achievement: the Defender was specifically marketed for the local market as a strategy to reduce the number of HIV cases in RMI. Two respondents identified YTYIH as a key achievement, one noting it was the only local NGO dealing with HIV-related issues. Another respondent identified the engagement of CSOs in the discussion of the UNGASS report as a positive step forward.

**162)**

**What are remaining challenges in this area:**

One respondents identified the need for more public awareness campaigns targeting at risk populations, especially in schools where programs such as sex education can be easily implemented in their curriculum. Two respondents identified the importance of collaboration between CSO and government as key challenges; with one also noting the importance of funding, and the other commenting that it is important to build the 'voice' of CSOs as well as Government. Two respondents did not comment at all.

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**163)**

**Part B, Section III: PREVENTION**

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

No (0)

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**164)**

## IF NO, how are HIV prevention programmes being scaled-up?

None of the respondents to the questionnaire considered that RMI had identified specific needs for the HIV prevention programs. One respondent thought that it was under consideration, but that nothing concrete had been implemented or decided. Another respondent indicated they were unaware of any scale up in any programs. Another responded that blood donations were now screened.

**165)**

## 1.1 To what extent has HIV prevention been implemented?

| | The majority of people in need have access |
|---|---|
| **HIV prevention component** | |
| Blood safety | N/A |
| Universal precautions in health care settings | Don't agree |
| Prevention of mother-to-child transmission of HIV | Don't agree |
| IEC* on risk reduction | Don't agree |
| IEC* on stigma and discrimination reduction | Don't agree |
| Condom promotion | Agree |
| HIV testing and counselling | Agree |
| Harm reduction for injecting drug users | N/A |
| Risk reduction for men who have sex with men | Don't agree |
| Risk reduction for sex workers | Don't agree |
| Reproductive health services including sexually transmitted infections prevention and treatment | Don't agree |
| School-based HIV education for young people | Don't agree |
| HIV prevention for out-of-school young people | Don't agree |
| HIV prevention in the workplace | Don't agree |
| Other: Hotline services for HIV and other needs | Agree |

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**166)**

## Since 2007, what have been key achievements in this area:

One respondent thought that YTYiH's scale up of its condom promotion activities and promotional work with youth was a key achievement in the prevention area.

**167)**

## What are remaining challenges in this area:

The same respondent noted that although there was the opportunity to understand and access condoms, studies showed that not many people were actually using condoms – creating the changed behaviors to promote safer sexual behaviors (using condoms) was a key challenge. They also noted the need to increase the focus on other at risk populations, such as sex workers and

seafarers; as well as increase the implementation of programs to address STI prevention and treatment.

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**168)**

## Part B, Section IV: TREATMENT, CARE AND SUPPORT

### 1. Has the country identified the specific needs for HIV treatment, care and support services?

Yes (0)

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**169)**

## Part B, Section IV: TREATMENT, CARE AND SUPPORT

### Question 1 (continued)
### IF YES, how were these specific needs determined?

Only two respondents thought that RMI had identified the specific needs for HIV treatment care and support services. One respondent was familiar with the 2006-2009 National Strategic Plan, which invited representatives from across the sectors to share ideas. This respondent was familiar with prevention activities: YTYIH's HIV & STI awareness campaigns, and volunteer sex education activities sometimes undertaken by teachers. However, they were not familiar with any government based programs or services to educate Marshallese on the availability of medical treatment for HIV+ Marshallese. The same respondent noted that although there were aware that there had been 24 cases of HIV in Majuro, they 'have no idea where the people are, or what they do, or if they are still here sleeping around or confined or in Hawai'i getting treatment or what'. Another respondent thought that RMIs' approach to treatment and care programs may have been drawn from the experience of other countries – this respondent was not able to comment on whether the existing services were being scaled up. Another respondent noted that they did not know much about treatment care and support services, although they thought that numbers about the number of HIV positive cases seems more accessible, with the identity of the HIV positive patients remaining confidential. While one respondent was able to identify that testing services were available; another respondent noted that they were not really able to comment on whether people who needed were able to access relevant HIV treatment, care and support services – but that they had not heard of any of these services being provided in Majuro. Another respondent agreed that they did not know anything about access to treatment and care services in Majuro.

**170)**

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

| HIV treatment, care and support service | The majority of people in need have access |
|---|---|
| Antiretroviral therapy | N/A |
| Nutritional care | Don't agree |

| | |
|---|---|
| Paediatric AIDS treatment | Don't agree |
| Sexually transmitted infection management | Don't agree |
| Psychosocial support for people living with HIV and their families | Don't agree |
| Home-based care | Don't agree |
| Palliative care and treatment of common HIV-related infections | Don't agree |
| HIV testing and counselling for TB patients | Don't agree |
| TB screening for HIV-infected people | Don't agree |
| TB preventive therapy for HIV-infected people | Don't agree |
| TB infection control in HIV treatment and care facilities | Don't agree |
| Cotrimoxazole prophylaxis in HIV-infected people | N/A |
| Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape) | N/A |
| HIV treatment services in the workplace or treatment referral systems through the workplace | Don't agree |
| HIV care and support in the workplace (including alternative working arrangements) | Don't agree |
| Other: please specify | |

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**171)**

**Since 2007, what have been key achievements in this area:**

One respondent noted that they understood that, since 2008, people infected/living with HIV on RMI no longer need to relocate to the mainland to seek treatment. RMI hospital can now supply them with antiretroviral drugs. There is funding for treatment.

**172)**

**What are remaining challenges in this area:**

One respondent questioned whether there are any support programs for those living with HIV. Another respondent, who said that they did not know anything about the treatment and care services available, also noted that they had had an HIV test at Majuro Hospital on a number of occasions because it was a condition of their work permit: they described an occasion when they were sitting with the form waiting for their blood to be taken, and discovered that a person sitting beside them also was waiting for an HIV test and that each had the same identification number on the form. When they reported this to the staff, they were each given new numbers. On a second occasion, the hospital lost their blood sample and had to have another sample taken.

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**173)**

**Part B, Section IV: TREATMENT, CARE AND SUPPORT**

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

N/A (0)