SOLOMON ISLANDS

GLOBAL AIDS RESPONSE PROGRESS REPORT 2015

STI/HIV UNIT OF THE MINISTRY OF HEALTH AND MEDICAL SERVICES

3/31/2015

FOREWORD

At the June 2011 United Nations General Assembly High Level Meeting on AIDS which took place in New York, Member States adopted a new Political Declaration which contained new targets to effectively respond to the AIDS epidemic. The 2011 Political Declaration mandates UNAIDS to support countries in reporting back on progress made towards achieving the new commitments. It also provides for the UN Secretary-General to report regularly to the General Assembly on progress achieved in realizing these commitments.

In 2014, Solomon Islands continued its commitment to the 2011 Political Declaration through reviewing and aligning the National Strategic Plan for HIV/AIDS and STI to the Declaration of Commitment on HIV/AIDS of 2011, identifying the country priorities and making estimations for the resource needs. We are proud of many activities implemented during the years to ensure wide information dissemination, advocacy, education and availability of HIV Testing and Counselling to all citizens of Solomon Islands, which has brought us to the present state where the national emphasis is now shifting to quality of services.

The revised NSP 2014-2018 shows evidence of raised expectations of the Government of Solomon Islands translated into figures and a performance based evidence of the key players in the national response to HIV&AIDS. There is also a rising expectation on the Government, not only to honour the commitment to the Political Declaration on AIDS endorsed in 2011 but also to ensure that the interventions set out to reach the commitments are successful, constructive and accountable. Common objectives such as reaching 'Universal Access to Prevention, Care and Treatment' and the Political Declaration of 2011 helped us to realize that HIV is one of the world's challenges which is highly interconnected and complex for any country to handle. These challenges further consolidate the need for greater collaboration between government and the civil society.

This is the official report for 2014 submitted by the Government of Solomon Islands to the UNAIDS Secretariat for the monitoring of progress towards the targets set in the 2011 Political Declaration on HIV/AIDS. This submission will form part of the basis of the UN Secretary-General's report to the General Assembly as well as the 2015 End of Year Report on the Global AIDS Epidemic.

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Dr. Henry Kako
Director STI/HIV Unit
Ministry of Health and Medical Services

STATEMENT BY THE MHMS ON THE OFFICIAL SUBMISSION

This report on the progress made in the Solomon Islands AIDS response between January and December 2014 was developed through a consultative process involving all the major stakeholders involved in the response. The report highlights the achievements, challenges and lessons learnt in the Solomon Islands AIDS response in the thematic areas of Prevention, Treatment, Care and Support as well as Health Systems Strengthening; in line with the UNAIDS Guidelines for Global AIDS Response Progress Reporting 2015.

The process for developing this report was led by the STI/HIV Unit of the Ministry of Health and Medical Services. UNAIDS and UNICEF provided technical support to the report writing process.

I wish to express my sincere thanks to the STI/HIV Unit and all partners for their contributions in this regard.

I also take this opportunity to convey our great appreciation to all the stakeholders in the national response including but not limited to the government line ministries, civil society, UN agencies, International NGOs, private sector, bilateral and multi-lateral agencies that have been contributed to the response since the Political Declaration in June 2011. I pay special tribute to the stakeholders who have been active in the national response during the reporting year 2014, and those who have participated directly in the reporting process through providing data and information, reviewing of the draft and participating in the different consultations held.

Lastly, I would like to extend special thanks to Mr. Sam O. Opwonya of UNICEF for steering the entire process of assembling and synthesizing the information for this report, and Ms. Gabriela Ionascu of UNAIDS for guiding the drafting and completion of the report.

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Dr. Tenneth Dalipanda
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Ministry of Health and Medical Services

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ACRONYMS AND ABREVIATIONS

AHC	Area Health Clinic
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
AOP	Annual Operational Plan
AOR	Adjusted Odds Ratio
ART	Anti Retroviral Therapy
ARV	Anti Retroviral drugs
BCC	Behavioural Change Communication
C4D	Communication for Development
CPT	Cotrimoxazole Preventive Therapy
CSO	Civil Society Organisation
CPR	Contraceptive Prevalence Rate
DFAT	Department of Foreign Affairs and Trade
DHS	Demographic and Health Survey
EID	Early Infant Diagnosis
EVA	Especially Vulnerable Adolescents
FBO	Faith Based Organisation
FEFO	First Expiry First Out
FIFO	First In First Out
GARPR	Global AIDS Response Progress Report
GBV	Gender Based Violence
GESI	Gender Equity and Social Inclusion
GFP	Gender Focal Point
GoA	Government of Australia
HBsAg	Hepatitis B surface Antigen
HCC	Honiara City Council
HDR	Human Development Report
HIES	Household Income and Expenditure Survey
HIS	Health Information System
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
HR	Human Resources
HRH	Human Resources for Health
HSS	Health Systems Strengthening
HSSP	Health Sector Support Programme
IEC	Information Education and Communication
IP	Implementing Partner
IPT	Isoniazid Preventive Therapy
IPV	Intimate Partner Violence
KAP	Knowledge Attitude and Practice
KPI	Key Performance Indicator
M&E	Monitoring and Evaluation

MDG	Millennium Development Goal
MDR	Multi Drug Resistant
MHMS	Ministry of Health and Medical Services
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSM	Men having Sex with Men
MWYCFA	Ministry of Women, Youth, Children and Family Affairs
NCD	Non Communicable Diseases
NDS	National Development Strategy
NGO	Non Governmental Organisation
NHSP	National Health Strategic Plan
NMS	National Medical Stores
NRH	National Referral Hospital
NSP	National Strategic Plan
NTP	National Tuberclosis Programme
OI	Opportunistic Infection
PHC	Primary Health Care
PHIS	Provincial Health Information System
PICT	Pacific Island Countries and Territories
PITC	Provider Initiated Testing and Counselling
PLHIV	Persons Living with HIV
PNG	Papua New Guinea
PWD	Persons With Disabilities
PMTCT	Prevention of Mother To Child Transmission of HIV
PoC	Point of Care
PPTCT	Prevention of Parent To Child Transmission of HIV
PS	Permanent Secretary
PSC	Public Service Commission
RHC	Rural Health Clinic
RDP	Role Delineation Policy
RDT	Rapid Diagnostic Test
RH	Reproductive Health
RMNCAH	Reproductive Maternal Newborn Child and Adolescent Health
RPR	Rapid Plasma Reagin
RWASH	Rural Water, Sanitation and Hygiene
S4D	Sports for Development
SBD	Solomon Dollars
SGSS	Second Generation Sentinel Survey
SI	Solomon Islands
SIFHS	Solomon Islands Family Health and Safety Study
SIG	Solomon Islands Government
SINAC	Solomon Islands National AIDS Council
SINCCM	Solomon Islands National Country Coordinating Mechanism

SIPPA	Solomon Islands Planned Parenthood Association
SPC	Secretariat of the Pacific Community
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SW	Sex Worker
SWAp	Sector Wide Approach
TA	Technical Assistance
TB	Tuberclosis
TPHA	Treponema Pallidum Haemagglutination Assay
UNAIDS	United Nations Joint Programme on AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US	United States
USD	United States Dollars
VAW	Violence Against Women
VCCT	Voluntary Confidential Counselling and Testing
WB	World Bank
WHO	World Health Organisation
YFHS	Youth Friendly Health Services

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I. STATUS AT A GLANCE

Since the first HIV case was discovered in Solomon Islands in 1994, the majority of people tested for HIV in the country to-date has been through Client Initiated Testing and Counselling accessed at Voluntary Confidential Counselling and Testing sites. Refusal to participate in HIV testing has been reported high in previous studies, such as in the 2008 SGSS, where 17% of the total 407 ANC study participants and 76% of the 392 youth participants excluded from HIV testing because they declined to take the test.

Available data shows that a high number of people are infected with STIs across the country. The Provincial Health Information System (PHIS) data for 2014 shows that there were 2,037 men reported with urethral discharge and 538 adults reported with genital ulcer identified through syndromic diagnosis of STIs during the reporting year. The large youth population, urban migration, high STI burden, high rates of Gender Based Violence (GBV), gender inequality, and proximity to Papua New Guinea where the HIV/AIDS epidemic is generalised, are all factors that place Solomon Island populations, particularly its youth, at risk of STIs and HIV infection. Condom use has been very low in the country as per surveillance studies in the last 10 years. Most study estimates are below 20%, with the highest at 26% for condom at last sex by men with a non-marital, non-cohabiting partner (2008 DHS), and 45% for consistent condom use by youth with non-commercial partners (2005 SGSS);

In Solomon Islands, more women (11) than men (4) are currently living with HIV. Social and cultural norms, including gender inequality and high rates of gender-based violence, contribute to women and girls' risk and vulnerability to infection and contribute to barriers in access to HIV services, however, men have less access and are less responsive to uptake of HIV&AIDS services. Of the 10 PLHIV who have so far died in the country, 7 were male and 3 were female. Primary Health Care facilities continue to have a strong focus on pregnant women and children; and access of young people and men through the PHC system, and especially vulnerable groups such as men that have sex with men is inhibited. There are four youth friendly clinics in the country – a good start, but insufficient to meet needs given lack of young people's access to alternative sources of reproductive and sexual health information and clinical services and products.

Young men and women are known to exchange sex for cash, food and goods. Increased sex work is connected to areas of economic activity including mining, logging, canning and infrastructure projects, but detailed evidence of the scale of sex work and risk factors is not available. An assessment of vulnerable groups in 2006 by Save the Children attracted the participation of just 6 men having sex with men and 38 sex workers, providing evidence of the existence of these two vulnerable groups in the country.

HIV&AIDS Treatment services are available at three health facilities nationwide which include the National Referral Hospital (NRH) in Honiara, Helena Goldie Hospital in Western Province and Kilu'ufi Hospital in Malaita Province. ARVs are procured, distributed and monitored regionally through the Global Fund, and the STI/HIV Unit monitors use of treatment through a HIV Core Care team which was set up in 2008 and more members recruited in 2014. Stigma and discrimination continues to challenge prevention, treatment, care and support efforts for HIV in the country. Economic constraints, including the cost of mobility due to geography and transport, are also barriers to client retention and follow-up for HIV treatment, care and support.

Available evidence indicates that Solomon Islands has a low prevalence rate of HIV among TB patients. However, this low prevalence could be misleading given that there is a weak TB/HIV programme collaboration in the country and not all TB patients are tested for HIV through PITC as recommended. In 2014 alone, out of a total 344 confirmed TB cases, only 45 were tested for HIV and 1 of them was HIV reactive. Low testing for HIV in the TB clinics is attributed to lack of HIV test kits and supplies, National TB Programme decision not to test all children due to the need for consent from their parents, and the challenge that many of the TB sites are not certified by the MHMS to conduct HIV Testing and Counselling. Also, the possibility of poor quality of pre-test Counselling during PITC cannot be overruled.

Solomon Islands' Ministry of Health and Medical Services (MHMS) is responsible for policy formulation and implementation, and coordination of the response in the country through the HIV & STI Unit. However, the Solomon Islands National AIDS Council (SINAC) also co-exists with somewhat duplicate roles in the response as the MHMS, While SINAC is responsible for the oversight of the National HIV Response, it is also complimented by another platform, the Solomon Islands National Country Coordinating Mechanism (SINCCM) whose mandate and focus is essentially the Global Fund Grant management, coordination and implementation processes for Tuberculosis, HIV/AIDS and Malaria. This challenge of more than one coordination structure for the response in the country poses a significant threat to having a streamlined well coordinated response to the epidemic in the country.

Another major challenge being faced in the Health Sector is in the area of strategic information, data collection and management, as well as procurement and supply chain management system especially in the monitoring the stock of drugs and other medical supplies and commodities in health facilities. There are no stock cards or tools for monitoring distribution, consumption and expiry of drugs and other medical supplies or commodities by all health facilities including the National Referral Hospital. For instance, HIV test kits are sent out to the Points of care providing HIV Testing and Counselling but no follow-up is made or tools developed to monitor the stock going out, or the consumption capacity per facility. This creates a high risk of expiry of drugs and stock-outs in the country's health facilities.

a) Indicator Data Overview Table

Table 1: indicator overview table

Target		***Indicators***	***Value***	***Source***	***Comments***
Target 1. Reduce sexual transmission of HIV by 50 per cent by 2015	*Indicators for the general population*	1.1 Young People: Knowledge about HIV Prevention*	N/A	N/A	No new national level survey was conducted during the reporting period
		1.2 Sex Before the Age of 15	N/A	N/A	Same comment as above
		1.3 Multiple sexual partners	N/A	N/A	Same comment as above
		1.4 Condom Use During Higher Risk-Sex*	N/A	N/A	Same comment as above
		1.5 HIV Testing in the General Population	N/A	N/A	Same comment as above
		1.6 HIV prevalence in young people	N/A	N/A	Same comment as above
	Indicators for sex workers	1.7 Sex Workers: Prevention programmes	79	SIPPA Annual Report 2014	Solomon Islands Planned Parenthood Association (SIPPA) is a local NGO working with 79 Sex Workers in Honiara Town Council
		1.8 Sex Workers: Condom Use	79	SIPPA	Participated in condom demonstration and are receiving condoms
		1.9 Sex Workers: HIV Testing	20	SIPPA	20 out of 79 SWs volunteered to test for HIV. None of them tested HIV positive
		1.10 Sex Workers: HIV Prevalence	0	SIPPA	Of the 79 sex workers, 20 were tested for HIV and none was reactive
	Indicators for men who have sex with men	1.11 Men who have sex with men: Prevention programmes	15	SIPPA	In 2014, SIPPA recruited 15 MSM and reached them with health education on HIV
		1.12 Men who have sex with men: Condom Use	0	N/A	No organization reported on this
		1.13 Men who have sex with men: HIV Testing	0	N/A	No organisation reported on this
		1.14. Men who have sex with men: HIV Prevalence	0	N/A	N/A

	Testing and Counselling	1.15 Number of Health facilities that provide HIV Testing and Counselling services	17	PHIS	Buala Hospital in Isabel is certified to conduct HIV Testing and Counselling but there is no lab technician there because of lack of accommodation
		1.16 HIV Testing in 15+ (from programme records)	4,354	Lab register	Not disaggregated by age, post test 2,603
	Sexually Transmitted Infections	1.17 Sexually Transmitted Infections (STIs)			
		1.17.1 Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit	100%	ANC & Lab registers	This data only reflects health facilities where testing is done. It excludes AHCs & RHCs where ANC is conducted but no access to lab services
		1.17.2 Percentage of antenatal care attendees who were positive for syphilis	14%	ANC & Lab registers	1,127 out of 8,322
		1.17.3 Percentage of antenatal care attendees positive for syphilis who received treatment	64%	ANC & Lab registers	719 out of 1,127
		1.17.4 Percentage of sex workers with active syphilis	10%	SIPPA	20 SWs were tested by SIPPA and 2 tested positive for Syphilis
		1.17.5 Percentage of men who have sex with men (MSM) with active syphilis	N/A	N/A	No implementing partner reported on this
		1.17.6 Number of adults reported with syphilis (primary/secondary and latent) during the reporting period	2,095	ANC & Lab registers	
		1.17.7 Number of reported congenital syphilis cases (live births and stillbirth) during the reporting period	N/A	N/A	No data available
		1.17.8 Number of men reported with gonorrhoea during the reporting period	71	Lab register	This is only data from NRH, Gizo Hospital and Taro Hospital. With 7 from NRH, 7 from Gizo and 57 from Taro (NRH used culture test and the other two used gram stain test)
		1.17.9 Number of men reported with urethral discharge during the reporting period	2,037	PHIS	Provincial Health Information System
		1.17.10 Number of adults reported with genital ulcer disease	538	PHIS	Provincial Health Information System

	during the reporting period			
Target 2. Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015	2.1 People who inject drugs: Number of needles/IDU	N/A	N/A	No evidence on IDU in the country
	2.2. People who inject drugs: Condom Use	N/A	N/A	No evidence on IDU in the country
	2.3 People who inject drugs: Safe Injecting Practices	N/A	N/A	No evidence on IDU in the country
	2.4 People who inject drugs: HIV Testing	N/A	N/A	No evidence on IDU in the country
	2.5 People who inject drugs: HIV Prevalence	N/A	N/A	No evidence on IDU in the country
	2.6 People on opnoid substitution therapy	N/A	N/A	No evidence on IDU in the country
	2.7 NSP and OST sites	N/A	N/A	No evidence on IDU in the country
Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths	3.1 Prevention of Mother-to-Child Transmission			
	3.1 a Prevention of mother-to-child transmission during breastfeeding	0	0	No new births to HIV positive women during the reporting period
	3.2 Early Infant Diagnosis	0	0	No EID client identified during the reporting period
	3.3 Mother-to-Child transmission rate (modelled)	20%	MHMS STI/HIV Unit	One of 5 children so far born to HIV positive mothers, turned out HIV positive after being tested through PITC at 13 years during the reporting period
	3.3 a Mother-to-child transmission of HIV (based on programme data)	20%	MHMS STI/HIV Unit	See comment above
	3.4 Pregnant women who were tested for HIV and received their results	1,511	Lab and clinic records	Total tested was 2,388
	3.5 Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months	N/A	N/A	No data available on partners
	3.6 Percentage of HIV-infected pregnant women who had a CD4 test	0	N/A	No pregnant woman was diagnosed with HIV
	3.7 Infants born to HIV-infected women receiving ARV prophylaxis for prevention of Mother-to-child-transmission	0	MHMS STI/HIV Unit	All children born to HIV positive mothers are above 5 years of age now, but none of them ever received ARVs for PMTCT since birth

	3.9 Percentage of infants born to HIV-infected women started on cotrimoxazole (CTX) prophylaxis within two months of birth	0	MHMS STI/HIV Unit	All children born to HIV positive mothers are above 5 years of age now, but none of them ever received CTX prophylaxis since birth
	3.10 Distribution of feeding practices for infants born to HIV-infected women at DTP3 visit	0	0	None of the children on record as born to HIV positive women is in this age bracket.
	3.11 Number of pregnant women attending ANC at least once during the reporting period	8,322	ANC & Lab registers	Equals first visit
Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015	4.1 ART coverage (adults and children)* , including Number of eligible adults and children who newly enrolled on antiretroviral therapy during the reporting period	10	MHMS STI/HIV Unit	
	4.2 HIV Treatment: 12 months retention	2	HIV Register	They were diagnosed with HIV in 2013 but were initiated on ART in 2013, and are still on treatment to date
	4.2b HIV Treatment: 24 months retention	1	HIV register	Was diagnosed with HIV in 2012 and was initiated on ART the same year
	4.2c HIV Treatment: 60 months retention	4	HIV register	
	4.3 Health facilities that offer antiretroviral therapy	3	MHMS STI/HIV Unit	Helena Goldie Hospital (Western Province), Kiluufi Hospital (Malaita province) and the National Referral Hospital Honiara
	4.4 ART stock-outs	0	N/A	There were no stock-outs
	4.5 Late HIV diagnoses	2	HIV register	One in WHO Clinical Stage 3who was lost to followup and the other Stage 4 who later died the patient died
	4.6 HIV Care	2	HIV register	One has a CD4 of 500 and the other refused ART but is under care
	4.7 Viral load suppression	N/A	N/A	Viral Load Testing is not available in Solomon Islands

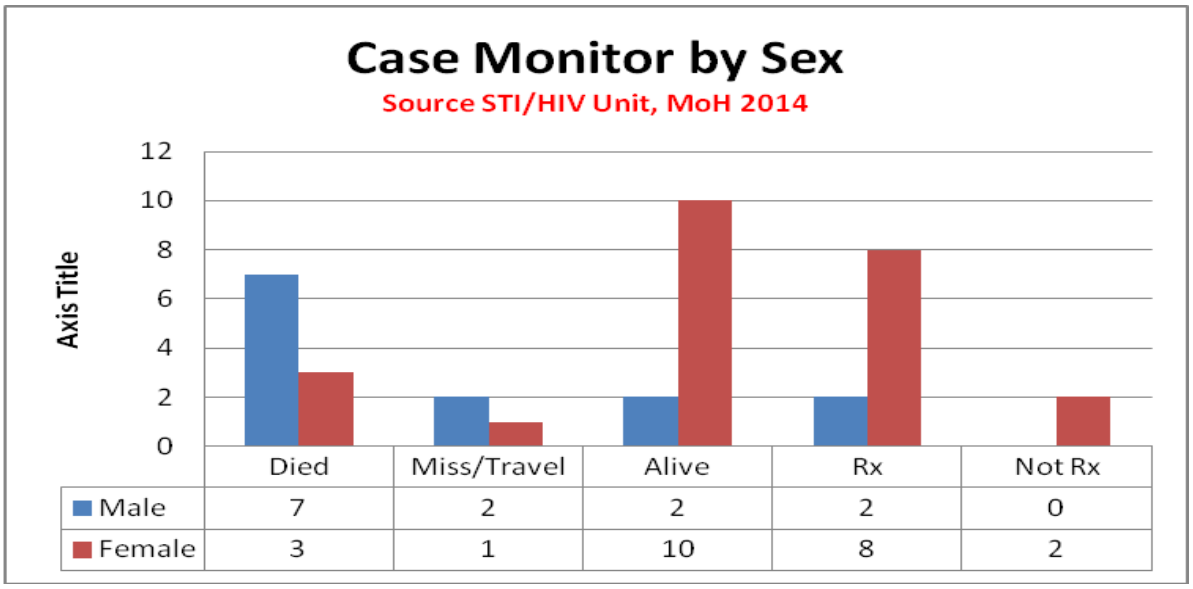
Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015	5.1. Co-Management of Tuberculosis and HIV Treatment	1	HIV register	This patient later died
	5.2 Health care facilities providing ART for PLHIV with demonstrable infection control practices that include TB control	3	MHMS STI/HIV Unit	Same as 4.3 above
	5.3 Percentage of adults and children newly enrolled in HIV care (starting Isoniazid Preventive Therapy (IPT))	0	MHMS STI/HIV Unit	None of the PLHIV in the country has ever been enrolled on IPT
	5.4 Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit	3	HIV register	1 died
Target 6. Close the resource gap	6.1 AIDS Spending - Domestic and international AIDS spending by categories and financing sources	USD 229,000 from UNICEF SBD 152,513 from SIG	MHMS AOP and UNICEF/ MHMS AWP 2014-2015	Annual Operational Plan and UNICEF/MHMS Joint Rolling Annual Work Plan 2014-2015
Target 7. Eliminating gender inequalities	7.1 Prevalence of Recent Intimate Partner Violence (IPV)	N/A	N/A	No new survey conducted on GBV in the country during the reporting period
Target 8. Eliminating stigma and discrimination	8.1 Discriminatory attitudes towards person living with HIV	N/A	N/A	No new survey conducted during the reporting period
Target 9. Eliminate Travel restrictions	Travel restriction data collected by Human Rights and Law Division at UNAIDS HQ, no data collected needed	N/A	N/A	Data on this not available
Target 10. Strengthening HIV integration	10.1 Orphans and non-orphans school attendance*	N/A	N/A	Data on this not available
	10.2 Economic support for eligible households	N/A	N/A	Data on this not available

b) The Status of the Epidemic

Solomon Islands has to date had 25 cumulative cases of HIV dating from 1994 to the end of 2014, with all but one of these cases having been identified from 2004 onwards, of whom 3 (2 males and 1 female) were diagnosed in 2014. As at the end of 2014, 10 (7 males and 3 females) of the Persons Living with HIV/AIDS had died from AIDS related causes. 10 (2 males and 8 females) were receiving antiretroviral therapy, 3(2 males and 1 female) were lost were foreigners who travelled back to their countries and the remaining 2 (both female) are not on treatment. Of the two females not on ART, one refused treatment whereas the other isn't yet eligible for treatment as per the ART Guidelines being used, since her CD4 count was at 500. However they both remain under medical management and monitoring.

Figure 1 below is a graph showing the HIV case fatality in the Solomon Islands, a country with an estimated population of 597,248 as at 2013 (Theonomi 2013).

Figure 1: HIV case fatality in Solomon Islands



HIV in Solomon Islands is thought to be primarily heterosexually driven, however a limited evidence base inhibits a more robust understanding of risk behaviours amongst certain vulnerable groups. Compared with other Pacific Island Countries and Territories, Solomon Islands has reported a relatively low number of HIV infections. However, while the official HIV prevalence rate is low (2 per 100,000) questions have been raised as to the whether this figure underestimates the true burden of HIV through under-reporting of new cases as a result of gender and socio-cultural barriers to utilising HIV Testing and Counselling services (such as actual or perceived stigma and

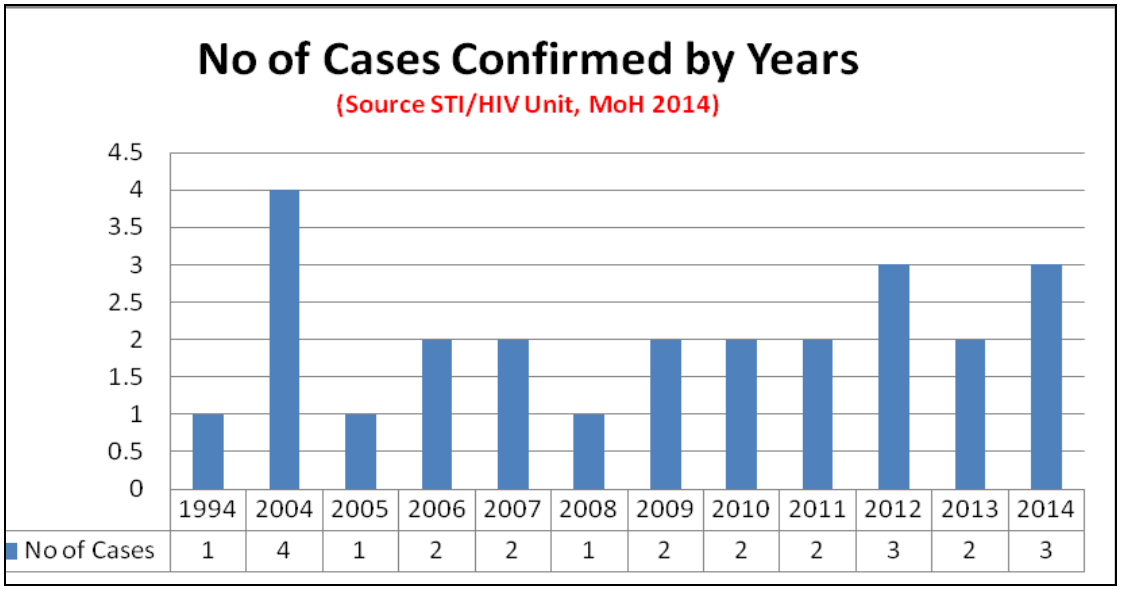
discrimination directed towards those found to be HIV positive); a paucity of testing services limiting access; and a weak, poorly representative surveillance system.

Despite the low prevalence of HIV, data consistently show that a high number of people are infected with STIs across the country. The Provincial Health Information System (PHIS) data for 2014 shows that there were 2,037 men reported with urethral discharge and 538 adults reported with genital ulcer identified through syndromic diagnosis of STIs during the reporting year. Limited laboratory testing facilities and poorly trained and resourced health workers in many settings, especially rural areas, make confirmatory diagnosis of specific infections difficult to ascertain, however comprehensive syndromic diagnosis and management of suspected STIs, and a number of surveillance activities provide a strong indicator of this significant contributory risk factor to both STI-related morbidity and HIV transmission. Furthermore, the high prevalence of STIs indicates that certain risk behaviours, such as unprotected sex with multiple partners are widespread, which in turn poses a significant risk for the exponential transmission of HIV.

Table 2: Showing the current cumulative number of diagnosed HIV cases in the Solomon Islands disaggregated by sex and AIDS related deaths during the period 1994 – 2014.

	Total	Died	Miss / Travel	Alive	Rx	Not Rx
Male	11	7	2	2	2	0
Female	14	3	1	10	8	2
Total	25	10	3	12	10	2

Figure 2; Showing the HIV new cases per year since the discovery of the first case



c) The Policy and Programmatic Response

i) The role of Ministry of Health and Medical Services (MHMS)

Solomon Islands' Ministry of Health and Medical Services (MHMS) is responsible for policy formulation and implementation, and it has an 11 year history of managing and implementing the health system's response to HIV, through the HIV & STI Unit. The unit has a team of 8 staff headed by the Director, a Medical Doctor who is deputized by the National STI/HIV Coordinator, a Nurse by profession. The other staff are nurses and counselors. The Ministry of Health recognises HIV in its National Health Strategic Plan for 2011-2015, and notes there is a probable increase in incidence, but responding to HIV is not explicitly included in other government policies or plans.

The HIV & STI Unit's work is aimed at improving prevention, increasing access to testing, coordinating HIV treatment and care, enhancing policy development and planning, developing capacity in monitoring and evaluation, strengthening technical expertise in health staff, and building relationships with technical and funding partners. It has strived to mount and maintain the national HIV response in the context of the epidemic's low prevalence and diminishing financial and human resources for HIV globally.

ii) The role of Solomon Islands National AIDS Council (SINAC)

The Solomon Islands National AIDS Council (SINAC) is a multi-sectoral body comprising representatives from government ministries, civil society, faith based organisations and people living with HIV. It was convened in 2004 to provide the overarching authority and oversight for the national HIV and AIDS response, including guidance, coordination, approval and accountability relating to policy development and program implementation. While SINAC is responsible for the oversight of the National HIV and Other STIs Responses, this governance and coordination is complimented by the Solomon Islands National Country Coordinating Mechanism (SINCCM) whose mandate and focus is essentially the Global Fund Grant management, coordination and implementation processes for Tuberculosis, HIV/AIDS and Malaria. SINAC meets quarterly, with ongoing Secretariat support provided through an employed coordinator, who operates within the HIV/STI Unit of the Ministry of Health and Medical Services (MHMS).

iii) The Policy Environment

Solomon Islands as a country a number of unfriendly HIV discriminatory laws and regulations, as elaborated in depth later in this document, which affect the rights of people living with HIV, or those of particular groups vulnerable to HIV infection such as sex workers and men having sex with men. However, it does have in its Constitution in Section 15 ample provision for discrimination which protects its citizen from any form of discrimination. An HIV Legislative Task Force was established in 2009 to analyse

legislative gaps and examine legal reforms towards addressing these, however the progress of this group is unknown. The HIV Legislative Taskforce in its May 2012 workshop developed a Draft HIV Management and Prevention and Control Legislation and also produced a Cabinet Paper to guide the request for a HIV Bill, which would be passed through the Ministry of Health and Medical Services for further review and tabling of a Bill in the next Parliamentary Session.

The country's national HIV response has been guided by a National Multi-sectoral Strategic Plan since 2001 (endorsed by Cabinet in 2003). A more detailed and resourced revision of this, the National HIV Policy and Multi-sectoral Strategic Plan 2005-2010, guided the response through addressing the following key strategies:

- Reduction of risky behaviour and vulnerability to HIV and STIs.
- Enhance Voluntary Counselling and Testing of HIV as an entry point for confidential prevention and treatment services for STIs and AIDS (including blood safety).
- Enhance HIV and STI surveillance, treatment and care.
- Enhance capacity building for the national HIV response at both the community and institutional level.
- Ensure sustainable development to enable an environment for behavioural change, de-stigmatization and against discrimination impacting on prevention and care.

The years 2011 and 2012 operated under the 2005-2010 plan before a new NSP 2011-2015 was developed, and in August 2014, it was revised to run from 2014-2018 but by the end of the reporting period it was yet to be endorsed by cabinet, the delay attributable to the impending elections at the end of the year. This new National Strategic Plan for HIV and STIs 2014-2018 continues the commitment to guide the national response through multi-sectoral collaboration and strategic direction and coordination based on evidence of the most appropriate interventions for HIV and STI prevention, treatment and care in the Solomon Islands. This National Strategic Plan has also identified legal and policy reform as a national response priority for the period 2014-2018.

iv) The Programmatic Response

Consistent with the low HIV prevalence, prevention has consumed the majority of resources for the Solomon Islands' HIV response to date and it continues to be a major priority under the current NSP, with increased focus on a more comprehensive approach to the prevention of STIs. The NSP was also tailored towards the targeting of prevention interventions to particularly vulnerable groups. A comprehensive approach to HIV and STI prevention was articulated under this thematic area, incorporating general and targeted awareness campaigns, behaviour change interventions, prevention of parent to child transmission programmes, improved condom promotion and distribution strategies, scaling-up of youth friendly health services and integration of

HIV and STI prevention activities with disaster preparedness interventions. The NSP 2014-2018 re-focuses high impact interventions to groups of individuals deemed to be more at risk based on previous studies (the MOH/UNICEF KAP Survey, 2009 and the MOH/SPC SGSS Survey, 2008) and project activity reports. These include;

- Men having sex with men (MSM) – particularly in the capital Honiara and three provinces: Malaita, Western and Choiseul.
- Individuals engaged in transaction sex in exchange for goods, food and/or money mostly occurring in urban centers.
- Commercial sex workers in informed activities mostly in urban centers because the solicitation of sex for money is illegal.
- Young people, 15-24 years due to higher level of engagement in high risk behaviors and low perception of being at risk for HIV and STIs.
- Pregnant women based on high rates of STIs (Chlamydia) in pregnant women upon routine antenatal screen as shown in the 2008 SGS study.
- Certain occupational/industry groups individuals engaged in shipping and fishing, mining, logging, transport, farming and occupations that requires frequent travels.

Before 2014, the HIV response, and prevention and awareness activities in particular, were delivered in collaborative partnership with a wide group of international and national NGOs, multilateral agencies, churches and community-based organisations. However, programming and funding for the HIV response has significantly decreased, and in 2013, only one NGO, World Vision and one faith-based organization were directly implementing HIV-related activities in Solomon Islands. The activities were mainly IEC related, integrated into their spiritual teachings to the communities;.

d) The inclusiveness of the stakeholders in the report writing process

This report has been developed with contributions and inputs from the relevant units in the Ministry of Health and Medical Services (MHMS) of Solomon Islands, and these include the STI/HIV Unit, the Reproductive Health Unit, Social Welfare Unit and the Policy and Planning Unit. Inputs were also received from the Solomon Islands National AIDS Council (SINAC), and other civil society organizations such as the Solomon Islands Planned Parenthood Association (SIPPA) and the Persons Living with HIV/AIDS (PLHIV).

United Nations Children's Fund (UNICEF), through a long-term HIV/AIDS Consultant, provided direct Technical Assistance to the MHMS throughout the report writing process. Other Development Partners who were engaged for their inputs included World Health Organization (WHO), Department of Foreign Affairs and Trade (DFAT), United Nations Population Fund (UNFPA) and Secretariat of the Pacific Community (SPC).

II. OVERVIEW OF THE AIDS EPIDEMIC

Since the first case of HIV was reported in the Solomon Islands in 1994, it to another ten years before another case was reported, but since the second case, new cases have been reported each year to date. The World Health Organization (WHO) has classified HIV as a low prevalence epidemic in most Pacific Island Countries and Territories (PICTs) except Papua New Guinea (WHO 2006). However, it should be recognised that most countries in this region do not have high quality surveillance systems to accurately estimate HIV prevalence. Second Generation Surveillance Surveys conducted in Fiji, Kiribati, Samoa, Solomon Islands, Tonga and Vanuatu in 2008 reported inadequate knowledge of HIV transmission, unsafe sexual practices, existence of high rates of sex partners and commercial sex in general populations (WHO 2013). UNAIDS has also classified Solomon Islands as a low HIV prevalent country with an estimated prevalence of 0.002% that remained unchanged since 2010 (UNAIDS 2012). However, the HIV testing coverage is also still low in the country. In 2014, a total of 4,354 people were tested for HIV in the country (PHIS 2014).

In spite of this low HIV prevalence in the country, geographic proximity to PNG may be a potential source of new infections for the Solomon Islands given the large differential in epidemic burden with respect to HIV and other STIs. However, there are scarce data on mobility between the two countries to assess this risk. Data on visitor arrivals collected by the Ministry of Finance suggest that the number of visits from PNG is relatively small—just 9%—but doubled during the period 2008-2011 from 900 to 2000 annually (**Table** 4). A comparatively larger number of visits to the country are by individuals residing in Australia (50%), Asia (12%) and other PICTs (11%).

Table 3: Visitor arrivals by area of residence, 2008-2011

Area of residence	2008		2009		2010		2011	
Australia	7,413	46%	8,902	49%	10,751	52%	11,392	50%
Asia	1,895	12%	2,299	13%	2,452	12%	2,827	12%
Other PICTs	2,461	15%	2,175	12%	1,981	10%	2,480	11%
PNG	906	6%	1,098	6%	1,361	7%	2,057	9%
New Zealand	1,097	7%	1,364	7%	1,710	8%	1,724	8%
USA	1,105	7%	1,034	6%	862	4%	1,040	5%
Europe	1,119	7%	1,032	6%	1,006	5%	431	2%
Total	16,264	100%	18,260	100%	20,521	100%	22,941	100 %

Source: Solomon Islands National Statistics Office, Ministry of Finance. "Statistical Bulletin: No: 11/2012: Visitor Statistics (Second Quarter 2012)." Accessed at http://www.spc.int/prism/solomons/index.php/solomon-stats-docs/cat_view/15-social-and-demography-statistics/18-tourism/81-2012 on 30 August 2013.

Unlike HIV, data regarding STIs in the Pacific Island Countries and Territories (PICTs) were rarely collected. Information are scattered and collected through passive surveillance. Regionally, Syphilis prevalence ranged from 0% (in Samoa) to 10% (in Solomon Islands) in 2005 according to a SGSS (WHO 2006). The prevalence among younger (<25 years) women was much higher (14.8%) than the older (≥ 25 years) women (6%) in Solomon Islands. The survey was repeated in Solomon Islands in 2008. In both surveys, prevalence of STIs including Syphilis (6% among ANC women in 2005 and 2% among ANC women in 2008) were found very high while the prevalence of HIV was reported negligible (WHO 2013). According to SPC surveillance study, Syphilis was found positive among 8% ANC attendees in 2012 (UNICEF 2013).

III. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

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

1. Prevention of Sexual transmission of HIV

1.1 HIV Testing/VCCT

Since the first HIV case was discovered in Solomon Islands in 1994, the majority of people tested for HIV in the country to date has been through Client Initiated Testing and Counselling accessed at Voluntary Confidential Counselling and Testing site. Estimates of HIV prevalence derive from the country's two integrated bio-behavioral surveillance studies (IBBSS) to-date, denominated Second-Generation Surveillance Surveys (SGSS). The 2004-2005 SGSS tested 241 women at health clinics in Honiara and 96 women in 3 Western Province clinics. The 2008 SGSS examined 298 clinics at these facilities and added Noro Soltai clinic, now called Noro solTuna clinic with 0 infections found.

Table 4: HIV prevalence findings from previous studies

Population / Study	Study locations	# tested for HIV	HIV Prevalence % (95% CI) [1]
ANC (15-44 years)			
SGSS, 2005	Honiara City: Kukum Clinic, Naha Clinic, Rove Clinic and Mataniko Clinic	241	0 (0.0–2.3)
	Western Province: Gizo Hospital, Helena Goldie Hospital and Noro Clinic	96	0 (0.0-5.6)
SGSS, 2008	Honiara City: Kukum, Naha, Rove and Mataniko Clinics Western Province: Gizo & Helena Goldie Hospitals, Noro and Noro Soltuna Clinics	298	0 (0.0-1.8)
Youth (15-24 years)			
SGSS, 2008	Honiara City ("hot spots")	94	0 (0.0-7.5)

The 2008 SGSS also included a sample of 94 youth ages 15 to 24 from areas in Honiara city reported to be "hot spots" by community informants, however the eligibility criteria used to select the hot spots or study participants—other than age—are not described in the study report. No infections were detected.

Refusal to participate in HIV testing was high in the 2008 SGSS, with 17% of the total 407 ANC study participants and 76% of the 392 youth participants excluded from testing as a result (**Table** 5). Both studies were conducted using linked, confidential testing and informed consent was required to participate in both the overall study and testing for HIV. However, the extent to which selective participation may have influenced study findings is unknown. In the 2005 study, all Honiara participants in the behavioral questionnaire underwent testing, so that no refusals to test appear to have occurred. This cannot be determined for Western Province, as the number of individuals tested is not mentioned.

Table 5: Non-response in HIV testing in previous SGSS

Population / Study	No. study participants	No. (%) tested for HIV	Non-response rate for HIV testing
ANC			
SGSS 2005			
Honiara	241	241 (100%)	0%
Western	96	Not reported	Unknown
SGSS S2008			
Honiara and Western	407	298 (73%)	17%
Youth			
SGSS 2008			
Honiara	392	94 (24%)	76%

Despite the 0% point estimates, 95% confidence limits imply that HIV prevalence as high as 1.8% (2008) and 5.6% (2005) in antenatal women and 7.5% in youth cannot be ruled out based on these studies.

WHO recommends that in a country experiencing a low level HIV epidemic such as Solomon Islands, Provider Initiated Testing and Counselling (PITC) should be offered to all adults, adolescents and children who present to health facilities with signs and symptoms suggestive of underlying HIV infection including tuberculosis. However, interactions with health workers in the country shows that some facilities are still offering HIV testing on VCCT basis as opposed to PITC.

In order to increase the number of people who are tested and know their HIV status, the Ministry of Health and Medical Services rolled out Provider Initiated Testing and Counselling (PITC) through rapid Point of Care Testing in 2011 starting with 3 provinces including the Capital, Honiara City council, and two other provinces: Western Province and Choiseul Province, accounting for 32% of the country's population. By the

end of 2011 HIV Testing and Counselling was available in six out of the nine provinces and including the Capital, Honiara City Council. Most counselling services are limited to Honiara, provincial hospitals and large clinics. As a result HIV testing and counselling is not accessible to the majority of the large rural population in the Solomon Islands. Through decentralising HIV testing and counselling services and introducing Point of Care (PoC) testing we will be able to reach a greater percentage of the Solomon Islands population. PoC will enable clients to access both HIV testing and counselling at the clinic level and will substantially reduce waiting time for ones results.

The MHMS has continued to increase its emphasis on PITC particularly for antenatal women, STI clients, youth and TB patients. During the reporting period a total of 7 health facilities (6 Provincial Hospitals and the National Referral Hospital continued HIV testing of blood samples received from 22 ANC clinics in their respective catchment areas. Data available at the time of writing this report indicates that a total of 2,860 blood samples of ANC clients were in 2014, and out of these, 1,243 received post test counselling as disaggregated by site in Table 6 below.

Table 6: Showing the number of ANC mothers tested for HIV in 2014 by province

Province	# Tested	# Received results
Honiara	921	859
Western	558	343
Malaita	118	89
Choiseul	271	76
Makira	392	73
Temotu	13	13

1.2 Condom promotion and distribution

Definitions of condom use with different types of sex partners have not been consistent across studies, however use of condoms has been very low irrespective of question phrasing (Table 7). Most estimates are below 20%, with the highest at 26% for condom at last sex by men with a non-marital, non-cohabiting partner (2008 DHS), and 45% for consistent condom use by youth with non-commercial partners (2005 SGSS); however the same estimate in the 2008 SGSS was lower (<11%).

Condom distribution is often provided at health and family planning clinics. However, condoms are often provided only to married couples and not to single individuals or members of risk groups, according to qualitative research in 2006 with sex workers and youth and interviews conducted for the field assessment with clinic staff in Honiara, Western and Malaita provinces.

Table 7. Findings on condom use from previous studies

	Condom use at last sex with a non-marital, non-cohabitating partner (ages 15-24)		Sex under the influence of alcohol, past 12 months (ages 15-24)		Consistent condom use with non-commercial partners or all partners		Consistent condom use with commercial partners	
Population / Study	N	%	N	%	N	%	N	%
General population (age15-49)								
DHS, 2006-2007								
Males	283	25.6	596	5.0 /	-	-	-	-
Females	334	16.5	1404	0.6 /	-	-	-	-
ANC								
SGSS, 2005								
SGSS, 2008								
15-24 years	-	-	-	-	185	0.0	-	-
25-44 years	-	-	-	-	215	0.0	-	-
Youth (ages 15-24 years)								
SGSS, 2005					374	45.1	nr	7.3
SGSS, 2008								
Males	-	-	-	-	206	10.7	-	-
Females	-	-	-	-	169	4.1	-	-

nr, not reported

In Solomon Islands, attitudes toward condom use involve complicated and strong cultural beliefs which must be considered when designing programmes and policies to increase the percentage of population practicing safer sex. The 2008-2009 KAP survey among youth in Solomon Islands revealed that if a girl accidentally dropped a packet of condoms, 12% of the witnesses would be impressed that she uses a condom, 27% would feel it was not their business and would pick it and give it back to her; but 15% would be embarrassed and not pick it or give it back to her, another 34% would also be embarrassed but would give it to her, and 9% would be shocked by her behaviour.

The same study revealed that overall reported condom use at last high-risk sex (with a non-regular partner) was lower at 32.8% than for last sex at 37.3%. The highest percentage of use at last high-risk sex was reported by Especially Vulnerable Adolescents (EVAs) at 52% with only 2% difference between the reported 52% for last high-risk sex and 54.5% for last sex. The lowest percentage reported condom use was for mainstream youth at 26% for last high-risk sex and 34% for last sex.

The combination of sporadic condom use with many partners contributes to risk and vulnerability for youth in Solomon Islands. Religious beliefs and school rules prevent some youth from having access condoms. Focus Group Discussions (FGDs) conducted among the youth in 2008-2009 indicated that youth were shy to ask for condoms and did not go to get if they ran out. They said that clinics were not youth friendly, were frightening, and that staff did not talk kindly to them. Many youth also believed that sex with condoms was not as enjoyable or intimate as skin to skin sex.

In 2014, 36,026 male condoms and 340 female condoms were distributed by the MHMS STI/HIV unit. These include condoms taken environmental health department of the Ministry to distribute to seafarers and fisher folks during their public health supervision visits.

1.3 Programmes for Mobile Populations / Seafarers

In Solomon Islands, Church of Malenesia has been working with seafarers but mainly dealing with health education and spiritual talks as FBOs normally do not promote condoms. However, data on the number of people reached by this organization was not available at the time of compiling this report. The seafarers also have a clinic at the logging port where they access HIV services such as condoms distributed by the MHMS.

1.4 Blood Transfusion

In Solomon Islands, blood donation takes place at the NRH in Honiara and all the provincial hospitals namely Kilu'uf & Atoifi (Malaita Province), Gizo & Helena Goldie (Western Province), Kirakira Hospital (Makira Hospital), Lata Hospital (Temotu Province) and Buala Hospital (Isabel Province) where blood donated is tested for HIV anti bodies through RDT, syphilis as well as Hepatitis B and C. However, in 2014, Buala and Lata Hospitals had no Lab technician and hence no blood transfusion took place in those hospitals. During blood donation, the practice is that if any blood donor turned out positive or reactive for any of the above tests, their blood is not drawn for donation but they are referred to the appropriate clinic for care and treatment.

In 2014, a total of 2,739 potential blood donors were screened for HIV using determine, and for Hepatitis B and C using determine RDT as well as Syphilis using RPR. Out of these, Some clients (unrecorded number) were reactive to the HIV Determine RDT but turned out negative on the confirmatory test with Unigold and Insti; 444 cleints were

found positive for Hepatitis B (HBsAg), 253 were found positive with Syphilis (RPR) and the challenge here is that these found reactive for Syphilis with this test were not referred for TPHA testing but are sent home; 5 turned out positive for Hepatitis C (Determine RDT).

Table 8: HIV, STI and Hepatitis A-C testing in 2014 under the blood bank at NRH only

# PEOPLE	TYPE OF TEST				
	HIV RDT	HIV (Unigold/ Insti)	Hepatitis B (HBsAg)	Hepatitis C (RDT)	Syphilis (RPR)
# tested	2,739	No record	2,739	2,739	2,739
# reactive	No Record	0	444	5	253

Therefore in 2014, 2,037 safe blood donations were made in total. However, the use of Determine RDT for testing HIV in potential blood donors still leaves a lapse in the event of a client being in the window period, as this blood is not tested again at a later stage.

The blood donation unit is only interested in the blood to be donated but are not interested in the management of any medical conditions discovered after the rapid tests. Due to this, there is no proper record of referral and follow-up, or linkage between the blood bank and other STI/HIV units. There is need to develop a guide on referral as the blood bank has never referred any positives for care.

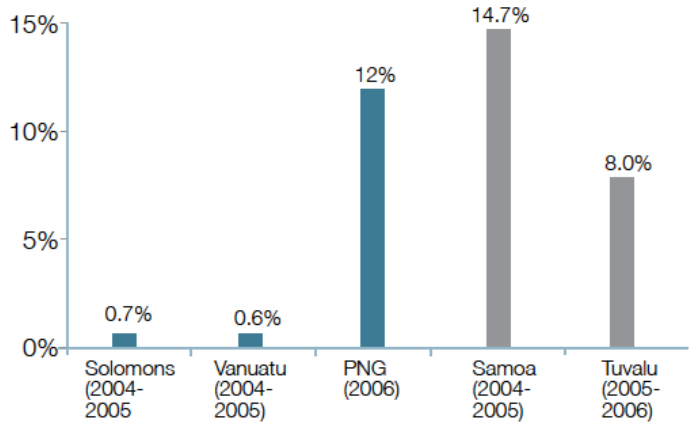
The unit also faces a significant HR problem. There were some trained counselors initially for the blood bank but currently all of them have been promoted to Management positions in the hospital and hence cannot work in the blood bank. Many of the workers in the unit now are Red Cross volunteers. In 2014 also there was no database in the blood bank and record management was poor.

1.5 Programmes for Men who have Sex with Men

The 2008 SGSS asked male respondents aged 15 to 24 in Honiara city about relationships with male sex partners in the past 12 months. Of approximately 240 respondents, 0.8% reported sex with another man in the last 12 months.

This figure may represent an under-estimate due to the illegality of male-to-male relationships in the Solomon Islands and social desirability bias due to stigma around sexual diversity. However, a similar proportion of MSM was found in Vanuatu, where same sex relationships are legal. These figures compare to rates between 12% and 15% male respondents in neighbouring PNG, Samoa and Tuvalu (Figure 3).

Figure 3. Proportion of males ages 15 to 24 reporting a same sex relationship in the last 12 months in PICTs



Source: reproduced from Turning the Tide, 2009.

MSM have proved difficult to reach for studies and outreach activities. Before 2014, there were no MSM organizations in the Solomon Islands. An assessment of vulnerable groups in 2006 by Save the Children to inform the design of HIV-STI interventions achieved participation of just 6 MSM compared to 38 FSW across Honiara, Western and Malaita provinces [15] and about 20 MSM were reached by a Save the Children outreach project in Honiara operating through 2012. No other prevention or research in MSM was identified.

In 2014, the Solomon Islands Planned Parenthood Association (SIPPA), a Civil Society Organization (CSO) in Solomon Islands, started engaging and working to build relationship with Men having Sex with Men (MSM) in Solomon Islands. The organisation started by targeting MSM population in Honiara Town Council, recruiting them and mobilizing them towards expanding the programme to enhance health education among MSM, and increase uptake and access to STI and HIV services among this Most at Risk Population through health education, referral and linkages.

By the end of 2014, SIPPA had enrolled a total of 15 MSMs into the programme. However, there was no documentation by the organisation on HIV services accessed by these MSM.

1.6 Programmes for Sex Workers and their clients

Three qualitative studies have identified practices of transactional and commercial sex and described such practices as common in the general population of young girls, women and young men. [14-16]

Yet, the number of individuals engaging in these activities is not well understood. As described above in Section **Error! Reference source not found.**, self-report of transactional and commercial sex among antenatal women is estimated at about 5%. This increases to about 20% in studies that have specifically targeted vulnerable groups, although inclusion criteria for "vulnerability" have been poorly defined.[14]

Sex work is not well organized either in urban or rural areas, brothels are illegal and there are no known sex work establishments.[14,15,19] Sex workers interviewed in previous qualitative NGO staff interviewed during the field assessment believed sex may also be exchanged with seafarers on fishing boats in return for transport.

Connections with clients are described as being established directly by the sex worker, or by family members or community members seeking material gain from one-off transactions. Elevated rates of commercial and transactional sex are thought to occur at or nearby high income-generating work sites, including:

- Logging camps
- Seaports and sea vessels
- Oil palm plantations
- SolTuna cannery in Noro

Of these, logging camps and seaports are the contexts most often referred to qualitative studies and interviews during the field assessment with NGOs, clinic staff as well as with the owner of a small logging company interviewed in Noro.

In 2014, the Solomon Islands Planned Parenthood Association (SIPPA), a Civil Society Organization (CSO) in Solomon Islands, continued working with Sex Workers (SW). SIPPA's HIV program targeting SWs in 2014 started with an evaluation in which they reviewed the impacts of Sex Workers program conducted in 2013. They also conducted continuous monitoring of SW knowledge and Behavioural Change Communication (BCC) progress slowly as per indicated in the evaluation reports below. As shown in the figures below extracted from the evaluation report, monitoring of SW sites and new girls joining the group increased per year as indicated.

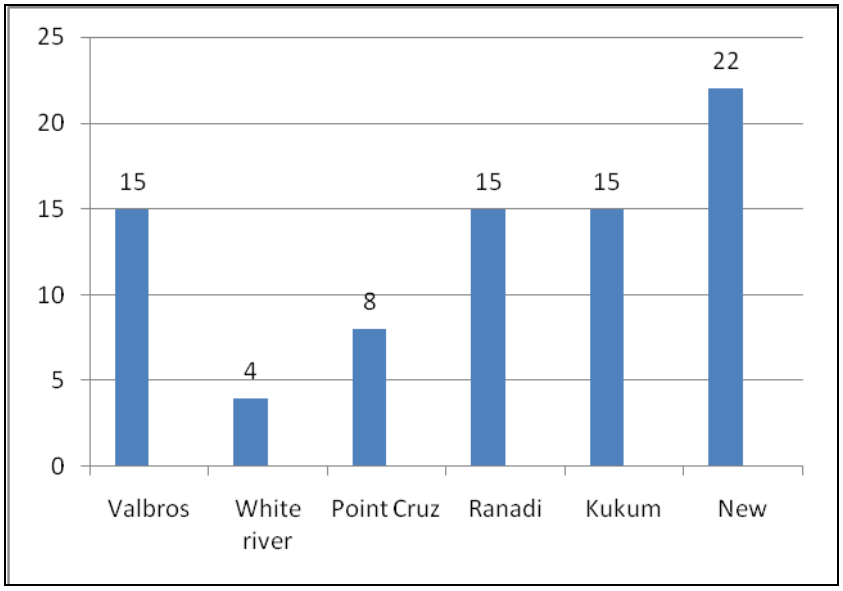
The following table shows a summary of responses received from survey respondents during the evaluation study conducted by SIPPA

Table 9: Showing analysis of STI/HIV knowledge, Attitude and Practices conducted among 20 SWs who volunteered to participate in the study conducted in 2014;

No	Questions	Respondent Rating			Analysis comments
		Yes	No	Don't Know	
1-K&A	HIV is a sexually transmitted infection	4	7	9	Level of knowledge on HIV and STI is not very clear by looking at the rate. Other determinants could be literacy level, how information is disseminated.
2	It is the homosexuals/gay men who had STI	9	1	10	Homosexual is not that common in SI. Nature of transmission might also not clear to them
3	You can tell by looking at the private parts if you or your part has got an STI	5	6	9	Myths around this question is known but people seem to be aware
4	Using two condoms at the same time is safer. It gives you double protection	7	5	8	The yes, might think its dual protection, don't have trust, or may be don't understand the question well
5-P	Have you had sex with any one in last 3 month?	20			Most say yes, I think its true, it would part of their survival.
6	Have you ever used condom for sex?	3	8	9	For the yes, I think it's true. But or may be it is request from their sex partner or their clients. Or probably some they known like brother in-law or girl friend's boy friend
7	Have you ever done a test at the clinic to check if you have an STI?	2	18	0	Most of them get treatment from friends and some go for home remedy
8	Did you use a condom the last time you have casual sex (one night stand"/ sex not with your regular partner?	3	7	10	The yes says yes become it's not their regular clients. the no says no become with their regular clients and some with their partner
9	Did you feel confident (safe) that you can talk to your boy friend or sex partners about using a condom?	3	8	9	
10	Did you feel confident to get tested after learning HIV and STI information?	10	3	7	Fear develops, some refuse at the first time, some think about the consequence (public) perception

In 2014, the organization engaged and recruited an additional 22 SWs in the months of February, April and May, bringing the cumulative number of SWs in the programme to 79. By the end of the year, all of 79 SWs were still in the programme, distributed in the areas of Valbros, White River, Point Cruz, Ranadi and Kukum in Honiara Town Council.

Figure 4 below shows the disaggregation of the old SWs by area and those newly recruited in 2014.



During 2014, SIPPA reached all 79 (female) SWs with health education on basic facts about HIV/AIDS, condom use (female and male condom demonstrations) and access to STI/HIV Counseling and Testing.

During the reporting year 2014, a total of 20 SWs were tested for STI and HIV through rapid diagnostic tests conducted on site, and all of them turned out negative for HIV whereas 2 SWs turned out reactive for an STI, as shown below.

Table 10: Showing STI and HIV Test Results among 20 SWs who were tested for STIs and HIV in 2014.

RPR	TPHA	HIV
20 Tested - 2 reactive	2 tested - 2 Reactive	20 tested – All Non Reactive

Of the 20 SWs who were tested, 18 received post test counseling and received their results and the other two declined. Most of these girls were aged between 14 – 30 years.

1.7 Programmes for transgender people

At the moment there is no evidence indicating the existence of transgender people in the Solomon Islands.

1.8 Programmes for children and adolescents

A 2010 UNICEF and MHMS study on HIV and AIDS risk and vulnerability among young people in three provinces plus Honiara found that 67% of sexually active youth were having unprotected high risk sex, and 15% of all 15-19 year olds had sex before the age of 15. First sex was forced for 20% of the sexually active youth overall, and in Choiseul it was over 45%. The study found low use of reproductive and sexual health services among young people, who explained this on the grounds that services were not available, not accessible and not youth friendly. Both boys (25%) and girls (20%) reported high rates of STIs in the past year.

Teenage pregnancies are common in the country. DHS (2007) found that by the age of 19, one in four teenage girls have become mothers with consequent impacts on their educational and economic prospects and those of their baby; children of teenage mothers tend to have poorer health and education outcomes. The median age of marriage was found to be 20.3 years for women. Teenage pregnancy is more common in rural than urban areas and among women with only a primary education. The DHS also found that rates of teenage pregnancy are higher in Guadalcanal than other regions. Use of contraception by young people is reportedly very low at 2% for 10-24 year olds. Up to date evidence on young people's sexual attitudes, knowledge and practices is urgently needed to support reproductive and sexual health programming for young people. Primary health care facilities continue to have a strong focus on pregnant women and children; and access of young people and men, and especially vulnerable groups such as men that have sex with men is inhibited. There are four youth friendly clinics in the country – a start, but insufficient to meet needs given lack of young people's access to alternative sources of reproductive and sexual health information and clinical services and products.

In Kukum Clinic, the facility has created a room towards the back of the building as an adolescent health area but to reach the room a young person would have to walk past the many women and children lined up waiting to see a practitioner. The staff appreciate that this deters young people who are fearful of being recognised at the clinic by someone in their community. Increasing young people's access to reproductive and sexual health care will require a number of important changes around service delivery, nursing attitudes and skills, and service protocols. Nurses and nurse aides will need orientation on government policies towards young people's sexual health, and awareness of the risks that poor sexual health carries. Nurse counselling skills need to be strengthened so they are better able to counsel young people, and protocols updated and revised to guide the delivery of reproductive and sexual health services in line with policy, including contraception and treatment of incomplete abortion.

1.9 Community mobilization

Community participation is fundamental to the principles of primary health care, and women's empowerment is a social determinant of health. International experience shows that community leadership, support and commitment is vital to improving health and tackling behaviours that undermine well-being. Important influencers of health in the Solomon Islands are the community structures that bind people together and hold authority. This includes traditional elder structures, as well as various church organisations and youth groups that have the communication structures and clout to influence attitudes and practices.

Community and traditional authority structures including the church have proved to have considerable influence over health seeking and access to care. Some churches inhibit discussion of reproductive health and sexuality and set strict norms for what is acceptable sexual behaviour, with obvious implications for family planning and safe sex. Cultural norms and attitudes apply to health workers too, and affect health protocols. Current maternal health guidelines restrict the provision of contraceptives to married persons, and from interactions with nurses during the 2014 GESI study, it was established that this protocol was still being practiced, with the exception of condoms. Attitudes among health staff towards the morning-after pill and abortion are also very sensitive. Nurses need information on new government policies, training, and up to date protocols aligned with government policy.

There are no formal functioning mechanisms for community participation in the delivery or management of health services in the Solomon Islands, although there is provision for Health Boards. There are few examples of citizen led social accountability with most advocacy being driven by Civil Society Organisations. Participatory planning is not well established in government, and in 2014, efforts by the RWASH program to involve communities in the planning of water systems struggled to negotiate space for women.

Church organisations and groups, village elders, and youth groups are seen by health workers and managers to be key vehicles for promoting demand for services and behaviour change. The involvement of community based structures and organisations is central to mobilising support for increased access to health services, addressing issues related to gender equity, gender based violence and social inclusion. The existing relationships between non-state actors and communities to address the determinants of health and increase access to services, provide government with a platform to strengthen its partnerships with communities for more equitable and inclusive health.

1.10 STI diagnosis and treatment

Considerable levels of other STIs have been documented by the past SGSS. STI prevalence has been higher among younger (ages 15-24) compared to older (25-44) ANC clients (Table 11). Chlamydia prevalence was 16% in younger ANC women and 6.1% in ages 25-44 in 2008. Syphilis (RPR and TPPA positive) was 5.0% and 1.9%, respectively. Prevalence of hepatitis B was between 12% and 16%.

Among youth (both male and female, not disaggregated), high levels of Chlamydia prevalence (14-15%), syphilis (10%) and hepatitis B (18%) were also identified.

Data from routine testing at health facilities collected by SPC provide additional support for high levels of chlamydia and syphilis in 2011 and 2012 (Table).

The elevated levels of STIs is of concern as the presence of HIV, infection with Chlamydia, syphilis and other STIs can increase the probability of sexual transmission of both infections.

Table 11: STI findings from previous studies

	Chlamydia		**Gonorrhoea**		**Syphilis**		**Hepatitis B**	
Population / Study	n/N	% (95% CI) [1]	n/N	% (95% CI) [1]	n/N	% (95% CI) [1]	n/N	% (95% CI) [1]
ANC (15-44 years)								
SGSS, 2005								
15-24 years (N=105)	-	7.3	-	0.0	-	14.8	-	-
25-44 years (N=136)	-	5.7	-	0.8	-	6.0	-	-
SGSS, 2008								
15-24 years	28/17	16.0 (10.9-22.3)	4/17	2.3 (0.6-5.7)	7/1	5.0 (2.0-10.1)	22/1	15.8 (10.2-23.0)
25-44 years	12/19	6.1 (3.2-10.5)	1/19	0.5 (0.0-2.8)	3/1	1.9 (0.4-5.5)	19/1	11.9 (7.4-18.0)
Youth (15-24years)								
SGSS, 2008								
Honiara	17/11	15.2 (9.1-23.2)	4/11	3.6 (1.0-8.9)	9/9	9.9 (4.6-17.9)	17/9	18.1 (10.9-27.4)
Western Province	13/90	14.4 (7.9-23.4)	2/90	2.2 (0.3-7.8)	-	-	-	-

[1] Confidence interval estimates as they appear in the study report (no adjustment for design effect)

Table 12: STI tests conducted in 2011-2012 and their results

	2011			2012		
	No. tests	No. positive	% Positive	No. tests	No. positive	% Positive
Chlamydia						
Males	nr	-	-	129	32	25%
Females						
ANC	1868	305	16%	2852	585	21%
STI clinics	452	127	28%	398	109	27%
Syphilis						
Males	nr	-	-	nr	-	-
Females						
ANC	5155	332	6%	5537	446	8%
STI clinics	nr	-	-	nr	-	-

Source: SPC surveillance data tables nr = not reported, data missing for at least one of the two biannual reports during the year

Data available at the time of compiling this report shows that in 2014, a total of 8,322 were tested for syphilis, as disaggregated by province, testing site / health facility, age and treatment in the table 13 below.

Table 13: Number of ANC mothers tested and treated for syphilis in Solomon Islands in 2014

SYPHILIS TESTING IN ANC									
Province	Health Facility	Total 1st Visit	NUMBER TESTED			NUMBER POSITIVE			NUMBER TREATED
			Total	15-24 Yrs	25+	Total	15-24 Yrs	25+	
Honiara	NRH	5,824	5,824	2,488	3,328	795	415	378	476
Western	HGH	629	629	262	367	86	35	51	74
Malaita	KILU'UFI	732	732	283	447	103	54	49	49
Choiseul	TARO	271	271	119	152	1	1	0	1
Malaita	ATOIFI	220	220	103	117	26	12	14	16
Western	GIZO	330	330	160	170	101	38	63	88
Makira	KIRAKIRA	316	316	134	180	15	7	8	15
Temotu	LATA	0	0	0	0	0	0	0	0
TOTAL		**8,322**	**8,322**	**3,549**	**4,761**	**1,127**	**562**	**563**	**719**

As shown in the table above, during the reporting period 2014, Syphilis testing was not done in Temotu and Isabel provinces because there was no lab officer in the respective provincial hospitals of Buala and Lata in those provinces. It is also important to note that most AHCs and RHCs do not have laboratory facilities, and cannot access the facilities at the provincial hospitals due to the distant geographical proximity, and yet they attend to ANC clients.

1.11 Behaviour change programmes

Previous national surveillance studies on HIV knowledge, sexual and risky behaviours include the 2006-2007 Demographic and Health Survey (DHS), the 2005 and 2008 SGSS studies among antenatal women and youth, and a Knowledge, Attitudes and Practices (KAP) survey conducted as part of a larger study entitled *Bad Sickness* in 2008-2009.[14]

Table 14 below summarizes selected indicators of sexual relationships. The 2008 SGSS estimated 2-4 sex partners in the past 12 months (at the time) among youth, however the extent to which high outlying values influence these means is unknown. Median number of partners was not reported in 2008, however the 2005 SGSS reported a median of 0, indicating that 50% of youth participants had no recent sex partners. Of ANC women, few reported more than one partner in the past year in 2005 (6.6%) and in 2008 there was an average of 1.1-1.3 past-year partners.

Table 14. Findings on sexual partnerships from previous studies

	No. sex partners / % with ≥2 partners in past 12 months		Purchased sex		Sold sex		Forced sex, ever	
Population / Study	N	[Median], (mean) or %	N	%	N	%	N	%
General population (ages 15-49)								
DHS, 2006-2007								
Males	-	-	2056	1.4	-	-	-	-
Females	-	-	-	-	-	-	-	-
ANC								
SGSS, 2005	241	6.6	-	-	241	0.4 [3]	-	-
SGSS, 2008								
15-24 years	nr	(1.3)	-	-	-	-	52	28.3
25-44 years	nr	(1.1)	-	-	-	-	61	28.8
Youth(ages 15-24 years)								
SGSS, 2005	374	[0]	374	9.5 [2]	-	-	-	-
SGSS, 2008								
Males	nr	(3.8)	nr	2.9 / 9.5 [4]	nr	6.2 / 10.5 [4]	-	-
Females	nr	(2.6)	nr	1.2 / 2.9 [4]	nr	5.3 / 5.8 [4]	-	-
Vulnerable youth(ages 15-24 years, sexually active)								
Bad Sickness, 2008-09					450	12.4 / 0.7 [4]	449	38.1
Males					231	6.5 / 5.2 [4]	nr	27.8
Females					219	18.7 / 16.5 [4]	nr	48.9

[1] Confidence interval estimates as they appear in the study report (no adjustment for design effect)
[2] Percent reporting "commercial sex"; [3] exchanged sex for money or gift; [4] money / goods or favours;
[5] sex for money
Nr= not reported

The MHMS's health promotion unit is a pivotal player in framing and prioritising areas of behaviour change and health promotion. However, at its current level of capacity it lacks the skills, resources and breadth to implement community based behaviour change interventions; there are a total of 49 Health Promotion Officers at provincial and facility levels. The Unit tends to focus on developing information, education and communication (IEC) materials and supporting campaigns funded by international agencies, such as World AIDS Day. Piecemeal event based activities seem to be the main focus. The malaria program has tended to use materials from Vanuatu but these have not always been appropriate.

Campaigns and IEC have an important role in creating an enabling environment for behaviour change but are often insufficient to tip behaviours that are culturally embedded or socially taboo. Unless well designed, campaigns may also marginalise frontline workers.

Collaboration between the Health Promotion Unit and public health programs is mixed. The institutional structure of vertical national programs working through provincial coordinators, and the budgeting system, do not encourage integration of messages across program areas. For example, RWASH's plan to roll out community led total sanitation nationwide has the potential to integrate other supporting health messages including SRH messages. There appears to be no integrated health promotion plan across MHMS.

Through the primary health care system, nurse led satellite clinics, village health talks, and school visits, which are the main vehicles for communicating on health with communities, are dependent on provincial funds which are not reliable. The Rubbish Sicki/Bad Sickness Baseline Report on understanding HIV and AIDS risk and vulnerability among Solomon Islands youth found 78% of respondents reporting that health facilities were their current and most preferred source of information and advice on HIV and AIDS, followed by radio (46%) and friends (25%). This finding illustrates that health clinics are an important channel of support for young people and access to them needs improvement. This will require improved infrastructure to accommodate private spaces for Counselling, and capacity building to improve health worker counseling skills, and non-judgemental attitudes towards young people.

Non-state actors including Churches, NGOs, CBOs, and private sector companies are often better placed to work with communities to facilitate behaviour change. For example, Soltuna provide a health clinic for their employees and their families and conduct talks, awareness raising and counseling activities, as reported during the 2014 GESI study. The use of condoms is being promoted especially with crew of foreign vessels.

Among NGOs and FBOs there are many examples of innovative behaviour change programs that build on community and cultural strengths including drama, peer networks, social media, and community groups. World Vision's Channels of Hope Program works through church organisations and uses teachings from the Bible to bring men and women together to discuss and reflect on lessons that promote respect and equality between men and women. Participatory theatre is being used by NGOs to break myths, confront gender-based violence, and promote healthy relationships. Church organisations, such as women's and men's fellowship are spreading health information and debating social issues, though we should not underplay the potential conflict between religious doctrine and reproductive and sexual health.

Target 3: Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths

2. Prevention of mother-to-child transmission

2.1 ARVs for PMTCT

A National Policy on the Prevention of Parent to Child Transmission of HIV was developed in 2010. The policy was further reviewed in 2014 and will be finalized and submitted for endorsement by Cabinet in 2015. There were 10 people living with HIV (PLHIV) receiving ART in 2014. Treatment services are available at three health facilities nationwide, which include the National Referral Hospital (NRH) in Honiara, Helena Goldie Hospital in Western Province and Kilu'ufi Hospital in Malaita Province. ARVs are procured, distributed and monitored regionally through the Global Fund and the National Pharmacy and the HIV Unit lead 6-monthly forecasting and monitors use of treatment.

To-date, five children have been born to women living with HIV in the country out of which one of the children was not tested before death, one was not tested at birth or in the first 18 months but later tested HIV positive at 13 years in 2014. The other three were tested at birth and follow up testing was done at 24 months, and both tests were negative for HIV among all three cases. All four children born to HIV positive women and are currently alive to date were on ART prophylaxis from birth for six weeks.

A total of 2,388 pregnant women were tested for HIV in 2014 alone. (15 years and above) out of a total 1st ANC visits of 8,322 in 2014. Out of these, 1,511 received their results. There were no HIV positive among the tested women. However, in the Solomon Islands, AHCs and RHCs also attend to ANC clients and yet most of these clinics do not have laboratoties for testing HIV or Syphilis, and are far away from provincial hospitals and therefore cannot transport blood samples for testing at the provincial hospitals. This presents many missed opportunities of testing ANC clients for HIV and Syphilis in the country.

Stigma and discrimination in Solomon Islands continue to challenge prevention efforts, and to the treatment, care and support of people living with HIV. Three foreigners who tested HIV positive in Solomon Islands missed their appointments and travelled back to their countries without informing the Core Care Team, for reasons attributed to fear of stigma and discrimination. Economic constraints, including the cost of mobility due to geography and transport, are also barriers to HIV treatment, care and support.

2.2 Non-ARV-related component of PMTCT

2.2.1 Contraceptive Use

Prong 2 of the four-pronged PMTCT approach, promotes the prevention of all unwanted pregnancies among PLHIV. However, in general the Contraceptive Prevalence Rate (CPR) in Solomon Islands has remained stagnant for several years. DHS (2007) estimated the CPR at 27.4 per cent and according to more recent government health records it remains under 30 per cent.

The DHS found that fear of side effects was a major deterrent among non-users and contraceptive users were not always informed of possible side effects. Dependence on government sources for supplies was also shown to limit access in rural areas. Poor reproductive health knowledge across all ages exists with 50 per cent of women who are not using contraception unaware of the time of the month when they are fertile.

The Kiribati communities that live in Nora, Western Province, tend to have larger families than Solomon Islanders, rely on traditional birth attendants, and use traditional forms of contraception; no evidence is available on their comparative maternal health outcomes.

Table 15 below shows the contraceptive use in Solomon Islands between 2011 and 2014.

Table 15: Contraceptive use per 1000 population by province 2011-2014 (PHIS March 2015)

	Contraception contacts per year per 1000 population			
Province	**2011**	**2012**	**2013**	**2014**
Central Islands	1085.6	612.5	562.2	470.2
Choiseul	206.8	202.9	179.4	193.3
Guadalcanal	79.7	100.2	109.5	123.2
Honiara	266.1	428.4	502.3	514.5
Isabel	332.3	328.9	452.4	452.9
Makira	229.9	264.4	287.4	221.6
Malaita	160.9	147.4	142.5	149
Renbel	76.6	79.5	58.5	56.3
Temotu	232.3	213.1	218.1	210.2
Western	222.3	251.4	219.2	175.6
National / SI	**234.1**	**236.5**	**245.8**	**235.5**

The PHIS was still being updated with more data from 2014 as at March 2015 when this report was prepared.

2.2.2 Antenatal Care

According to the 2014 GESI study, there are challenges of women going to health facilities for services, including ANC. There is a tendency among rural women to only seek care during emergencies or complications during pregnancy. Women in Munda reported that lack of funds is one of the main reasons for not going to hospital, and covering the cost of referral is a major problem. In emergency cases, people report that they look to borrow money from family and tribal group, and if necessary take out a loan. There appears to be no established tradition of saving groups or community emergency funds; though some saving groups have been established by development projects these are not widespread.

While general outpatient and inpatient services are provided free of charge, in practice some fees are levied. Fees are however not uniform and management of the fees is opaque; in some cases nurses are using the fees to help patients pay for referral transport. MHMS's "Community and Primary Care Facility Staff Consultations" (May, 2010) found that most Health Centres charge fees for service or sell patient health record books, for example SBD 50 for a malaria test. Recent evidence on out-of-pocket spending on direct and indirect health costs is not available. The 2005/6 Household Income and Expenditure Survey found that less than 1 per cent of total household income was spent on health care, and household survey evidence suggests that costs are not a major barrier to health care; though this is not what the women and men who were interviewed during the GESI study reported.

This notwithstanding, DHS (2007) found high uptake of antenatal care with 95% of pregnant women reporting at least one visit, and 65% making four or more antenatal visits; care was primarily provided by nurse/midwives (72%) and nurse aides (21%). Table 16 below details the trend of 1st ANC coverage by province between 2011 and 2014.

Table 16: ANC 1+ Coverage by province 2011 – 2014 (PHIS March 2015)

	ANC 1+ Coverage			
Province	**2011**	**2012**	**2013**	**2014**
Central Islands	133.3	110.6	129.8	116.4
Choiseul	117.5	122.7	128	103.5
Guadalcanal	149.4	144	166	151.7
Honiara	70.8	87.4	75.4	74.2
Isabel	92.6	82.9	115.2	123.1
Makira	107.5	101.2	108	119.9
Malaita	156	149.1	113.6	127.1
Renbel	200	235.3	365	337.5
Temotu	100.2	93.6	102.9	102.5
Western	101	100	94.3	92.9
National / SI	**106**	**108.8**	**102.9**	**103.9**

More 2014 data from some provinces was yet to be updated into the PHIS at the time of compiling this report

2.2.3 Skilled Deliveries

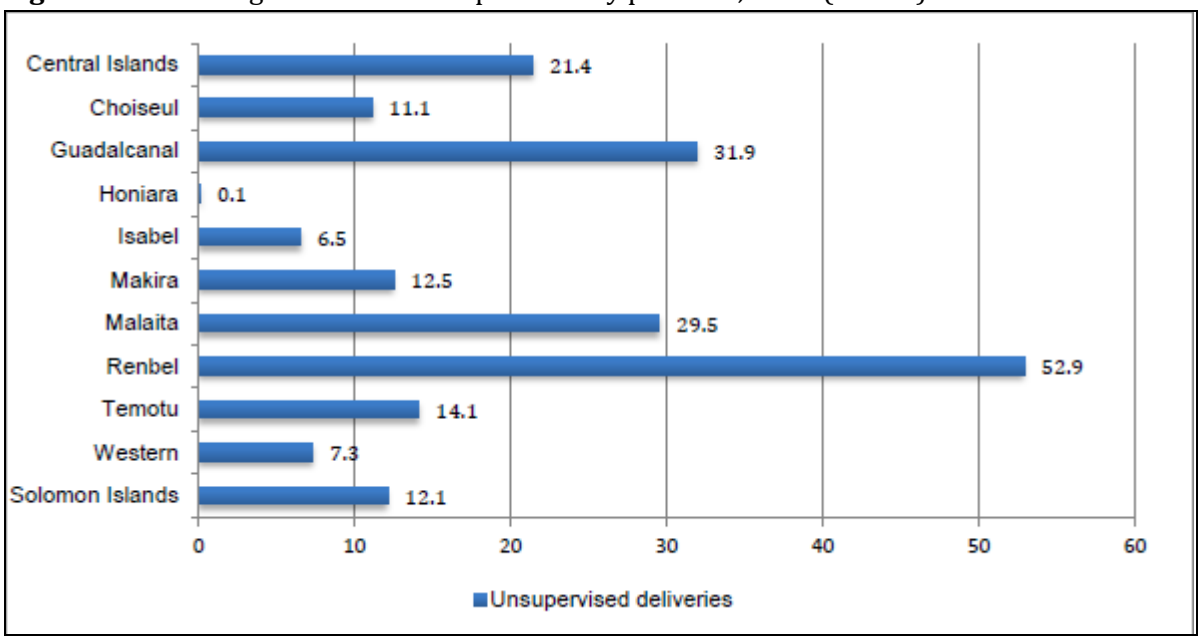
In Solomon Islands, more women than men are living with HIV at the moment. Eleven (11) women, and three (4) men are currently with HIV. Social and cultural norms, including gender inequality and high rates of gender-based violence, contribute to women and girls' risk and vulnerability to infection and contribute to barriers in access to HIV services, including testing.

Cognizant to the different modes of transmission of HIV from a HIV positive pregnant mother to the unborn baby, coverage of institutional deliveries or deliveries attended by a skilled provider is an important indicator of access to maternal and neonatal health services including PMTCT, since transmission of HIV from mother to child can happen during delivery. DHS (2007) found that 85% of births were delivered at a health facility showing a very high demand for skilled birth attendance. Institutional deliveries were more likely among women from urban (94%) than rural areas (83%) and varied by province, with Guadalcanal (68%) fairing worst.

As generally found internationally, mother's education and wealth were directly correlated to the uptake of institutional deliveries; 74% of women in the lowest wealth

quintile had a facility-based birth compared to 94% in the highest quintile. Evidence from the health information system also shows a continuing high attendance of skilled health workers at births, reaching 88 per cent in 2012 though with much variation between and within provinces.

Figure 5 - Percentage deliveries unsupervised by province, 2012 (MHMS)



Target 4: Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015

3. Universal access to treatment

3.1 Pre-ART care and palliative care

In Solomon Islands to date, the procedure taken when a client tests HIV positive has not changed and follows the recommended WHO guidelines. All clients living with HIV or deceased due to AIDS related illnesses underwent the same procedure which involved the following services

- TB screening
- Hepatitis B, Syphilis, Gonorrhoea and Chlamydia
- CD4 cell count
- ART prep counselling
- Routine Clinical monitoring

There is no viral load machine in the country. Sometimes the MHMS sends down samples for viral load testing at Reference Lab in Melbourne but this is only done to confirm if there is any ambiguity in the HIV test done in-country.

At the moment, the two clients who are not under ART are undergoing clinical monitoring, however, none of them is on IPT therapy for TB or Cotrimoxazole prophylaxis. The issue is not the lack of IPT or Cotrimoxazole but the preventive therapies are not just being done. The HIV Core Care team will find the HIV Care and Treatment consolidated guidelines scheduled to be developed in 2015 helpful in being up to date with recommended international practice.

In 2008, the MHMS formed a HIV Core Care team whose membership was later reviewed during the reporting year of 2014 to comprise of 12 core members and 8 other members. The team is led by the Director STI/HIV Unit and comprises of Specialist Medical cadres including Doctors, Pharmacists, Obstetricians, Nurses, Laboratory technicians and STI/HIV Counsellors. The team is charged with the responsibility of following up and linking all PLHIV to the continuum of HIV care.

3.2 Adult antiretroviral treatment

Solomon Islands is currently implementing the World Health Organizations (WHO) Antiretroviral Therapy for HIV Infection in Adults and Adolescents (2010 Revision) as its eligibility and treatment guideline. A combination of AZT + 3TC + EFV is the first line treatment regimen used for antiretroviral therapy. There are plans in place to update the guidelines in 2015 in line with the WHO Consolidated guidelines of 2013.

Three health facilities in the Solomon Islands offer ART. Two are based at provincial health facilities and the National Referral Hospital serves as the third. There are ten people living with HIV currently enrolled on ART (2 male and 8 female), and an additional two (both female) who are not on ART but are under clinical monitoring.

3.3 Paediatric antiretroviral treatment

At the moment, only one of the children born to HIV positive mothers has tested HIV positive, and this diagnosis was done in 2014 when the child was 13 years. The diagnosis was done through PITC after the child presenting with a fungal infection in her genital area which turned out to be candidiasis. According to the core-care team, which has been following up this client from the time of birth, no DBS was done when the child was born. At the time of writing this report, the child hadn't yet been put on any medication for HIV, as the core care team was still preparing and discussing disclosure to the child with the child's mother given that the child is in school and may be affected academically.

There are other four children currently aged between 5 and 6 years who were also born to HIV positive mothers, were tested at birth using HIV antibody determine tests, and

follow-up tests were done at 24 months instead of 18 months, though according to the core care team members interviewed reported that both tests at birth and 24 months were negative for all 4 children. During this time none of these children were taking any HIV related medication but their mothers were on ART for PMTCT. This gap in PMTCT is highly attributable to the outdated PMTCT guidelines being used in the country, which were only developed a few years back. The guidelines are in line with the Option B+ strategy.

3.4 Support and retention

The HIV core care team is charged with following up, Counselling and linking all PLHIV to care and treatment. The team maintains a maximum level of confidentiality in handling these clients and at all times limits the identity of all PLHIV to team members only to prevent stigma and discrimination of PLHIV, and promote adherence to care and treatment.

Target 5: Reduce tuberculosis (TB) deaths in people living with HIV by 50 percent by 2015 TB

4. TB-HIV Co-infection

The MHMS and the National Tuberculosis Programme (NTP), through sustained TB prevention and control efforts, made excellent progress towards achieving the Millennium Development Goals (MDG) and the global targets set by the Stop TB Partnership for 2015: the burden of morbidity and mortality has been decreasing steadily since 1990, falling respectively by 76% and 84% in comparison with 1990 figures.

Similarly, the country has already reached the WHO's Western Pacific Region goal in the Regional Strategy to Stop TB in the Western Pacific 2011-2015 to reduce by half the morbidity and mortality from all forms of TB by 2015, relative to 2000 levels. By 2013 the morbidity was reduced by 59% and the mortality by 64%.

In order to address the remaining challenges the country, with support from development partners notably the World Health Organization, developed and successfully submitted a proposal for funding for the period from 2015-17 to the Global Fund against AIDS, Tuberculosis and Malaria. This involved an in-depth situational analysis of the epidemic and the response as well as the underlying health and community systems challenges, followed by strategic prioritization of interventions, leading to the planning of high impact activities targeting high burden geographic locations as well as key populations affected by the disease, including patients' family members exposed to the disease, people with debilitating diseases and conditions, inmates, and people living in informal settlements and remote areas.

The immediate purpose of the interventions is to ensure universal access to TB care and prevention through improving institutional and human capacity within the health system, empowerment and involvement of communities with meaningful patient support, collaborative activities with other disease programs including child and mother health, and engagement of all heath care providers beyond the TB program and the public sector. The ultimate goal is to speed up the current decline of the burden of the disease so that to reach the internationally agreed targets in the framework of the post 2015 development agenda.

4.1 TB screening and diagnostics for PLHIV

Available evidence indicates that Solomon Islands has a low prevalence rate of HIV among TB patients, however, the HIV testing coverage among TB patients is very low in the country. Prior to 2010, TB patients were not routinely tested for HIV infection. In 2014, out of a total of 344 TB cases throughout the year, only 45 were tested for HIV and one of them was found HIV positive through PITC but this was a late diagnosis hence the patient died. The patient had been initiated on ART before he died.

Table 17: TB patients tested for HIV in 2014.

Patients tested for HIV at the time of TB diagnosis or with known HIV status at the time of TB diagnosis	HIV+ TB patients	HIV+ TB patients on antiretroviral therapy (ART)	HIV-positive TB patients on cotrimoxazole preventive therapy (CPT)
45	1	**0**	**0**

The low level of HIV testing among TB patients was attributed to the following factors;

- The decision by the National TB Programme not to test all TB diagnosed children for HIV due to the need to get consent from their parents
- Non certification of many of the 10 TB sites nationwide to conduct HIV testing. Certification would only be approved after a visit by the STI/HIV team to ascertain whether these cites meet the required HIV testing standards in terms of trained personnel, space, furniture and storage for commodities. Plans to visit the sites towards certification were made in 2014 but these were prevented by emergencies and logistical challenges during the year.
- Lack of HIV testing kits and supplies in some of the certified TB sites.
- Despite the rollout of PITC as the recommended type of Counselling for TB patients, some sites still tend to practice VCCT.
- In some cases, despite PITC provision, some clients still declined to consent to an HIV test, leaving room for doubt for the quality of pre-test Counselling being offered.

Historically, there has been few programmatic links between the Solomon Islands National TB Programme and the HIV response. In 2010, TB treatment and management guidelines were formally reviewed and updated to include HIV/TB co-management, and in 2011, 12 TB nurses and coordinators throughout the country were trained to do HIV counseling and testing.

In 2014 the country continued strengthening TB control by introducing a new rapid diagnostic technology, the GeneXpert test, which is considered an important breakthrough in the fight against TB. This technology will be particularly useful in the diagnosis of TB among people living with HIV as TB forms in this population are more frequently negative at smear microscopy. Moreover, it allows to quickly diagnose rifampicin resistance prompting early treatment, which is of great benefit for people living with HIV as MDR TB carries higher risk of mortality in this population. HIV positive presumptive TB cases are highlighted in the revised TB diagnosis algorithm.

To this end the TB program will make use of enhanced existing technologies, tools and approaches as well as new ones using among others modern technologies including new rapid diagnostic tests, SMS notification of lab results and electronic recording, reporting and follow up of TB patients.

Specifically, the NTP has planned the following actions to counter the TB/HIV co-infection component:

- Establish screening of all people living with HIV for TB at every contact within the HIV clinic
- Put all people living with HIV on Isoniazid Preventive Therapy after ruling out a TB disease
- Establish sentinel surveillance of HIV among TB patients, pregnant women and blood donors.
- Test TB patients for HIV and put any TB/HIV co-infected patient on CPT and ART

4.2 TB treatment for PLHIV

So far on record, only one patient has presented with a TB/HIV co-infection and this was in 2014 where the patient was admitted to the Medical ward and was tested HIV reactive through PITC. In this case the HIV core care team decided that the patient first completes the TB treatment for 2 months before being initiated on ART. This patient later died because it was a late diagnosis in WHO Clinical Stage four where the patient had presented with advanced an Opportunistic Infection (OI).

Target 6: Close the global AIDS resource gap by 2015 and reach annual global investment of US$22-24 billion in low- and middle-income countries

During the financial year of 2014, the Solomon Islands Government allocated SBD 152,513.00 only to the MHMS STI/HIV Unit for the response. This money was used by the unit for only operational costs which included office stationery, staff travel and transport, fuel and vehicle maintenance, capital expenditure, office equipment overseas travel and staff annual leave.

UNICEF in its Joint Annual Work Plan for 2014 with the MHMS allocated USD 229,000 in Financial and TA to the STI/HIV Unit for the national response. This was apportioned as USD 107,500 for Planning, Coordination and M&E (Strategic Information), USD 61,000 for strengthening HIV Prevention Programmes and Policies (specifically PMTCT and HIV Testing and Counselling) and USD 60,500 for strengthening YFHS and programmes for adolescents and young people.

5. Governance and Sustainability

5.1 Strategic information

The health information system is under development and many improvements have been made over the past couple of years including the preparation of annual statistical reports disaggregated by province and facility, and the preparation of the "Core Indicators Report". The latter benchmarks progress made against the National Health Strategic Plan that is the policy platform of the Sector Wide Approach (SWAp). However, gaps remain in reporting with estimates of 60% and 85% of reports being submitted in 2011 and 2012. Gaps in administrative staff at busy facilities, such as NRH, hinder reporting, and innovative ways of engaging volunteers or interns for example, could be a way to address this.

Evidence gaps have also arisen due to the long time lag between DHS; the last was in 2007 and the next was due in 2014 but this was not conducted. No health focused household sample survey of a similar breadth and rigour has been undertaken in-between. Similarly there has been a long gap between household income and expenditure surveys, 2005/6 being the last one; and the next was due 2014. The result has been a long period without accurate disaggregated evidence of key health outcomes and behaviours. The planned DFAT funded poverty and health outcome study and UNICEF funded Second Generation Sentinel Surveillence (SGSS) study for HIV and STIs will be important sources of evidence for identifying health vulnerability, as will the Monash University costing study which includes measurement of out of pocket spending on health. All three studies will be important to inform stronger pro-poor and inclusive programming.

The data that is being collected by facilities is reported up to provincial and national levels but is often not used at the local level for provincial and facility based planning and monitoring. In turn there is a lack of geographic and context specific planning and this is an area that the Director of Reproductive Health intends to strengthen. The Family Health Card, which is kept at the facility, is reportedly being completed well in some provinces but not universally; though use of the data at provincial or facility level is weak. Further analysis is needed to find out how collection and use of this data could be improved.

There is a legal requirement to report all births and deaths in the Solomon Islands, but the system is out-dated, time consuming and costly as it requires the reporting person to visit Honiara. With support from UNICEF, the birth and death registration system became electronic in December 2012 but the Ministry of Home Affairs has not been able to devolve this responsibility to provinces and hence people still have to travel to Honiara.

Looking forward, the MHMS plans to decentralise the health information system in the three most populous provinces namely Guadalcanal, Malaita and Western; and to provide parallel management strengthening support through the Health Sector Support Program (HSSP). This will provide a platform to improve provincial and facility planning, monitoring and management.

5.2 Planning and coordination

The Solomon Islands Government spends more than 10% of its domestic budget on the health sector and this is not expected to grow in the medium term. The 2013 independent performance assessment of the Health Sector Support Program (SWAp) found that 36.4% of the 2013 sector budget allocation was allocated to the provinces; increasing the share of provincial grants is one of the objectives of HSSP. Provincial budgets are used to hire direct wage employees and fund outreach and supervision activities, which are essential for increasing access to services. Budget constraints at the provincial level are commonly reported to result in cancelled outreach and supervision, and inhibit access to services of those living in remote and difficult to reach areas.

In 2014, the Annual Operational Planning (AOP) and budgeting process improved with some divisions submitting fully costed plans for 2014. Planning guidelines are prepared but have yet to introduce gender issues and guidance. Divisions tend to develop their AOPs in isolation and more work is needed to strengthen the synergy and coordination between them, with for example cross-cutting areas like health promotion more integrated into achieving the objectives of technical divisions and programs; and common approaches taken to meeting the needs of underserved populations that may be geographically and/or socially marginalised such as adolescents.

Provincial level planning and management capacity is generally considered to be poor. Geographic and context specific service delivery planning is not happening although there is considerable diversity in access to services between and within provinces, let alone in meeting the needs of particularly vulnerable populations such as youth, the very remote, and the culturally different, such as Kiribati populations.

5.3 Procurement and logistics

5.3.1 MHMS Procurement System

The National Medical Stores (NMS) does procurement of drugs for the country. NMS then distributes to Pharmacies in Provincial Health Centres from where the drugs are distributed to the Rural Health Clinics and Nurse Aide Posts. The Procurement team of the MHMS sits under the Policy and Planning Unit.

The MHMS has no procurement plan or matrix in place, and data management for procurement and supplies is poor. There are steps being taken under the Global Fund Malaria Program to conduct HSS including in the area of procurement where the programme will fund a procurement position and develop procurement tools and guidelines such as a procurement matrix and plan.

5.3.2 Supplies and Supply Chain Management

MDG 8 has a number of indicators, and one of them relates to health – "proportion of the population which has access to affordable essential drugs on a sustainable basis." The 2003 HDR reported that this essential drug "access" varied from 80 to 94% throughout the Solomon Islands. This was at the time when the civil disturbance was just ending. There is no global proposal for the quantum or percentage of change for this indicator and MDG goal, but the modality of the MHMS operation with essential drugs available free of charge at all service delivery points makes it axiomatic that the public's sustainable and affordable (free) access to these drugs is only a matter of the public's access to services. It could be argued that the MHMS service delivery network could be expanded further so that access was easier for more of the population. However, countries that have done this at this stage in the demographic and epidemiological transitions have often found that these new peripheral service facilities get by-passed almost as soon as they are constructed. Therefore, this issue of access is more of a function of transport infrastructure and transport cost than the public being disenfranchised by cost or other access factors. Therefore, for the Solomon Islands this MDG can be considered achieved.

In recent years however, attributable to the increasing uptake of health services in the facilities, stock-outs have been frequently reported. In 2014, stock outs were reported by several stakeholder groups to remain a problem, though it was generally felt that the situation was better than the previous year(s). During visits to facilities in Honiara,

health workers reported stock outs of cord clamps at NRH, and chloroquine at Kukum Health Centre. Stock-outs of HIV and STI test kits and supplies were also reported as a major challenge for HIV testing especially in the provinces. Some participants in past health studies reported that stock-outs and absent health providers were two factors that discouraged them from attending health facilities. The In-charge of NRH Lab in Honiara also reported a high level of expiry of HIV test kits, which later led to luck of supply of test kits in some facilities because the existing stock at the time of need is expired. This shows a lapse in the management of stock. The Lab Technologist at NRH laboratory reported that the consumption method they are using is First in First Out (FIFO) which may not be effective in minimizing expiry of supplies as compared to the First Expiry First Out (FEFO) approach.

The essential drug list supports the SI Government to prioritise cost-effective interventions, and affordable medicines. Challenges to those principles are however being voiced as elite groups lobby to include expensive medicines for minority conditions. MHMS will need to remain firm in protecting the fundamental principles of the essential drug list so that it is not hijacked by elite interests.

5.4 Health Systems Strengthening

5.4.1 Health System

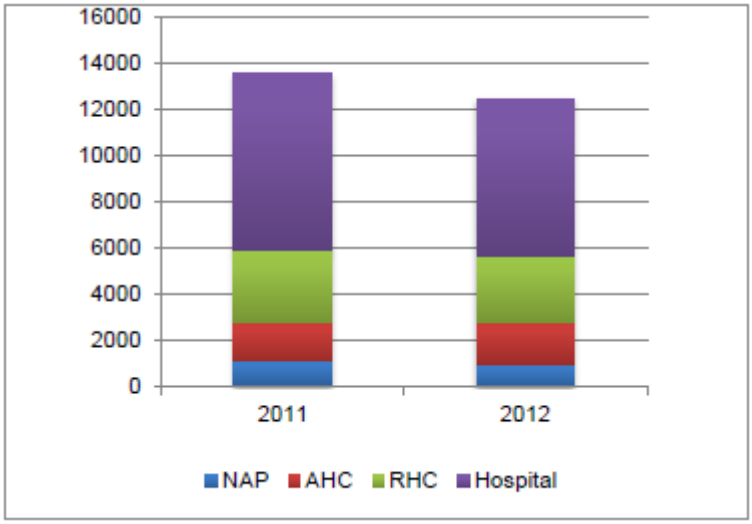
The health system has achieved impressive results. The nurse led Primary Health Care (PHC) system, run at a modest cost of the equivalent of US$150 per person, has achieved high service utilisation across all income groups as found in the 2007 DHS. This is especially remarkable given the geographical context and scattered population. Other countries are spending much more (in the order of US$400) to achieve similar health results. In 2006, a survey found that nearly 87% of people sought care when ill, with the majority (85%) attending a public sector provider. By comparison, only 60-75% of the population seek care when ill from a modern medical provider in many low-income countries in East Asia and the Pacific. However, the Solomon Islands faces many of the same health sector strains of other Pacific Island countries as discussed in this section of the report. This includes a weak fiscal outlook, gaps in and aging of human resources, and the double burdens of maternal, newborn and communicable disease and burgeoning NCDs, alongside high child under-nutrition and adult obesity.

5.4.2 Health Facility Coverage

MHMS data on the place of delivery by facility type for 2011 and 2012 shows that more than 50 per cent of institutional deliveries take place at a hospital.

See figure below for deliveries taking place at facilities between 2011 and 2012, to give an indication of the demand for health facilities in the country.

Figure 6: Institutional deliveries by facility level, 2011 and 2012



This reflects a strong demand for heath facilities for different services including ANC and hospital level delivery and care, given the geographical spread and isolation of the population.

In 2011, 40% of all institutional deliveries took place in Honiara alone, dropping to 36 per cent in 2012, though Honiara makes up only 12.5% of the national population. On cost-efficiency and equity grounds one would expect to see the proportion of women delivering in Honiara further decline as the capacity to handle complications in provincial facilities improves, and public confidence in local delivery care increases. For example, during the 2014 GESI study, the Director Planning reported that many women travel from Malaita and outlying islands to deliver in Honiara because they perceive the care to be of better quality. Similarly, women interviewed at Helena Goldie hospital reported their preference to deliver at the hospital rather than closer primary health care facilities because of perceived quality of care.

The Role Delineation Policy (RDP) that was approved in 2014 by the Health Minister sets the norms for the organisation and staffing of the health sector, and the parameters for future expansion of the health network. It also provides the basis for defining the essential packages of care. As such, the role delineation policy has important implications for ensuring equitable access to services and reaching underserved groups, and potentially for defining remote area packages of care. While expansion of the health facility network is not planned for the next three years, implementation of the policy will require the physical mapping of facilities and populations and topography. This exercise will enable MHMS, community representatives and citizens to assess the gaps in the current spread of health facilities and identify where new facilities are needed. Stakeholder buy-in to the RDP will be essential to bring political, church and community groups on board to avoid the building of ad-hoc clinics.

5.4.3 Human Resources for Health (HRH)

Government is the main provider of health services in the country and employs 97% of the country's health professionals. In 2013, Solomon Islands Government (SIG) employed 1,827 health workers of which 5.9% were doctors, 44.3% nurses and 5.9% nurse aides. With 1.71 health workers (doctors, nurses and midwives) per 1,000 population, this is well below the WHO minimum threshold of 2.3 workers per 1,000 population. Women make up 66.6% of the nurses and nurse aides but only 20.6% of doctors. All executive positions in MHMS are held by men, as are all nurse leadership positions. Male dominated leadership cuts across Solomon Islands political, cultural and religious domains.

The uneven distribution of health workers across the country impacts on access to services and quality of care. Skilled health workers are concentrated in Honiara where only 12.5% of the country's population lives, and continuing migration of health workers to Honiara is likely to deepen the imbalance. In 2013, the doctor: population ratio was 1:1,319 in Honiara and 1:18,929 in rural areas; the nurse: population ratio was 1:305 in Honiara and 1:885 in rural areas.

Human resources are also inequitably distributed across the provinces. The concentration of medical and specialist health staff in Honiara fuels high referral costs for the health system as well as adding strain on family incomes as people have to cover time away from their livelihoods, and living expenses while in Honiara. It also encourages by-passing of primary health care facilities, increasing the cost to the system of delivering primary level care, as well as the out of pocket spending users make on services that could be provided closer to home.

The Government's commitment to free health services, while a laudable equity principle, does not incentivise care seeking at lower levels of the service delivery chain and as demands for hospital level care increase this may put further pressure on the National Referral Hospital (NRH). Renbel with 0.6% of the national population has no provincial hospital, but nearly ten times the number of referrals to NRH than other provinces (Negin, 2011).

Poor working conditions, lack of or poor quality accommodation, and lack of school opportunities for children in rural areas increasingly discourage staff from taking rural and remote postings as expectations rise. Unattractive remuneration packages and limited support provided to health workers further add to the low morale reported. Absenteeism and the difficulty in retaining staff in rural areas has been recognised by all stakeholder groups; leaving some areas underserved. Weak supervision throughout the health system partly linked to high transport costs, lack of funding and low prioritisation, contributes to the problem of absenteeism. Nurses at Kukum Health

Clinic in Honiara, during the 2014 GESI study, reported high workloads, limited support, and few promotion prospects. They also felt that the Nursing Council was not an effective advocate for nursing in the country, and provided no tangible benefits to those registered.

Due to a lack of skills and equipment in-country some HIV&AIDS related testing has to be sent out to Fiji and Australia. This is costly and time-consuming. In 2013, Kukum clinic in Honiara sent a sample for gonorrhea testing to Fiji in January and the results were returned in October after a baby was born with an eye infection; the mother was positive. It was confirmed that test results were delayed that year because MHMS held outstanding bills.

Also according the 2014 GESI study, a major HRH issue that the country is facing that could distort resourcing is the imminent return of 100 Cuban trained doctors. While the new stock of doctors will help fill gaps in the country the large allowances they are entitled to will significantly raise the salary budget. This is at a time when a government employment freeze has left graduating nurses without jobs and as the numbers of retiring nurses is expected to increase. The impact of these challenging HRH decisions carries a strong weight, especially as urban elites and influential members of soceity are demanding higher level services that are at odds with the PHC focus of the health system.

Going forward, posting and retaining health workers in rural and remote areas will be key to assuring access to health services. This will require carefully crafted strategies to motivate and support nurses in rural and remote settings. This may include financial allowances, aligning nurse promotion prospects and training opportunities with time spent in rural facilities, improved clinic environments and better supportive supervision. Further work possibly linked to the implementation of the Rural Development Policy is needed to assess what is needed to retain and motivate rural nurses.

Target 7: Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV

6. HIV Related GBV Activities

The ground breaking Solomon Islands Family Health and Safety Study conducted by SPC in 2009 revealed extremely high incidence of violence against women and children. Two out of three women (64%) aged 15-49, who have ever been in a relationship, reported experiencing some form of physical and/or sexual violence by an intimate partner. Sexual violence was more common. Violence reported was more likely to be severe than moderate, including punching, kicking, and having a weapon used against them. Levels of violence were higher in Honiara than the provinces, and this may be related to the

wider availability and consumption of alcohol (which acts as a dis-inhibitor), as well as social problems such as unemployment and overcrowding.

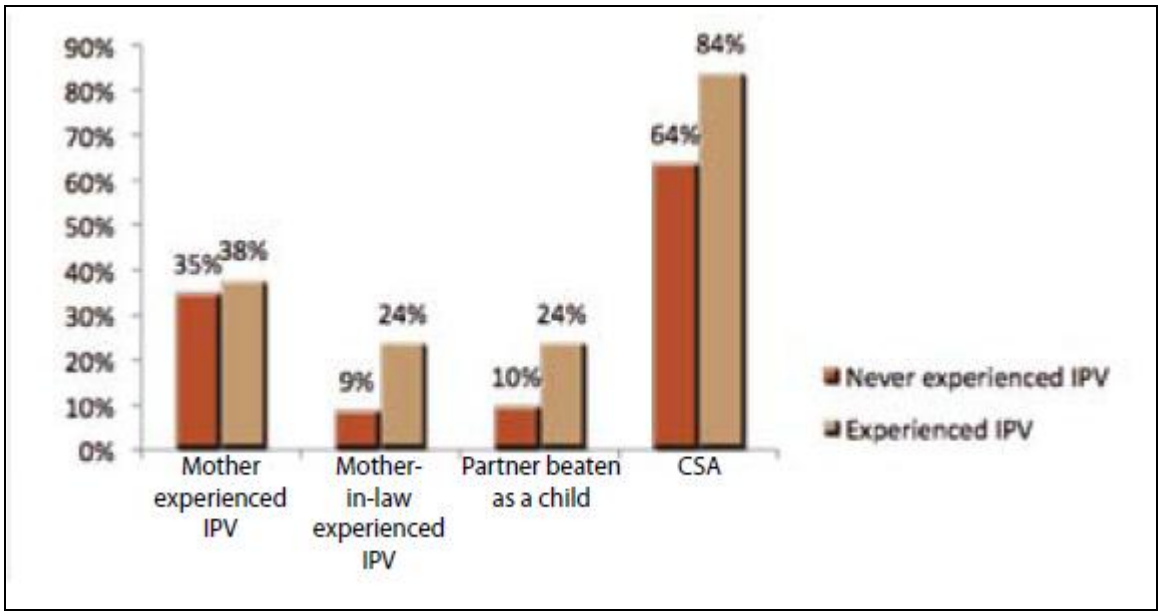
The study also found high levels of child sexual abuse and forced first sex. Some 37% of women aged between 15 and 49 reported they had been sexually abused before the age of 15 with girls mostly at risk from male acquaintances and male family members. Of women who reported to have ever had sexual intercourse, 38% reported that their first sexual intercourse was coerced or forced. The Solomon Islands Family Health and Safety Study (SIFHS) in 2009 also found that for many girls their first experience of sexual intercourse was forced.

According to the SIFHS, women who were victims of Intimate Partner Violence (IPV) were significantly more likely to report that their current partner, or any other partner, had abused their children (emotionally, physically and/or sexually) (36% versus 11%, P<0.001). In fact, women who have experienced IPV are 4.5 times more likely to have children who are also abused than those who have not experienced partner violence ($AOR_1 = 4$).

Table 18: Percentage of women, who have ever been in a relationship and had children, reporting that their partner had physically or sexually abused their children, by respondent's experience of partner violence.

	Total Solomon Islands		Never experienced partner violence		Experienced partner violence		P value
	number	%	number	%	number	%	
Total	**2290**		**822**		**1468**		
Did things to scare child(ren) on purpose	509	22.2%	60	7.3%	449	30.6%	P<0.001
Slapped, pushed or thrown something that could hurt them	429	18.7%	57	6.9%	372	25.3%	P<0.001
Hit with his fist, kicked, beaten them up	229	10.0%	30	3.6%	199	13.6%	P<0.001
Shaken, choked, burnt on purpose	49	2.1%	7	0.9%	42	2.9%	P=0.001
Touched child(ren) sexually	25	1.1%	4	0.5%	21	1.4%	P=0.037
Ever emotionally, physically or sexually abused children	608	26.6%	89	10.8%	519	35.4%	P<0.001

Figure 7: Showing respondent and partner's exposure to violence during childhood, by respondent's experience of IPV.



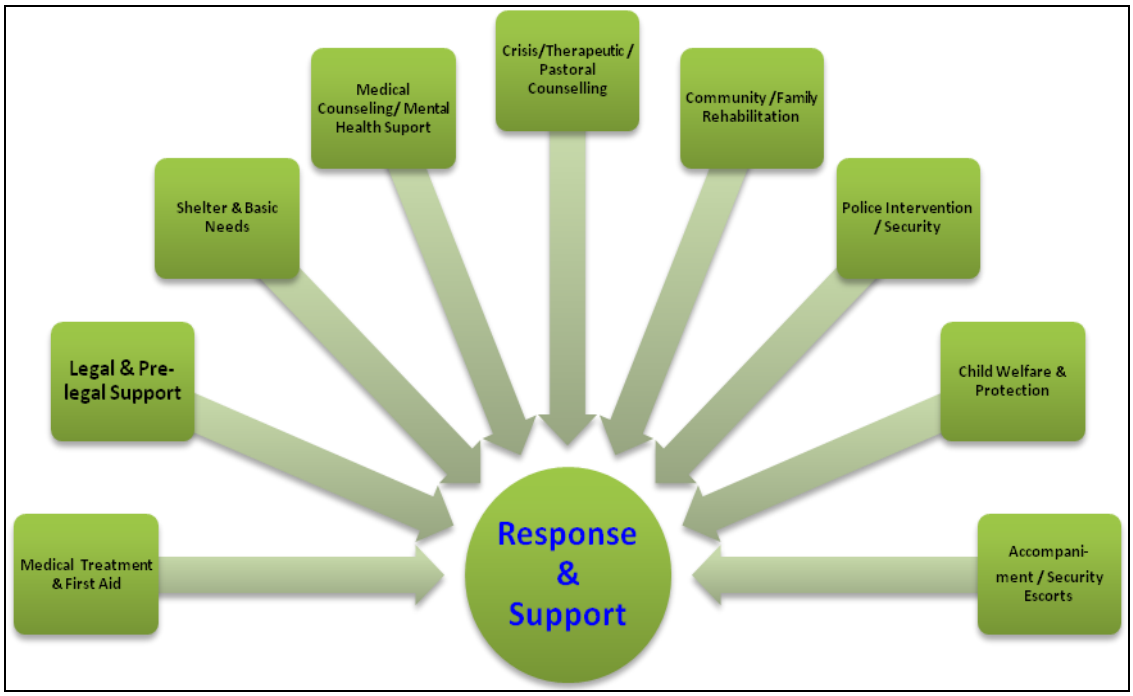
Referral SAFENET is the Solomon Islands Government formal Gender Based Violence (GBV) referral system which was launched on the 14th March 2013. It is made up of both government and non-government organizations/ agencies to provide coordinated, frontline services and support to victims/survivors of Bender Based Violence/ Violence Against Women.

It is a multi-sectoral approach which includes the following parties.

- Ministry of Health & Medical Services who also host the office of Coordination
- Royal Solomon Islands Police Force
- Public Solicitor office
- Family Support Centre (NGO)
- Christian Care Centre (NGO/FBO)

These five Organizations signed a Memorandum of Understanding that binds their collaborative efforts. The organisations work closely and maintain a referral pathway and network among themselves, and this network is proving very effective in increasing access to and confidence in GBV services among the people of Solomon Islands.

Figure 8: GBV Services provided under SAFENET



According to the SAFENET annual report for 2014, a total of 806 cases of family violence were reported to the Royal Solomon Islands Police Force in 2014, and out of these, 87% were female victims whereas 13% were male victims. The highest age group 30 – 35 years had the highest number of victims and the perpetrators were mainly male intimate partners. One (01) death was recorded as a result of a domestic violence incident. This data covers the whole country.

In Honiara alone, the following GBV services were offered to clients in 2014, a total of 532 GBV victims received counselling services, out of which 382 were referred on to the next level of care. The number of women seeking shelter was 170 and the number of children accompanying their mothers seeking shelter was 22 in 2014. The number of GBV cases attended to at health facilities was; 72 cases at HCC clinics, 52 cases at Seif Ples clinic, 130 cases at NRH and data from the Public Solicitor which was not available at the time of compiling this report. In terms of GBV Hotline services, the number of calls received and were given information/ counseled on options of services available for them were 855 cases, Number of clients receiving legal services were 29 cases.

In addition, 60 people were trained on GBV response in Honiara in 2014. These included 40 health workers and 20 staff of Civil Society Organizations. Awareness campaigns on GBV were also conducted in 10 schools and 8 communities in Honiara City Council.

Target 8: Eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms

7. Critical enablers

7.1 Policy dialogue

The 2011 – 2015 National Strategic Plan was reviewed in 2014 and the newly reviewed National Strategic Plan 2014-2018 (draft) has identified legal and policy reform as a national response priority for the period 2014-2018.

7.2 Stigma reduction

Solomon Islands as a country, has no specific discriminatory laws and regulations to protect the rights of people living with HIV, or those of particularly vulnerable groups. However it does have in its Constitution under Section 15, a provision for discrimination which protects its citizen from any form of discrimination.

In 2014, there was no progress towards the protection or fulfillment of the rights of some vulnerable populations, or towards minimizing their vulnerability. Political leadership, media coverage and public advocacy efforts in support of the HIV response waned in 2013. No progress towards the development of HIV-related legislation was achieved during the year and Solomon Islands laws that discriminate against men who have sex with men and sex workers continue to impede prevention efforts.

7.3 Law reform and enforcement

Solomon Islands has no explicit anti-discrimination laws or regulations to protect the rights of people living with HIV. Section 15 of the Constitution makes discrimination unlawful on the grounds of race, place of origin, political opinions, color, creed or sex. There are very weak legal protections for vulnerable groups and no specific protections for people living with HIV or those assumed to have HIV by reason of their membership in a vulnerable group.

Homosexual acts (sodomy) are criminalised in Section 160 of the Solomon Islands Penal Code; 'buggery' with another person, the permitting of a person to commit buggery on him or her; and attempts. Section 161 of the Penal Code outlines the lesser offence of 'committing any act of gross indecency' by persons of the same sex. Attempting to procure another person of the same sex to commit an act of indecency is an offence.

Offences relating to sex work in the Solomon Islands Penal Code include 'knowingly living on the earnings of prostitution' (Section153), 'soliciting in a public place for immoral purposes' (Section153), 'aiding, abetting or compelling the prostitution of a prostitute for the purpose of gain' (Section153), 'keeping a brothel' (Section155), and 'permitting premises to be used as a brothel' (Section155).

An HIV Legislative Working Group was established in 2009 to analyze legislative gaps and examine legal reforms towards addressing them. The HIV Legislative Taskforce developed a draft **HIV Management, Prevention and Control Legislation** in May 2012 and produced a Cabinet Paper to guide the process for a HIV Bill to be passed through the Ministry of Health and Medical Services for review, and tabled in Parliament. The proposed Bill incorporates international good practices outlined for the *United Nations International Guidelines on HIV and Human Rights*, the *Handbook for Legislators on HIV and the Pacific*, and *Enabling HIV Responses: HIV for Pacific Islands Countries*. No progress toward development of the HIV Bill was made in 2014.

7.4 AIDS-specific institutional development/community mobilization

The MHMS STI/HIV Unit has continued to benefit from capacity building programmes of partners, with one staff attending specialized training in HIV Testing and Counselling at Empower Pacific in 2014 sponsored by UNICEF.

UNICEF also sponsored one youth from SIPPA, a local NGO to attend the AIDS 2014 International AIDS Conference in Melbourne, Australia. The youth was facilitated to attend this conference so as to come and share his key messages and lessons learned at the conference as well as replicate best practices from other countries with his fellow youths in the Solomon Islands.

Target 9: Eliminate HIV-related restrictions on entry, stay and residence

8. Progress made in amendment and removal of such laws

The Ministry of Health and Medical Services is currently in discussions with the Solomon Islands Department of Immigrations to review a law that forbids HIV positive individuals from entering the Solomon Islands. The MHMS acknowledges that such a law is an infringement on the rights of Persons Living with HIV (PLHIV) and hence could discourage uptake of HIV testing and counselling and disclosure in the fight against HIV in the country.

Target 10: Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts, as well as to strengthen social protection systems

9. Synergies with development sectors

It is important to note that while the health sector plays a key role in promoting the health and well-being of the country, the social determinants of health highlight the need for multi-sectoral action across government sectors (for example, trade and economy, education, infrastructure), and non-state actors and cultural leaders to improve health outcomes.

9.1 Social protection

Bearing in mind that any service delivery model has to be based on affordability, cost-effectiveness, efficiency and equity, we identify areas of social inclusion in existing government plans, and service delivery models which aim to meet the needs of the most vulnerable.

The Role Delineation Policy (RDP) is the backbone of planning service delivery and essential packages of care. As implementation of the RDP unfolds it will be important that user perspectives, opportunities for integrating vertical programs, and reaching unreached populations such as youth and people with disability are given due attention. Physical mapping of facilities, populations and topography to allow travel times to be measured will be necessary to assess where the gaps in service coverage are and where future expansion should take place.

To improve privacy for Counselling and space for youth friendly services, MHMS could plans that space and appropriate layouts are incorporated into any upgrading or building of new clinics. However, access of physically challenged persons also needs to be taken into account. New clinic buildings need to be designed to be accessible to persons with disability. For existing clinics, plans need to be developed for providing care to persons who cannot physically access the clinic.

Central to the rebalancing agenda is an enhanced push for more outreach and more effective health promotion. This has organisational, programmatic and budgetary implications at the national and provincial level. Greater integration of national programs and services at the provincial level could result in more effective service delivery and health promotion, and increase efficiency.

At a practical level, improved outreach and health promotion has implications for how nurses and nurse aides work together with health promotion officers. Institutional change and program integration will require policy level reform, the amendment of unfriendly HIV laws will particularly be instrumental.

Men have poor access to sexual health care, are common perpetrators of family violence, and play minor roles in taking responsibility for reproductive and family health. The network of male nurses exposed to the men as partners in reproductive health training are a valuable resource for championing male involvement and responsibility.

9.2 Gender programmes

Gender mainstreaming (GM) is no longer just the business of the Ministry of Women (MWYCFA). The Public Service Commission (PSC) has taken leadership in pursuing a whole of Government responsibility for this. In March 2013, the PSC took the significant step as part of the public service reforms, to have all permanent secretaries sign a

performance contract which includes GM as one of the seven common or 'generic' principal Key Performance Indicators (KPIs) with six performance measures.

These are:

- Having a gender implementation strategy as part of the Corporate Plan
- Appointment of a gender focal point/gender desk
- Evidence of gender sensitivity within the recruitment and selection process in the Ministry
- Gender profiles and statistics collected and disseminated
- Zero tolerance on work place harassment including sexual harassment
- Gender report to be part of the monthly and annual reporting processes.

The Gender Focal Point (GFP) in the MHMS has been assigned to the Senior Planning Officer. Although a new post has not been created, the GFP plays an influential role in assisting the PS to fulfill their contractual obligations. The GFP reports directly to the PS, and is responsible for coordinating the ministry-wide activities linked to the gender mainstreaming performance KPI. The GFP leads the ministry's response to gender issues, and initiates the process of developing the Gender Implementation Strategy and work plan.

The gender mainstreaming contractual requirement and the KPIs provide a high level entry point for MHMS to position Gender Equity and Social Inclusion (GESI), and to consider developing a GESI strategy and implementation plan as an expansion of the required gender strategy. It was made clear that some technical support will be required to support a ministry led and owned process, as Gender and GESI are relatively new approaches in the Solomon Islands with few if any national technical experts.

In 2014, the Gender Focal Point identified activities to progress the development of a gender strategy though little progress had been made. Planned activities include: gender awareness raising and a gender mapping exercise, data collection and evidence gathering, the development of gender indicators to incorporate into a review of the Health Information System, and the development of gender training and guidelines to integrate into existing training programs. There are GESI champions in the MHMS but they are not working in a coordinated way to push the agenda forward. For example, the 100 male nurses that have been trained in the area of men as partners in reproductive health have had few opportunities for advocacy activities post training, though the Director and Deputy Director Nursing are champions of male involvement.

9.3 Education

The social determinants of health and the barriers to accessing health information and services provide the context in which demand side interventions seek to promote healthy living and change harmful behaviours. Health promotion to reduce individual and family related risk factors is a national health priority, and given the evidence

presented by the various studies cited in this report, improving reproductive and sexual health behaviours, and preventing non-communicable diseases are two priority areas of behaviour change through health education and promotion.

The National Development Priority, NDS Objective 3 aims to "Ensure all have access to quality health care and combat malaria, HIV, non-communicable diseases and other diseases;" and Objective 4 aims to "Ensure all access quality education and the nation's manpower needs are sustainably met."

MHMS has a MOU with the Ministry of Education to work together on health promotion for young people through information technologies. Arrangements to work with NGOs and non-state actors more broadly are less formal. However, as reported in the last GARPR, the open and collaborative relationship between government and civil society is an example of good practice and a contributing factor to the steady progress being made in raising awareness about HIV/AIDS and reaching hard to reach populations.

9.4 Workplace

There is no evidence to show the existence of promotion of workplace HIV in the country, and this practice may only exist within the individual policies of the Development Partners and International NGOs working in the Country.

No specific National HIV/AIDS policy exists in the country and therefore the SIG has no HIV workplace policies. However, this may be actionable in future given the current policy dialogue ongoing within the MHMS and the other SIG arms of government regarding amendment and or removal of unfriendly HIV policies from the constitution.

9.5 Synergies with health sector

One of the two central focus areas of the Solomon Island National Development Strategy (2011-2020) is *Taking better care of all the people of the Solomon Islands*, under which a specific objective has been identified to ensure access to quality health care and combat HIV & other diseases (Objective No.3). The National Development Strategy specifically outlines a need to develop a national HIV framework. Therefore, the Solomon Islands National Strategic Plan (NSP) for HIV and STIs 2011-2015 was developed in 2012 to provide strategic guidance and direction to all individuals, groups, organisations and agencies responsible for contributing to the national HIV and STI response in the Solomon Islands. The NSP is also guided by the commitment of the Government of the Solomon Islands to its people as documented in the overarching vision statement of the National Health Strategic Plan (2011 – 2015): *The people of the Solomon Islands will be Healthy, Happy and Productive.*

The main priority of the NSP is to re-direct high impact interventions to the underserved and most at risk population groups. This NSP places particular emphasis

on improved communication to halt the transmission of HIV and STIs through informed HIV and STIs awareness and behaviour change interventions, as well as improved access to quality prevention, care and support services aimed of enhancing the quality of life and dignity of PLHIV and affected persons, as well as reduction in the transmission of HIV and STIs to others.

The STI/HIV Unit has been making efforts to integrate with other divisions in the ministry, through inclusion of some HIV indicators in the HMIS of the MHMS. However, HIV indicators are not included in the NHSP 2011-2015 except for the indicator measuring STI/HIV surveillance studies conducted in the country.

There is need to do more in terms of Joint planning with other Units eg RH and Gender Unit, participation in Joint sector meetings and incorporation of all HIV national indicators in the national database.

IV. BEST PRACTICES

a) Formation of a HIV Core Care team

The formation of a HIV Core Care team in the country has promoted client retention and access to a continuum of care among PLHIV in the Solomon Islands. The team is made up of key medical personnel interacting with clients testing for HIV in health facilities and as such, once a client tests HIV positive the team takes up the case for medical monitoring, ART prep and follow-up. The team also identifies and builds the capacity of treatment buddies for PLHIV. The team is responsible for delivering the client's ARV refills and hence the client does not have to come to the health facility for their regular refills. This has promoted client retention and adherence to ARVs among PLHIV in the country. Currently the only 3 clients who have so far been lost to follow-up were travelers who tested HIV positive and by the time their blood samples were confirmed positive through a second test, they could not be located.

b) SAFENET

On the 14th March 2013 the MHMS launched a GBV referral network called SAFENET comprising a working group / consortium made up of both government and non-government organizations/ agencies to provide coordinated, frontline services and support to victims/survivors of Bender Based Violence/ Violence Against Women.

It is a multi-sectoral approach which includes the following parties.

- Ministry of Health & Medical Services who also host the office of Coordination
- Royal Solomon Islands Police Force
- Public Solicitor office
- Family Support Centre (NGO)
- Christian Care Centre (NGO/FBO)

This approach has enhanced the quality of support and response to GBV in the country, with each entity providing specialized services to GBV clients in the country, and easily referring clients to the next level of support. In 2014 alone, through SAFENET, a total of 532 GBV victims received Counselling services, out of which 382 were referred on to the next level of care. The number of women seeking shelter was 170 and the number of children accompanying their mothers seeking shelter was 22 in 2014. The number of GBV cases attended to at health facilities was; 72 cases at HCC clinics, 52 cases at Seif Ples clinic, 130 cases at NRH and data from the Public Solicitor which was not available at the time of compiling this report. In terms of GBV Hotline services, the number of calls received and were given information/ options available for them were 855 cases, Number of clients receiving legal services were 29 cases.

In addition, 60 people were trained on GBV response in Honiara in 2014. These included 40 health workers and 20 staff of Civil Society Organizations. Awareness campaigns on GBV were also conducted in 10 schools and 8 communities in Honiara City Council.

This is a remarkable achievement considering the fact that Solomon Islands is a country where many cultures and norms which promote violence and discrimination against women exist.

c) Reaching out to Vulnerable Groups through Civil Society

The Solomon Islands Planned Parenthood Association (SIPPA) a local NGO has during the reporting period managed to create rapport and reach out to commercial sex workers and men having sex with men in the capital Honiara despite the country laws against the two groups of people.

SIPPA's HIV program targeting SWs in 2014 started with an evaluation in which they reviewed the impacts of Sex Workers program conducted in 2013. They also conducted continuous monitoring of SW knowledge and Behavioral Change Communication (BCC) progress. Through the evaluation study, the organization designed appropriate livelihood and health education activities for the SWs, and this has encouraged others to join the programme. In 2014 alone SIPPA recruited another 22 SWs into the programme, and these joined voluntarily through hearing about the programme and activities from their peer SWs already in the programme.

SIPPA conducts activities such as group discussions, counselling, one-on-one sessions, health education on basic HIV facts, weekly meetings, as well as livelihood support in terms of food, clothing and shelter. Of the 79 sex workers so far in the programme, 20 of them volunteered to be tested for HIV and STIs in 2014 and out of which, none of them was reactive for HIV whereas 2 of them were reactive for STIs and were referred for treatment.

The organization also started reaching out to and recruiting men having sex with men into their HIV programme and by the end of 2014 they had recruited 15 MSM though none of them had yet been linked to any STI/HIV related services, but were attending health education sessions.

This is a groundbreaking achievement towards reaching out to and linking vulnerable groups to HIV&AIDS services.

V. MAJOR CHALLENGES AND REMEDIAL ACTIONS

a) Progress made towards addressing Challenges faced in 2013

- The STI/HIV unit is now fully staffed with 8 staff of different cadres, capable of effectively running the unit's responsibilities
- The HIV Unit continues to receive ongoing technical support from development partners notably WHO, UNICEF, UNFPA, etc in implementing STI/HIV activities in the country.

b) Challenges faced during this reporting period 2014

i) SIG Institutional Challenges

- There was a significantly reduced funding for HIV/AIDS activities in the country during the reporting period and this is seen to continue well into 2015 with the impending Global Fund framework limited to only TB and Malaria Programmes. Also, previously HIV implementing International NGOs such as World Vision and Oxfam are no longer implementing HIV activities.

- Unfriendly HIV Laws: Criminalization of male-male sex and commercial sex: Sex between men is illegal under Sections 160-161 of the Solomon Islands Penal Code and is punishable with imprisonment of up to 14 years. Both selling sex as well as owning a brothel or "aiding or abetting" prostitution for personal gain are illegal under Section 153 and 155 of the penal code. The current legal creates challenges for accessing most-at-risk populations for prevention and surveillance purposes.

- Limitations of SINAC: Since 2011, there has been low engagement among SINAC members and limited commitment and capacity among SINAC leadership and staff to carry out the Council's national steering role. No representatives of SINAC spoke publicly or in the media on any HIV related topic or in support of the response in 2013 and 2014.

- National level political changes, internal capacity gaps, and a reduction in the involvement of Civil Society stakeholders due to lack of funding and donor support, has eroded the effectiveness of SINAC, and has adversely impacted on the progress

and performance of the national HIV response. In addition, an overlap of roles with Solomon Islands' National Country Coordinating Mechanism (SINCCM), whose mandate includes managing, coordinating and implementing the Global Fund Grant for Tuberculosis, HIV/AIDS and Malaria, has weakened SINAC's influence and profile.

- Obsolete HIV statistics: The response is currently based on Surveillance studies conducted five years ago and beyond, making it a challenge to realistically plan for the HIV and STI needs of this country.

- Outdated and Unendorsed HIV Policies: Solomon Islands is currently using the out-dated WHO ART Guidelines of 2010 for eligibility and treatment of PLHIV. This limits access to treatment for PLHIV and especially life-long treatment (Option B+) for HIV positive women as per the WHO 2013 consolidated guidelines. The country's HIV Testing and Counselling Guideline and National Strategic Plan for HIV and STIs are both in draft form pending finalization and endorsement by the Government. According to the Permanent Secretary, un-endorsed policies make it difficult for them to be adopted and used for guidance by other line ministries and sectors in the country.

ii) Socio-Cultural Challenges

- The complexity of the social and cultural factors that affect health cannot be understated as they play out in multiple forms, sometimes presenting as a barrier and then at times an enabler of development. All stakeholder groups considered gender norms, culture, and *Kastom* to be key inter-related factors that impact on health outcomes and behaviours, including the high prevalence of violence against women and girls, and low male involvement in the care of children. Although some ethnic groups practice matrilineal inheritance, across the country, men dominate decision-making at all levels of society.

- Religion and spiritual beliefs play a strong part in people's everyday lives. Competition between church affiliated groups sometimes leads to violent conflict. The practice of demanding compensation for social and legal wrong-doing is widespread and inhibits individuals and families seeking justice, such as in the case of violence against women, and has been known to be charged against health workers.

- Strong kinship bonds and w*antok* identity is a social asset that fosters social cohesion and helps mobilise communities behind development agendas. However, as in the case of violence against women and girls, kinship and obligation inhibit families and women from seeking social justice as *wantok* allegiance and its maintenance takes precedence. As to be expected, in areas where social cohesion is

strong, such as Isabel where one religious denomination holds sway, it was reported that it is easier to mobilize the community behind health and other development agendas.

- Physical factors such as geography and transport were identified as barriers to accessing health services, employment opportunities and information.

- Employment, education, and links to wealth and poverty are perceived to impact on health outcomes, and people's ability to access health information including SRH and HIV/AIDS information, services and pay for nutritious diets especially for PLHIV.

iii) Socio-Economic Challenges

- The Household Income and Expenditure Survey (HIES) (2005/6) provides the most recent estimates of poverty distribution in the country. A repeat HIES was expected in 2014 but it did not happen. The 2005/6 survey reported an incidence of basic needs poverty at 22.7% of the population. This varied from 32.2% for Honiara, 13.6% for provincial urban, and 18.8% for rural populations. An additional large number of people live just above the poverty line and are vulnerable to falling into poverty.

- The lack of reliable and up-to-date health outcome data disaggregated by poverty makes it difficult to identify common patterns of inequality across health indicators, although certain disparities and vulnerabilities are evident. First, women and girls are highly vulnerable to family violence, which carries personal, family and public health costs. Second, geographical remoteness is linked to poverty and poor access to services such as in the case of Choiseul where maternal deaths are higher than average.

- Urbanisation: Twenty per cent of the population live in urban areas, and the urban growth rate was estimated at 4.7 per cent in 2009, the highest in the Pacific region. Honiara is the main urban centre and as noted above has the highest poverty levels in the country. Informants from the MHMS reported that migration to Honiara is not slowing as people from outlying islands seek employment and access to services. UNICEF reports that the number of informal settlements in Honiara now stands at 52 growing from 30 in 1989. Poor access to basic amenities and health services places poor peri-urban communities at high risk. Health clinics serving Honiara city by the Honiara City Council, and Honiara Referral Hospital have very high patient loads, and are struggling to keep up with the growing urban population and increasing demand for hospital services from outer islands.

c) Remedial actions in place towards addressing 2014 challenges

- To address the challenge of unfriendly HIV laws in the country, the MHMS is currently in dialogue with the Solomon Islands Department for Immigrations to remove the law against entry of HIV positive persons or PLHIV into the Solomon Islands. The Ministry also set up a taskforce to draft a HIV Bill to be tabled in Parliament to guide policy reform in the area of HIV in the country if passed into law. This bill will go a long way in protecting the rights of PLHIV and reduction of stigma and discrimination against PLHIV in the Solomon Islands. The reviewed NSP for HIV and STIs 2014-2018 has earmarked Policy reform as a key priority for its implementation period.

- To addressing limitations of SINAC, UNICEF through the services of a long-term HIV/AIDS Consultant will be strengthening the capacity of SINAC through capacity building, mentoring and coaching, to streamline their role in the coordination of HIV response in the Country.

- To addressing the challenge of obsolete HIV and STI statistics for planning, UNICEF is funding Second Generation Sentinel Survey (SGSS) 2015 on HIV and STI prevalence among ANC attendees in eight provinces of the Solomon Islands. This study will give the national response updated statistics on HIV and STIs in the country for a more realistic planning of the response as well as proper allocation of resources

- To addressing the challenge of outdated and unendorsed HIV Policies, UNICEF is supporting the revision of the National Strategic Plan for HIV and STIs 2014-2018, the national PPTCT policy and the National HIV Testing and Counselling policy. This support is in terms of funding the policy review, production and dissemination processes, as well as technical support in updating the policies through a long-term HIV/AIDS Consultant.

d) Concrete remedial actions planned to ensure achievement of agreed targets.

The Government of Solomon Islands is undertaking the following concrete remedial actions to ensure achievement of agreed targets.

i) Close Monitoring and Supportive Supervision:

With support from the Global Fund and DFAT under the Malaria Programme, the MHMS intends to set up a separate unit in the ministry to monitor and supervise all programmes and funding supported by development partners. The unit will be charged with the role of monitoring targets achieved against the funds disbursed, and it will work closely with development partners supporting the MHMS to monitor the targets and expenditures. This has been planned in view of the new Cash on Delivery (COD) funding model of the Global Fund which requires the Government to fund its own activities of the Framework Agreement, and at the end of an implementation year the

Global Fund reimburses all funds expended only on condition that the agreed targets are met.

ii) Financial Management & Accountability:

The Government of Solomon Islands has set up a separate account called the Development Partners Account, where funds from all Development Partners supporting the MHMS are deposited directly by the Development Partners, and monitored centrally by the Ministry of Finance and Trade. This was done to avoid circumstances where Development Partners funds meant for the MHMS is used by other sectors because it has been deposited in a general account for all sectors.

iii) Health Systems Strengthening:

The MHMS under the Global Fund Malaria programme will be supporting receiving HSS support in terms of support for 17 key functions in the Ministry (including finance, HIS, procurement and HR), procurement systems and HIS development.

UNICEF through their Joint work plan with the MHMS for 2014-2015 is also supporting the training of Health Workers, and strengthening of data collection and reporting from the points of care in the provinces.

VI. SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

a) Key support received from Development Partners in 2014

During the reporting period, UNICEF was the only Development Partner directly supporting the STI/HIV Unit of the MHMS in the response through financial and technical support. UNAIDS provided additional technical support especially in the revision of the NSP 2014 – 2018.

Other Development Partners, notably WHO, WB, DFAT, SPC and UNFPA did not directly support the STI/HIV unit in the response, but other units of the MHMS both financially and technically, which support positively impacted on the national response in one way or another. In particular, the support to the Reproductive Health Unit of the MHMS under the Joint UN RMNCAH Programme, jointly implemented by UNICEF, WHO and UNFPA, supported indicators linked to the response such as GBV, CPR, ANC consultations and IYCF.

Support from United Nations Children's Fund (UNICEF) in 2014

Under the Joint MHMS/UNICEF 2014-2015 Rolling Annual Work Plan, the UNICEF HIV&AIDS programme continued to provide funding and technical support assistance to the MHMS STI/HIV unit in the areas of strategic information & data collection through funding of a Second Generation Sentinel Survey on STIs and HIV, HIV prevention services for pregnant women and adolescents, provision of HIV test kits & supplies; and

capacity building for health workers in HTC & PMTCT. The SGSS process was initiated but the actual field work for the study was pushed to 2015.

UNICEF also continued to support system strengthening to increase access to HIV prevention and quality youth friendly health services for adolescents in- and out-of-school, with emphasis on reaching adolescents at increased risk to HIV exposure. UNICEF provided strategic support to ensure that adolescents in Solomon Island schools benefit from information and have relevant skills to protect themselves from HIV. In addition, UNICEF will provided technical support to increase knowledge and skills of out of school youth to reduce their risks and vulnerabilities to HIV through identification and creation of youth friendly health service spaces together with the MHMS.

Specifically, UNICEF provided the following support to the national response through the MHMS during this reporting period of January to December 2014;

- UNICEF is supporting the strengthening of routine data collection including assessing the feasibility and appropriateness of introducing mobile health (mHealth) data collection tools in Solomon Islands.
- UNICEF, in partnership with Empower Pacific (a regional organization providing HIV counselling training), supported a training of trainers on provider initiated testing and counselling which included two participants from Solomon Islands.
- With UNICEF support, Solomon Islands conducted two trainings at provincial level to scale up point of care testing using rapid diagnostic tests. At year end, 20 facilities at national and provincial levels are providing HIV point of care testing to pregnant women and their partners and young people.
- UNICEF also supported Solomon Islands to strengthen point of care HIV testing and counselling services for adolescents and youth, with five facilities now providing adolescent and youth friendly services, including HIV testing and counselling.
- UNICEF supported 1 youth to attend the 2014 International AIDS Conference in Melbourne Australia which allowed for sharing of information, experiences and lessons from Solomon Islands
- UNICEF is supporting the roll out of a Second Generation Sentinel Surveillance for HIV and syphilis. In 2014, the study proposal was finalized, ethics approval obtained and the lead researcher contracted. The study is scheduled to begin in January 2015.
- UNICEF supported the Ministry of Health and Medical Services in the review and update of the PMTCT Policy to the 2013 WHO Consolidated guidelines. Support from UNICEF, along with WHO and UNAIDS, will continue in 2015 to finalize the policy.

In the next reporting period of January to December 2015, UNICEF will continue providing the following support to the national response through the MHMS STI/HIV Unit.

- Conduct a Second Generation Sentinel Survey (SGSS) study on STI and HIV prevalence, as well as sexual behaviour among ANC attendees at 12 selected health facilities in the 8 provinces of HCC, Guadalcanal, Malaita, Isabel, Temotu, Choiseul, Makira and Western. The study will provide updated information on STIs, HIV and sexual behaviour among ANC attendees, as well as male partner involvement in ANC.
- Implement Communication for Development (C4D) and Sports for Development (S4D) activities linked with strengthening of PPTCT, HIV Testing and counseling and promoting Youth Friendly Health Services (YFHS) through production of new IEC materials and development of key health education messages.
- Strengthen the Stepping Stones programme to involve and reach more youth / adolescents with key health messages and link them to YFHS
- Provision of supplies to strengthen PPTCT, HIV testing and counseling services, patient monitoring (viral load testing) and Early Infant Diagnosis (EID)
- Support the revision, finalization, production and dissemination of the PPTCT policy; which in the context of SI, will be a consolidated HIV Care and Treatment policy to include components of PPTCT, ART, EID and Infant Feeding in the context of HIV.
- Support the revision, finalization, production and dissemination of the HIV Counselling and Testing Policy
- Support monitor and supportive supervision to the STI/HIV program including monitoring of PoC HIV testing and Counselling, PPTCT and youth targeted C4D, S4D and YFHS activities.

b) Actions to be taken by Development Partners to ensure achievement of targets.

- Support the NRH, Provincial Hospitals and Clinics in the effective consumption and monitoring usage of medical supplies including drugs, HIV test kits and other commodities. Specifically, support them by designing, printing and distributing stock cards to all health facilities, mentoring health workers on filling of stock cards, providing support supervision and monitoring on compliance to filling of stock cards, and adherence to the use of FEFO methodology as opposed to FIFO to minimize expiry of drugs, test kits and other Medical supplies.
- Build the capacity of NGOs/FBOs in designing, planning, implementing, monitoring and evaluation of STI/HIV programmes. and involve them in the national response

- Immediately implement TB/HIV activities – all TB patients should be tested for HIV and all HIV patients tested for TB. All PLHIV should be put on IPT
- Scale up HIV rapid testing at Points of Care to stop transportation of blood samples to bigger hospitals
- Scale up HIV testing among pregnant women (currently only at 28.7%) and other vulnerable groups through strengthening Provider Initiated Testing and Counselling.
- Operationalise a routine reporting system for HIV and STIs
- Strengthen internet connection at medical institutions and the STI/HIV Unit to allow for electronic reporting
- Strengthen patient follow-up, retention and adherence to treatment. There are currently 2 patients lost to treatment out of 10.
- Support the establishment of an organisation for PLHIV
- Ensure service coverage of key populations – people who use drugs, men who have sex with men and sex workers.
- Enhance advocacy and action for expansion of ART initiation at CD4 count of 500.
- Update all country policies in HIV Testing, Treatment, Care and Support.

VII. MONITORING AND EVALUATION ENVIRONMENT

a) Overview of the current M&E system;

A monitoring system capable of providing strategic information and guidance on HIV programming is a significant challenge for the Ministry of Health and there is currently no effective system for monitoring of the HIV epidemic or response. The draft *National Strategic Plan 2014-2018* does not yet have a monitoring and evaluation framework linked to it.

Capacity to monitor prevention efforts, evaluate progress and use the information to guide the HIV response remains weak. The system for data collection and analysis of HIV & STI testing and prevention activities from provincial clinics (and even those based in Honiara) is not well established or consistent. A very limited evidence base hinders understanding of the epidemic, especially risk behaviours among vulnerable groups, and results in very little quality information to guide program responses.

b) Challenges faced in the implementation of a comprehensive M&E system

- The use of multiple databases (National Laboratory, MHMS Statistics Unit DHIS, HIV Unit), contribute to data limitations and pose a challenge in reporting. The DHIS rolled out in 2014 does not capture many of the national HIV response indicators.

- M&E HR is also a challenge, with no specific M&E staff recruited in the STI/HIV unit, but one staff assigned the secondary task of compiling reports. However, this is not happening since the Unit has no file of compiled periodic reports available at the time of writing this report. The MHMS planning unit also informed that the STI/HIV Unit has not submitted any previous reports for inclusion in the national reports for the Ministry.

c) Remedial actions planned/Implemented to overcome the challenges,

- An effort to integrate HIV data collection in the broader MHMS Health Information System (HIS) through a new section on the HIS data collection form was operationalised. A series of questions that capture HIV testing data were included in the HIS in 2013, and this improved the collection of HIV data from the provinces in 2014
- Plan to develop a simple monthly reporting tool for CSOs and NGOs in the response to report to the MHMS STI/HIV unit on a monthly basis.

d) Support Needed to further strengthen the M&E System of the MHMS

- M&E Technical Assistance to strengthen the capacity of STI/HIV Unit personnel in routing and quality data collection and reporting, including collating of data from CSOs and other partners in the response. This TA can be provided in terms of training, mentoring and coaching through a M&E specialist stationed at the unit.
- M&E support could also be in terms of Human Resource through funding of an experienced and M&E focused position in the unit, to deal with the current situation of multi-tasking by a staff who is not M&E trained or experienced.
- Strengthen the capacity of Health CSOs through training, mentoring and coaching on quality documentation and reporting of STI/HIV activities, and submission of these reports to the MHMS on a regular basis.

VIII. ANNEXES

ANNEX 1: Consultation/preparation process of the GARPR 2015

Table 19: GARPR 2015 Narrative Work plan – Solomon Islands

Step	GARPR Task	Person(s) Responsible	Source	Support Needed	Output	Status / Timeline
1	Participate in GARPR Training	- Japhet Honimae, MHMS - Sam Opwonya, UNICEF SIFO	UNAIDS	GARPR guiding resource materials	- Instructions on GARPR 2015 reporting	Done
2	Desk review of literature and data from studies conducted during the reporting period	- Sam Opwonya	Sentinel surveillance, National surveys and specific studies	Recommendation of materials to review	- Indicator data, - Status of the HIV epidemic in Solomon Islands, - Latest STI and HIV Statistics	Received some materials from Gabriela - UNAIDS
3	Consultative engagements with stakeholders to consolidate their input to the report	- Sam Opwonya	MHMS, UNAIDS, WHO, UNFPA, SINAC, SIPPA, DFAT, SPC	Unicef SIFO Chief - Intro to HIV focal point persons of health IPs in SI	- 2014 Health Reports, Resource documents / literature to review and include in the report	4th week of Feb and 1st Week of March 2015
4	Collating of quantitative data for 2014 as per GARPR indicators	- Japhet Honimae - Sam Opwonya	Data for 2014 from the provinces, DHIS	N/A	- Up-to-date data on GARPR indicators	1st & 2nd Week of March 2015
5	GARPR Narrative writing	- Sam Opwonya	Literature review	Review by Gabriela I.- UNAIDS	- GARPR Narrative	4th week of Feb 2015, ongoing
6	GARPR online entry of Data	- Japhet Honimae	Data collected from provinces	Consult Gabriela in case of a hitch	- Interim submission	2nd – 3rd Week of March
7	Online Submission of GARPR 2015 Narrative	- Sam Opwonya	N/A	Consult Gabriela in case of a hitch	- GARPR online report for SI submitted	By 31st March 2015