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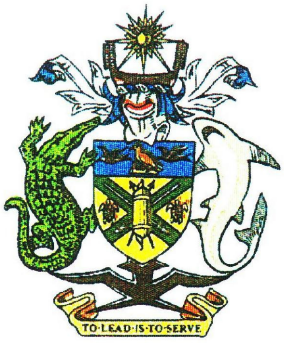
HE NATIONAL HIV POLICY AND MULTISECTORAL STRATEGIC PLAN 2005-10 Solomon Islands



By

Solomon Islands Government
Solomon Islands National AIDS Council
Non-Government Organizations
cluding the Churches and Community Based Organizations)

January 2005
(Vol. No.1)

Contents:

Acronyms

AIDS	Acquired Immuno-deficiency Syndrome
AUSAID	Australian Assistance for International Development
BSS	Behavioral Sentinel Surveillance
CBO	Community Based Organization
CEDAW	Convention for the Discrimination Against Women
COM	Church of Melanesia
FSC	Family Support Center
HAART	Highly Active Anti-Retro Viral Treatment
HEPD	Health Education and Promotion Division
HIS	Health Information System
HIV	Human Immuno-deficiency Virus
HSPU	HIV/STI Prevention Unit
HTC	Honiara Town Council
IEC	Information, Education and Communication
KAP	Knowledge, Attitudes, Practices and Behaviours
MEHRD	Ministry of Education and Human Resource Development
MHMS	Ministry of Health
MSM	Men Sex with Men
NCW	National Council of Women
NGO	Non-Government Organization
NHREC	National Health Research and Ethic Committee
NHSPU	National HIV/STI Prevention Unit
NMSP–I	Solomon Island's 1st National Multi-sectoral Strategic Plan
PEP	Post-Exposure Prophylaxis
PLWHA	People Living with HIV/AIDS
RC	Roman Catholic Church
RHD	Reproductive Health Division
SCFA	Save the Children's Fund Australia
SGS	Second Generation Surveillance
SICA	Solomon Islands Christian Association
SICHE	Solomon Island College of Higher Education
SIG	Solomon Islands Government

SINAC	Solomon Islands National AIDS Council
SIPPA	Solomon Island Planned Parenthood Association
SSEC	South Seas Evangelical Church
STI	Sexually Transmitted Infections
WHO	World Health Organization

Executive Summary:

The planning period of 2005 to 2010 will be a challenging one as the projected number of HIV positives are increasing. It is estimated using the WHO estimates that by end of 2010 the minimum number of HIV positives will increase to about 350-400. However, about 1,350 people as cumulative estimate could have been infected with the virus. This is a significant increase in-light of the limited resources in the country.

This revised National HIV Policy and Multi-sectoral Strategic Plan 2005-2010 provides the policy direction framework and multi-sectoral strategies, which forms the basis of the operational plans of all stakeholders.

The formation of the Solomon Islands National AIDS Council, which has its inaugural meeting on the 28th September 2004, is a boost to the policy and strategic plan. The conceptional underpinning of the vision and the mission of the policy and plan is for the HIV outbreak not to have a toll on the population health of the people.

Thus, to achieve the vision and mission, the several steps were undertaken to develop the policy and the multisectoral plan. Firstly, a situation analysis determined the needs and problems that required refinement and strengthening in the strategic plan. Consequently, the goals and key result areas could be decided on. Different strategies were subsequently determined by brainstorming on different ways to achieve the identified goals. These key strategies were further refined by elaborating on the activities and input required. Accordingly, the output of the activities as well as the outcome and impact of the strategies could be concluded. All steps of the process were developed with input and contribution of different stakeholders which, is hoped to lead to a sense of ownership amongst all stakeholders. As a result, the proposed plan should be broad and targeted in its approach as well as realistic in its achievements.

The policy addresses the HIV problem according to its impact on different gender group in the country by first identifying the key issues recognized in the [i] service delivery health sector and [ii] the non-government organizations, and [iii] the youth, the women and girls as well as men. Having understood the behavioural as well as system issues, the key directions and options were developed jointly by all key stakeholders, with worse a scenario building of the HIV epidemic in the next five years. Whilst limited information undermined a proper gap analysis, the policy capitalized on the trend analysis based some data and information already available.

The key result areas of the policy and multisectoral plan are listed below:-

1. Reduction of risks and Vulnerability to HIV and other STIs
2. Increasing access to Screening and strengthening Confidentiality in services
3. Establishing, expanding and strengthening STI/HIV Surveillance, and the continuum of treatment and care.
4. Capacity building of the health system, as well as NGOs, Churches and CBOs to effectively and efficiently implement HIV programs and activities, which ensures integration of prevention and care.
5. Sustainable development to enable environment for behavioral change, de- stigmatisation, and against discrimination impacting on prevention and care.

Finally but not the least, the effective implementation of the strategic plan and the activities depends on the commitment of the key stakeholders and a proper management of programs and projects including the monitoring and evaluation. Thus, there is a monitoring and evaluation framework developed to help with assessing the outputs, the outcomes and the long-term impact to the vulnerable group as well as the population health as a whole.

The Solomon Islands National AIDS Council has an important role in ensuring that the revised National HIV Policy and Multi-sectoral Strategic Plan is effectively implemented to make a big difference.

Part 1: Introduction:

- This is the revised ***National HIV Policy and Multi-sectoral Strategic Plan 2005-2010.***
- It provides the policy direction framework and multi-sectoral strategies, which forms the basis of the operational plans of all stakeholders.
- The plan is a revision of the 1st the National Multi-sectoral Strategic Plan endorsed in 2001.
- The plan is developed locally by the Ministry of Health and key stakeholders from the NGOs including the churches and CBOs, through a wide consultation process and workshops.
- Part 2 concerns with the Background information of the country highlighting the social environmental situation of the HIV policy. It briefly explains the diversity in terms of geography and demography of the people of the country as having implications of the epidemiology of HIV. This section also views the political and social environment surrounding the past and the hope of return of peace and law and order as crucial to stop the spread of HIV among the local communities.
- Part 3 deals more specific with the HIV situation of the country and the projected threat as the worse scenario for the policy and plan.
- Part 4 concerns the history of the national response to HIV in Solomon Islands. This section lists in brief some of the events of the national response.
- Part 5 highlights the scenario building for the next five years, for which the policy and strategic plans are developed and to be implemented to achieve the vision and mission.
- Part 6 briefly highlight the process undertook to develop the policy and multi-sectoral plan. This section recognizes the inputs from key stakeholders in the build up of the policy and plan. This is included to promote the multi-sectoral approach in the fight against HIV in the country.
- Part 7, 8, 9 concerns with the key issues and problems as the causative and potential factors to HIV epidermic in the country. Part 7 outlines the issues related to HIV as perceived within the health care system. It covers problems related to HIV prevention, screening and testing, and care and treatment. Part 8 concerns with NGOs perspective in preventing of the HIV spread. Part 9 deals with young people and HIV.

1.1. Vision,

The health and well being of the people of the country will not be undermined due to the burden by HIV.

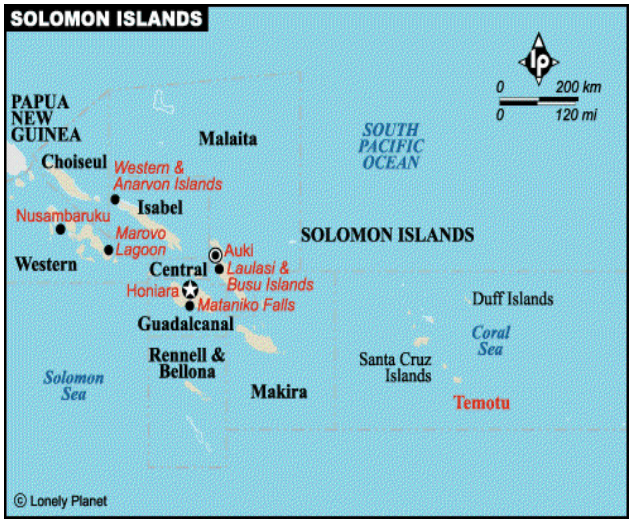
1.2. Mission & Principles*:*

The Vulnerable groups,(young people, women and children of the country) are sensitised through informed HIV awareness and behavioural change interventions to stop the transmission of HIV, and to ensure accessibility to quality voluntary, confidential, counselling and testing as the entry point for the HAART and the continuum of quality care for people living with HIV/AIDS.

Part 2: Background (General):

2.1. Country Profile (Solomon Islands[1]):

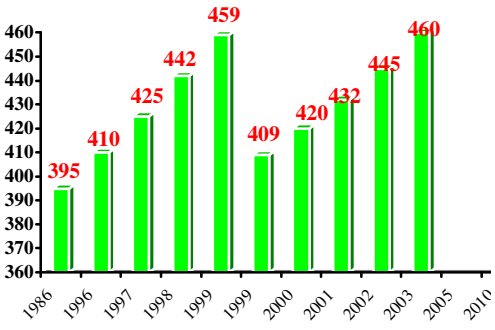
Solomon Islands has a total land area of 28,369 sq. km from a sea area covering 1,632,964 sq. km. It is a widely scattered archipelago of rugged mountainous islands and low lying coral atoll, stretching over some 1,667 km in a southeast direction between Papua New Guinea and the Republic of Vanuatu, and North-East of Australia.



On the Islands the location of villages are scattered. Majority of villages in the country (52.0%) were situated in the coast, 32.9% live inland with no sea access, whilst 15.0% lived inland with sea access. Theses factors undermine the primary health activities such as the clinic outreach. It also undermines physical access to basic health care services particularly 30% of population living more than 3 kilometer from a nearest health clinic[2]. Around 70% of the total population live within 3 km to a nearest clinic. Poor shipping and domestic air-transport services has been a problem.

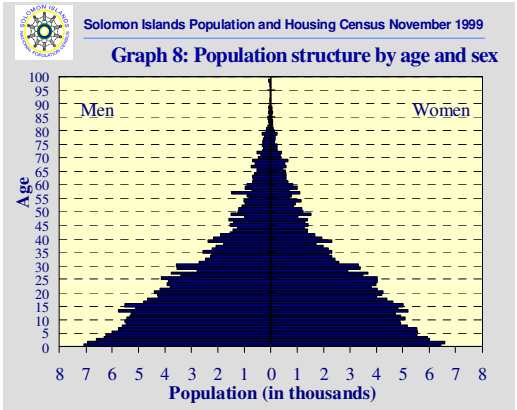
2.2. The demography :

Graph showing population trend 1986-2004 ('000)



The population in 2004, is around 460,000 [3], compared to 285,000 in 1986[4]. The increasing population of the country is a major challenge to the health care services, especially, with regards to the distribution of limited health resource to meet the vast health demand of the people.

The Solomon Islands Population has been increasing at a declining rate but still very high by pacific standard. In 1999, the annual growth rate of the which



Solomon Islands Population was 2.8% compared to 1986, was 3.5%. Solomon Islands still has the highest annual population growth in the pacific.

Whilst the population is growing faster, it is also a young (Graph 8). The pyramid base is very wide. By there is a transition from more (45.2%) age-group of very 1999, 15-44

[1] Salesi F Katoanga, WHO, Country Liaison Officer for Solom
[2] MOH (1996) Comprehensive Health Review
[3] SI Population and Housing Census November 1999
[4] National Census 1986

than those of 0-14 (41.5%) as compared to 1970. A similar demographic transition change is also reflected in the TFR (Total Fertility Rate), which is 4.8 in 1999 as compared to 6 in 1986.

The overall population density is 13 people per square kilometer.

2.3. Health Status:

		As of (year)			As of (Year)
POPULATION	[Total]	444,564 (2002)	LIFE EXPECTANCY AT BIRTH (years)	[Both]	65.00 (1999)
	[0-14 years]	179,234 (40.32%)		[Male]	63.60 (1999)
	[65+ years]	15,316 (3.45%)		[Female]	67.40 (1999)
CRUDE BIRTH RATE (per 1 000 population)		34 (1999)	TOTAL FERTILITY RATE		4.80 (1999)
CRUDE DEATH RATE (per 1 000 population)		9.00 (1999)	% OF POPULATION SERVED WITH SAFE WATER	[Total]	71.00 (2000)
				[Urban]	94.00 (2000)
				[Rural]	65.00 (2000)
INFANT MORTALITY RATE (per 1 000 live births)		66.00 (1999)	% OF POPULATION WITH ADEQUATE SANITARY FACILITIES	[Total]	34.00 (2000)
				[Urban]	98.00 (2000)
				[Rural]	18.00 (2000)
MATERNAL MORTALITY RATIO (per 100 000 live births)		295 (2003)			

The confirmed statistic for maternal mortality ratio in 2003 is 295/100,000 live births as compared to 125/100,000 in 1999[5]. The unfavourable effect of the ethnic conflict on the provision of maternal health care services is being mentioned as a major contributing factor to this notable increase. Other figures for 2003, indicated the following changes but are yet to be confirmed; viz; life expectancy (male-63.6 and female 76.4); crude birth rate (37.6/1000 total population); total fertility rate (4.05). There are no recent data on infant mortality and crude death rate besides those that are given in table (1) below. The total population for 2003 was estimated to be 456,800 as compared to the census figure of 409,042 in 1999 and 444,564 for 2002.

Table 1: CORE POPULATION AND HEALTH DATA AS OF (YEAR)-above

The country's economy was heading towards total collapse as a result of the ethnic conflict that peaked between 1999 and 2003. At the beginning of 2003, the main sources of the country's economy like the palm oil industry; fishing and fish-cannery; logging/timber industry; copra, cocoa, and coffee; gold/silver mining and tourism were either shut down or reduced to minimal production level. The country's poor economic situation was further affected by decision of certain development and donor partners like the World Bank and European Union to temporarily suspend their financial support; while countries like Australia/AusAID, Japan/JICA, New Zealand/NZODA and Taiwan continued to provide financial and technical support but on a well controlled and a regularly revised rate. This extremely poor status of economy disrupted and affected all Government and public services (including health services) where wages were not paid for months, gross inadequacy of supplies and equipment, poor maintenance of health facilities, job redundancy and increased unemployment, alleged corruption among senior officers within the Government system, poor morale among the Government employees at all levels with several leaving the Public/Civil Services.

During the same period, there was an almost total breakdown of law and order in most parts of the country. As a consequence of the progressively decline of law and order and worsening status of the economy; Solomon Island was referred to in the year 2002 and 2003, as a 'failing state'. Fortunately, the arrival in early July 2003, of the of the Regional Assistance Mission to Solomon Islands (RAMSI) comprised of soldiers and policemen from New Zealand, Papua New Guinea, Fiji, Tonga, Samoa and Cook Islands led by the Australian Army and Police contingent helped not only restore law and order in the country, but also helped in the rebuilding of the economy and saved the country from becoming a 'failed state'.

2.4. Political Situation

The most important political event that generated great hope and goodwill for peace, prosperity and progress to the Government and people of Solomon Island was the arrival of RAMSI in July 2003, as mentioned above. The security and law and order situation had improved substantially since the arrival of RAMSI.

These achievements contributed to the gradual return of the Government services including health services. Most of the hospitals, health centres, clinics and nurse-aide posts were operational with improved provision to normalcy of supplies, equipment and staff by the end of 2003.

2.5. Economic Situation.

The main sources of the country's economy were either shut down or reduced to minimal production level. Correspondingly, the Gross Domestic Product (GDP) declined to SBD$584 (US$84) in 2002 while the external and internal Government debts stood at SBD$1087.3

[5] Ministry of Health, SI (2004) Health Status Report 2004:

million and SBD$458.6 million respectively for the same period. The external reserve was also estimated to be SBD$129.9 million (US$29.4million) representing an import cover of about 1.5 months only. The ill-effects and consequences of the poor status of the economy are already mentioned under section (1) above.

However, by the end of 2003 (six months after the arrival of RAMSI), the country's economy showed a positive recovery along with the restoration of law and order. (The total revenue collection up to the end of September 2003, was SBD$257 million, compared to the estimated SBD$195 million) The palm oil factory and the gold/silver mines (major revenue earners) are still closed but the others are gradually returning to normal operation.

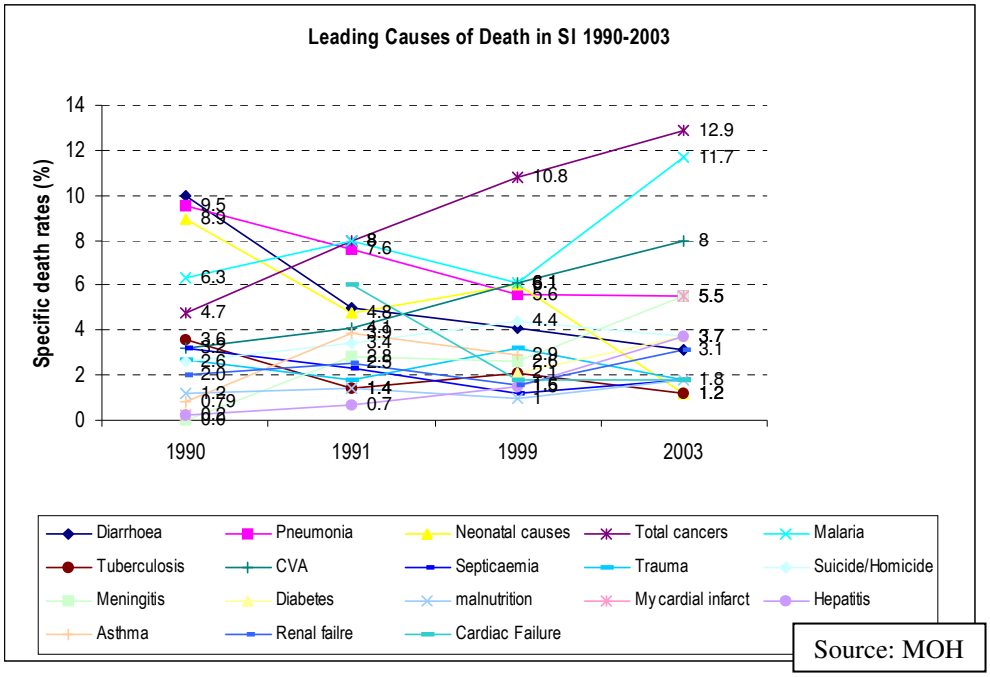
2.6. Health Funding for HIV Program:

Although, the Government is the major source of funding for health services at both the central and provincial levels, it has to rely heavily on outside financial assistance during the years of ethnic conflict.

For the first time in history, the Solomon Islands Government through the Ministry of Health budget for 2005 have allocated SBD0.5 Million (SBD516,000). This is a very encouraging commitment from the Government of Solomon Islands. Other financial support is being received from the AusAID Health Trust Fund to the Ministry of Health operations, the Global Fund Against HIV/AIDS, TB and Malaria and (GFATM), and WHO.

The total required operational fund for the Solomon Islands Government to provide the health services to the people of the country in 2005 is around SBD131Million. Of the total the SIG, is committed about 67% (SBD87.1M), whilst the Australian Government through the Health Sector Trust Fund (HSTF) will contribute (33%) SBD44.7Million[6].

2.6. Disease Trends.



Source: MOH

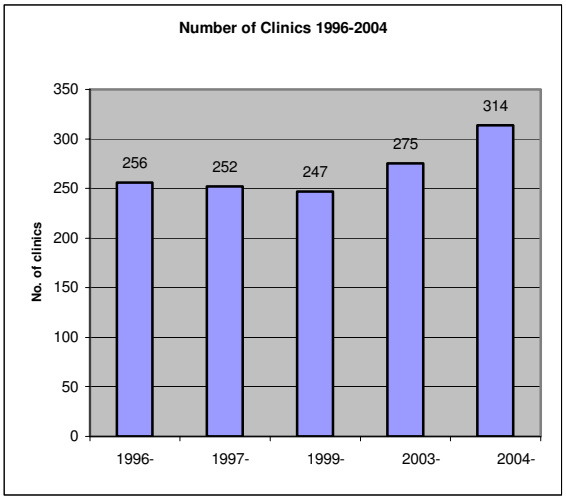
[6] Financial Management Adviser-Health Sector Institutional Strengthening Project (2004): 2005 Budget Briefing: 276 Ministry of Health; 2005 Ministry information.

The available figures (in 2003) have shown change in the top ten leading causes of death in the country[7]. The causes of death due to the Non-communicable disease such as CVA, cancer, and Myocardial infarction have significantly increased in the past decades. Deaths due to neonatal causes are no longer among the five leading causes of mortality. However Malaria remained a common cause of death still. The reduction in mortality and morbidity in children from diarrhea diseases is attributed to the improved status of sanitation, water supply, personal hygiene and breast-feeding. The reduction of mortality due to neonatal causes is attributed to the improved status of maternal/safe motherhood programmes and services supported by much improved pediatric care and the current focus on Integrated Management of Childhood Illness approach. Incidentally, the impressive impact of the five-year malaria programme based on the 1993 National Malaria Control Policy that resulted in achieving several set targets was severely disrupted and affected by the years of ethnic conflict (1999-2003) with the number of reported new cases of malaria (to be confirmed) being increased from 74,865 in 2002 to 91,606 in 2003. At the same time, diseases like tuberculosis (647 and 421 confirmed new cases at Honiara National Hospital in 2001 and 2002 respectively); eye infection (10,311 new cases in 2003) and sexually transmitted infections are still among the major causes of morbidity and mortality.

Having to face both the control of infectious diseases and the rising of non-communicable diseases, and HIV/ AIDS with very limited resources, poses a major challenge for the Government at this difficult stage of recovering from the aftermath of the years of ethnic conflict.

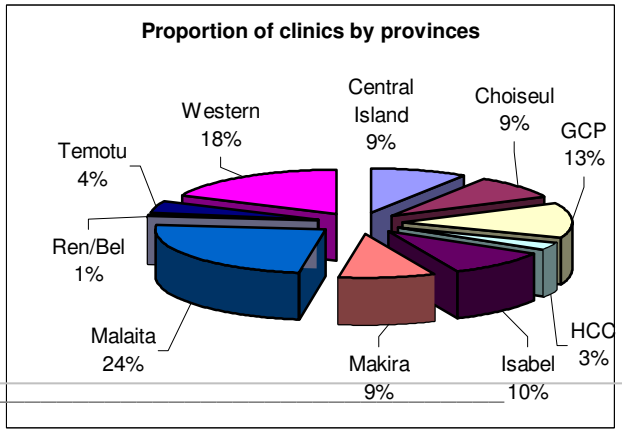
There was no major out break of diseases in 2002/2003. However, the world wide threat of SARS and HIV/AIDS resulted in the development of new policies and strategies to strengthen and revitalize the disease prevention, control and surveillance and preparedness for action.

2.7. Health Services



The number of primary health centers (rural clinics) have increased in 2004 by additional 39 clinics (or 14% increase)[8].

Each of the nine provinces has a hospital except Guadalcanal Province where the National Referral Hospital is located. The area and rural health centres and nurse aid nurse posts are well distributed through out the provinces based on the size and geographical distribution of the population. Several provincial hospitals were not fully operational during the years of ethnic conflict. However, by the end of 2003, all hospitals were full operational but most are still in dire needs of repairs, refurbishing as well as supplies of certain equipments and drugs.



At end of 2003[9], a total of 57 doctors (ratio of 1 doctor per 7176 population) were employed

[7] Ibid,
[8] Ministry of Health (2004): Updated Clinic database October 2004:
[9] Ministry of Health (2004): National Health Report 20

by the Government and actually working in the country. (The minimum need is a total of 75 doctors). Of these 57 doctors, 32 (56%) are based at the Honiara National Referral Hospital, twenty-two in the other eight provincial hospitals, five at the Guadalcanal province and Honiara City Council and three at the Ministry of Health's Head Quarters. In terms of nurses, a total 605 nurses (including sixty one nurse aids) were employed under the Ministry of Health (a ratio of 1 nurse per 676 populations) for the same period. Unlike, the doctors, the number of nurses are more or less evenly distributed among the hospitals and the area and rural centers and clinics. There are also five private medical parishioners that are practicing mainly in Honiara and Gizo.

Shortage of staff is still a major problem and is affecting mainly the big provinces like Malaita, Guadalcanal and Western provinces. The hospital in Malaita needs more doctors while the main national referral hospital/Honiara has no Consultant Physician and it needs one urgently. At the same time, the Public Health Division needs an Epidemiologist.

Human resource development in health is still a priority programme. To this end, a number of doctors are currently undertaking postgraduate training in pathology, psychiatry, and internal medicine and obstetric/gynecology. The Ministry has also established a six-month midwifery course in 2002 in Honiara. The first seven midwife graduates are now employed in provincial hospitals and health centers. The course was, however, not implemented in 2003 due to the suspension of the World Bank's financial support. The Ministry of Health is determined to reopen the midwifery course in 2004.

The first training for local clinicians on the HIV treatment and care was held in September 2003. However, there is need for continuous and ongoing education on HIV prevention and care for all clinicians including nurses and laboratory technicians and other health workers.

2.8. National Health Priorities:

The Ministry of Health's priority health programmes based on the following eight core issues under its 1999-2003 National Health Policies and Development Plans[10] have been reviewed and evaluated at the end of 2003: -

- Improvement of management and supervision of services;
- Access and improvement of care and quality of services;
- Human resources development for health;
- Morbidity and mortality reduction;
- Environmental health;
- Health promotion and education;
- Reproductive health, family planning and population concerns and
- Developing partnership in health development.

The results of this review and evaluation exercise are being finalized. In the meantime, the Ministry of Health indicated that its National Health Plan for 2004-2005 would be based on these results. The improving of Public Health and Primary Health Care functions, focussing on the prevention and control of Non-Communicable Diseases and STIs/HIV-AIDS will be among the top priority programmes[11].

In the meantime, the Government has finalized and endorsed its 2003-2006 National Economic Recovery, Reform and Development Plan (NERRDP)" at the end of 2003[12]. The programmes will focus on five main priority areas. "(To) Restore basic social services in

[10] Ministry of Health (2000): National Health Policies and Development Plan 1999-2003;
[11] G.Malefoasi; USHI: Ministry of Health (2004): Public Health Vision and Policy Framework: Presentations.
[12] SIG (2004): National Economic Recovery Plan: 2003-2006;

health and education," is one of these priority areas. In terms of restoring health services, the Government identified the following indicators as the main measuring tools of the progress of the implementation of recommended programmes and activities under 2003-2006 NERRDP: -

- Reduce Malaria rate from 160/1000 population (2001) to less than 80 per 1000 by end 2005. (The rate (to be confirmed) in 2003 is 200/1000 population which is much higher than the 2001 figure).
- Reduce infant mortally rate from 66 per 1000 live births in 1999 to less than 50/1000 by the end of 2005.
- Reduce maternal mortality rate from 129/100,000 live births in 1999 to less than 80 by the end 2005. (The confirmed MMR for 2003 is however 295/100,000 live births. This means more challenges to tackle).
- Achieve 90% coverage of immunization of children by the end of 2004.

The National Health Plan for 2004-2005 is also aimed at achieving these NERRDP's indicators resulting in a collective contribution towards the attainment of health related Millennium Development Goals.

The Ministry of Health, in the meantime have developed a number of health strategies and policies as follows:

- Draft National Tobacco Control Legislation (Policy)[13]. (Completed and finalized in 2002. It is still awaiting endorsement by the Cabinet and to be introduced into Parliament to be legally adopted).
- Draft National Blood Safety Policy[14]. (Completed/finalized in 2003 and is awaiting endorsement by the government)
- Draft National Health Promotion Policy[15]. (Completed/finalized in 2003 and is awaiting endorsement).
- Draft National EPI Policy[16] (Being reviewed and revised)
- HIV/AIDS Strategy[17] (Completed and adopted in 2003, currently revised)

2.9 Historical Development-Managing Change:

Figure below illustrates the historical developments changes that have influenced health status of the people, the health care system and the services delivered. The first HIV confirmed infected person was recorded in 1995.

Stage 1, designates the period from the Nation's Independence, 1978 to 1989 when the problems were related to high mortality and high birth rates. Decentralization of the health system and the establishment of the provincial government occurred in ensuring effective delivery of health services at the provincial level. Specific vertical programs such as malaria control programs coupled with health services and public health legislative support eventuated to reduce the morbidity and mortality.

Within the next ten years that followed, Stage 2, 1990 to 2000, approaching the 21st century, population growth, nutritional and sanitation issues and the increasing uncontrolled malaria, which was at its highest peak in 1992. Re-centralization of personnel and funding to the Ministry of Health occurred in ensuring financial accountability and funds effectively

[13] Ministry of Health (2002): Draft National Tobacco Control Legislation: Still at the AG Chambers.
[14] Ministry of Health (2004): Draft National Blood Safety Policy:
[15] Ministry of Health (2004): Draft National Health Promotion Policy
[16] Ministry of Health (2004): Draft National EPI Policy (revised)
[17] The Solomon Island's 1st National Multi-sectoral Strategic Plan

spent on health activities. The first HIV infected person was diagnosed. The HIV situation was monitored.

The 21st century (stage 3, from 2000) brings along new challenges among which the second HIV (and clinical AIDS) infected person was confirmed. The ethnic tension from 1998-2001 affected health of the people significantly, which is evident from the health status below. The primary health care was in crisis. Emerging diseases such as SARS and influenzae coupled with the confirmed HIV infected person in early 2004 added further challenge.

Historical development-managing change

STAGE I: 1978-1989

Solomon Islands became Independent Nation

Provincial Government System adopted.

•Decentralization of health care services administration

•High Mortality

•High Birth rate

•Endemic of communicable Diseases-malaria, diptheria, polio, filariasis,

•Poor food and sanitation

Planning and Policy in Stag 1: 1978-89:

Vertical Public Health Programs

•Health Services Act 1979

•Public Health Act

•Provincial Government Act and Decentralization of health

Source: MOH 2004: Health Status Report

Problems/ Issues in Stage II: 1990-2000:

• Population growth

•Endemic Chronic Infectious Disease: TB, Hepatitis B

•Evidence of Non-communicable Disease e.g. diabetes and Hypertension.

•Fist HIV Positive 1995

Planning and Policy in Stage II: 1990-2000:

• Re-centralization of health administration to the MOH Headquarter.

•Computerized Health Information System

•Health Reform at its infant stage-Health Institution Strengthening Project.

STAGE II: 1990-2000

Natural Disaster :Cyclone Namu hit Solomon Islands

Re-centralization of health care system administration

Malaria hits the highest level in 1992. Honiara the malarious town in the world.

Public Services Policy and Structural Policy emerged for the first time ever.

Stage III: Conflict

Political –military crisis-Ethnic Tension

Economic Crisis- Delay and non-payment of health grants

Population growth-UNSTABLE (2.8-3.6)

Disaster management (Cyclone Zoe)

•PHC Crisis-Interruption of all primary health care services – primary health care activities at the lowest level, low family planning coverage, and lower EPI coverage.

•Low staff morale-industrial actions

•Infant mortality higher than previous record (1999 Census).

•Increase of malaria incidence by 19% by end of 2003.

•Emerging & threat of (new) diseases –SARS, Avian influenzae & HIV/AIDS

•Post-conflict: Recovery Stage

•More participation of CBO, NGOs, & Churches

•Social Origins of diseases

•Gender impact/ balance

Part 3: HIV Situation in Solomon Islands:

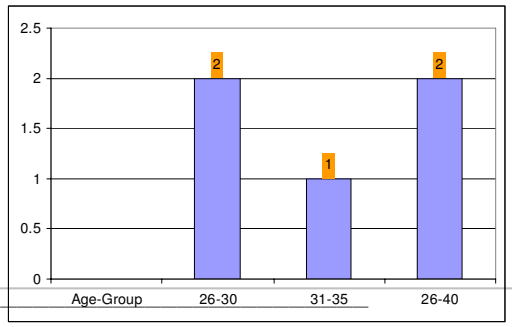
3.1. Basic epidemiology and transmission dynamic of HIV in Solomon Islands Context:

- Sexual transmission- major HIV transmission globally and locally-most likely.
- Blood transfusion
- Injecting drug use
- Mother-to-child transmission

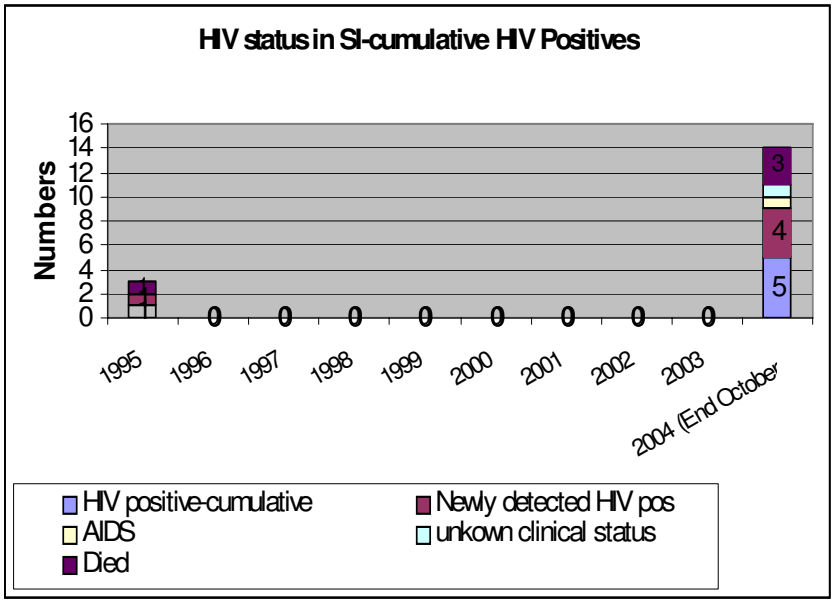
The complete epidemiological picture of HIV infection and transmission is still unclear in Solomon Islands. However, the main transmission route (in the box left) is through sexual transmission.

HIV transmission by blood transfusion, IDU, and MCT is yet to be established in the country.

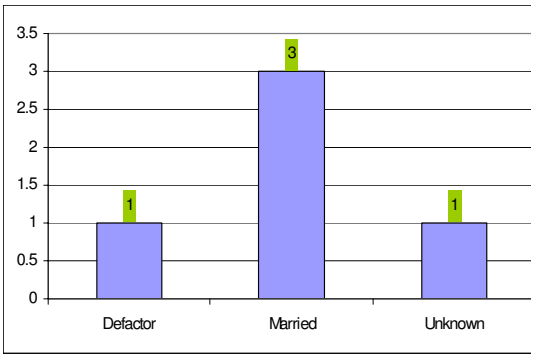
3.2. Update HIV Situation as of end October 2004:

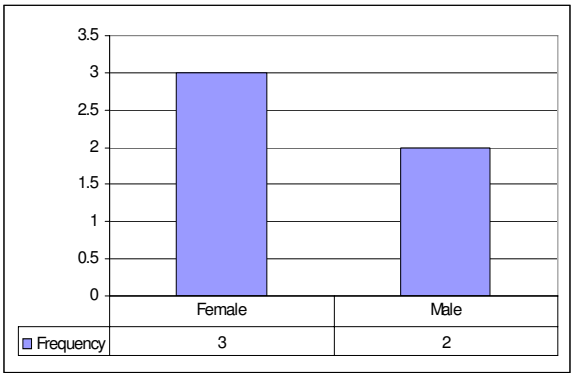


As of October 2004[18], Solomon Islands detected additional (4) four new cases in eleven months, therefore a cumulative of five (5) in the past ten years since the first detected HIV positive in 1995. The age-group affected so far ranges from 26-30 years old, but there is concern that younger age-group are affected but not detected. This is because young people start having unsafe sex even before 13 years old. It is expected that there will be change in the trend of people affected sooner or later.

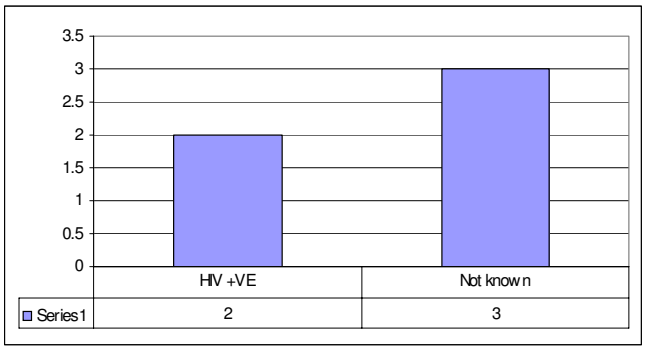


More female affected than male.





Two of the five HIV positive person's partner were previously confirmed HIV positives. Four HIV positives were detected as requested by clinicians. One (1) is detected as a voluntary blood donor but was refused to give blood donation. However, once VCCT starts it is expected to see an increase in cases.



[18] Ministry of Health (2004) HIV Update as of End of October 2004: Presentation Second National AIDS Council; 26 November:

Part 4: History of Solomon Islands National responses:

4.1. Response at the political level:

1. Response at the Political level:

- The endorsement of the National Multi-sectoral Plan (NMSP) in March 2003 by Cabinet was a recognition of the HIV/AIDS problem.
- Launching NMSP November 2003 –National Health Conference & adopted.
- Creation of the Solomo Islands National AIDS Council 2004
- First Meeting of the SINAC 28th September 2004.

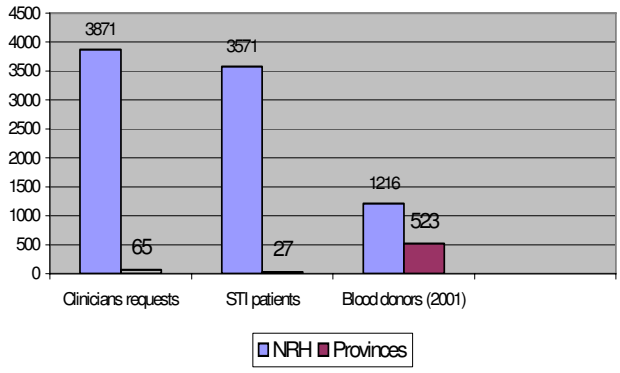
4.2. Response at the policy level:

2. Response at the Policy level:

- National AIDS Council proposed 1995
- Treatment Recommendations For STI (not including AIDS).
- Situational Analysis and Response Review (1999)
- Writing of the Multi-Sectoral Strategic Plan (NMSP) for STI/HIV/AIDS(2000)
- NMSP endorsed by Cabinet March 2003
- HIV Technical Working Group created April 2004

4.3. National response: Service Delivery

Graph showing number of HIV tests from 1998-2001



Source: Darcy, A: (2001): NRH Laboratory Report

3. National Response: Service Delivery: surveillance and treatment of STIs:

- HIV Screening begun 1988: 1995: Confirmation done by Royal Brisbane Hospital.
- Treatment of STI @ main PHC centers and hospitals.
- Government & Church Hospitals and clinics
- Worked with partners and reviewed testing protocols and breaches in confidentiality in the health system and have developed a draft testing policy.
- Efforts are being made in the collection and analysis of STI surveillance data from the provinces and to strengthen these systems.

The MOH will give technical and logistics upport to the CPL and HSS and BSS eams, and in the input and analysis of data. Project is just beginning and an dvisory group has been formed

4. National Response: Treatment and Care:

- Introduction of ART June 2004.
- Development of a draft treatment protocol was completed and it is in review
- Development of Home Care & Support Team for PLWHA with SCA & ADRA.
- PEP protocol is being developed with WHO, pharmacy and NRH
- Held a Treatment and Care workshop with a WHO advisor/consultant in June 2004 with stakeholders
- Creation of a clinical management team for PLWHA and liaison with an Australian doctor at Cairns Base Hospital and for clinical support
- Facilitated the input of Dr. John McBride for treatment and care workshops for clinicians and nurses, in services with VCT and Support team, clinical assessment of PLWHA and technical input in the development of PEP and treatment policies, review the VCT protocol and the section of the NMSP for care and support (treatment)

4.4. National Response: Treatment & Care:

4.5. National Response: Prevention; awareness and advocacy:

5. National Response: Prevention: Awareness and advocacy activities: Health sector: Health Education and Promotion:

- Prior to 1988: HIV/AIDS sessions held for parliamentarians, PS, key church leaders, schools and communities.

- After 1988: National Campaigns:

-Annual World AIDS Day (1st December).
-Public HIV/ AIDS campaigns-Marine School, Prison Services, YWCA, Church groups.
-Media: Bill Board Henderson Terminal: Solomon Star: SIBC
-Drama-markets: plaza: schools.
-OFC Tournament.

- Provincial Campaigns:
- Community level: Integrated health and HIV/AIDS campaigns for rural training centers:
- Funding: UNAIDS and SPC Small grants-till late 1990s

4.6. National Response by NGOs, Churches and CCBOs:

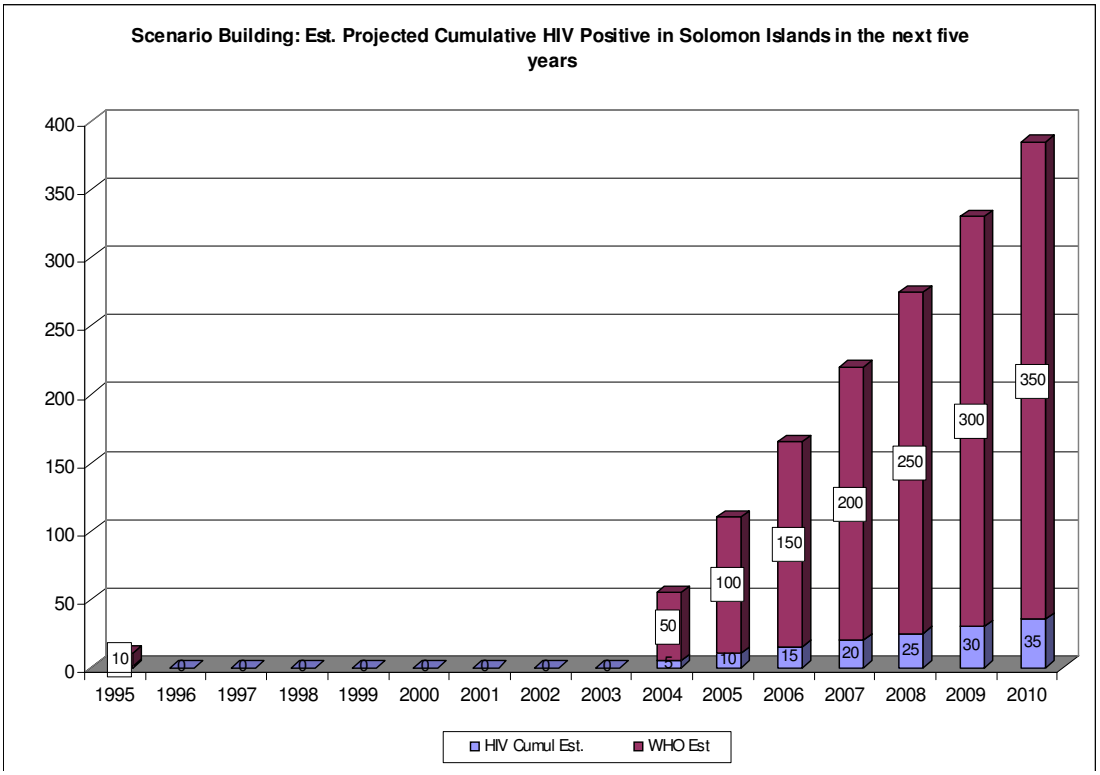
6. National Response by NGOs, Churches and CBOs:

- Churches
- NGOs-local & international
- Community-based organizations
- Services delivery
- Advocacy-sporting events
- Community awareness
- Stakeholders meeting-March 2004

- **Save Children Australia (SCA_Solomon Islands):** -extensive youth outreach program (YOP) that empowers young people, trains peer educators, supports them, distributes condoms, and engage with YP about their sexual health.
- **Adolescent Reproductive Health Project:** work with teachers strengthening their ability to talk about reproductive health, workshops with church and school youth, -newspaper about sexual and reproductive health,- workshops with mothers and daughters and also parents about reproductive health, -organized CHAMPS peer education outreach at Sol games with SIPPA, nursing students and SCA, - creation of IEC materials about STI, - work with SIPPA on youth centre.
- **Unicef:** training of life skills trainers with young people - with COM,- research on child sexual exploitation - planning for children and HIV, and in 2004 support for PMTCT
- **Church of Melanesia:** - peer education program with YP and a directed youth program
- **Family Planning Australia (FPA):** creation of a curriculum for teachers at the SICHE in teaching young people about sexual and reproductive health.
- **Solomon Islands Development Trust (SIDT):** (voice blong meri) has a theatre group with young people who participated in the Solomon Games with a drama on HIV
- **Family Support Center (FSC):** drama group that made a video about teenage pregnancy and have done drama about sexual health
- **Solomon Islands Planned Parent Association (SIPPA):** development of a youth drop-in centre, expanding youth friendly clinical services, has a youth coordinator and started condom distribution with taxi drivers and in hotels

Part 5: Scenario Building for the planning period:

5.1. Scenario building:



The planning period will be challenging as the projected number of HIV positives are increasing. It is estimated using the WHO estimates that by end of 2010 the minimum number of HIV positives will increase to about 350-400. However, about 1,350 people as cumulative estimate could have been infected with the virus. This is a significant increase in-light of the limited resources in the country. Many more will be infected that there is a fear that in the next decade (in ten years time), Solomon Islands will be at the generalized epidemic of around 4,000 people infected. Thus, the Solomon Islands National AIDS Council in their second meeting on the 26th November 2004 strongly called on all stakeholders to apply more radical measures to stop the spread of the disease.

Part 6: The process undertaken to develop the Policy and the multi-sectoral strategy:

In order to review the existing National Multi-sectoral Strategic Plan for STI/HIV several steps were undertaken. Firstly, a situation analysis determined the needs and problems that required refinement and strengthening in the strategic plan. Consequently, the goals and key result areas could be decided on. Different strategies were subsequently determined by brainstorming on different ways to achieve the identified goals. These key strategies were further refined by elaborating on the activities and input required. Accordingly, the output of the activities as well as the outcome and impact of the strategies could be concluded.

All steps of the process were developed with input and contribution of different stakeholders which, is hoped to lead to a sense of ownership amongst all stakeholders. As a result, the

proposed plan should be broad and targeted in its approach as well as realistic in its achievements.

6.1 .Situation analysis:

A situation analysis was undertaken whereby the existing responses to HIV of different stakeholders were examined. This information was collected during a two day review workshop and by carrying out surveys amongst 48 stakeholders. As a result the existing response was known. In addition, it was possible to identify the gaps, the obstacles, as well as the opportunities for the HIV/STI response to each target group.

6.2. Goals

The goals as established in the existing plan were reviewed taking into consideration the information collected in the situation analysis. Accordingly, the goals and key result areas were refined.

6.3. Strategies:

These goals and key result areas were the starting point for a two-day strategic planning workshop with different stakeholders. The following areas were identified;

6. Reduction of risks and Vulnerability to HIV and other STIs
7. Increasing access to Screening and strengthening Confidentiality in services
8. Establishing, expanding and strengthening STI/HIV Surveillance, and the continuum of treatment and care.
9. Capacity building of the health system, as well as NGOs, Churches and CBOs to effectively and efficiently implement HIV programs and activities, which ensures integration of prevention and care.
10. Sustainable development to enable environment for behavioral change, de-stigmatisation, and against discrimination impacting on prevention and care.

It was recognised that the approach on these areas needs to be different for each target group. The target groups identified were; Youth and Children; Women; Men and the Health Sector. Different stakeholders associated with these target groups all have specific knowledge about these target groups. Therefore these stakeholders brainstormed together on different strategies to effectively reach the different target groups. Consequently, the strategies focused on reaching the target groups in an innovative as well as a realistic way. Each working group ensured the specific vulnerable groups within their target group (e.g. commercial sex workers, men having sex with men) would be addressed appropriately.

6.4. Activities and Input:

The identified strategies were elaborated on further by identifying specific activities and input required. Stakeholders also suggested the most appropriate partner to implement specific activities. Consequently, the activities were encompassing roles and activities to be carried

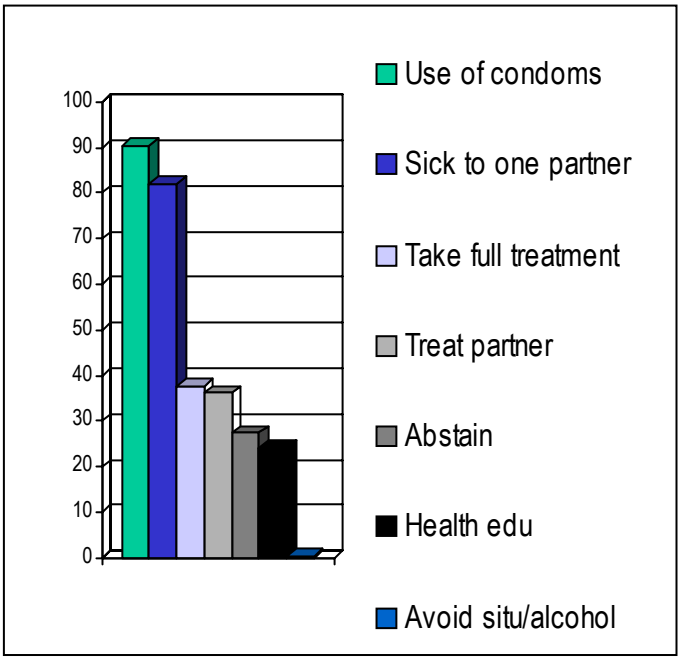
out by different stakeholders. This assists in ensuring the plan is a broad, targeted response as well as realistic.

Part 7: Issues of the Health Care System

7.1. Service Delivery Factors:

- No effective policy and protocols
- Limited community awareness.
- Lack of logistics for programs
- Lack of funds for program activities
- Limited condom access
- Lack of appropriate skills-counseling & communication

There are factors relating to service delivery recognized to have affected effective treatment prevention of sexually transmitted infections especially at the rural levels. The common factors are no effective policy and protocols. The health workers are not familiar with certain procedures to STIs. There has been limited community awareness on STIs including HIV/AIDS. Ongoing public education on STIs was not possible. Many programs were ad-hoc and not sustained. Other factors noted are lack of logistics and limited funds for the programs. Condoms are not readily available in the urban or community levels. Appropriate skills for counselling and communication in HIV/AIDS are limited coupled with cultural and religious barriers towards education on sex.



7.2. Finance and Management Factors:

Political commitment is been noted as having significant effect in reduction of new HIV infections. This is being recognized from Uganda and Thailand. In Solomon Islands not many politicians and community leaders know about HIV and its impact and their appropriate roles and responsibilities in preventing the virus from spreading. Poor coordination and management of prevention programs, and treatment of STIs has been in effective. Inadequate trained staff and available of appropriate testing kits for HIV

- Political committment
- Poor coordination of STI/HIV/AIDS activities at provincial level.
- No budget for programs.
- Lack of IEC materials
- Inadequate qualified trained manpower in supportive services to perform HIV & VDRL testing.
- Poor disease surveillance-recording and reporting system.

and other STIs such as syphilis and Chlamydia has been noted. Finally but not the least, case reporting and surveillance has been inadequate and ineffective, thus, clear picture of the epidemiology of HIV has been difficult to attain.

7.3. Summary of Issues[19]:

1. STI/ HIV testing & confidentiality:-

    - No access-laboratory
    - Restriction of lab results
    - No confidentiality.
    - No contract tracing no clear protocol for contact tracing

2. Treatment and Care for STI/ HIV and AIDS, and surveillance:-

    - Insufficient drug supply-STI esp. Cipro & Doxycyline
    - No proper case recording not standardized format
    - No update on new STI/ Training/ Treatment
    - No funding for program
    - Poor record keeping
    - Poor coordination with pharmacy
    - Nurses not allow for prescribed
    - Custom remedies
    - Compensation-
    - No regular supervisory tours
    - Need revised protocols for treatment of STI.

3. Reduction of vulnerability (PREVENTION)

    - Minimal condom distribution at clinics
    - Condom preference.
    - Littke HIV awareness and prevention.
    - No protection for health workers
    - No waste disposal.
    - Safety at work.

4. Capacity building of the Health System and the NGO to effectively and efficiently implement HIV treatment and prevention.

    - Lack of clear protocols -prevention, treatment and care
    - Lack of adequate funding of programs
    - Unclear structure
    - Limited staffing
    - Limited funding.

[19] Issues raised at the National Stakeholders Workshop in Honiara, 2004

Part 8: Issues of the NGOs

8.1. Summary of Issues:

1. STI/HIV testing and confidentiality:

    - lack of youth friendly services
    - lack of privacy in clinic facilities and confidential services
    - Confidentiality in the health system
    - Lack of networking/coordination between private clinics, MOH & HCC

2. Treatment and Care for STI/HIV/AIDS and surveillance:

    - High level of stigma and discrimination amongst families and community members to participate on the support and care team
    - lack of informed trained and skilled workers to provide care and support
    - need to strengthen partnerships with the churches, other NGOs and affected families, as it will be difficult and unrealistic for the Ministry of Heath to try to provide the care and support for PLWHA alone
    - No coordination mechanism
    - No IEC materials developed on care and support, or positive living
    - Lack of proper and updated statistics

3. Reduction of vulnerability (Prevention):

    - lack accessible IEC materials at a national level
    - need to standardize materials
    - Churches stand in relation to contraceptives can be unclear

4. Capacity Building of the Health System and NGOs to effectively and efficiently implement HIV treatment and prevention:

    - Lack of resources ie: funding, personnel
    - Lack of technical expertise
    - Lack of coordination among stakeholders
    - Need to target other vulnerable groups rather than just youth and women.
    - Need to monitor and evaluate HIV/AIDS Programs
    - lack the equipment, funds, technical resources and expertise to produce IEC materials locally

Part 9: Issues of Youth (including Children)

9.1. Social environmental factors: Risk Behaviors:

There are recognized risk behaviours among the young people[20]. These risk behaviours are consequences of external factors having influenced the unsafe sexual behaviour of young people in the country. These behaviours caused concerns in light of the HIV/ AIDS situation of the country. There is high unsafe sex behaviour, and multiple partners. The use of condom as a protective measure against sexually transmitted infections has been very low. It is alarming to learn that sex begun at a very young age as 11 to 13 years old.

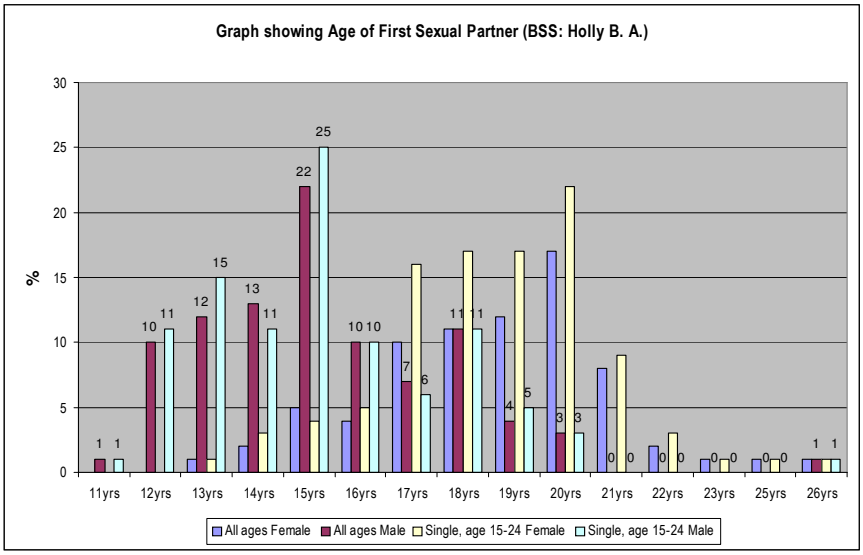
- High risk behavior
- Unsafe sex
- Multiple partners:

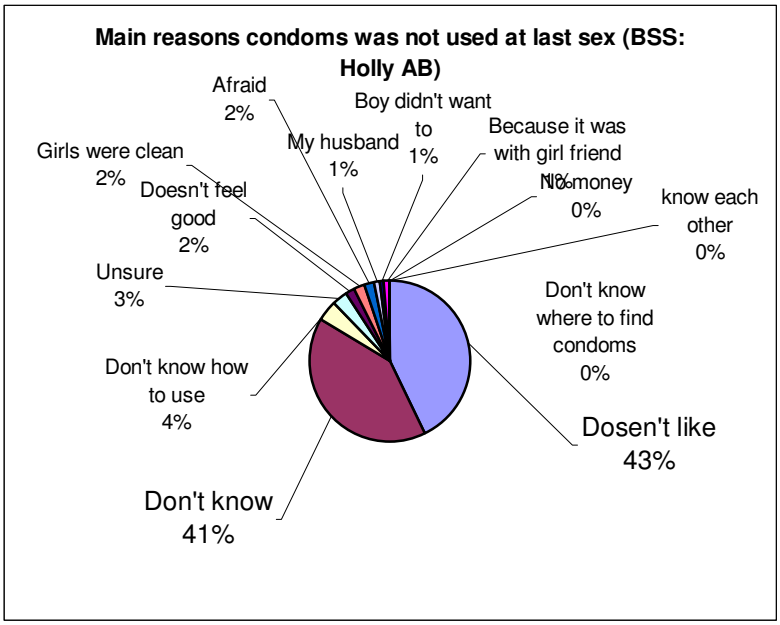
Condom and sexual behavior:

- Use of condom at first sex is very low (4%)
- Use of condom at last sex also very low (14%) 86% did not use condom.

Age and sexual behavior:

- Sex begun at a very early age as early as 11-13 years.





The reasons for not using condom at the last sex were mainly either young people "dosen't like" or "don't know". Others were because they do no know how to use, doesen't feel good, girls were clean and boy didn't want to".

[20] Holly R B A. (2002): Global Movements and Local Desires: Youth Sexuality and Urban Life in Auki: Malaita, pages 126-139.

Part 10: Issues of the Women and HIV

10.1. Summary of Issues for Women[21]:

1. STI/HIV testing and confidentiality
    - lack of privacy in clinic facilities and confidential services
    - No confidence in Health system
    - Attitudes of health workers

2. Treatment and Care for STI/HIV/AIDS and surveillance
    - Stigma and discrimination from communities
    - Awareness program only targets certain places and does not target village level or workplace programs
    - Lack of focus to reduce stigma and discrimination for PLWHA
    - Need to research into the sexual behaviours of married men

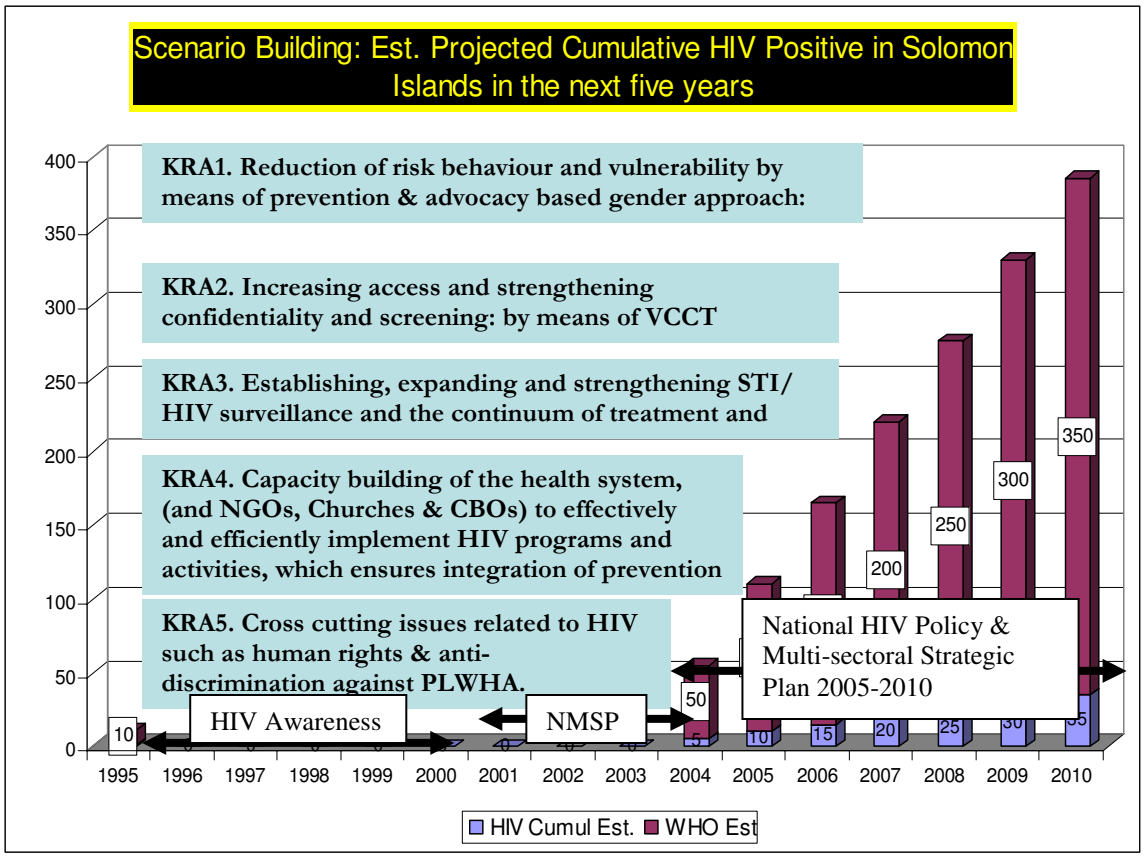
3. Reduction of vulnerability (Prevention)
    - Low status of women therefore unable to negotiate safer sex
    - Lack of standardized training materials manual
    - No IEC materials on transmission, prevention and stigma related issues
    - Programs also need to target men.
    - Church beliefs - barriers

5. Capacity Building of the Health System and NGOs to effectively and efficiently implement HIV treatment and prevention.
    - Lack of resources ie: funding, personnel, transport
    - Capacity - expertise
    - Lack of coordination among stakeholders
    - Current programs only targeting urban areas and not rural areas
    - Women are still not delivering at clinics if the attending nurse is male.
    - In some cases, women also cannot afford to go to the clinic

Part 11: The key direction in the policy and strategic plan:

- Radical measures in prevention.
- Stop further spread through behavioral change interventions and increase condom utilization by vulnerable groups
- Increase access and opportunities for VCCT
- Increase access of quality care to vulnerable people including PLWHA
- Integration of prevention and care
- Build capacity to manage, implement, monitor and evaluate.
- Integration all key stakeholders annual plans of action in preventing and care for HIV/AIDS.

[21] IBID



Part 12. Conceptual underpinning and methodology for the policy and strategic Plan:

- Identification and involvement of all key stakeholders for the fight against STI/HIV
- Identification of key vulnerable groups and their related issues and high behaviour risks to STI/HIV.
- Gender-based approach in implementation and evaluation.
- Reduction of vulnerability to STI/ HIV in youth, women and men, and a particular recognized group such as the seafarers, loggers and border crossers.
- Practising recognized, Behavioral Change Interventions such as IEC up-scaling for BCC.
- Strengthen national responses through increasing integration and coordination of planning, implementation, and evaluation of all prevention and care by all government sectors, non-government sectors including the Churches and Community Based Organizations.
- Strengthen national response through establishing, expanding and strengthening STI/ HIV surveillance, treatment and care.
- Scale up STI treatment and prevention services to stop potency to spread HIV

- Strengthening national response through scaling up and active promotion of ABC by relevant stakeholders.
- Strengthen national response through capacity building to manage, implement, monitor and evaluate prevention and care programs and services by key stakeholders.
- Strengthen national response in addressing cross cutting issues relating to HIV stigmatisation and discrimination, and individual human and communal rights.

Part 13: Policy Directions and Strategic areas and key actions and activities:

The key strategies are categorized under five key results areas (KRA). The actions steps and individual activities are linked to the key strategies. The strategies and the ensured actions and individual activities made up the national response by the people, community and NGOs and the Government's efforts in reducing the burden by stopping further spread of HIV.

Policy 1: Reduction of risk-behaviour and vulnerability to HIV and STIs.

- *Key Result Area 1*. Reduction of vulnerability by means of prevention & advocacy based on Gender approach: Youth/children/women/men

Policy 2: Enhance voluntary counseling and testing for HIV as an entry point for confidentiality, prevention and treatment for STIs and AIDS (including blood safety).

- *Key Result Area 2*. Increasing access and strengthening confidentiality and screening: by means of VCCT

Policy 3: Enhance HIV/ STIs surveillance, treatment and care.

- *Key Result Area 3.* Establishing, expanding and strengthening HIV/STI surveillance, and the continuum of Treatment and Care.

Policy 4: Enhance capacity building for the national HIV response at both the community, and institutional level.

- *Key Result Area 4.* Capacity building of the health system, as well as NGOs, Churches and CBOs to effectively and efficiently implement HIV programs and activities, which ensures integration of prevention and care.

Policy 5: Ensure sustainable development to enable environment for behavioral change, de-stigmatization and against discrimination impacting on prevention and care.

- *Key Result Area 5.* Address cross cutting issues related to HIV such as human rights & anti-discrimination against PLWHA.

Part 14: Policies, Key Result Areas: Objectives: Strategies: Actions/ Activities

HIV Policy 1: Reduction of risk-behaviour and vulnerability to HIV and STIs.

KRA 1. Reduction of risk behaviour and vulnerability by means of prevention & advocacy based Gender approach: Youth (including children), women and men

Objective: To ensure people make informed decisions in regards to risk behaviour and safe sex practices by providing appropriate information of (ABC), and increase availability of condoms.

Strategies:

- Ensure there are mechanisms for political commitment, advocacy and resource mobilization.
- Increase condom availability, accessibility and usage through social marketing at the private sectors, the health systems and NGO & CBOS.
- Strengthen IEC –Behavioral Change.
- Expand men as partners in reproductive health'.
- Support HIV prevention initiatives in youths+ ARH/ sexual education + family life
- Encourage participation of private companies.
- Implement PMTCT.

Key Actions/ Activities:

- Scale up condom-order/purchase/distribution at health clinics/ NGOs, CBOs, VCCT as well as use Vending machines.
- Establish VCCT sites
- Revise protocols on condom use and IEC-BCC accordingly,
- increase awareness and production of IEC-BCC on ABC
- implement sex education (formal & informal) schools.

HIV Policy 2: Enhance voluntary counselling and testing for HIV as an entry point for confidentiality, prevention and treatment for STIs and AIDS (including ensuring blood safety..

KRA 2. Increasing access and strengthening confidentiality and screening by means of VCCT and ensuring blood safety.

Objective: To provide a comprehensive continuum of care through voluntary confidential counseling and testing as entry point for STI/ HIV prevention and care.

Strategies:

- Active implementation of VCCT
- Review and strengthening of the conventional HIV testing and VCCT protocols/ guidelines
- Training of health workers on VCCT
- Develop a referral system from the VCCT to care.
- Ensure adequate kits and facilities for VCCT.
- Strengthen the Blood Safety
- Expand and increase resources for VCCT –health system, NGO+churches & CBOs.
- Incorporate contact tracing-confidential Partner notification.
- Strengthen Code of Practices-confidentiality

Key Actions/ Activities:

- Finalize Testing (VCCT) protocols
- Establish VCCTs-Honiara & provincial centers-health system, NGOs, CBOs, private sectors.
- Public awareness-promotion of VCCT.
- Form the National Blood Council and increase safe blood donor recuritment.
- improve laboratory support to VCCT sites.
- General awareness on confidentiality/breach

HIV Policy 3. Enhance HIV/ STI surveillance, Treatment and Care.

KRA 3. Establishing, expanding and strengthening STI/ HIV surveillance, and the continuum of treatment and Care.

Objective: To provide a comprehensive continuum of care through surveillance and increasing accessibility to appropriate treatment for STI as well as providing quality treatment and care to cater for the needs of PLWHA.

Strategies:

- Strengthen the STI treatment protocols.
- Increase access and availability to effective medicines against STIs.
- Strengthen availability and distribution to clinics.
- Finalize the HIV treatment protocol and ensure availability and accessibility.
- Provide the best quality of care to the PLWHA at all levels-hospital, clinics and community.
- Build in measures to ensure ARV adherence.
- Update and enhance skills and knowledge of health workers on ART.
- Secure adequate funding for ARVs from Government and other external sources.

- Work closely with traditional healers to ensure mutual understanding of the roles towards treatment of HIV.
- Assist formed support care groups and communities in the care for PLHWA.
- Institutionalized Second Generation Surveillance

Key Actions/ Activities:

- Update STI protocol-review and revise-training workshop.
- Increase production of pre-packed STI medicines and increase distributions to all clinics & hospitals.
- Finalize and subsequently train health workers on the HIV treatment protocol on HAART.
- Training of health workers on all issues related to HIV.
- Increase awareness on ARV to support care groups, families and including traditional healers.
- Ensure counseling in preparation for starting of ARV.
- Plan and allocate resources for Second Generation Surveillance (SGS)

HIV Policy 4. To enhance capacity building for the national HIV response at both the community and institutional level.

KRA 4. Capacity Building of the health system as well as, NGOs, Churches and CBOs to effectively implement HIV programs and activities, which ensures integration of HIV prevention and care.

Objectives: To ensure a coordinated and targeted national HIV response through appropriate political support and by strengthening the capacity of relevant key stakeholders to implement the activities of the national multi-sectoral HIV response plan

Strategies:

- Strengthen political advocacy and commitment, and leadership at all levels.
- Strengthen the capacity of the STI/HIV Prevention Unit/ MOH to effectively manage, coordinate and integrate, and plan and monitor activities with all other stakeholders within and outside the health system.
- Assist in empowering the capacity of NGOs (+churches) to ensure participation in decision making related to HIV policy development and implementation of HIV programs and activities.
- Integrate and strengthen PMTCT.
- Strengthen SINAC
- Strengthen research-SGS & Traditional medicine

Key Actions/ Activities:

- Regular consultations/ reporting Solomon Islands National AIDS Council, Cabinet, MOH Executive.
- Parliamentary awareness talks
- Quarterly Stakeholders meetings and consultations.

- Hold meetings for community leaders.
- Additional resources to the HIV Prevention Unit/MOH-funding, staff & equipments.
- implement partnership initiatives-PRHP, GFATM, NHPSP,
- PMTCT Policy and training.
- Capacity building for SINAC members & legislative support.
- Reporting and supervisory visits.
- Research on available herbs presented for efficacy and safety testing

HIV Policy 5. Ensure sustainable development to enable an environment for behavioral change, de-stigmatization and against discrimination impacting on prevention and care.

KRA 5. Addressing cross cutting issues related to HIV, such as human rights & anti-discrimination against PLWHA and sustainable development.

Objective: To develop an environment conducive to the rights of PLWHA through development and implementation of relevant legislation and consequently resulting in behaviour change to ensure appropriate prevention and care for HIV/AIDS.

Strategies:

- De-stigmatization in the health system and the community.
- Ensure awareness for HIV prevention, safety and de-stigmatization at workplace.
- Protect women and children against abuse: support CEDAW
- Address border crossings
- Human rights-ant-discrimination law

Key Actions/ Activities:

- General awareness in trainings/workshops for health workers on risks & infection control.
- Availability of PEP for health workers.
- Strengthen confidentiality through professional boards.
- Develop legislation on anti-discrimination in favor of PLWHA.
- See advice and consult with immigration, customs and other authorities in dealing with cross border issues.
- Offer VCCT sites at the border.

Part 15: Implementation & Review

- Development of annual operational plans by key stakeholders inline with the strategies and actions and individual activities of the National HIV Policy and Multi-sectoral Plan 2005-2010.
- Capacity building of key stakeholders to ensure appropriate implementation of the activities as described in the plan.
- Coordination of activities through regular meetings with stakeholders and strengthening of SINAC.
- Development of annual budgets to fund operational plans.

- Allocate and mobilize staff and logistics to carry out the activities.
- Regular reporting by all key-stakeholders on progress
- Carry out a midterm review in 2007.
- See attached operational plans (future directions) by key stakeholders.

Part 16 Monitoring and Evaluation

Monitoring and evaluating the implementation of the plan is essential to ensure the progress of the HIV/STI response as well as its relevance. In view of this, output and outcome indicators were identified during the two day strategic planning workshop.

Output and outcome indicators
Monitoring that the activities in the proposed strategic plan are implemented accordingly, ensures the plan becomes a working document rather than just a plan. Therefore appropriate output and outcome indicators were identified by each working group. The output indicators clarify what activities are expected to be performed.

However, implementing certain activities is only useful if they are impacting and contributing to the objectives. This is described in the outcome indicators.

Reporting
Regular reporting on the output indicators against the proposed activities will update all stakeholders on the progress of the implementation of the plan. It will assist in accountability of resources and identifying new gaps and obstacles that require further attention or involvement of stakeholders.

In addition, reporting on the outcome indicators assists in measuring the impact of the implementation of the proposed plan. This leads to evidence-based decision making in relation to evaluating whether strategies chosen and activities implemented are achieving the expected result. Furthermore, it assists in deciding where resources should be allocated. Consequently, the plan can be refined and strengthened to ensure the HIV/STI response continuously achieves the highest impact.

A complete mid-term review of the plan is proposed to be carried out in 2007.

Overall Framework for ME[22]*:*

- Indicators are used at different levels to measure what goes into the action plans.
- The used framework for the indicators for M&E is the **input-Activities (process)-output-outcome-impact**[23]**.**
- **Inputs** -such as money and staff time
- will result in **outputs** such as stocks and delivery systems for drugs and other essential commodities, new or improved services, trained staff, information materials, etc. These outputs are then result of specific processes, such as training sessions for staff, that should be included as key activities aimed at achieving the outputs.

[22] Ibid.
[23] UNAIDS Model

- These outputs reach the populations for which they were intended, the program is likely to have positive short-term **effects** or **outcomes**, for example increased condom use with casual partners, adherence to ARV drugs, or later age at first sex among young people.
- These positive short-term outcomes should lead to changes in the longer-term **impact** of programs, measured in fewer new cases of HIV. In the case of HIV, a desired impact among those infected includes increased survival time and behavioral change.

Reporting Timing;

- Quarterly reporting will be done.
- Components of the Report:-

1. Programmatic Reporting
2. Financial Reprting

Principles:

a. Levels of ME:

I. Outcome and impact –Outcome evaluation
II. Input/ Output – process evaluation

b. Skills and Expertise required[24]*:*

- Epidemiological expertise in the M&E unit or affiliated with the unit
- Behavioural/social science expertise in the M&E unit or affiliated with the unit
- Data processing and statistical expertise in the M&E unit or affiliated with the unit
- Data dissemination expertise in the M&E unit or affiliated with the unit
- Well-defined national programme or project plans with clear goals, targets and operational plans
- Regular reviews/evaluations of the progress of the implementation of the national programme or project plans Guidelines and guidance to districts and regions or provinces for M&E
- Guidelines for linking M&E to other key stakeholders.

c. Clear Goals:

- The logframe summarizes clear goals, objectives and indicators
- Indicators will be compared over.

Responsible authority:-

[24] GFATM (2004): MONITORING AND EVALUATIONTOOL KIT HIV/AIDS, TUBERCULOSIS AND MALARIA

- ME to be done at the National HIV/STI Prevention Unit, Ministry of Health.
- There is designated technical and data management staff.
- Integration of links with other key stakeholders through communication strategic plan.

Responsible person:-

- National HIV/STI Coordinator
- SINAC Secretariat.
- A multisectoral working group to provide input and achieve consensus on indicator selection and various aspects of M&E design and implementation

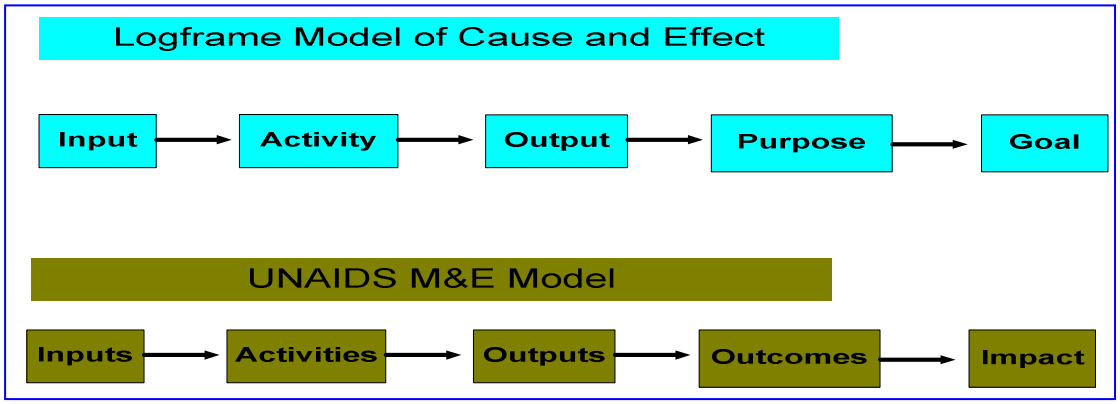
Budget for ME:

- Funds for ME included in the annual budget for the operations of the NHSPU

Data Collection and Analysis:

- Second Generation Surveillance , where behavioural data are linked to HIV/STI surveillance data
- An overall national level data dissemination plan to be developed.
- A well-disseminated, informative annual report of the M&E unit
- Annual meetings to disseminate and discuss M&E and research findings with policy makers, planners and implementers

UNAIDS Module used:



Mid-Term Review 2007:

Introduction of the purpose of the Midtwern Review:

A midterm review is planned to be undertaken in 2007. The MTR is an opportunity to take stock of overall performance and, if necessary, make adjustments. The MTR should ascertain that the NHPMSP remains relevant, achieves its objectives and uses resources in a cost-effective manner.
The final details of the MTR will be developed when an appropriate time is identified later. The analysis attempted in the MTR will be based on the data provided by the

MOH and key stakeholders in HIV prevention and care. The indicators in the NHPMSP will form the basis for data analysis.

Acknowledgements

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ANNEXURE

ANNEX TABLE A: LogFrame:

Key Result Areas	Strategies	Activities	Input	Output	Outcome (MSC)	Impact
KRA 1. Reduction of risk behaviour and vulnerability by means of prevention & advocacy based Gender approach: Youth (including children), women and men	**1. Reduction of risk-behavior and vulnerability of HIV in the local community through the Health Care System.**					
	1. Increase condom availability and access-social marketing.	Increase procurement and distribution of condom through the primary health care network.	Condoms/Funds.	increased no. of condom purchased and distributed.	increased usage of condoms by clinics.	Reduced STI prevalence by clinics. Reduced no. of HIV positive.
	2. Strengthen distribution –health system and provide support to NGOs.	Scale up condom availability in clinics .-	.Condom stock in all (304) clinics.	All clinics (304) adequately stocked with condoms.	increased CPR/	
	3. Strengthen the IEC resources for BCC.	3.Strengthen IEC committee functions- with multi-sectoral links. Linking more/ distributing and support.-	IEC Committee/ staff +NGOs/ equipments $/ production $/ testing $/ provincial & NGO distribution $.	[i] increased no. and range of appropriate IEC materials for STI/ HIV.[ii] Same message by Stake holders, [iii] increased posters, bill boards/ media-radio & TV, newspapers [iv] IEC materials available in the		

		support and scale up resources-equipments and resources for increase production.		provinces & NGOs-urban and rural.		
	4. Support expansion and strengthening 'Men as Partners in Reproductive Health'	4. Development of operational plan, for the establishment of men's clinic.	Building/ staff/ equipment/ facilities/ communications/ promotion programs	[i] VCCT for men (including prisoners), [ii] increased testing in men, [iii] information activities for men.	I] preferred way of sex of men [ii] Safe sex practices	
	2. Reduction of vulnerability : HIV prevention in Youths:					
	2.1. Support Prevention initiatives in Youth	Establish new Youth friendly centers, and strengthening existing ones: information centers: & VCCT .	Building/ staff/ equipment/ facilities/ communications/ promotion programs	[i] VCCT for youth, [ii] increased testing in youths, [iii] information activities for youth.		Reduced HIV positivity in youths. Reduced teenage pregnancy/ Reduced STIs/
	2.2. Social marketing for condom-shipping companies/ hotels/ seafarers	Revise protocols in relation to use of condom.	Printing $/ distribution $/ training $/ models/ Condom venduring machines/fixed boxes/ staff/.	Condom use manual/ Condom demonstration/ different brands of condom-male and female	Preferred way of sex of youth.	
	2.3. Increase access to Condoms by youths	2.3.1.Change attitudes of condom for family planning to prevention of STI/HIV/AIDS	More condoms for STI/HIV	Increased condom used by reproductive health services for STI/ HIV prevention.	Increased % of young people using condom for STI/ HIV as proportionate t0 FP	Reduction of STI and increased CPR.
		2.3.2.Condom	Survey	Different brand of condoms:	Increased condom usage in	Safe sex and

		preference survey to ascertain the preferred brand and types of condom for young people.		Male and Female ordered and purchased for youth.	youth	reduced teenage pregnancy.
		Increase awareness on condom usage instruction	IEC production in condom packages	Condom manual in condom package/ wrappings	100% condom effectivity	Reduced STI incidence in among young people.
	2.4.Awareness raising through ARH/Sex education and Family Life skills	2.4.1. Review existing IEC materials for ARH education 2.4.2. Develop appropriate IEC for BCI in ARH education: 2.4.3. Curriculum review and development for primary level (social science & science), secondary level.	[1] IEC/Behavioral Change Intervention materials [2] Curriculum for primary & secondary levels.	# IEC/BCC curriculum developed & distributed	YP making informed life choices	Behavioural Change Reduce STIs/HIV/AIDS
		2.4.4. Training for teachers/educators	Training: workshops: Fund, staff time.	Teachers trained in ARH	Increased skilled teachers in ARH	Fewer STI and teenage pregnancy.
		2.4.5 Increased Awareness raising through Mass Media and other related activities Such as Drama, video show, condom demo and	Fund, staff time, travel expenses, hiring og groups, radio spots, posters, developed and distributed.	Increasing number of young people exposed to HIV/ AIDS awareness to enable them to change their unsafe sexual behavior.	BC in young people.	Fewer STI and teenage pregnancy.

		distribution for young people.				
		Mobilize local taxis companies to distribute IEC materials and condoms for young people.	Condoms, pamphlets and manuals.	Increased number of seafarers exposed to HIV/AIDS awareness and prevention knowledge.	STI/ HIV prevention	Fewer STI and teenage pregnancy
	3. Reduction of risk and vulnerability : HIV prevention in men (including seafarers, Loggers and MSM:					
	3.1. Accessibility of STI / HIV Prevention treatment to sailors	Support to Mission to Seafarers, which include [1] STI/HIV awareness and prevention.	IEC production for seafarers e.g. Bill board. Training awareness-fund, staff time, accommodation:	1.Increased number of seafarers exposed to HIV/AIDS awareness and prevention knowledge. 2. By July 2005, all stakeholders should celebrate seafarers day with sailors. 3. A billboard on HIV/AIDS/STIs set up on specified and selected sited e.: Point Cruz Wharfs, Local/international Ranadi.	STI/ HIV prevention in seafarers	Safe sexual behavior among seafarers.
		Establishment of VCCT & STI clinics at key strategic sites.	Civil works; staff; funds	STI including VCCT set up in key strategic sites	Seafarers accessing STI treatment and HIV prevention	Reduction of STI transmission in seafarers.
	3.2. Lobby for the inclusion of HIV/AIDS & STIs into marine school curriculum	Include health studies (including STI/ HIV prevention) in the marine school.	Curriculum development: staff time; fund;	1.Increased number of (FUTURE) seafarers exposed to HIV/AIDS awareness and prevention knowledge	Increase access of health services to sailors Reduction of spread of HIV/AIDS, STI in 2 years time	Safe sexual behavior among seafarers
	3.3. Encourage companies to address	Develop an seafarers alliance against STI/ HIV prevention. And	Policy development on engagement and occupational health (optional) HIV testings. Condom	Policies, code of laws or companies rules includes HIV/AIDS STI prevention by	Companies include HIV/AIDS/STI in company policies	

	HIV/AIDS and STI-E.g. Quality time with family	create Network with agencies for international shipping lines and domestic seafarers.	supply at workplace.	next few years (supply of ccndoms).		
	3.4. Distribution of condoms and IEC materials Through networking with agencies for international shipping and fisiching industries and nd taxi services for locals	Monthly supply Condoms IEC materials Staff Peer groups Training and Logistic Support	Condoms, IEC materials, funds	288 condoms distributed per vessel or company Each company personnel to collect condoms All loggers/MSM/Seafarers should have a clinic	Proper recording of data of condom distribution Accessibility of health facilities to all loggers/seafarers/MSM	Reduction of new case detection Increase data usages of condom Increase knowledge on STI/HIV/Aids amongst MSM and other vulnerable groups
	4. Reduction of risk and vulnerability in Women and girls:					
	4.1. Strengthen reproductive health services	Include VCCT services in Antenatal Clinics	VCCT trainings for reproductive health nurses: staff time, funds.	Skilled HIV counselors in the reproductive health services.	HIV prevention in women of child bearing age (WCBA)	Fewer cases of STI/ HIV infection in women.
	4.2. Promoting reproductive rights is critical to HIV prevention and women's empowerment, and for preventing poverty, maternal and child deaths and STI.	Public awareness of women's right in-light of STI/ HIV prevention.	Mass media: radio talks, posters, and pamphlets.	Increased awareness of women's right to HIV prevention. Increase No. of women aware of rights More respect for women at all level Recognition/participation at all level Increase status of women Increase change in men's attitude	Women empowered to make decisions on their reproductive health to prevent HIV/ STI and unwanted pregnancies.	Fewer cases of STI/ HIV infection in women.

	4.3. Adolescents need sexual education and appropriate services as many young people especially girls have poor awareness.	Expand Adolescence and sexual health for young women to all provinces.	Training workshops: staff time; funding	Increasing exposure to adolescence and young women to healthy and safe practices.	Safer sexual behaviors in young women.	Fewer cases of STI/ HIV infection in adolescence and young women.
	4.4. Strengthen women's networks and organizations	4.4.1. Assist capacity building for women's organizations and networks.	Training workshops: staff time and funding.	Improve management and implementation of HIV prevention initiatives in women in the community.	Effective HIV prevention program for women.	Fewer cases of STI/ HIV infection in women.
		4.4.2. Provide technical support to women's network and organization in implementing STI/ HIV prevention initiatives in women.	Staff time; IEC production and funding	Technical support available to women' community based groups	Majority of women reached by community outreach activities	Behavioral change.
	Income generating project	Provide opportunities for income generating projects for women.	Funding (small grants) Staff Materials Supplies	NO. of projects No. of women involved or benefit No. of sex workers involved	Women economically productive and pre-occupied.	Minimize women's vulnerability to STI and HIV.
	Social marketing of condoms targeting marginalized women.	Condom distribution	IEC Staff Condoms, modules Transport, training	Increased use of condom for STI/ HIV prevention and FP.	High usage of condom Higher Contraceptive Prevalence Rate (CPR)	Fewer STI/ HIV cases and family control.
	Promote healthy lifestyle for women's health	Encourage physical exercise and regular medical check including pap smear along with VCCT.	IEC-media Condoms, Papsmear VCCT: staff time, fund	Life-skilled programs for women	Healthy behavior for women	Minimize women's vulnerability to STI and HIV.
	Ensure Political	Include women in	Funds/transport	Increase support system	Strengthening funding	Minimize

	commitment and leadership	decision making at all levels such the politics and AIDS Council.	Will Staff	No. of projects benefiting Status of women No. of funding support	support for women Support financially NGOs, CBOs involved	women's vulnerability to STI and HIV.
KRA 2. Increasing access and strengthening confidentiality and screening by means of VCCT and ensuring blood safety.	**1. Increase access and strengthening confidential and screening from the Health Sector**					
	1.1.Active implementation of VCCT	2.1 Finalization and implementing the HIV Testing protocols including referral system to maintain continuum of care	staff time, funds for accommodation; travel and perdiem;.	Clear HIV testing protocol	There is pre and post testing counseling and clear referral system to ensure continuum of care for clients.	Quality VCCT services leading to HIV prevention.
		2.2. Establishment of VCCT sites at strategic sites both for the Government clinics and NGOs. And provide basic equipments to reach different Gender.	Staff; funding; equipments; condoms; civil works; communications; IEC materials;.	VCCT sites established at strategic sites for different gender	Increased VCCT in Honiara and Urban Provincial centers.	Behavioral change as a result of VCCT
	1.2.Capcity building	Review the current	Staff; funding; equipments;	Increased HIV testing at the	Friendly, quality confidential	Quality VCCT

	for the laboratories including the review and strengthen the conventional testing And Ensure adequate testing kits	status of laboratory in terms of requirements for testing and confidentiality, and do training for laboratory technicians in new testing methodology and VCCT.	condoms; civil works; communications; IEC materials;.	laboratory with confidentiality.	HIV counseling and testing at the laboratory levels.	services leading to HIV
	1.3. Inform the public on the VCCT services offered.	2.3.Public awareness on VCCT for BCC.	Mass media-radio spot, newspaper, and pamphlets & Bill boards at VCCT Sites	Increased attendance	More and more people request for voluntary counseling and testing (Increased no. of people exposed to VCCT)	HIV/STI prevention through VCCT
	1.4. Capacity building on VCCT	2.2.1.Refresher training for existing VCCT Counselors	staff time, funds for accommodation; travel and perdiem;.	Annual refresher training for VCCT counselors	More and more people request for voluntary counseling and testing (Increased no. of people exposed to VCCT)	HIV/STI prevention through VCCT
		2.2.2.Training of new VCCT Counselors (including all laboratory technicians and nurses)	staff time, funds for accommodation; travel and perdiem;.	Increased counseling skills and knowledge to health workers	More and more people request for voluntary counseling and testing((Increased no. of people exposed to VCCT)	HIV/STI prevention through VCCT
	1.5.Strengthen Blood Safety	2.4.1. Establish the National Blood Council and clear TOR and reference to HIV.	Staff time : funding for meetings	Multisectoral National Blood Council formed	Widely practiced blood safety to prevent HIV, Hep B and C transmission through the blood supply system	HIV, Hep B & C prevention through safety blood supply system
		2.4.2. Hold regular training on blood safety protocols and new technology.	staff time, funds for accommodation; travel and perdiem;.	Good practices by laboratory staff	Widely practiced blood safety to prevent HIV, Hep B and C transmission through the blood supply system	HIV, Hep B & C prevention through safety blood supply system

KRA 3. Establishing, expanding and strengthening STI/ HIV surveillance, and the continuum of treatment and Care.	**1.Establishing, expanding and strengthening STI/ HIV surveillance, Treatment and Care from the health sector:**					
	1.1.Review and strengthen STI Treatment protocol , and Improve skills & knowledge	1.1. Review and update training on STI Treatment Protocol- for Govt. and NGOs health workers	Meetings, stationeries, printing & production, training costs.	No. of training/ no. of nurses trained/ clinics with trained nurses/	Improved quality of STI treatment.	Reduced treatment failure. Reduced ulcerative STIs
	1.2. Strengthen distribution of drugs + messages +condom to increase the access & availability	1.2. Scale up packing of STI drugs with prevention messages.	Staff time; Packing machine; fund, design and printing of pamphlets for the STI packs.	Increased No. of STI packs for the clinics and VCCT sites.	High risk group accessed to STI drugs and preventive messages at the community level.	Reduced STI and HIV prevention
	1.3. Strengthen availability and access to ARV.	1.3.1.Finalize and implement HIV Treatment Protocol.	Staff time; Meetings; Printing & production	HIV Treatment Guide for all clinicians and nurses	All infected person are treated and followed up properly.	Reduced stigmatization; increased VCCT and thus, reduced HIV new infections.
		1.3.2. Free ARVs	ARV funding from Solomon islands Government and alternative sources	100% availability of ARV to all AIDS sufferers.	Improved quality of life for PLWHA	Reduced stigmatization; increased VCCT

		for all AIDS sufferers in SI				and thus, reduced HIV new infections.
	1.4.To provide the best possible quality of care and treatment for PLWHA in the hospital and clinics	1.4.1.Enhance the knowledge and skills of health care workers at all levels of the health care system (central, provincial and community levels) through training. 1.4.2.Increase	Staff time; Training workshops for health workers and support groups; IEC production including pamphlet s-printing and community talks, and Workshop for traditional healers; operational fund.	Skilled health workers on care for PLWHA at all levels. Supportive IEC materials (pamphlets) for families and communities supporting PLWHA.	All health care workers skilled in care for PLWHA Families and Communities empowered to be able to care for their own PLWHA Correct information to TH on HIV/AIDS Increased participation AND cooperation of TH Reduced delay to HAART. Foresters ARV 100% adherence.	Reduced stigmatization; increased VCCT and thus, reduced HIV new infections.

		awareness information for families and communities. Integrate traditional healers health care within the care and treatment of HIV/AIDS				
	1.5.Strengthen confidential contact tracing through a confidential Partner Notification (CPN).	1.5.1. Encourage partner notification during and as part of the VCCT. Develop confidential mechanisms for partner notification.	VCCT-encourage couples to test. Confidential friendly and supportive letters	Increased no. of couple testing.	Increased couple HIV counseling and testing.	Effective confidential contact tracing, Prevent further transmission Foresters Behavioral changes among couples or partners.
	1.6. Ensure people treated with HAART continue to take their treatment regularly and faithfully (adherence to ARV)	1.6.1. Training of health workers on HAART / ARV including Prepare the infected person well before starting ARV- through a thorough medical checks including TLC/ CD4	Training workshop; Clinical consultation or referral and counseling TLC serum for CD4 Counts(referral cost)	Skilled health workers on HAART. Preparedness of PLHWA for treatment in the HIV Treatment Guideline. Traditional Healers trained and aware of HIV/ AIDS disease and prevention [i] No. of health workers	[i] Health workers skilled in treating PLWHA. [ii] Health workers aware of the SE and adverse effects of missing doses. [iii] Health workers skilled in preparing the person for ARV treatment. [iv] clinical staging of the HIV	A very effective treatment plan for the HIV infected person. Reduced prevalence of Opportunistic Infections. foresters

		etc., Awareness (Counseling) on the ARVs, draw up regular follow: set up follow up program (as part of the ART Protocol). [iii] ustilize traditional healer??		trained on HAART/ARV. [ii] HIV person informed of the Treatment Plan, SE and adverse of missing treatment. [iii] Clinical stage of the HIV infection established. [iv] constraints and likely hindrance factors known established and possible solutions reached with the infected person.	infected person is established in preparation for ARV if needed. [v] pharmacy is aware of the persons needs for the ARV when required to be supplied. [vi] proper timing in starting ARV. [vii] minimal ARV delay.	pharmaceutical and ARV supply planning.
	1.7. Introduction and sustaining Second Generation Surveillance (SGS).	1.7.1.Monthly HIS Case reporting from Clinics. 1.7.2.Monthly reporting from Pathology Services/ Laboratory. 1.7.3.Behavioral Survey 3 yearly	Fund Staff Printing IT support facilities; computer Survey costs-travel; perdiem; accommodatiom & incidentials. Fund/ data entry clerks/ epidemiologist/ BSS	Using Statistics for Epidemiological surveillances, Behavioral pattern of vulnerable group known.	Effective planning and ME based on data and information (evidence-based).	Effective HIV prevention.
	1.8. Develop research capacity in custom medicines' efficacy and safety.	1.8.1.Review and develop research capacity in traditional herbal medicines' efficacy and safety, and documentation.	Staff time; equipments & facilities;	List of traditional herbal medicines with ARV properties.	No. of traditional healers exposed to correct HIV/AIDS information in respect to ARV.	Mainstream lining of appropriate TM (if any) in HIV treatment
	1.9. Establish care and support groups with the community.	Identify/recruit YP Conduct training Identify suitable	Staff Training workshop Finance and transport/logistics Institutional support Institutional/structures	Support group formed Funds available Institutions/structures available and capacity built	PLWHA have support	Quality care provided outside health system

		institutions Source funding Build capacity of institutions/who agrees to support				
KRA 4. Capacity Building of the health system as well as, NGOs, Churches and CBOs to effectively implement HIV programs and activities, which ensures integration of HIV prevention and care.	4.1.Strengthen and lobby or political support, and leadership at all levels.	4.1.1. Regular informed communications (reports and consultations) to the SINAC, Cabinet, and MOH Executive Meetings.	Funds/ Reports/ wider consultations/ quarterly SINAC meetings, Cabinet Information Papers, Executive Meetings.	SINAC / Cabinet/ MOH Executive are well informed on the HIV prevention and care developments.	Resource mobilization and political support for multi-sectoral coalition is established for the fight against STI/HIV/AIDS	Political impact and local ownership leading to the reduction of HIV prevalence and prevention of a HIV generalized epidermic.
		Parliamentarians Awareness Talks/ communities.	Funds to mobilize parliamentarians advocates/ or sponsors	Parliamentarians' advocacy program: Parliamentary Committee for HIV Prevention.	Political support for HIV legislation developments, 1.2.2. Mobilization of funds for HIV prevention and care programs.	
		Continue Quarterly Stakeholders Meetings on HIV prevention and care	Funds for meetings of all stakeholders on the fight against HIV/ AIDS.	All key players in the fight against HIV/AIDS are well versed and informed accurate and timely on the	Leaders taking the lead in the fight against HIV/AIDS at all levels.	

		activities		developments of prevention and care programs against HIV/AIDS.		
		Hold Community Leaders Meetings	Funds for meetings of all stakeholders on the fight against HIV/ AIDS at the community levels.	Community leaders involved and participated in decision making, interventions, and mobilizing local resources.		HIV community Resilience
	2. Strengthen the capacity of the HIV/ STI Prevention Unit (HSPU) of the Ministry of Health to manage, coordination plans and activities, monitor and evaluate.	Increase level of resources such as staffing, dedicated budget for HIV national response programs, appropriate logistics, capacity building trainings for staff, and clear role delineation for the staff both at the Nationald and the Provincial level.	1.Additional staff. 2.Annual program budget 3. Adequate facilities for logistics support-telephones/internet/ transport/ facilities 4.Ttraining opportunities/ attend workshops and conferences. 5. linking and networking with NGOs and provincial STI/ HIV Provincial Coordinators, 6. Clear TOR and performance management for all STI/HIV health workers.	2.1. An Effective (100%) program implementation, and management. 2.2. Proactive and innovative program staffing, 2.3. Effective Secretariat functions to the SINAC. 2.4. Effective monitoring and Evaluation of the National Strategic Plan (NSP). 2.5. Strong provincial support from the national office and effective communication strategy and link established. 2.6. Effective performance management system for all health care workers.	1.Information sharing, 2.maximizing limited resources by reducing overlapping, and inefficiency spendings, 3. Resource mobilization-utilization of available resources. 2.1. Effective integration of STI and HIV prevention and care activities. 2.2. Good management and coordination of the STI/ HIV program. 2.3. Good national coverage of prevention and care programs. 2.4. Effective interventions at provincial level due to good management and supervision from National level.	Effective HIV prevention programs leading to fewer new STI and declining HIV transmissions.
	3. Assist in strengthening and empowering of NGO's capacity in	3.1.Strengthen the organizational links through partnerships for HIV prevention and	3.1. Stakeholder meetings (as above). 3.1.2. Implementation of the joint Pacific Regional	3.1. Regular Stakeholder Meetings-consultations, 3.1.2. Effective implementation of PRHP (Government & NGOs	1.4. Community programs effectively implemented with support from community leaders.	Prevent further increase in STI prevalence, [ii] reduced high

	decision making, management, planning, and ME.	care between the Government sectors and NGOs (including the churches and the private sectors).	HIV Project (PRHP- NAC & CDO) for Government and NGOs. 3.1.3. Partnership of NGOs and Government at the CCM for the Global Fund Against AIDS, TB, Malaria and (GFATM). 3.1.4. Partnership in the implementation of the Pacific Regional HIV Plan. 3.1.5. Partnerhsip in implementation, monitoring and evaluation of the revised NSP 2005-10.	including the churches & private sectors) 3.1.3. Effective implementation of GFATM (Government & NGOs including the churches & private sectors.3.1.4. Effective implementation of Pacific Regional HIV Plan (Government & NGOs including the churches & private sectors.3.1.5. Effective implementation of NSP 2005-10 (Government & NGOs including the churches & private sectors).	2. Sustain joint decision makings and ME.	risk sexual behavior, [iii] reduced HIV transmission among and between vulnerable groups in the provincial communities.
			1. Referral systems for pathology, serology (HIV) microbiology testings. 2. Referral system for specialists' care.	1. Increased no. of testings and screening for STI and HIV by the NGO with referral care system established.	Continuum of care for NGO clients	
		3.2.Provide opportunities for capacity building in [1] HRD and training, [2] policy development [3] Operational Planning and [4] Monitoring	Training workshops: staff time; funding; technical advisers.	1.Trained HIV health workers at the NGO level. 100% implementation of 2.Annual operational plan and ME	Increased participation of NGOs and Churches in STI/ HIV prevention.	Prevent further increase in STI prevalence, [ii] reduced high risk sexual behavior, [iii] reduced HIV transmission among and between

						vulnerable groups in the provincial communities.
	Integrate and strengthen PMTCT into the Health System	Trainning of health workers (including provincial health workers) on the PMTCT. 5.2. Develop PMTCT Policy	Training workshops: travel, perdien, funds, printing and production.	Established Effective PMTCT Policy.	Chances for HIV transmission at pregnancy, during delivery and postnatal reduced to less than 5%.	MTCT minimized to less than 5%.
	Strengthen ME at the STI / HIV Prevention Unit.	Quaterly Programatic Reports: 6.2. Quarterly Financial Reporting., 6.3. Supervisory visits to NGOs and provinces. Strengthen the ME at the HIV Unit and improve link with key stakeholders	Funds; printing; staff time- HIV Coordinator; proper financial system-Accounts.	1. Regular feed back, 2. Progress Reporting on program and financial performances, 3.Clear work schedules,4. Ongoing Performance Assessment-Process evaluation.	1. Effective implementation of activities.2. Early warnings of problems.	Effective Good management and 100% implementation .
	Strengthen SINAC's roles and responsibility towards prevention and care: SINAC to ensure effective and efficient	i] Cap[acity building for Working Groups to the SINAC [ii] legislative support	1. Workshop training awareness. 2. Study Tour. 3.Newsletters 4.IEC materials from different sources/website	Robust and active SINAC members	Effective SINAC	7.1. Effective national response in reducing the HIV transmission-new infections.

	implementation of protocol/ policies – treatment & care, testing VCT and continuum care					
KRA 5. Addressing cross cutting issues related to HIV, such as human rights & anti-discrimination against PLWHA and sustainable development.	5.1. De-stigmatization at health systems.	5.1.[i] General awareness through trainings (at local levels), [2] clear protocols on infection control and nursing care procedures.[3] Clear disciplinary actions in the breach of confidentiality, [4] strengthen confidentiality through the professional boards	5.1.1. Workshop training awareness-peer education. 1.2. Study Tour. 1.3. Newsletters. 1.4. Production and printing of IEC materials. 1.5. Posters / notice boards. 1.6. Memorandum letter on breach of confidentiality.	5.1.1. General awareness against stigmatization in the health systems. 5.1.2. Breach of confidentiality will be dealt seriously by the MOH and the professional bodies.	5.1.1. Friendly hospital environment. 5.1.2. PLWHA will access the health services freely without being discriminated and stigmatized.	5.1.1. Image of the health systems is very friendly leading to more VCCT, and information seeking from the public.
	5.2. HIV at workplace: Strengthen and promote awareness on prevention and de-stigmatization.	5.2.1.General awareness for health workers on HIV prevention, risks and confidentiality at work. 5.2.2. Establish VCCT and referral system for Post exposure: 5.2.3. Develop a PEP	5.2.1[i.]].Workshops/$., [ii] IEC-pamphlets. 5.2.2 & 5.2.3. PEP protocol with referral system.	5.2.1. Prevention at Work Place program. 5.2.2. Clear PEP protocol and referral system.	HIV Prevention initiatives at workplace	Safe wok place and no HIV transmission at work place.

		Policy.				
	5.3. Protect women and children against HIV transmission through abuse	5.3.1. Empower girls and women through awareness and lifeskill trainings	Staff time, fund for workshops	Increased awareness of women's right to HIV prevention. Increase No. of women aware of rights More respect for women at all level Recognition/participation at all level Increase status of women Increase change in men's attitude	Women empowered to make decisions on their reproductive health to prevent HIV/ STI and unwanted pregnancies.	Fewer cases of STI/ HIV infection in women.
		2. Ratify and apply the Convention on the Elimination of Al Forms of Discrimination Against Women (CEDAW)	Funding and technical assistance to National Council of Women and related organizations and advocacy groups	CEDAW signed and ratified	Women protected from sexual abuse	Fewer cases of STI/ HIV infection in women.
		3. Provide educational opportunities for girls,	Ministry of Education and Human Resources Policy forecasting on more education for girls.	Increased proportion of girls in schools (informal and formal)	Policy to increase girls intake to Schools.	Increase literacy and educational opportunities to girls
		4. Develop and establish human rights watch.	Policy development: Workshops and consultations	Effective implementation of policies and relevant legislations on human rights.	Women protected from sexual abuse	Fewer cases of STI/ HIV infection in women.
		5. Adhere to the CRC- protect the child from abuse	Attend meetings of the Solomon Islands National Children's Advisory Council - Support the Child Rights Bill and Child Protection Bill	Support and active participation in ensuring the Child Right Convention through the NACC.	Child protected from sexual abuse	Fewer cases of STI/ HIV infection in Children.
		6. Migration &	Hold dialogues and consultation	Policy developed migration	Effective migration control	Fewer cases of

		border crossing issues to be addressed by Immigration dept, tourism and travel agency sector	with relevant key stakeholders such as immigration, customs and quarantine etc.	and HIV prevention.	and HIV prevention.	STI/ HIV infection as a result of migration.
		7.Review and develop appropriate Legislation to forester of human rights especially PLHWA.	Fund for workshops and meetings –to hold dialogues and consultation with relevant key stakeholders, develop policy and first principles governing the intended legislations.	Supportive human rights legislation for PLWHA	PLWHA's right respected	PLWHA's quality of life improved.

ANNEX TABLE B: Monitoring and Evaluation Framework

Policy Goals	**HIV Policy 1: To reduce risk behaviour and vulnerability of HIV and STIs in vulenarble and different agender.**
KRA 1:	**1. Reduction of risk behavior and vulnerability of HIV in the local community through the Health Care System.**
Objective:	**To ensure people make informed decisions in regards to risk behaviour and safe sex practices by providing appropriate information of**

(ABC), and increase availability of condoms.

Activities	Output Indicators	Sources & Means of Veification	Outcome (effects) Indicators	Sources & Means of Veification	Impact	Sources & Means of Veification	Resporting agencies/ officer	Data Collecting and compilation agencies/ officers
1.1. Increase procurement of condom through the primary health care network.	No. of condoms procured by the Government (MOH)	Quarterly [1] Programatic quaterly reporting PQR) [2] Financial Reporting	No. and percent % of condom availability by clinics	Quarterly Survey or 2.Include in HIS monthly report data-base.	Increased use of condom for Family Planning and reductions of unsafe sex.	HIS	National Medical Store (NMS)	National Medical Store (NMS)
1.2. Scale up condom availability in clinics through distribution of condom through the primary health care network. .-	No. & percent (%) clinics stocked with condoms.	Quarterly Survey or 2.Include in HIS monthly report data-base.	No. and percent % of condom usage by clinics	Quarterly Survey or 2.Include in HIS monthly report data-base.	Reduction of risk of STI / HIV	SGS (+BSS)	1. Epidemiologist-MO at HSPU 2.BSS Team	1. Medical Statistics Unit & HSPU 2.BSS Team
1.3. Strengthen IEC committee functions- with multi-sectoral links. Linking more/ distributing and support.-support and scale up resources- equipments and resources for increase production.	No. & percent (%) of IEC produced	Programatic quaterly reporting PQR)	No. of IEC productions	Programatic quaterly reporting PQR)	Increased awareness of HIV leading to Behavioral Change observed at the individual and community levels.	SGS (+BSS)	IEC Committee of the Health Education inliasion with other stakeholders.	

1.4. Development of operational plan, for the establishment of men's clinic.	Men's clinic constructed	Draft Development plan for the establishment of the men's clinic	Increased access (attendances) of men to reproductive health services including prevention and treatment for STI and HIV/AIDS.	Programatic quaterly reporting PQR)	Increased participation of men in HIV/ STI prevention and treatment (including reproductive health services-contraceptive usage.)	Programatic quaterly reporting PQR)	Incharge of Men's clinic	Incharge of Men's clinic
	2. Reduction of risk behavior and vulnerability of HIV in youths: .							
2.1. Establish new Youth friendly centers, and strengthening existing ones: information centers: & VCCT .	No. of service delivery points offering VCCT for youths	Programatic quaterly reporting PQR)	No. of youths completing the testing and counseling process	Programatic quaterly reporting PQR)	Reduction of risk of STI / HIV in youths	SGS (+BSS)	1. Epidemiologist-MO at HSPU 2.BSS Team	1. Medical Statistics Unit & HSPU
2.2. Social marketing for condom access and availability to the youth and young people.	No. & % of condom selling sites in the private sectors, hotels, motels, bars, shops, pharmacies etc.	Programatic quaterly reporting PQR)	No. & % of young people who had higher risk sex with in the last year, who used a condom at last higher risk sex	BSS	Condom: preferred way of safe sex	SGS (+BSS)	1.Selling sites 2.BSS Team	1. Medical Statistics Unit & HSPU 2.BSS Team
2.3. Change attitudes of condom for family planning to prevention of STI/HIV/AIDS	No. & % of condom used by reproductive health services for STI/ HIV prevention.	Programatic quaterly reporting PQR)	same as above	same as above	same as above	same as above	same as above	same as above

2.4. Condom preference survey to ascertain the preferred brand and types of condom for young people.	Different brand of condoms: Male and Female ordered and purchased for youth.	Survey Report & No. of different types of condom available for young people.	same as above	same as above	same as above	same as above	same as above	same as above
2.5. Increased awareness on condom usage instruction	Condom manual in condom package/ wrappings	Programatic quaterly reporting PQR)	same as above	same as above	same as above	same as above	same as above	same as above
2.6. [1] Review existing IEC materials for ARH education	No. of young people exposed to ARH HIV/AIDS education on STI/ HIV outside school settings	Programatic quaterly reporting PQR)	No. and % of young people reached by community outreach activities	Reports	Increasing number and % of young people who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV	BSS	1. Epidemiologist-MO at HSPU 2.BSS Team	1. Medical Statistics Unit & HSPU 2.BSS Team
2.7. Develop appropriate IEC for BCI in ARH education in schools: Curriculum review and development	No. of young people exposed to ARH HIV/AIDS education on STI/ HIV in school settings	Programatic quaterly reporting PQR)	No. and % of young people reached by school activities.	Reports from Schools	same as above	same as above	same as above	same as above
2.8. ARH Training for teachers/educators	Number and % teachers trained in ARH curriculum.	Programatic quaterly reporting PQR)	No. of young people exposed to HIV/AIDS education in school settings	Programatic quaterly reporting PQR)	Increased awareness of HIV leading to Behavioral Change observed in young people	SGS (+BSS)	1. Epidemiologist-MO at HSPU 2.BSS Team	1. Medical Statistics Unit & HSPU 2.BSS Team

2.9. Increased Awareness raising through Mass Media and other related activitiesSuch as Drama, video show, condom demo and distribution (pri & sec)	No of mass media IEC products. No of mass media activities.	Programatic quaterly reporting PQR)	Increasing number of young people exposed to HIV/ AIDS awareness to enable them to change their unsafe sexual behavior.No. of young people reached by mass media activities	Programatic quaterly reporting PQR)	Increased awareness of HIV leading to Behavioral Change observed in young people	SGS (+BSS)	Health Education and Promotion coordinating the IEC production, distribution and facilitating the mass media.	Health Education and Promotion coordinating the IEC production, distribution and facilitating the mass media; and the HSPU
	3. Reduction of risk behavior and vulnerability of HIV in men such as seafrers, loggers and MSM: .							
3.1. Establishment of VCCT & STI clinics at key strategic sites	No. of sea farers exposed to HIV/AIDS education in school settings	Programatic quaterly reporting PQR)	STI including VCCT set up in key strategic sites: [1] No. of health facililties providing treatment for STIs for seafarers & [2]No. of service delivery points offering VCT for seafarers	Programatic quaterly reporting PQR)	Reduction of STIs among seafarers	SGS (+BSS)	1. Epidemiologist-MO at HSPU 2.BSS Team	1. Medical Statistics Unit & HSPU 2.BSS Team

3.2. Include health studies (including STI/ HIV prevention) in the marine school.	No. of young people (marine students) exposed to HIV/AIDS education at workplace.	Programatic quaterly reporting PQR)	Increased awareness of HIV leading to Behavioral Change in (future) seafarers.	BSS	Reduction of STIs among seafarers	SGS (+BSS)	1. Epidemiologist-MO at HSPU 2.BSS Team	1. Medical Statistics Unit & HSPU 2.BSS Team
3.3. Encourage companies to address HIV/AIDS and STI-E.g. Quality time with family	No. and % of large enterprises/ companies that have HIV/AIDS workplace policies and programs	Programatic quaterly reporting PQR)	Increased awareness of HIV leading to Behavioral Change in (future) seafarers.	BSS	Reduction of STIs among seafarers	SGS (+BSS)	1. Epidemiologist-MO at HSPU 2.BSS Team	1. Medical Statistics Unit & HSPU 2.BSS Team
3.4.Distribution of condoms and IEC materials through networking with agencies for international shipping and fisiching industries and nd taxi services for locals	No. of sea farers and other industrial travellers exposed to STI/ HIV/AIDS awreness and prevention.	Programatic quaterly reporting PQR)	Increased awareness of HIV leading to Behavioral Change in (future) seafarers.	BSS	Reduction of STIs among seafarers	SGS (+BSS)	1. Epidemiologist-MO at HSPU 2.BSS Team	1. Medical Statistics Unit & HSPU 2.BSS Team
	4. Reduction of risk behavior and vulnerability of HIV in WOMEN in the local communities:							
4.1. Include VCCT services and condom distribution in Antenatal Clinics	No. of Antenatal Clinics offering VCT	Programatic quaterly reporting PQR)	Skilled HIV counselors in the reproductive health services: No. of ANC mothers completing the testing and counseling	Reports from ANC: in Programatic quaterly reporting PQR)	HIV prevention in women of child bearing age (WCBA): Fewer cases of STI/ HIV infection in women.	1.Epidemiological reports. 2. BSS	1. Epidemiologist-MO at HSPU 2.BSS Team	HSPU

			process					
4.2. Promoting reproductive rights is critical to HIV prevention and women's empowerment, and for preventing poverty, maternal and child deaths and STI through Public awareness of women's right in-light of STI/ HIV prevention.	No. of women exposed to women's right awareness.	Programatic quaterly reporting PQR)	Women empowered to make decisions on their reproductive health to prevent HIV/ STI and unwanted pregnancies.	Programatic quaterly reporting PQR)	Fewer women abuse	SGS (+BSS)	1. Epidemiologist-MO at HSPU	HSPU
4.3. Expand Adolescence and sexual health for young women to all provinces	No. of adolences / young women exposed to to healthy and safe sexual practices.	Programatic quaterly reporting PQR)	Safer sexual behaviors in young women.	BSS	Fewer cases of STI/ HIV infection in adolescence and young women	SGS (+BSS)	1. Epidemiologist-MO at HSPU 2.BSS Team	HSPU
4.4. Assist capacity building for women's organizations and networks.	No. of women's benefiting from capacity building.	Programatic quaterly reporting PQR)	Improve management and implementation of HIV prevention initiatives in women in the community	ME Reports	Fewer cases of STI/ HIV infection in women.	ME Reports	1. Epidemiologist-MO at HSPU	HSPU

4.5. Provide technical support to women's network and organization in implementing STI/ HIV prevention initiatives in women.	Technical support available to women' community based groups	Programatic quaterly reporting PQR)	Majority of women reached by community outreach activities	Programatic quaterly reporting PQR)	Behavioral change.	ME Reports	1. Epidemiologist-MO at HSPU	HSPU
4.6. Provide opportunities for income generating projects for women 4.7. Encourage physical exercise and regular medical check including pap smear along with VCCT. 4.8. Include women in decision making at all levels such the politics and AIDS Council.	Small Grants: No. of projects No. of women involved or benefit	Programatic quaterly reporting PQR)	Women economically productive and pre-occupied.	Programatic quaterly reporting PQR)	Minimize vulnerability to STI and HIV.	ME Reports	1. Epidemiologist-MO at HSPU	HSPU

Policy Goals	**HIV Policy 2: Enhance HIV counseling and testing as an entry point for confidentiality, prevention ad treatment for STIs and AIDS.** **(incldуing blood safety)**
KRA 2:	**Increasing access and strengthening confidentiality and screening: + VCCT**
Objective:	**To provide a comprehensive continuum of care through voluntary confidential counseling and testing** **an entry point for STI/ hiv prevention and care.**

Activities	Output Indicators	Sources & Means of Veification	Outcome (effects) Indicators	Sources & Means of Veification	Impact	Sources & Means of Veification	Reporting agencies/ officer	Data Collecting and compilation agencies/ officers
1.1 Finalization and implementing the HIV Testing protocols.	No. of protocols developed and training workshops held.	Programatic quaterly reporting PQR)	No. of health staff (including laboratory) exposed to new HIV Testing Protocol	Report on training	No. of people completing the testing and counseling process	Programatic quaterly reporting PQR)	National HIV/STI Coordinator @ HSPU	1. Epidemiologist-MO at HSPU
1.2. Establishment of VCCT sites at strategic sites both for the Government clinics and NGOs. And provide basic equipments to reach different Gender.	No. of service delivery points offering VCT	Programatic quaterly reporting PQR)	No. of people completing the testing and counseling process	Programatic quaterly reporting PQR)	STI/ HIV prevention and BC	SGS (+BSS)	VCCT Clinics	1. Epidemiologist-MO at HSPU
1.3. Capcity building for the laboratories including the review and strengthen the conventional testing And Ensure adequate testing	No. of laboratory staff trained in VCT	Programatic quaterly reporting PQR)	No. of people completing the testing and counseling process from the conventional laboratory setting	Programatic quaterly reporting PQR)	Widely practiced VCCT by all laboratories	SGS (+BSS)	Laboratory Incharge	1. Epidemiologist-MO at HSPU
1.4. Public awareness on VCCT	No. of people completing the testing and counseling process (attendance at VCCT clinics)	Programatic quaterly reporting PQR)	No. of people completing the testing and counseling process	Programatic quaterly reporting PQR)	STI/ HIV prevention and BC	SGS (+BSS)	VCCT Clinics	1. Epidemiologist-MO at HSPU

1.5. Capacity building :Refresher training for existing VCCT Counselors.	No of Annual refresher training for current VCCT counselors	Programatic quaterly reporting PQR)	More and more people request for voluntary counseling and testing: (No. of people exposed to VCCT)	Programatic quaterly reporting PQR)	STI/ HIV prevention and BC	SGS (+BSS)	National HIV/STI Coordinator @ HSPU	1. Epidemiologist-MO at HSPU
1.6. Capacity Building: Training of new VCCT Counselors (including all laboratory technicians and nurses)	No of new trainied VCCT counselors	Programatic quaterly reporting PQR)	More and more people request for voluntary counseling and testing: (No. of people exposed to VCCT)	Programatic quaterly reporting PQR)	STI/ HIV prevention and BC	SGS (+BSS)	National HIV/STI Coordinator @ HSPU	1. Epidemiologist-MO at HSPU
1.7. Strengthen Blood Safety: Establish the National Blood Council and clear TOR and reference to HIV.	No. of National Blood Council Meeyings	Programatic quaterly reporting PQR)	Widely practiced blood safety to prevent HIV, Hep B and C transmission through the blood supply system	Programatic quaterly reporting PQR)	HIV, Hep B & C prevention through safety blood supply system	SGS (+BSS)	Blood Supply Technician incharge	1. Epidemiologist-MO at HSPU
1.8. Strengthen Blood Safety: Hold regular training on blood safety protocols and new technology	No. of blood safety protocols and trainings.	Programatic quaterly reporting PQR)	Widely practiced blood safety to prevent HIV, Hep B and C transmission through the	Programatic quaterly reporting PQR)	HIV, Hep B & C prevention through safety blood supply system	SGS (+BSS)	Blood Supply Technician incharge	1. Epidemiologist-MO at HSPU

blood supply system

Policy Goals	**HIV Policy 3: Enhance HIV/ STI surveillance, Treatment and Care.**
KRA 3	**Establishing, expanding and strengthening STI/ HIV surveillance, Treatment and Care.**
Objective:	**To provide a comprehensive continuum of care through HIV surveillance and increasing accessibility to STI drugs and HAART, including treatment and care needs of PLWHA.**

Activities	Output Indicators	Sources & Means of Veification	Outcome (effects) Indicators	Sources & Means of Veification	Impact	Sources & Means of Veification	Reporting agencies/ officer	Data Collecting and compilation agencies/ officers
3.1Review and updatetraining on STI Treatment Protocol-for Govt. and NGOs health workers	No. of training/ no. of nurses trained/ clinics with trained nurses/	Programatic quaterly reporting PQR)	Improved quality of STI treatment (diagnosis and treatment)	KAP survey	Reduced treatment failure. Reduced ulcerative STIs	Programatic quaterly reporting PQR)	Clinic nurses	Epidemiologist-MO at HSPU

3.2. Scale up packing of STI drugs with prevention messages.	No. of STI packs for the clinics and VCCT sites.	Programatic quaterly reporting PQR)	High risk group accessed to STI drugs and preventive messages at the community level.	Programatic quaterly reporting PQR)	Reduced STI and HIV prevention	HIS-Monthly Clinic Report	NMS	Epidemiologist-MO at HSPU
3.3.Finalize and implement HIV Treatment Protocol.	HIV Treatment Guide for all clinicians and nurses	Programatic quaterly reporting PQR)	All infected person are treated and followed up properly	Programatic quaterly reporting PQR)	Reduced stigmatization; increased VCCT and thus, reduced HIV new infections.	Programatic quaterly reporting PQR)	National HIV/STI Coordinator @ HSPU	Epidemiologist-MO at HSPU
3.4.Free ARVs/ OI drugs for all AIDS sufferers in SI	100% availability of ARV to all AIDS sufferers.	Programatic quaterly reporting PQR)	Improved quality of life for PLWHA	Programatic quaterly reporting PQR)	Reduced stigmatization; increased VCCT and thus, reduced HIV new infections.	Programatic quaterly reporting PQR)	Underscretary Health Improvement	Undersecretary Health Improvement.

3.5.Enhance the knowledge and skills of health care workers at all levels of the health care system (central, provincial and community levels) through training.1.4.2.Increase awareness information for families and communities.Integrate traditional healers health care within the care and treatment of HIV/AIDS	Skilled health workers on care for PLWHA at all levels. Supportive IEC materials (pamphlets) for families and communities supporting PLWHA.	Programatic quaterly reporting PQR)	All health care workers skilled in care for PLWHA Families and Communities empowered to be able to care for their own PLWHA Correct information to TH on HIV/AIDS Increased participation AND cooperation of TH Reduced delay to HAART. Foresters ARV 100% adherence.	Programatic quaterly reporting PQR)	Reduced stigmatization; increased VCCT and thus, reduced HIV new infections.	Programatic quaterly reporting PQR)	Community Facilitator-HSPU	Epidemiologist-MO at HSPU
3.6. Encourage partner notification during and as part of the VCCT. Develop confidential mechanisms for partner notification	Increased no. of couple (partner) testing.	Programatic quaterly reporting PQR)	Increased couple HIV counseling and testing	Programatic quaterly reporting PQR)	Effective confidential contact tracing, Prevent further transmission Foresters Behavioral changes among couples or partners.	Programatic quaterly reporting PQR)	VCCT Clinics	Epidemiologist-MO at HSPU

3.7.Training of health workers on HAART / ARV including Prepare the infected person well before starting ARV- through a thorough medical checks including TLC/ CD4 etc., Awareness (Counseling) on the ARVs, draw up regular follow: set up follow up program (as part of the ART Protocol). [iii] ustilize traditional healer??	Skilled health workers on HAART. Preparedness of PLHWA for treatment in the HIV Treatment Guideline. Traditional Healers trained and aware of HIV/ AIDS disease and prevention [i] No. of health workers trained on HAART/ARV. [ii] HIV person informed of the Treatment Plan, SE and adverse of missing treatment. [iii] Clinical stage of the HIV infection established. [iv] constraints and likely hindrance factors known established and possible solutions reached with the infected person.	Programatic quaterly reporting PQR)	[i] Health workers skilled in treating PLWHA. [ii] Health workers aware of the SE and adverse effects of missing doses. [iii] Health workers skilled in preparing the person for ARV treatment. [iv] clinical staging of the HIV infected person is established in preparation for ARV if needed. [v] pharmacy is aware of the persons needs for the ARV when required to be supplied. [vi] proper	Programatic quaterly reporting PQR)	[i] Health workers skilled in treating PLWHA. [ii] Health workers aware of the SE and adverse effects of missing doses. [iii] Health workers skilled in preparing the person for ARV treatment. [iv] clinical staging of the HIV infected person is established in preparation for ARV if needed. [v] pharmacy is aware of the persons needs for the ARV when required to be supplied. [vi] proper timing in starting ARV. [vii] minimal ARV delay.	Programatic quaterly reporting PQR)	Trainers & Facilitators	National HIV/STI Coordinator @ HSPU

			timing in starting ARV. [vii] minimal ARV delay					
3.8.Introduction and sustaining Second General Surveillance (SGS)-[1].Monthly HIS Case reporting from Clinics.[2].Monthly reporting from Pathology Services/ Laboratory, [3] Behavioral Survey 3 yearly	3 in 1 principle: [1] Case Reporting by HIS and Laboratory [2] Serological Reporting by Laboratories and [3] Bahavioral Surveillance by HSPU:	Using Statistics for Epidemiological surveillances,Behavioral pattern of vulnerable group known	Effective planning and ME based on data and information (evidence-based).	Programatic quaterly reporting PQR)	Effective HIV prevention and care policy and strategies leading to reduction of new HIV infections.	Mid-Term Review	[1] Health Information System [2] Laboratory Reporting [3] BSS survey and monitoring.	Epidemiologist & National HIV/STI Coordinator @ HSPU
3.8.Review and develop research capacity in traditional herbal medicines' efficacy and safety, and documentation.	List of traditional herbal medicines with some ARV properties	Research Findings	No. of traditional healers exposed to correct HIV/AIDS information in respect to ARV.	Programatic quaterly reporting PQR)	Mainstreaming of appropriate TM (if any) in HIV and OI treatment	TM listings	Research Officer-TM @ SIMTRI	Epidemiologist & National HIV/STI Coordinator @ HSPU

3.9.Establish care and support groups with the communityIdentify/recruit YPConduct trainingIdentify suitable institutionsSource fundingBuild capacity of institutions/who agrees to support	Support group formed Funds available Institutions/structures available and capacity built	Programatic quaterly reporting PQR)	Continuum of care to PLWHA sustained.	Programatic quaterly reporting PQR)	Quality care provided outside health system	Interviews	Epidemiologist & National HIV/STI Coordinator @ HSPU	Epidemiologist & National HIV/STI Coordinator @ HSPU

Policy Goals	**HIV Policy 4: Enhance Capacity Building of national response at the community, institutions, programs and specific activities.**
KRA 4	**Capacity Building of the health system, NGOs+Churches+CBOs to effectively implement, coordinate, monitor and evaluate integration of HIV prevention and care**
Objective:	**To ensure a coordinated and targeted national HIV response through appropriate political support and by strengthening the capacity stakeholders to implement the activities of the national multi-sectoral HIV response plan relevant key stakeholders to implement the activities of the national multi-sectoral HIV response plan**

Activities	Output Indicators	Sources & Means of Veification	Outcome (effects) Indicators	Sources & Means of Veification	Impact	Sources & Means of Veification	Reporting agencies/ officer	Data Collecting and compilation agencies/ officers

Regular informed communications (reports and consultations) to the SINAC, Cabinet, and MOH Executive Meetings.	SINAC / Cabinet/ MOH Executive are well informed on the HIV prevention and care developments.	Programatic quaterly reporting PQR)	Resource mobilization and political support for multi-sectoral coalition is established for the fight against STI/HIV/AIDS	Programatic quaterly reporting PQR)	Strong political support and leadership from the Government and key stakholders : Political impact and local ownership leading to the reduction of HIV prevalence and prevention of a HIV generalized epidermic.	Programatic quaterly reporting PQR)	Undersecretary, and the National HIV/STI Coordinator @ HSPU	National HIV/STI Coordinator @ HSPU
Parliamentarians Awareness Talks/ communities.	Parliamentarians' advocacy program: Parliamentary Committee for HIV Prevention.	Programatic quaterly reporting PQR)	Political support for HIV legislation developments , 1.2.2. Mobilization of funds for HIV prevention and care programs.	Programatic quaterly reporting PQR)		Programatic quaterly reporting PQR)	Undersecretary, and the National HIV/STI Coordinator @ HSPU	National HIV/STI Coordinator @ HSPU
Continue Quarterly Stakeholders Meetings on HIV prevention and care activities	All key players in the fight against HIV/AIDS are well versed and informed accurate and timely on the developments of prevention and care programs against	Programatic quaterly reporting PQR)	Leaders taking the lead in the fight against HIV/AIDS at all levels.	Programatic quaterly reporting PQR)		Programatic quaterly reporting PQR)	Undersecretary, and the National HIV/STI Coordinator @ HSPU	National HIV/STI Coordinator @ HSPU

	HIV/AIDS.						
Hold Community Leaders Meetings	Community leaders involved and participated in decision making, interventions, and mobilizing local resources.	Programatic quaterly reporting PQR)	Programatic quaterly reporting PQR)	HIV community Resilience	Programatic quaterly reporting PQR)	Undersecretary, and the National HIV/STI Coordinator @ HSPU	National HIV/STI Coordinator @ HSPU

Increase level of resources such as staffing, dedicated budget for HIV national response programs, appropriate logistics, capacity building trainings for staff, and clear role delineation for the staff both at the Nationald and the Provincial level.	1. An Effective (100%) program implementation, and management. 2. Proactive and innovative program staffing,.3. Effective Secretariat functions to the SINAC.4. Effective monitoring and Evaluation of the National Strategic Plan (NSP).5. Strong provincial support from the national office and effective communication strategy and link established. 6. Effective performance management system for all health care workers.	Programatic quaterly reporting PQR)	1.Information sharing, 2.maximizing limited resources by reducing overlapping, and inefficiency spendings, 3. Resource mobilization-utilization of available resources. 4. Effective integration of STI and HIV prevention and care activities.5. Good management and coordination of the STI/ HIV program.6.Good national coverage of prevention and care programs.7. Effective interventions at provincial level due to good management and supervision from National level.	Programatic quaterly reporting PQR)	Effective HIV prevention programs leading to fewer new STI and declining HIV transmissions.	Programatic quaterly reporting PQR)	Undersecretary, and the National HIV/STI Coordinator @ HSPU	National HIV/STI Coordinator @ HSPU

Strengthen the organizational links through partnerships for HIV prevention and care between the Government sectors and NGOs (including the churches and the private sectors).	3.1. Regular Stakeholder Meetings-consultations, 3.1.2. Effective implementation of PRHP (Government & NGOs including the churches & private sectors)3.1.3. Effective implementation of GFATM (Government & NGOs including the churches & private sectors.3.1.4. Effective implementation of Pacific Regional HIV Plan (Government & NGOs including the churches & private sectors.3.1.5. Effective implementation of NSP 2005-10 (Government & NGOs including the churches & private sectors).	Programatic quaterly reporting PQR)	1.4. Community programs effectively implemented with support from community leaders. 2. Sustain joint decision makings and ME.	Programatic quaterly reporting PQR)	Prevent further increase in STI prevalence, [ii] reduced high risk sexual behavior, [iii] reduced HIV transmission among and between vulnerable groups in the provincial communities.	Programatic quaterly reporting PQR)	Undersecretary, and the National HIV/STI Coordinator @ HSPU	National HIV/STI Coordinator @ HSPU

Provide opportunities for capacity building in [1] HRD and training, [2] policy development [3] Operational Planning and [4] Monitoring	1.Trained HIV health workers at the NGO level. 100% implementation of 2.Annual operational plan and ME	Programatic quaterly reporting PQR)	Increased participation of NGOs and Churches in STI/ HIV prevention.	Programatic quaterly reporting PQR)	Prevent further increase in STI prevalence, [ii] reduced high risk sexual behavior, [iii] reduced HIV transmission among and between vulnerable groups in the provincial communities. MTCT minimized to less than 5%.	Programatic quaterly reporting PQR)	National HIV/STI Coordinator @ HSPU	National HIV/STI Coordinator @ HSPU
Strengthen ME at the STI / HIV Prevention Unit: Quaterly Programatic Reports: 2. Quarterly Financial Reporting., 3. Supervisory visits to NGOs and provinces. Strengthen the ME at the HIV Unit and improve link with key stakeholders.	1. Regular feed back, 2. Progress Reporting on program and financial performances, 3.Clear work schedules,4. Ongoing Performance Assessment- Process evaluation.	Programatic quaterly reporting PQR)	1. Effective implementation of activities.2. Early warnings of problems	Programatic quaterly reporting PQR)	Effective Good management and 100% implementation	Programatic quaterly reporting PQR)	National HIV/STI Coordinator @ HSPU	National HIV/STI Coordinator @ HSPU

Strengthen SINAC's roles and responsibility towards prevention and care: SINAC to ensure effective and efficient implementation of protocol/ policies – treatment & care, testing VCT and continuum care	Robust and active SINAC members	Programatic quaterly reporting PQR)	Effective SINAC	Programatic quaterly reporting PQR)	Effective national response in reducing the HIV transmission-new infections	Programatic quaterly reporting PQR)	Undersecretary, and the National HIV/STI Coordinator @ HSPU	National HIV/STI Coordinator @ HSPU

KRA 5 — Ensure sustainable development to enable environment for behavioral change, de-stigmatization and against discrimination impacting on prevention and care.

Objective: To develop an environment conducive to the rights of PLWHA through development and implementation of relevant legislation and consequently resulting in behaviour change to ensure appropriate prevention and care for HIV/AIDS.

Activities	Output Indicators	Sources & Means of Veification	Outcome (effects) Indicators	Sources & Means of Veification	Impact	Sources & Means of Veification	Reporting agencies/ officer	Data Collecting and compilation agencies/ officers

De-stigmatization at health systems.5.1.[i] General awareness through trainings (at local levels), [2] clear protocols on infection control and nursing care procedures.[3] Clear disciplinary actions in the breach of confidentiality, [4] strengthen confidentiality through the professional boards	5.1.1. General awareness against stigmatization in the health systems. 5.1.2. Breach of confidentiality will be dealt seriously by the MOH and the professional bodies.	Programatic quaterly reporting PQR)	5.1.1. Friendly hospital environment. 5.1.2. PLWHA will access the health services freely without being discriminated and stigmatized.	Programatic quaterly reporting PQR)	5.1.1. Image of the health systems is very friendly leading to more VCCT, and information seeking from the public	Programatic quaterly reporting PQR)	National HIV/STI Coordinator @ HSPU	National HIV/STI Coordinator @ HSPU
5.2.1.General awareness for health workers on HIV prevention, risks and confidentiality at work. 5.2.2. Establish VCCT and referral system for Post exposure: 5.2.3. Develop a PEP Policy.	5.2.1. Policy of Prevention at Work Place program. 5.2.2. Clear PEP and VCCT protocol and referral system.	Programatic quaterly reporting PQR)	HIV Prevention initiatives at workplace	Programatic quaterly reporting PQR)	Safe wok place and no HIV transmissio n at work place	Programatic quaterly reporting PQR)	National HIV/STI Coordinator @ HSPU	National HIV/STI Coordinator @ HSPU
5.3. Protect women and children against HIV transmission through abuse: Empower girls and women through awareness and lifeskill trainings.	Increased awareness of women's right to HIV prevention.Increase No. of women aware of rightsMore respect for women at all levelRecognition/partici pation at all levelIncrease status of womenIncrease change in men's attitude	Programatic quaterly reporting PQR)	Women empowered to make decisions on their reproductive health to prevent HIV/ STI and unwanted pregnancies.	Programatic quaterly reporting PQR)	Fewer cases of STI/ HIV infection in women.	Programatic quaterly reporting PQR)	National HIV/STI Coordinator @ HSPU	National HIV/STI Coordinator @ HSPU

2. Ratify and apply the Convention on the Elimination of Al Forms of Discrimination Against Women (CEDAW)	CEDAW signed and ratified	Programatic quaterly reporting PQR)	Women protected from sexual abuse	Programatic quaterly reporting PQR)	Fewer cases of STI/ HIV infection in women.	Programatic quaterly reporting PQR)	National HIV/STI Coordinator @ HSPU	National HIV/STI Coordinator @ HSPU
3. Provide educational opportunities for girls,	Increased proportion of girls in schools (informal and formal)	Programatic quaterly reporting PQR)	Policy to increase girls intake to Schools.	Programatic quaterly reporting PQR)	Increase literacy and educational opportunitie s to girls	Programatic quaterly reporting PQR)	National HIV/STI Coordinator @ HSPU	National HIV/STI Coordinator @ HSPU
4. Develop and establish human rights watch.	Effective implementation of policies and relevant legislations on human rights.	Programatic quaterly reporting PQR)	Women protected from sexual abuse	Programatic quaterly reporting PQR)	Fewer cases of STI/ HIV infection in women.	Programatic quaterly reporting PQR)	National HIV/STI Coordinator @ HSPU	National HIV/STI Coordinator @ HSPU
5. Adhere to the CRC- protect the child from abuse	Support and active participation in ensuring the Child Right Convention through the NACC.	Programatic quaterly reporting PQR)	Child protected from sexual abuse	Programatic quaterly reporting PQR)	Fewer cases of STI/ HIV infection in Children.	Programatic quaterly reporting PQR)	National HIV/STI Coordinator @ HSPU	National HIV/STI Coordinator @ HSPU
6. Migration & border crossing issues to be addressed by Immigration dept, tourism and travel agency sector	Policy developed migration and HIV prevention.	Programatic quaterly reporting PQR)	Effective migration control and HIV prevention.	Programatic quaterly reporting PQR)	Fewer cases of STI/ HIV infection as a result of migration.	Programatic quaterly reporting PQR)	National HIV/STI Coordinator @ HSPU	National HIV/STI Coordinator @ HSPU
7.Review and develop appropriate Legislation to forester of human rights especially PLHWA.	Supportive human rights legislation for PLWHA	Programatic quaterly reporting PQR)	PLWHA's right respected	Programatic quaterly reporting PQR)	PLWHA's quality of life improved	Programatic quaterly reporting PQR)	National HIV/STI Coordinator @ HSPU	National HIV/STI Coordinator @ HSPU

ANNEX TABLE C: List of Key Stakeholders

	Organisation	Sector
1	ADRA	NGO
2	Caritas	NGO
3	Chamber of Commerce	Commerce
4	Church of Melanesia – Christian Care Centre	Church
5	Church of Melanesia – Mission to Seafarers	Church
6	Church of Melanesia – Mothers Union	Church
7	Community Peace and Restoration Fund	Donor
8	Development Services Exchange	NGO
9	European Union	Donor
10	Family Support Centre	NGO
11	Govt Pharmacy - MOH	Health
12	Honiara City Council – Health Promotion & Youth Depts	Health/Youth
13	Honiara City Council - Nursing	Health
14	Live and Learn	NGO
15	Ministry of Education	Education
16	MOH – Health Promotion Dept	Health
17	MOH – Nursing Dept	Health
18	MOH – HIV Unit	Youth
19	MOH – NRH Lab	Health
20	MOH – NRH Blood Services	Health
21	MOH – Infection Control Unit	Health
22	MOH – Reproductive Health Dept	Health

23	MOH – Planning Dept	Health
24	National Council of Women	Women
25	Oxfam Australia	INGO
26	Royal Solomon Islands Police- Welfare Unit	Police
27	SSEC`	Church
28	Roman Catholic Church	Church
29	SICA	Church
30	SICA – Federation of Women	Church
31	Save the Children	INGO
32	Save the Children – Youth Program	INGO
33	SI Development Trust	NGO
34	SI Red Cross	INGO
35	SIPPA	Youth
36	Solomon Star	Media - Newspaper
37	UNDP - RRRT	Legal
38	UNICEF	Health
39	Vois Blo Mere	Women
40	Vois Blo Mere – Drama Group	Youth
41	Wantok FM	Media - FM Radio
42	World Health Organisation	Health
43	World Vision	INGO

ANNEX TABLE D: Health Sector Operational Plan 2005